HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A PATIENT/FAMILY CARE STUDY ON

ANAEMIA

BY

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

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PREFACE

Nursing emerged as a profession in the mid-19th century. Historian's credit Florence Nightingale, a well-educated woman from Britain, as the founder of modern nursing. Nightingale challenged social norms – and her wealthy parents – by becoming a nurse.

Modern nursing is a profession that requires knowledge, skills and attitude. The ability to render comprehensive nursing care rests on the nurses' ability to assess the client's condition, analysis, plan, implement and evaluate the effects of management on client health status.

The Patient/ family care study is a detailed account of nursing care rendered to the Patient and family to meet their needs. The study is designed to give a comprehensive nursing care to both patient and family from the time of admission till when patient is finally discharged to go home, as well as follow-ups or home visits for continuity of care.

The study also involves the nursing process which involves assessment of patient/ family, planning of care to be rendered, implementing the plan and evaluating care rendered to patient/ family.

The study is carried out to enable the student nurse put into practice the knowledge and skills acquired from the three years training period in school to ascertain how best the theoretical knowledge would be used to nurse patients who will come under his or her care in the near future.

The study also forms part of the requirements of the Nursing and Midwifery Council of Ghana for the award of licence in General Nursing.

In this study, initials of patient are used for confidentiality.

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INTRODUCTION

The patient and family care study are a study conducted on patient/family using the nursing process to nursing the patient and family as an individual, taking into account all the patient needs to arrive at a desired outcome. It also takes into account of patient's psychological and social needs in planning the care.

This care is about Miss K.B.A., a twenty-year-old girl. Patient arrived on the Female Medical Ward on 23rd November,2021 at around 1:00pm per wheel chair accompanied by a staff nurse, rotational nurse and her mother. On arrival patient was fairly ill, weak and with an unsatisfactory level of hydration. Patient was fully conscious and alert. Patient had been detained at the Accident and Emergency unit for one day with the diagnosis of Severe Anaemia with history of dizziness, headache and weakness. Patient was trans-out from the E/R to the female medical ward. With the use of nursing process, the problems identified were developed into nursing diagnosis with nursing orders which were implemented to help solve these problems and promote recovery.

Using the nursing care plan, effective nursing care was carried out on the patient to ensure full recovery of patient. Among the care provided to her were bed making, monitoring of vital signs (temperature, pulse, respiration, and blood pressure), proper positioning in bed, administration of medication, and patient/family education on personal hygiene was done. She was discharged on 27th November, 2021 when her condition had improved and was declared fit to go home with no complains. Goals were fully met during evaluation of care. Three home visits were paid to her to assess progress of her condition at home. She reported to the hospital for review on the 6th December, 2021. Care was terminated on 14th December, 2021.

This care study comprises of six chapters as follows:

Chapter one deals with assessment of patient and his family. This involves collection of data about the patient to identify her problems.

Chapter two deals with analysis of data.

Chapter three comprises the planning phase of the nursing process and has the tabulated plan of care for the stated nursing diagnoses spanning the objective criteria, nursing orders, intervention and evaluation.

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

Chapter six focuses on the summary and conclusion of the care study report by reviewing thematic issues that arose in the care study from admission to last home visit after discharge.

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CHAPTER ONE

ASSESSMENT OF PATIENT/FAMILY

1.0 Introduction

According to the North American Nursing Diagnosis Association (NANDA-I) (2018), assessment encompasses the gathering of subjective and objective data and review of past information provided by the patient/family, or found within the patient chart (Herdman & Kamitsuru, 2018). Nursing assessment begins with the nursing process with appraisal of the health status of the patient. Through observation, questioning and examination, data about the patient and her family is gathered and analysed. In this chapter is where relevant information is obtained from the patient and her family. Assessment of the patient was performed through the collection, organizing and documentation of data obtained from the following sources; review of literature related to study, history taking from the patient's parents, physical examination, observations, interviews and laboratory investigations. Data gathered was subjective data from patient and her family. Objective data was gotten from laboratory investigations as well as observation.

1.1 Patient's Particulars

Patients particulars refers to facts or details about an individual which are written down and kept as a record (Merriam-Webster, 2022). Miss K.B.A., a twenty-year-old girl was born on 8th December, 2000 to Mr. E.B. and Mrs C.Y. both parents are civil servants. She comes from Odumase in the Sunyani West constituency and currently resides at Odumase with house number (K7~9). She is dark in complexion, 1.65m tall and weighs 57kg with a Body Mass Index (BMI) of 20.6kg/m^2, which shows that she has a normal BMI. She is a currently not in any intimate relationship with anyone. Patient is a Christian who worships with the Methodist Church at Odumase. She is the last born of four children. Patient is a form one student at

Dunkwa on Offin nursing training college. Her next of kin is her mother. Her mother also resides at the same place as the patient. She speaks both English and Twi. Patient is a National Health Insurance beneficiary. She has no physical impairments or disabilities.

1.2 Family's Medical/Surgical 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, ethnic, and cultural background on a person's health. Information is obtained on both paternal and maternal sides of the family (Hinkle & Cheever, 2014). Patient stated that her parents are alive and doing well. However, her grandparents are dead. Their demise was as a result of old age. According to patient her siblings are alive and healthy. On interaction with the patient's parents, patient's father explained that there was no known hereditary disease such as asthma, sickle cell, hypertension, diabetes and epilepsy in the family after an interview with him. However, the family members who were present made it known that, periodically they do suffer some ailments like headache and common cold which are treated by self-medication (using both over-the-counter drugs and traditional medicines) but if symptoms persist, they report to the hospital. Based on this information I educated the patient and family about the harmful effects of the use of over the counter drugs and urged them to seek medical care from any health center when they are suffering from any condition. She has never been hospitalized. The source of medical treatment for patient and family are both orthodox and herbal medicine. There are no known allergies in the family.

1.3 Family's Socio-Economic History

Patient has a very good relationship and cohesion with her family. Socially the family is not noted for smoking or alcoholism. Most of her family members as well as her parents are civil servants. The father is an accountant at the Ghana Education Service and her mother, an

accounts clerk. Economically, the family is mid-income earning class, so they leave comfortably in their own house with their daily needs provided. Family members are always ready and willing to support each other in times of financial hardships. According to patient majority of her family members have at least completed secondary school and most have gone on to acquire tertiary level education. Patient depends solely on her parents and older siblings for financial and other forms of support. Her family members are well known for their massive participation in religious activities. Patient is a member of the youth wing at her church. Patient expressed that all of her family members are Christians. She revealed that most of her family members depend on National Health Insurance Scheme (NHIS) for medical care. Patient is a student.

1.4 Patient's Developmental History

Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Weller, 2014). Maturation is the process of developing (Weller, 2014).Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development (Weller, 2014). The developmental history was given by patient herself as told by her mother. Patient indicated that her mother went through normal pregnancy of nine months' gestation without any pregnancy associated-disorders and had spontaneous vaginal delivery with the help of medical staff at Sunyani Municipal Hospital. She was born without any congenital abnormalities such as cleft lip or palate, hydrocephalus and was immunized against the childhood vaccine-preventable diseases as evidenced by Bacillus Calmette-Guerin (BCG) scar on her right shoulder. Miss K.B.A.s' mother practiced exclusive breastfeeding for six months and started introducing supplementary feeds like "lactogen" which the patient usually vomits out. Patient gradually adopted the supplementary feeds whilst growing. She went through a normal developmental milestone. This includes sitting up at the 7th month, crawling at the 10th month, walking, talking

and running between the ages of one and three. Mrs. M.K. around the age of twelve begun to experience secondary sexual characteristics such as enlargement of breast, broadening of hips, growing of pubic hairs and had her menarche around the age of fourteen. Patient is currently attending Dunkwa on Offin nursing training college. Patient stated that she has never had challenges understanding what was taught in school. Patient is single. Upon asking patient about the aspirations and career plans, she said she wants to be able to complete nursing training and get her diploma certificate. She also dreams of working outside Ghana in the foreseeable future.

Erik Erikson (1902 to 1994) focused on cultural and societal influences as determinants of behavior. Erickson was concerned with the growth of **ego,** the conscious, organized, rational part of the personality. He described eight stages of personality development that encompass the life span. Each stage is characterized by a distinct conflict, or crisis, relating to the person's physiologic maturation and to what society expects of a person at that age. Patient is within the sixth stage; Intimacy versus Isolation (20 to 35 years) and thus the patient falls under young adulthood, during which there is a conflict centered on forming intimate and loving relationships with other people and failure to establish them results in loneliness and isolation. Through various interactions with the patient, it was concluded that patient had fulfilled intimacy through his close relationship with her family.

1.5 Obstetric History

According to patient she had her menarche around the age of fourteen. Patient has never delivered before. Patient indicated that she has never committed an abortion before. She revealed that she has never used oral contraceptives to prevent herself from getting pregnant. She also revealed that she has a regular menstrual cycle and that she usually gets her menses every twenty-seven days.

1.6 Patient's Lifestyle and Hobbies

Life style is defined as the pattern of daily living that an individual develops (Weller, 2014). Patient goes to bed around 11:00 pm, she always prays before going to bed. She wakes up at 5:00am and says her morning prayers. She maintains her oral hygiene with the use of tooth brush and tooth paste. After that she sweeps her compound, empties her bowel, takes her bath. Patients favourite food is fufu with groundnut soup and meat which she sometimes cooks it herself or by the mother. She stated that food is bought by parents and only buys food when in school. Patient does not have any fixated habit such as drinking, smoking, gossiping etc. For breakfast, patient mostly takes milo with bread. When on campus, patient indicated that she normally goes to lectures at 8:00am and closes at 4:00pm. she attends prep during the hours of 7:00pm to 9:00pm. When on vacation, she mostly helps her mother with household chores. On Saturdays she has to wash her clothes. She described herself as an extrovert who likes to attend birthday parties of friends and weddings with her mother. On Sundays she gets ready for church and after church she prepares herself for the weekdays ahead. Patient has no known allergy to food or drugs. Patient cited that she mostly takes three square meals per day thus breakfast, lunch and supper. She sometimes enjoys snacks. Patient does not experience any difficulties when it comes to studies. Through our interaction patient revealed that her major stress is the fact that the workload regarding academic activities when on campus is too much to bear, yet she sleeps or watches movie whenever she is stressed up. Patient cited that she likes honest people but dislikes dishonest individuals. Patient is an active member of the youth wing at church.

1.7 Patient's Past Medical/Surgical 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 (MediLexicon, 2009). Patient never experienced any childhood illness like whooping cough, poliomyelitis, measles, tetanus, tuberculosis, and

diphtheria and has not identified any allergy to drugs, animals or insects. She revealed that she usually suffers from minor ailments such as headache and common cold which she treats with over-the-counter medications. When symptoms persist or become worse, she visits a nearby hospital or clinic. Patient said she has never had any major accident but cited that she sometimes suffers from minor cuts when carrying out household chores like cooking. My patient has never been hospitalized but has been in and out of the outpatient departments on quite a few occasions.

1.8 Patient's Present Medical/Surgical History

The history of the present health concern or illness is the single most important factor in helping the health care team arrive at a diagnosis or determine the patient's needs. The physical examination is helpful but often only validates the information obtained from the history. A careful history assists in correct selection of appropriate diagnostic tests (Hinkle & Cheever, 2014). According to patient, she was well until 21st November, 2021 when she complained of slight headache, dizziness, high temperature which was intermittent, where she was quickly rushed to a health centre nearby, upon examination, patient was transferred to the Bono Regional Hospital. On 22nd November, 2021 at 10:00am, patient was brought to the emergency unit of the Bono Regional Hospital, where patient was diagnosed of severe anaemia after several assessment by doctors at the unit which includes lab investigations which indicates an haemoglobin level of 6.7g/dL. At the emergency unit patient was transfused with one unit of packed cells, intravenous fluids and series of laboratory investigations were carried out. After some hours of detention at the emergency unit, she was trans out to the female medical ward for continuity of care.

1.9 Admission of the Patient

Patient arrived on the Female Medical Ward on 23rd November,2021 at around 1:00pm per wheel chair accompanied by a staff nurse, rotational nurse and her mother. On arrival patient was fairly ill, weak and with an unsatisfactory level of hydration. Patient was fully conscious and alert.

Patient had been detained at the Accident and Emergency Centre for one day with the diagnosis of Severe Anaemia with history of dizziness, headache and weakness. Patient was trans-out from the E/R to the female medical ward. She was then warmly welcomed and immediately made comfortable in a simple unoccupied bed. Her particulars such as name, sex, age, and residential address were entered into the admission and discharge book and the daily ward state. Vital signs were checked and recorded accurately as follows:

1. Temperature 37.4°C
2. Pulse 128bpm
3. Respiration 22cpm
4. Blood Pressure 100/60mm/Hg

Her weight was 57kg and her height was 1.64m.

Patient was introduced to her roommates; she was also introduced to the staffs present and was assured of the competency of the healthcare team. Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained. Patient was properly orientated to the ward environment and its annexes. Physical examination on the patient was performed from head to toe and patient looked pale, capillary refill was slow and conjunctiva looked pale.

The following treatment plan were ordered:

1. Two units of blood (packed cells)
2. One ampoule of Tot 'Hema 100-200mg/day x 30 days
3. Intravenous normal saline (0.9%) 3 liters for 72 hours
4. Intravenous dextrose (5%) 3liters for 72 hours
5. Albendazole 400mg nocte x 24hours
6. Intravenous hydrocortisone 100mg stat
7. Intravenous paracetamol 1g tid x 48hours
8. Tablet folic acid 5mg/day x 30days

The following laboratory investigations had already been carried out at the emergency unit:

1. Blood grouping and cross matching
2. Full blood count
3. Blood film for Malaria Parasites
4. Urine routine examination
5. Stool routine examination
6. Blood culture and sensitivity

Miss K.B.A on admission looked dehydrated so she was infused with Iv normal saline (0.9%). Patient looked anxious. She was reassured to allay all fears and anxiety. Self introduction was given to patient, as a final year student nurse of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take her and her family for my care study. Patient and her mother were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of license to practice as a professional Registered General Nurse. Explanation was given to the patient and her mother about the concept of the patient/family care study and assured them of privacy and confidentiality. It was added that a report will be written after the entire event. Patient and her mother agreed to my request and promised to offer me the necessary information and

assistance. Expression of gratitude to them was done. Discharge planning was initiated with the relatives; thus, they will continue the care at home once she is well. Decision was made to choose this patient for the study because I wanted to know more about how to render individualized care to a patient with Anemia.

As part of the care and treatment of the patient throughout her hospitalization, a care plan was done to render care for the patient. Patient complained of feeling dizzy, she has headache and was weak. The plan of the care done for her during her admission is as follows;

On admission at 1:00pm, patient complained of headache hence the nursing diagnosis of headache related to decreased oxygen supply to the brain was formulated. An objective was set to help relieve patient of headache within 24 hours. Interventions implemented are as follows: Patient was reassured that her condition will improve. Pain was assessed using the pain rating scale (0-10) which patient indicated 5. Patient was put in Trendelenburg position. Patient was supported and complete bed rest was ensured in a calm environment and bed was also free from creases and cramps. Vital signs were monitored frequently. IV paracetamol were served.

At 1:10pm, patient complained of dizziness hence the nursing diagnosis of Risk for falls related to dizziness as evidenced by self-report of feeling dizzy was formulated. An objective was set to prevent patient from falls throughout her period of hospitalization. The following interventions were implemented: Patients' need to use the bathroom every two hours was assessed to aid her. An orderly environment was maintained by making sure walkways were unobstructed. Patient was oriented to her new environment. Necessary items (including water, snacks, phone) were kept within easy reach. Adequate lighting at night was ensured. Patient's bed was kept in the lowest position with padded side rails at all times to prevent falls.

At 1:20pm, assessment revealed that patient was weak hence the nursing diagnosis of activity intolerance related to decreased oxygen-carrying capacity of the blood occurring with anemia was made. An objective was set to help patient partake in activities of daily living

unassisted within 48 hours. The following interventions were implemented: Patient was reassured that she will regain strength for her daily activities, level of physical activity and mobility was assessed by engaging patient in activities such as walking, patients respiratory response to activity was monitored, emotional support was provided so as to enable patient perform activities, items of daily use like comb, cup, brush and others were placed within patient's reach.

1.10 Patients Concept of Her Illness

Patient had more knowledge about disease condition but the parents had little knowledge about patient's illness when they were asked. Patient's mother believes humans are prone to diseases and it is normal for everyone to get sick. Parents hope that the health team will intervene to improve child's condition.

1.11 Literature Review on Anemia

This part talks about the charter information about the condition Mrs K.B.A. was diagnosed with that is Severe Anaemia.

Definition of Anaemia

Anaemia is a condition in which the level of haemoglobin in the blood is below the expected normal range that is, 14-18g/dl for males and 12-16g/dl for females taken into account both age and sex. It can also be defined as a condition in which the haemoglobin concentration is lower than normal, reflects the presence of fewer than normal red blood cells within circulation. As a result, the amount of oxygen delivered to the body tissues is also diminished (Hinkle & Cheever, 2014).

Incidence

Anaemia occurs in all age group and is the most common haematological condition. A type called iron deficiency anaemia is by far the most common in the world. More than 500

million people are affected often in developing countries where there is inadequate intake of iron seen with vegetarian diet. It is also common in children, adolescent and pregnant women due to inadequate iron in the diet to keep up with increase growth (Kumar & Clark, 2017).

Aetiology

There are many different kinds of anaemia but all can be classified into three broad etiologic categories. They may include

a. Loss of red blood cells; occurs when bleeding potentially from any major source such as bleeding from the gastrointestinal tract, uterus, nose or wound (Williams & Hopper, 2015).
b. Decreased production of red blood cells resulting from a deficiency in the cofactors (including folic acid, vitaminB12 and iron) required for erythropoiesis. Red blood cells production may also be reduced if the bone marrow is suppressed (example, by tumors, medication, toxins) or is inadequately stimulated because of lack of erythropoietin (as occurs in chronic renal disease) (Williams & Hopper, 2015).
c. Increased destruction of red blood cells resulting from an overactive reticuloendothelial system (including hypersplenism) or when the bone marrow produces abnormal red blood cells that are then destroyed by the reticuloendothelial system (example sickle cell anemia) (Williams & Hopper, 2015).

A conclusion as to whether anaemia is caused by destruction, or by inadequate production of red blood cells or a loss of red blood cells usually can be reached on the basis of the following factors;

1. The marrows' ability to respond to the decreased red blood cell (as evidence by an increased reticulocyte count in the circulating blood)

2. The degree to which young red blood cells proliferate in the bone marrow and the manner in which they mature (as observed on bone marrow biopsy)
3. The presence or absence of the end products of red blood cell destruction within circulation. (Example bilirubin level and decreased haptoglobin level) (Kumar & Clark, 2017).

Types of Anaemia

Anaemia may be classified according to the factor that contributes to its development. The three main classifications are:

1. Hemorrhagic Anemia: This form of anemia occurs as a result of an acute loss of large amount of blood over a short period (Hinkle & Cheever, 2014).
2. Haemopoietic Anemia: This results from inadequate production of red blood cells. Haemopoietic anemia can be classified into
   - Iron Deficiency Anemia: this is as a result of inadequate intake of food rich in iron or vital component in the manufacture.
   - pernicious anemia: occurs when there is a deficiency of vitamin B12
   - megaloblastic anemia: resulting from deficiency of vitamin B12 and folates. This leads to the production of an abnormally large but immature red blood cells.
   - aplastic anemia: results from an injury to or a destruction of the stem cells in bone marrow causing pancytopenia (reduction in the number of all types of blood cells due to failure of bone marrow formation). This form of anemia is as a result of excessive red blood cell destruction as in sickle cell disease (Hinkle & Cheever, 2014).

3. Haemolytic Anaemia: This is a rare form of anaemia in which red blood cells are destroyed and removed from the bloodstream before their usual lifespan is up. Healthy red blood cells

usually live about 120 days (4 months) in the bloodstream before the body removes them. In haemolytic anaemia, the body breaks down and removes red blood cells faster than it can replace them. The breakdown of red blood cells is called haemolysis (Hinkle & Cheever, 2014).

Clinical Features

As specified in Hinkle and Cheever (2014), the more rapidly an anaemia develops, the severe its signs and symptoms. The signs and symptoms of anaemia may include the following;

1. Palpitation
2. Tachycardia
3. Dizziness
4. General body weakness
5. Pallor of the skin and mucous membrane [sclera, oral mucosa]
6. Brittle, ridge and concave nails
7. Fall in hemoglobin level
8. Ulceration of the corners of the mouth
9. Jaundice may be present
10. Dyspnea
11. Cold sweaty skin

Diagnostic Investigations

According to Hinkle and Cheever (2014), general diagnostic investigation requested by clinicians may include;

1. History from patient
2. Clinical manifestation
3. Full blood count

4. Bone aspiration is stained to detect iron, which will show a low level or absent
5. Blood film for malaria parasites
6. Stool specimen for occult blood
7. Sickling status if positive, hemoglobin electrophoresis done
8. Serum erythropoietin levels may be inappropriately low

Specific Medical Treatment

The medical treatment of anaemia is directed toward correcting or controlling the cause of anaemia (Hinkle & Cheever, 2014). If anaemia is severe, the red blood cells that are lost or destroyed may be replaced with a transfusion of packed red blood cells or whole blood.

In mild cases haematinics such as iron, folic acid, fersolate, vitamins and others to increase blood haemoglobin level are given. Intravenous fluid such as Normal saline may also be given to increase the plasma level of the blood component. Antibiotics are given to control infection (Kumar & Clark, 2017).

Nursing Management

The major nursing management directed towards patients with anaemia may include;

Psychological Care

The psychological care of every patient is important since patient may be anxious of his/her disease condition as well as about the period of hospitalization. Therefore, it is important for the nurse to reassure patient that her disease condition will be managed with the presence of competent health workers and the modern techniques of curing for the patient. Explain every procedure step to patient in order to allay her fear and anxiety and involve patient in all the care rendered to her.

Rest and Sleep

This is instituted to promote relaxation and healing processes. To ensure this, patient's bed must be fresh and free from creases and cramps. Also, a warm bath is given to patients and a quite dim environment is created to induce sleep in the patient. Opening of windows and restricting visitors also help patients to relax and induce sleep. Putting patients in the most comfortable position that is not contraindicated will also enhance rest and sleep

Monitoring and Management of Potential Complication

A significant complication of anaemia is heart failure from chronic diminished blood volume and the heart's compensatory effort to increase cardiac output. Patients with anaemia should be assessed for signs and symptoms of heart failure. A serial record of body weights can be more useful. In megaloblastic forms of anaemia, the significant potential complications are neurologic. A neurologic assessment should be performed for patients with known or suspected megaloblastic anaemia.

Maintaining Adequate Perfusion

Patients with acute blood loss or severe haemolysis may have decreased tissue perfusion from decreased blood volume or reduced circulating red blood cells. Lost volume is replaced with transfusions or intravenous fluid based on the symptoms and the laboratory findings. Supplemental oxygen may be necessary but is rarely needed on a long – term basis unless there is underlying severe cardiac or pulmonary disease as well. The nurse monitors vital signs closely, that is, temperature, pulse, respiration and blood pressure.

Managing Fatigue

The most frequent symptom and complication of anaemia is fatigue. Fatigue is often the symptom that has the greater negative impact on the individual's level of functioning and consequent quality of life. It can be significant, yet the anaemia may not be severe enough to

warrant transfusion. Patients often lose interest in hobbies and activities including sexual activity. Fatigue can interfere with an individual ability to work both inside and outside the home. Nursing management focus on assisting the patient to prioritize activities and to establish a balance between activities and rest that is realistic and feasible from the patient's perspective. Patients with chronic anaemia need to maintain some physical activity and exercise to prevent the reconditioning that results from inactivity.

Personal Hygiene

Good personal hygiene is maintained to promote health. Patient's personal hygiene such as bathing and grooming, mouth care should be maintained to enhance patient's self – confidence, comfort, promote circulation and reduce the number of micro-organism in the mouth to stimulate patient's appetite. It prevents oral infections such as stomatitis, dental caries and others. Again, patient hair is washed with shampoo and water to rinse out any dust in the hair and combed. Patient's fingernails are cut short to prevent them from harbouring microbes. Patients pressure areas are also treated three times daily, soiled linens are also changed frequently to prevent bedsore and discomfort.

Maintaining Adequate Nutrition

Inadequate intake of essential nutrients such as iron, vitamin B12, folic acid and protein can cause some anaemia. Therefore, a healthy diet rich in these essential nutrients should be encouraged. Since alcohol interferes with the utilization of essential nutrients, the nurse should advise the patient to avoid alcoholic beverages or to limit their intake and the rationale for these recommendations should be provided. Dietary teaching sessions should be individualized including cultural aspects related to food preferences and food preparation. The involvement of family members enhances compliance with dietary recommendations. Dietary supplements (e.g. vitamins, iron, foliate, protein) may be prescribed as well.

Promoting Compliance with Prescribed Therapy

For patients with anaemia, medications or nutritional supplements are often prescribed to alleviate or correct the condition. These patients need to understand the purpose of medication, how to take the medication and over what time period and how to manage any side effects of therapy. To enhance compliance, the nurse can assist patients in developing ways to incorporate the therapeutic plan into their lives, rather than merely giving the patient a list of instructions. For example, many patients have difficulty taking iron supplements because of related gastrointestinal effects. Rather than seeking assistance from a health care provider in managing the problem, some of these patients simply stop taking the iron.

Health Education

Educate patient to eat food rich in iron, folates, vitamins, folic acid and protein such as kontomire, liver, vegetables, and meat and to also comply with supplementary drugs like iron and the like. Educate patent to report any form of bleeding for prompt measures to be taken. Educate patient to avoid or reduce the intake of alcohol since it interferes with the utilization of essential nutrients like vitamin B12.

Elimination

With regards to this, patient is served with a warm bedpan to empty her bowel or bladder. Depending on patient's conditions, fluid and roughage intake is encouraged to help patient have free bowel. If patient however is having urinary retention, measures such as opening nearby taps, applications of warm compress at the lower abdomen etc, are instituted to stimulate patient to urinate. If all nursing measures fail, catheter is passed to empty the bladder.

Complications

According to Hinkle and Cheever (2014), the following are complications of anaemia;

1. Heat failure
2. Kidney failure
3. Renal failure
4. Confusion
5. Blurred vision
6. Infections like pneumonia
7. Hypovolemic shock

1.12 Validation of Data

Validation is defined as the process of establishing the truth or logical cogency of something (American Psychological Association, 2020).

With reference to the data collected, the signs and symptoms which patient exhibited are the true clinical manifestations of severe anaemia as confirmed by the literature review of the condition.

Data collected from patient's particulars, clinical features in the literature obtained from textbooks and the results of the full blood count confirms that Miss KBA. has severe anaemia as diagnosed by the Doctor. Information collected from books were in harmony with the data from laboratory investigation and patient's particulars.

CHAPTER TWO

ANALYSIS OF DATA

Analysis is a statistic that measures differences among group means and uses a statistical technique to equate the groups under study in relation to another given variable. (Weller, Bailliere's Nurses' Dictionary: For Nurses and Healthcare Workers, 2014). Data analysis in this chapter is done by comparing the values of patient's laboratory investigations with the normal standard values, comparing the clinical features exhibited by the patient with those features outlined in the medical literature and the pharmacology of drugs. It is also important in this chapter to identify the actual and potential problems of the patient as well as the general and specific strengths of the patient and formulate nursing diagnosis.

2.1 Comparison of Data with Standards

This is the point where the data collected on the health of the patient is compared with those outlined in the literature review. These includes diagnostic investigations, causes, signs and symptoms, treatments and complications.

Diagnostic Investigations/Test

The following diagnostic tests were carried out on patient;

- Blood grouping and cross matching
- Full blood count
- Blood film for Malaria Parasites
- Stool routine examination
- Urine routine examination
- Blood for culture and sensitivity

Table 2:1 Diagnostic tests/investigation in literature review compared with those carried out on patient

Diagnostic tests carried out in literature review	Diagnostic tests carried out on client
1. History from patient	1. History was taken
2. Clinical manifestation	2. Patient exhibited signs such as dizziness and headache
3. Full blood count	3. Full blood count was done
4. Bone aspiration	4. Bone aspiration was not done
5. Blood film for malaria parasites	5. Blood film for malaria parasites was done
6. Stool specimen for occult blood	6. Stool specimen for occult blood was not done
7. Sickling status	7. Patient was known to be sickling negative
8. Serum erythropoietin levels	8. Serum erythropoietin levels were not checked

Bone aspiration, stool specimen for occult blood, sickling status, serum erythropoietin levels were not carried out because diagnosis was arrived and confirmed by patient history, clinical manifestations, blood film for malaria parasites and full blood count. Blood grouping and cross matching was done because patient was to be transfused with 2 units of packed cells.

Table 1:2 Results of Diagnostic investigations carried Out on Patient

Ordered Date	Specimen	Investigations	Results	Normal values	Interpretation	Remarks
23/11/21	Blood	Grouping and cross matching	O positive	A (+/-), B (+/-), AB (+/-) and O (+/-)	Patient has blood group O+	Patient was transfused with O+ packed cells
		Full Blood Count Haemoglobin level	6.7g/dL	**Males:** 12g/dL - 18g/dL **Females:** 11g/dL - 16g/dL	Haemoglobin level was low indicating anaemia	Patient was transfused with packed cells Patient was encouraged to eat nutritious diet
		White Blood Cell	$5.6x10^9/L$	$5.0\ x10^9/L$ -$10.5\ x10^9/L$	White blood cells were normal	No treatment given
		Red Blood Cell	$3.5x10^{12}/L$	**Males:** $4.5\ x10^{12}/L$ - $5.9\ x10^{12}/L$ **Females:** $4.1\ x10^{12}/L$-$5.1\ x10^{12}/L$	RBC count was normal	Patient was transfused with packed cells

		Blood film for malaria parasite	Negative (-)	Negative (-)	Patient did not have malaria	No treatment given
25/11/21	Blood	Haemoglobin estimation	10.5g/dL	**Males:** 12g/dL - 18g/dL **Females:** 11g/dL - 16g/dL	Haemoglobin level was low indicating anaemia	Patient was encouraged to eat nutritious diet. Tablet folic acid was prescribed

B. Causes of Patient's Condition

With reference to the various textbooks on the causes of anaemia and the various laboratory investigations carried out, it was proved that patient's condition was as a result of low intake of foods rich in iron. The classical laboratory signs for iron deficiency anaemia are low microcytic volume which indicates the size of the red blood cells and a low hypochromic volume.

B. Clinical Features/ Signs and Symptoms

Table 2:3 Clinical Features of Patient Compared with those in the Literature Review

Clinical Features in Literature Review	Clinical Features Exhibited by Patient
1. Palpitation	1. Patient did not complain of palpitations
2. Tachycardia	2. Patient had tachycardia on admission (128bpm)
3. Dizziness	3. Patient complained of feeling dizzy
4. General body weakness	4. Patient complain of general body weakness
5. Pallor of the skin and mucous membrane [sclera, oral mucosa]	5. Patient was pale
6. Brittle, ridge and concave nails	6. Patient did not have brittle, ridge and concave n
7. Fall in hemoglobin level	7. Patients Hb pre transfusion was 6.7g/dl
8. Ulceration of the corners of the mouth	8. Patient did not have mouth ulceration
9. Jaundice may be present	9. Jaundice was absent in patient
10. Dyspnea	10. Patient did not experience dyspnea

11. Cold sweaty skin	11. Patient experience cold sweaty skin

The following manifestations were not outline in the literature but patient however exhibited these symptoms; headache, loss of appetite, sleeping difficulty and she said had inadequate knowledge on her condition thus led to Ms. KBA's diagnosis.

D. Specific Medical Treatment

Patient was treated medically with the aim of correcting the anaemia and maintaining nutrition. The following drugs were used in the treatment of the condition:

9. Two units of blood (packed cells)
10. One ampoule of Tot 'Hema 100-200mg/day x 30 days
11. Intravenous normal saline (0.9%) 3 liters for 72 hours
12. Intravenous Dextrose (5%) 3 liters for 72 hours
13. Albendazole 400mg Nocte x 24hours
14. Intravenous Hydrocortisone 100mg stat
15. Intravenous Paracetamol 1g tid x 48hours
16. Tablet folic acid 5mg/day x 30days

Table 2:4 Treatment Given to Patient as Compared with Literature Review

Treatment as in literature review	**Treatment given to patient**
1. Blood transfusion with whole blood or packed cells	1. Patient was transfused with 2 units packed cells
2. Hematinic such as iron, folic acid, fersolate	2. Hematinic were prescribed I. Tablet folic acid 5mg once daily x 30days was prescribed II. Ampoule Tot 'Hema bd x 30 days
3. Intravenous fluids such as normal saline	3. Patient was prescribed I. Intravenous normal saline (0.9%) 3 liters for 72 hours II. Intravenous Dextrose (5%) 3 liters for 72hours
4. Antibiotics	4. Antibiotics were not prescribed
5. Corticosteroid was not literature review	5. Corticosteroid was prescribed I. Intravenous hydrocortisone 100mg stat
6. Anthelminthic was not in literature review	6. Anthelminthic was prescribed I. Albendazole nocte x 24hours

Patient was given majority of the medications outlined in literature and that shows why she recovered as fast as possible without any complications. Patient was given hydrocortisone because corticosteroid is able to increase hemoglobin and red cell content of blood. Anemia is mostly associated with hookworm infection and that justifies the reason why patient was given albendazole.

Table 2:5 Pharmacology of Drugs Administered to Patient

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side-effect/ Remedies
23/11/21	Packed cells	**Dosage** Amount depends on haemoglobin level **Route** Intravenous	**Dosage** 2 packed cells **Route** Intravenously	Colloids	To provide red cells	Patients Hb was raised	Back pain, dark urine, fever, dizziness. None of these side effects were observed.
23/11/21	Ampoule Tot'hema	**Dosage** 100-200mg/day (2-4 ampoules) **Route**	**Dosage** 1 ampoule 100mg/day x 30 days **Route**	Iron supplement	Works by contributing to the formation of blood cells	Patients Hb improved	Nausea, vomiting, constipation None of these side effects were observed.

		Oral	Oral				

Table 2:5 Pharmacology of Drugs Administered to Patient Cont'd…

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/ Remedies**
23/11/21	Normal saline (0.9%)	**Dosage** Amount depends on patient's fluid and electrolyte level. **Route** Intravenous	**Dosage** 3 litres for 72 hours **Route** Intravenously	Isotonic solution	To correct fluid and electrolyte imbalance	Patient's body fluids and electrolytes were raised	over hydration, hypocalcaemia. None of these side effects were observed.

23/11/21	Dextrose (5%)	**Dosage** Amount depends on hydration status of patient **Route** Intravenous	**Dosage** 3 litres x 72 hours **Route** Intravenously	Glucose elevating agent	Provides supplementary calories and fluids	Patient was hydrated and energy restored.	Apnea, muscle pain, fluid overload. None of these side effects were observed.

Table 2:5 Pharmacology of Drugs Administered to Patient Cont'd…

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	side-effect/ Remedies
23/11/21	Hydrocortisone	**Dosage** 100-500mg/dose every 6 hours **Route** Intravenous, Intramuscular	**Dosage** 100mg stat **Route** Intravenous	Corticosteroid	Increases haemoglobin and red blood cell content of blood, possibly by retarding erythrophagocytosis	Patient's condition improved	Swollen ankles, nausea, vomiting. None of these side effects were observed.
23/11/21	Albendazole	**Dosage** 400mg bd for 1 day **Route**	**Dosage** 400mg nocte x 24 hours	Anthelmintic	In reducing the prevalence of STH and anaemia	Patient's condition improved	Stomach pain, nausea, vomiting, hair loss. None of

		Oral	**Route** Oral				these side effects were observed.

Table 2:5 Pharmacology of Drugs Administered to Patient Cont'd…

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side-Effect/ Remedies
23/11/21	Folic acid	**Dosage** 10mg dly **Route** Oral	**Dosage** 5mg dly x 30 **Route** Oral	Vitamin-water soluble	To manufacture red blood cells	Patient's condition improved	Gastrointestinal disturbances such as nausea, vomiting. None of these side effects were observed.
23/11/21	Paracetamol	**Dosage** 0.5–1 g every 4–6 hours; maximum 4g per day **Route** Oral and IV.	**Dosage** 1g tid for 48 hours **Route**	Anti-pyretic/Analgesic	Has a central analgesic effect that is mediated through activation of descending	Patient had a reduction in temperature	Skin reactions, liver damage following overdose. Patient experienced no side effects.

			Intravenous		serotonergic pathways.		

E. Complications

With reference to the complications listed in the literature review such as kidney failure, heart failure, confusion etc., Patient exhibited no complications throughout the period of hospitalization which resulted in her speedy recovery.

2.2 Patient/Family Strengths

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

1. Patient was able to verbalize the intensity of the headache (23/11/21)
2. Patient was able to walk when given some form of assistant (23/11/21)
3. Patient was able to participate in passive activities (23/11/21)
4. Patient was able to take in small amount of meal served (23/11/21)
5. Patient was able to sleep for at most 3 hours during the night (24/11/21)
6. Patient's and relatives were willing to know more about anemia (25/11/21)

2.3 Patient's Health Problems

Problem is defined as a situation, person that needs attention and needs to be dealt with or solved (McIntosh, 2017). From the data collected during assessment, the following health problems were noticed on patient:

1. Patient complained of headache (23/11/21)
2. Patient grumbled about feeling dizzy (23/11/21)
3. Patient was feeling weak (23/11/21)
4. Patient complained of loss of appetite (24/11/21)
5. Patient complained of inadequate sleep (24/11/21)
6. Patient and relatives had inadequate knowledge on anemia (25/11/21)

2.4 Nursing Diagnosis

According to McIntosh (2017), diagnosis is a judgment about what a particular illness or problem is made after examining it. This is the phase of the nursing care plan where the identified health problems are developed into prioritized diagnoses. The nurse through his/her education and experience is able to identify and treat patient and family health problems**.**

1. Headache related to decreased oxygen supply to the brain (23/11/21)
2. Risk for falls related to dizziness as evidenced by self-report of feeling dizzy (23/11/21)
3. Activity intolerance related to decreased oxygen carrying capacity of blood occurring with anemia (23/11/21)
4. Nutritional imbalance (less than body requirement) related to inadequate of dietary intake (24/11/21)
5. Disturbed sleep pattern related to ambient noise (24/11/21)
6. Knowledge deficit related to lack of exposure to information about the disease process, its treatment, and prognosis (25/11/21)

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's potential problems in everyday life and draw an individual care plan (Weller, 2014). Planning for patient/family care is the third stage of the nursing process. A nursing care plan commences with the nursing diagnosis, the goals and objectives. Once these goals are identified, unique nursing actions are outlined to achieve the goals and objectives. It is based on the potential and actual problems identified. The nurse further goes on to evaluate the care given to find out whether set goals and objectives are fully met, partially met or unmet.

3.1 Objectives/ Outcome Criteria

1. Patient will be relieved from headache within 24 hours as evidenced by;
    a. Patient verbalizing that she is relieved of headache
    b. Nurse observing a cheerful facial expression
2. Patient will not fall and sustain any injury throughout her period of hospitalization as evidenced by;
    a. Patient verbalizing, she no longer feeling dizzy
    b. Nurse observing that patient is free of any trauma
3. Patient will partake in activities of daily living unassisted within 48 hours as evidenced by;
    a. Patient verbalizing that she no longer has any feels weak
    b. Nurse observing that patient perform activities of daily living independently
4. Patient will achieve and continue adequate nutrition within 48 hours as evidenced by';
    a. Patient verbalizing that she has been able to take in food been served
    b. Nurse observing that patient takes at least two thirds of meal served

5. Patient will achieve optimal sleep and rest within 24 hours as evidenced by;
    a. Patient verbalizing her sleeping hours has returned to normal
    b. The nurse observing patient having a sound uninterrupted sleep for at least 6-8 hours.
6. Patient and relatives will gain adequate knowledge on anemia within 6 hours of hospitalization as evidenced by;
    a. Patient and relatives verbalizing understanding of what they have been educated on
    b. Nurse observing patient and relatives are able to answer simple questions asked about the disease condition.

Table 3:1 **Nursing care plan for Patient**

Date/ Time	**Nursing Diagnosis**	**Objectives/ Outcome criteria**	**Nursing Orders**	**Nursing intervention**	**Date/ Time**	**Evaluation**	**Sign**
23/11/21 1:00pm	Headache related to decreased oxygen supply to the brain	Patient will be relieved from headache within 24 hours as evidenced by; 1. Patient verbalizing that she is relieved of headache 2. Nurse observing a cheerful facial expression	1. Reassure patient. 2. Assess patient level of pain 3. Patient should be in Trendelenburg position 4. Support patient and ensure a complete bed rest. 5. Monitor vital signs frequently. 6. Serve prescribed analgesics	1. Patient was reassured that her condition will improve 2. Pain was assessed using the pain rating scale (0-10) which patient indicated 5. 3. Patient was put in Trendelenburg position 4. Patient was supported and complete bed rest was ensured in a calm environment and bed was also free from creases and cramps. 5. Vital signs was monitored frequently as temp. 36.6℃, pulse 69bpm, resp. 19cpm and B.P. 111/60 6. IV paracetamol was served.	24/11/21 1:00pm	Goal fully met as patient verbalized that she is relieved of headache and nurse observed a cheerful facial expression	**A. V**

Table 6: Nursing care plan for Patient Continued

Date/ Time	Nursing Diagnosis	Objectives/ Outcome criteria	Nursing Orders	Nursing intervention	Date/ Time	Evaluation	Sign
23/11/21 1:10pm	Risk for falls related to dizziness as evidenced by self-report of feeling dizzy	Patient will not fall and sustain any injury throughout her period of hospitalization as evidenced by; 1. Patient verbalizing she no longer feels dizzy 2. Nurse observing that patient is free of any trauma	1. Assess patient need to use the bathroom every two hours. 2. Maintain an orderly environment with unobstructed walkways 3. Orient the patient to new surroundings. 4. Keep necessary items within easy reach. 5. Ensure adequate lighting at night 6. Keep bed in its lowest position with padded side rails on.	1. Patients' need to use the bathroom every two hours was assessed to aid her. 2. An orderly environment was maintained by making sure walkways were unobstructed 3. Patient was oriented to her new environment 4. Necessary items (including water, snacks, phone) were kept within easy reach. 5. Adequate lighting at night was ensured 6. Patient's bed was kept in the lowest position with padded side rails on at all times to prevent falls	27/11/21 11:00am	Goal fully met as patient verbalized, she no longer feels dizzy and nurse observed that patient was free of any trauma	**A. V**

Table 6: Nursing care plan for Patient Continued

Date/ Time	Nursing Diagnosis	Objectives/ Outcome criteria	Nursing Orders	Nursing intervention	Date/ Time	Evaluation	Sign
23/11/21 1:20pm	Activity intolerance related to decreased oxygen-carrying capacity of the blood occurring with anemia	Patient will partake in activities of daily living unassisted within 48 hours as evidenced by; 1. Patient verbalizes that she no longer feels weak 2. Nurse observing that patient perform activities of daily living independently	1. Reassure patient of regaining strength for daily activities. 2. Assess the patient level of physical activity and mobility. 3. Monitor the patient's respiratory response to activity 4. Provide emotional support while increasing activity. 5. Arrange items of daily use within patient's reach 6. Serve prescribed medications	1. Patient was reassured that she will regain strength for her daily activities. 2. Level of physical activity and mobility was assessed by engaging patient in activities such as walking. 3. Patients respiratory response to activity was monitored 4. Emotional support was provided so as to enable patient perform activities. 5. Items of daily use like comb, cup, brush and others were placed within patient's reach 6. Tot Hema was served.	25/11/21 1:20pm	Goal fully met as patient verbalized that that she no longer has any feeling of fatigue and nurse observed that patient performed activities of daily living	**A. V**

Table 6: Nursing care plan for Patient Continued

Date/Time	Nursing Diagnosis	Outcome Criteria	Nursing Orders	Nursing Intervention	Date /Time	Evaluation	Sign
24/11/21 8:25am	Nutritional imbalance (less than body requirement) related to inadequate dietary intake	Patient will achieve and continue adequate nutrition within 48 hours as evidenced by; 1. Patient verbalizing that she has been able to take in food 2. Nurse observing that patient takes at least two thirds meal served	1. Discuss with patient and family about the importance of food for the body. 2. Monitor the amount of food intake. 3. Plan diet with dietician and make sure patient preferences are considered 4. Provide a varied diet to stimulate patient's appetite. 5. Provide food in small portions but frequently. 6. Educate patient on the need to take in nutritionally rich diets.	1. Patient and family were educated on the importance of food for the body. 2. The amount of food intake was monitored. 3. Diets were planned with dietician and patient's preferences were taken into consideration 4. A varied diet was provided according to patient's diet to stimulate her appetite. 5. Food was provided in small portions but frequently. 6. Patient was educated on the need to take in nutritionally rich diets.	26/11/21 8:25am	Goal fully met as patient verbalized that she has gained appetite for food and nurse observed that patient takes at least two thirds of 500ml of porridge served	**A. V**

Table 6: Nursing care plan for Patient Continued

Date/Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	ign
24/11/21 8:30am	Disturbed sleep pattern related to ambient noise	Patient will achieve optimal sleep and rest within 24 hours as evidenced by; 1. Patient verbalizing her sleeping hours has returned to normal 2. The nurse observing patient having a sound uninterrupted sleep for at least 6-8 hours	1. Reassure patient. 2. Plan time for treatment and assessment with the patient. 3. Restrict and Limit visitors 4. Provide warm bath. 5. Ensure dim light at night. 6. Ensure adequate ventilation.	1. Patient was reassured that all actions will be done at the right time. 2. Time for assessment and treatment were planned with the patient. 3. The number of visitors and their length of stay were restricted and limited. 4. Patient took a warm bath in the evening to induce sleep. 5. patient was nursed under dimmed light 6. Windows were opened to ensure adequate ventilation.	**25/11/21** **8:30am**	Goal fully met as patient verbalized her sleeping hours has returned to normal and nurse visualized patient having a sound uninterrupted sleep for at least 6-8 hours	**A. V**

Table 6: Nursing care plan for Patient Continued

Date/ Time	Nursing Diagnosis	Objectives/ Outcome criteria	Nursing Orders	Nursing intervention	Date/ Time	Evaluation	Sign
25/11/21 9:25am	Knowledge deficit related to inadequate exposure to information about the disease process, its treatment, and prognosis	Patient and relative will gain adequate knowledge on anemia within 6 hours as evidenced by; 1. Patient and relatives verbalizing understanding of what they have been educated on 2. Nurse observing that patient adhering to therapy and nutritional advice	1. Reassure patient and family 2. Establish a quiet environment 3. Assess patient and family level of knowledge about disease condition 4. Clarify any misconceptions 5. Educate patient and family on disease condition 6. Allow patient and family to ask questions	1. Patient and family were reassured that they would understand and gain adequate knowledge about anemia 2. A conducive environment of mutual trust and understanding was maintained to enhance learning. 3. Patient and family's knowledge on disease condition were assessed 4. Misconceptions about the disease condition were clarified 5. Patient and family were educated on the causes, clinical features and management of anemia in simple terms to make them well informed 6. Questions asked by patient and family were answered to clarify information given	26/11/21 3:25pm	Goal fully met as patient verbalized understanding of what she has been educated on and nurse observed that patient adhered to therapy and nutritional advice	**A. V**

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

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

4.1 Summary of Actual Nursing Care Rendered to Patient/ Family

The actual nursing care rendered to patient and her family began on the day of admission, 23th November, 2021 to the time care was terminated on 14th December, 2021. The management of patient and her family was aimed at meeting her psychological, physiological and spiritual needs.

First Day of Admission (23rd November, 2021)

Patient arrived on the Female Medical Ward on 23rd November,2021 at 1:00pm per wheel chair accompanied by a staff nurse, rotational nurse and her mother. On arrival patient was fairly ill, weak and with an unsatisfactory level of hydration. Patient was fully conscious and alert.

Patient had been detained at the Accident and Emergency Centre for one day with the diagnosis of Severe Anaemia with history of dizziness, headache and weakness. Patient was trans-out from the E/R to the female medical ward. At the time of arrival, patient was handed over to me

and admission was carried out. Patient's particulars were taken from the accompanying staff nurse by me. The patient's identity was verified by mentioning her name for her to respond. She was then warmly welcomed and immediately made comfortable in a simple unoccupied bed. Her particulars such as name, sex, age, and residential address were entered into the admission and discharge book and the daily ward state. Vital signs were checked and recorded accurately as follows:

5. Temperature 37.4^{o}C
6. Pulse 128bpm
7. Respiration 22cpm
8. Blood Pressure 100/60mm/Hg

Her weight was 57kg and her height was 1.64m.

Patient was introduced to her roommates; she was also introduced to the staffs present and was assured of the competency of the healthcare team. Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained. Patient was properly orientated to the ward environment and its annexes. Physical examination on the patient was performed from head to toe and it was observed that patient looked pale, capillary refill was slow and conjunctiva looked pale.

The following treatment plan were ordered:

17. Two units of blood (packed cells)
18. One ampoule of Tot 'Hema 100-200mg/day* 30 days
19. Intravenous normal saline (0.9%) 3 liters for 72 hours
20. Intravenous dextrose (5%) 3liters for 72hours
21. Albendazole 400mg nocte x 24hours
22. Intravenous hydrocortisone 100mg stat

23. Intravenous paracetamol 1g tid x 48hours

24. Tablet folic acid 5mg/day x 30days

The following laboratory investigations had already been carried out at the emergency unit:

7. Blood grouping and cross matching
8. Full blood count
9. Blood film for Malaria Parasites

Patient looked anxious. Miss K.B.A was infused with 0.9% Iv normal saline to hydrate her. She was reassured to allay all fears and anxiety. Self-introduction was given to patient as a final year student nurse of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take her and her family for my care study. Patient and her mother were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of license to practice as a professional Registered General Nurse. Explanation about the concept of the patient/family care study was given and assured them of privacy and confidentiality. It was added that a report will be written after the entire event. Patient and her mother agreed to my request and promised to offer me the necessary information and assistance. Expression of gratitude was made to them. Discharge planning was initiated with the relatives; thus, they will continue the care at home once she is well. A decision was made to choose this patient for the study because, knowing more about how to render individualized care to a patient with Anemia was my priority.

On admission at 1:00pm, patient complained of headache hence the nursing diagnosis of headache related to decreased oxygen supply to the brain was formulated. An objective was set to help relieve patient of headache within 24 hours. Interventions implemented are as follows: Patient was reassured that her condition will improve. Pain was assessed using the pain rating scale (0-10) which patient indicated 5. Patient was put in Trendelenburg position. Patient was supported and complete bed rest was ensured in a calm environment and bed was

also free from creases and cramps. Vital signs were monitored frequently. IV paracetamol were served.

At 1:10pm, patient complained of dizziness hence the nursing diagnosis of Risk for falls related to dizziness as evidenced by self-report of feeling dizzy was formulated. An objective was set to prevent patient from falls throughout her period of hospitalization. The following interventions were implemented: Patients' need to use the bathroom every two hours was assessed to aid her. An orderly environment was maintained by making sure walkways were unobstructed. Patient was oriented to her new environment. Necessary items (including water, snacks, phone) were kept within easy reach. Adequate lighting at night was ensured. Patient's bed was kept in the lowest position with padded side rails at all times to prevent falls.

At 1:20pm, assessment revealed that patient was weak hence the nursing diagnosis of activity intolerance related to decreased oxygen-carrying capacity of the blood occurring with anemia was made. An objective was set to help patient partake in activities of daily living unassisted within 48 hours. The following interventions were implemented: Patient was reassured that she will regain strength for her daily activities, level of physical activity and mobility was assessed by engaging patient in activities such as walking, patients respiratory response to activity was monitored, emotional support was provided so as to enable patient perform activities, items of daily use like comb, cup, brush and others were placed within patient's reach.

At 1:30pm, patient was informed that blood transfusion has been ordered by the doctor in charge Dr. I.M. since laboratory investigation indicates low of hemoglobin of 6.7g/dL. Patient was educated on the needs for transfusion and its reactions also the need to prompt nurse if such reactions are seen. Therefore, arrangement to get a donor was done after which grouping and cross matching was done to secure a blood for transfusion from the laboratory.

At 2:40pm per arrangements for Miss K.B.A.'s to receive blood, her first pint of O+ packed cells were received from the laboratory. At 4:20pm, her pre transfusion vital signs were checked and recorded as temp-36.0ºC, pulse-72, resp.-22, B.P.110/60. Blood was properly warmed at room temperature to prevent patient from developing chills during transfusion patient was educated on the transfusion reactions and asked to report should any is observed. The following information were cross checked with that of the patient; blood component (O+ packed cells, batch number of BRH945, blood type O, Rh factor of negative+, expiration date of 35days and screening test was compatible. Patient was given Iv hydrocortisone 100mg stat dose before the transfusion to prevent allergies and urticaria rushes. Patient was then properly identified after which one-unit of O+ packed cells with batch number BRH945 was transfused over a period of 4 hours. Patient was consistently monitored for any possible transfusion reaction.

At 6:00pm, blood was transfused successfully and hemoglobin level was rechecked and it was 7.6g/dL, which indicates a rise in hemoglobin level. Miss, K.B.A post transfusion vital signs were checked and recorded as; Temperature: 36.8℃, Pulse: 70bpm, Respiration: 21cpm, Blood pressure: 120/70.

Miss K.B.A took her supper around 6:10pm which was rice and tomato stew and took her bath after she was done taking her supper. She then decided to have some little chat with her parents since she was not feeling sleepy and watched TV programs especially her favorite telenovela on Joy prime.

At 6:30pm, miss K.B.A.'s vital signs were checked and recorded as indicated in the appendix.

At 10pm, vital signs were checked and recorded as indicated in the appendix and due medications IV paracetamol 1g and tothema100mg were served. Patient was made comfortable in bed and she slept around 10:30pm.

Second Day of Admission (24th November, 2021)

The following day I went to the ward to continue with my nursing care to patient. At 6:00am, Miss K.B.A.'s due medications which was folic acid 5mg/day and 0.9% of normal saline were administered and vital signs were checked and recorded as indicated in the appendix. Patient was assisted to perform her personal hygiene and her bed was straightened to make it free from creases and crumps.

At 7:00am, patient took porridge with bread as breakfast. It was observed that patient could not take much of food served.

At 8:25am, patient complained of loss of appetite hence the nursing diagnosis of Nutritional imbalance (less than body requirement) related to inadequate dietary intake was formulated. An objective was set to enable patient achieve and continue adequate nutrition within 48 hours. The following interventions were implemented: Patient and family were educated about the importance of food for the body. The amount of food intake was monitored. Diets were planned with dietician and patient's preferences were taken into consideration. A varied diet was provided according to patient's diet to stimulate her appetite. Food was provided in small portions but frequently. Patient was educated on the need to take in nutritionally rich diets.

At 8:30am, patient revealed she was not getting enough sleep hence the nursing diagnosis of Disturbed sleep pattern related to ambient noise was formulated. An objective was set to help patient achieve optimal sleep and rest within 24 hours. The following interventions were implemented: Patient was reassured that all actions will be done at the right time. Time for assessment and treatment were planned with the patient. The number of visitors and their length of stay were restricted and limited. Patient took a warm bath in the evening to induce sleep. Patient was nursed under dim light. Windows were opened to ensure adequate ventilation.

At 9am, patient was reviewed by the medical team during ward rounds and the plan was to continue treatment.

On 24th November, 2021 at 1:00pm, evaluation of the set objective on 23rd November, 2021 to help relieve patient of headache within 24 hours was done and goal was fully met as patient verbalized, she has been relieved from the headache and nurse observed patient had a relaxed facial expression.

She ate water melon in the afternoon after which she slept for a while. In the evening patient's meals was served.

I declared my intention of paying a visit to their house and explained my reason for the visit to gain her consent. Which detailed information about their home and how to get there was given to me by Miss K.B.A.

At 5:20pm arrangement was made for Miss K.B.A.'s second pint of O+ packed cells to be transfused. Her pre transfusion vital signs were, temp-36.0, pulse-72, resp.-22, B.P.110/60. After collecting blood from the laboratory, it was properly warmed at room temperature to prevent patient from developing chills during transfusion patient was educated on the transfusion reactions and asked to report should any is observed. The following information were compared with patients results for grouping and cross matching; blood component (O+ packed cells, batch number of BRH 745, blood type O, Rh factor of negative+, expiration date of (29/12/21) and screening test was compatible. At 5:40pm, patient was then properly identified, after which one-unit of O+ packed cells with batch number BRH 745 was transfused over a period of 4 hours. Patient was consistently monitored for any possible transfusion reaction. Patient was consistently monitored for any possible transfusion reaction.

At 9:40pm, blood was transfused successfully and hemoglobin level was rechecked and it was 10.5g/dL, which indicates a rise in hemoglobin level. Her post transfusion vital signs were checked and recorded as temp.-36.8, pulse 70, resp. 22 and B.P. 110/60. She was made

comfortably in bed was happily chatting her relatives while watching TV when her post transfusion medications Iv paracetamol 1g and tot Hema 100mg were served. Miss K.B.A. went to bed after falling asleep in the middle of chats with her mother.

Third Day of Admission (25th November, 2021)

On the third day of admission patient was rendered assistance in maintaining her personal hygiene and her bed was straightened nicely with free creases and cramps. The night nurses report read that she was able to sleep well upon the measures put in place. Her due medications Iv normal saline 0.9% were served and her vital signs had already been checked and recorded at 6am as indicated in the appendix. At 7:50am, she was served with brown porridge with bread as breakfast.

On 25th November, 2021. at 8:30am, evaluation of the set objective on 24th November, 2021 to help patient achieve optimal sleep and rest within 24 hours was done and goal was met as patient verbalized her sleeping hours has returned to normal and nurse visualized patient having a sound uninterrupted sleep for at least 6-8 hours.

At 9am, patient was reviewed by the medical team during ward rounds and the plan was to continue treatment given.

During the ward rounds at 9:30am, patient made no new complains so the medical team ordered for treatment to continue. A hemoglobin estimation test was ordered for patient. The results indicated patient Hb, post transfusion as 10.5g/dL.

On 25th November, 2021 at 1:10pm, evaluation of the set objective on 23rd November, 2021 to help patient partake in activities of daily living within 48 hours was done and goal was fully met as patient verbalized that that she no longer has any feeling of fatigue and nurse observed that patient performed activities of daily living.

At 2:00pm, her vital signs were checked and recorded as shown in the appendix. She was served with Jollof rice and chicken in the afternoon as lunch. At 3:25pm the objective set to help them understand the condition, within 6 hours was evaluated and goal fully met as patient verbalized understanding of what she has been educated on and nurse observed that patient adhered to therapy and nutritional advice. In the evening, she took fufu and light soup around 5:30pm for supper. She carried out her personal hygiene needs in the evening.

At 10pm, her due medications 0.9% normal saline were served, her vital signs were checked and recorded as shown in the appendix. Patient went to bed around 10:30pm.

Fourth Day of Admission (26th November, 2021)

Patient woke up around 5:30, her routine personal hygiene practices were carried out and her bed linen was changed and a new one was used and was laid nicely without creases and cramps. Her 6:00am vital signs were checked and recorded as shown in the appendix. Her morning medications folic acid 5mg/day and tot Hema 100-200mg were also served and documented.

At 8:00am, she took milo and bread for breakfast. at 8:25am, evaluation of the set objective on 24th November, 2021 to help patient achieve and continue adequate nutrition within 48 hours was done and goal was fully met as patient verbalized that she has gained appetite for food and nurse observed that patient takes two thirds of 500ml of porridge served. At 9am, she was reviewed in the morning and it was made known to her that she will be discharged possibly the next day.

On 26th November, 2021 at 9:25am, evaluation of the set objective on 25th November, 2021 to help patient and relatives gain understanding on condition within 24 hours was done and goal was fully met as patient verbalized understanding of what she has been educated on and nurse observed that patient adhered to therapy and nutritional advice.

At 2:00pm, patient's vital signs were checked and recorded as shown in the appendix. She took banana with groundnut in the afternoon. Patient ate rice and vegetable stew as her last meal for the day and water melon as desert. Patient brushed her teeth with tooth brush and paste after meal and took her bath with warm water before bed time.

At 10:00pm, her due medications tot Hema 100mg were served, her vital signs were checked and recorded as shown in the appendix. Patient slept around 10:15pm.

Fifth Day of Admission/Day of Discharge (27th November, 2021)

I went to continue the nursing care rendered to patient. Patient woke up early in the morning feeling strong and better. Her due medications folic acid 5mg and tot Hema 100mg were served and her vital signs were checked and recorded at 6am as indicated in the appendix. The report from the night nurse read that patient had a sound sleep at night. Patient maintained her personal hygiene. The bed was laid nicely making sure it was free from creases and cramps. She took oaths and bread as breakfast at 8:00am on which she made a complement on the food that its very nice and satisfactory. At 9am, she was reviewed in the morning and she was declared healthy and the medical team ordered for her to be discharged.

On 27th November, 2021 at 8:30am, evaluation of the set objective on 23rd November, 2021 to help prevent patient from falls throughout her period of hospitalization was done and goal was fully met as patient verbalized, she no longer feels dizzy and nurse observed that patient was free of any trauma.

Patient and her mother were informed about the discharge. Her mother was asked to see the accounts department to settle her daughter's bill so they can go home as soon as possible. Bills which were not covered by National Health Insurance Scheme were paid. I provided a clear and understandable education on how she should live her life, creating an awareness most especially on her diets and how important it is in maintain optimal health. Patient was informed

to come for review on 6th December, 2021 at the main OPD. The need to continue with medications were emphasized and review date was stretched on. I assisted in packing patient's belongings, at exactly 2:00pm, patient and the family bid the ward inmates and staff a goodbye. Patient and relative left the ward accompanied by me to the hospital entrance as I waved at them as they waved back, bidding them a warmly goodbye and also informed them that I will be coming to their house to check on her. Disinfection of patient's bed and locker were done to prevent infection and necessary information wad recorded into the admission and discharge book as well as the ward state.

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

Preparation for discharge commenced from the time of admission at the hospital, at 1:00pm on 23rd November, 2021 till the last day of admission or day of discharge, 14th December, 2021. The patient and family were informed that staying in the hospital was for a temporal period of time. Education of patient and family on the causes, clinical features and management of anemia were reemphasized. This was aimed at helping the patient and relatives in the provision of adequate care. Prior to patient discharge, health education was given to the patient and relatives on the importance of diet and avoiding over the counter medication. Patient was encouraged to take in food rich in the essential food nutrients. Patient was also told to exercise more often. Patient and her family were also educated on the need to maintain personal and environmental hygiene to help improve immunity. A great emphasis was made on the need to continue with medication and to report to the hospital if any problem does occur. Patient was informed to come for review on 6th December, 2021. Necessary information was recorded into the admission and discharge book as well as the ward state.

4.3 Follow Up / Home Visit / Continuity of Care

Home visit is a form of continuity of care using the public health care approach to render nursing assistance to a client with consideration of available resource to solve client problems.

It helps the nurse to know whether the client's environment has an influence on him, his family or the community at large. Home visit can be selective or routine. With the selective, the health team visits clients with specific conditions identified for continuity of care. The routine deals with visits paid from house to house on regular basis. The selective home visit was made.

First Home Visit (24th November, 2021)

First home visit was made on 24th November, 2021 while patient was still on admission. I gave a prior notice to my patient and other family members and they willingly gave me the permission. The purpose of this visit was to know patient's residence and the environment in which she lives, verify the information given to me as well as to identify the risk factors such as familial tendency and stresses that can lead to her condition and to identify patients nearest health facility for possible referral. A planned visit was made to Sunyani Odumase where patient resides. I picked a taxi in Sunyani around 2:30am. I alighted at Odumase at 3:00pm. I then called patient's mother; she then gave me detailed directions to their house which was about 4minutes walk away from the where alighted. I was warmly received by patient's mother and offered a seat. Per my observation, they live in a self-contained house built with blocks, painted peach and white and roofed with aluminum sheets and is wired correctly with electricity power, had windows. Their source of water is from the pipe bone water which occasionally does not flow. However, they have some big containers which are well covered. They had a neat bathroom and toilet facilities and a storage room. I educated her on the need to open the windows to promote proper ventilation. They have a dustbin outside their main gate with a well-fitting lid in which they dump their waste materials and it is emptied every morning into Zoom lion waste-truck. Observations made in patients' room revealed well-furnished hall with television set, sound system, an air condition, couch and a glass center table, it was very neat and well organized and they were applauded for that. Patients mother was educated on the need to practice good environmental and personal health and also encouraged them to continue

to keep their home and surroundings clean. I reassured patients mother of competent nursing care and that she will be well very soon. I had an extensive interaction with the mother and through that I was able to confirm most of the information I have been given by Miss K.B.A. No identifiable factor to patient's condition was found during the visit. I left the house at 4:00pm. Comments made on the condition of the house, education and recommendations were repeated to patient. I identified on the first home visit that patient's house was not very far from Regional Hospital, Sunyani and for that reason I informed one public health nurse about handing over the patient to her and she agreed.

Second Home Visit (4th December, 2021)

This visit was made on 4th December, 2021. Intentions of this visit to find out how patient was doing and to see if she was following her treatment regimen and also to remind patient of the review date which was 6th December, 2021.

On assessment patient windows were opened as they were educated to do. The environment was neat and they were commended for that. The importance of taking drugs as ordered was reinforced to patient and family. Education on good nutrition was stressed on to help protect patient and family from any diseases.

Patient and family were thanked for their cooperation and permission was sought to leave. I promised them of another visit which will be my last. Patient's elder brother escorted me to the road side where I bordered a taxi to my house.

Review (6th December, 2021)

On 6th December, 2021 patient and her mother were met at the Out-Patient Department of Bono Regional Hospital at 9:00am looking cheerful and lovely as noted from facial expression. I accompanied them to do encounter thus register patients name into the hospital system. The vital signs checked and recorded as follows;

Temperature	35.9ºC
Pulse	74bpm
Respiration	22cpm
Blood pressure	110/70mmHg

At the Out-Patient Department, patient was seen by the medical officer at consulting room 1. Upon assessment by the doctor, patient was healthy. Patient did not have complains. She was told not to hesitate to report to the hospital if she should encounter any health problem. She was encouraged to adhere to the diet and medication therapy. She was also encouraged to practice personal and environmental hygiene to protect herself from getting diseases. Patient was assured of a third home visit. I then accompanied them to the hospital entrance where they left to their home.

Third Home Visit (14th December, 2021)

The main reason for conducting the third home visit was to: Assess the general condition of patient and family, reinforce the need to comply with treatment regimen and finally terminate care. I passed by Bono Regional Hospital to inform the public health nurse about what we had previously discussed and so she accompanied me to patient's house. Patient and her family were happy to see me around and we were warmly welcomed and offered seats after greeting them. I introduced the public health nurse to the patient and her relatives. A quick assessment was made on patient which proved that patient was in good health. The environment was clean and tidy and they were again applauded for that. During the interaction with them, I made it known to them that I am officially terminating the care. I asked about patient's drugs and it was found that she had been taking her medications and the recommended diet had also been adhered to. After interacting with patient and family for a while, I reemphasized on health

educations that had been given to them already. Since it happened to be my last day of therapeutic relationship with patient and family, I handed over the patient to the public health nurse and terminated my care and thanked them for their cooperation which made my study a success. I finally thanked them for their co-operation throughout the event and making the study a successful one. I sought permission to leave and I was accompanied to the roadside where I boarded a car back to the house.

CHAPTER FIVE

EVALUATION OF CARE RENDED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation is the process of measuring the effectiveness of nursing actions, medical care and forms of health care by other providers. It helps to determine whether outcome criteria have been met and how care for the patient might be improved.

5.1 Statement of Evaluation

The nursing care was based on the nursing process. During the period of her stay at the hospital a nursing care plan was designed to aid in delivery of quality care to the patient with emphasis on the nursing diagnosis. During the nursing care, actual and potential problems were identified, objectives were set, plans for patient's and family care implemented and later evaluated.

A. Patient was relieved of headache

On 23rd November, 2021 at 1:00pm, patient complained of headache hence the nursing diagnosis of Headache related to decreased oxygen supply to the brain was formulated. An objective was set to help relieve patient of headache within 24 hours. Interventions implemented are as follows: Patient was reassured that her condition will improve. Pain was assessed using the pain rating scale (0-10) which patient indicated 5. Patient was put in Trendelenburg position. Patient was supported and complete bed rest was ensured in a calm environment and bed was also free from creases and cramps. Vital signs were monitored frequently. IV paracetamol 1g was served.

On 24th November, 2021 at 1:00pm, evaluation of the set objective on 23rd November, 2021 to help relieve patient of headache within 24 hours was done and goal was fully met as patient

verbalized, she has been relieved from the headache and nurse observed patient had a relaxed facial expression.

B. Patient was prevented from falls

On 23rd November, 2021 at 1:20pm, patient complained of dizziness hence the nursing diagnosis of Risk for falls related to dizziness as evidenced by self-report of feeling dizzy was formulated. An objective was set to prevent patient from falls throughout her period of hospitalization. The following interventions were implemented: Patients' need to use the bathroom every two hours was assessed to aid her. An orderly environment was maintained by making sure walkways were unobstructed. Patient was oriented to her new environment. Necessary items (including water, snacks, phone) were kept within easy reach. Adequate lighting at night was ensured. Patient's bed was kept in the lowest position with bed brakes on at all times to prevent falls.

On 27th November, 2021 at 8:00pm, evaluation of the set objective on 23rd November, 2021 to help prevent patient from falls throughout her period of hospitalization was done and goal was fully met as patient verbalized, she no longer feels dizzy and nurse observed that patient was free of any trauma.

Patient was able to partake in activities of daily living

On 23rd November, 2021 at 1:10pm, assessment revealed that patient was weak hence the nursing diagnosis of Activity intolerance related to decreased oxygen-carrying capacity of the blood occurring with anemia was made. An objective was set to help patient partake in activities of daily living unassisted within 48 hours. The following interventions were implemented: Patient was reassured that she will regain strength for her daily activities. Level of physical activity and mobility was assessed by engaging patient in activities such as

walking. Patients respiratory response to activity was monitored. Emotional support was provided so as to enable patient perform activities. Items of daily use like comb, cup, brush and others were placed within patient's reach. Iv paracetamol 1g and Tot 'Hema was served.

On 25th November, 2021 at 1:10pm, evaluation of the set objective on 23rd November, 2021 to help patient partake in activities of daily living within 48 hours was done and goal was fully met as patient verbalized that that she no longer has any feeling of fatigue and nurse observed that patient performed activities of daily living.

D. Patient was able to achieve and continue adequate nutrition

On 24th November, 2021 at 8:25am, patient complained of loss of appetite hence the nursing diagnosis of Nutritional imbalance (less than body requirement) related to loss of appetite was formulated. An objective was set to enable patient achieve and continue adequate nutrition within 48 hours. The following interventions were implemented: Patient and family were educated about the importance of food for the body. The amount of food intake was monitored. Diets were planned with dietician and patients' preferences were taken into consideration. A varied diet was provided according to patient's diet to stimulate her appetite. Food was provided in small portions but frequently. Patient was educated on the need to take in nutritionally rich diets.

On 26th November, 2021 at 8:25am, evaluation of the set objective on 24th November, 2021 to help patient achieve and continue adequate nutrition within 48 hours was done and goal was fully met as patient verbalized that she has gained appetite for food and nurse observed that patient takes at least two thirds of meal served.

E. Patient was able to achieve optimal sleep and rest

On 24th November, 2021 at 8:30am, patient revealed she was not getting enough sleep hence the nursing diagnosis of Disturbed sleep pattern related to altered environment was formulated.

An objective was set to help patient achieve optimal sleep and rest within 24 hours. The following interventions were implemented: Patient was reassured that all actions will be done at the right time. Time for assessment and treatment were planned with the patient. The number of visitors and their length of stay were restricted and limited. Patient took a warm bath in the evening to induce sleep. Room light was turned off in the night. Windows were opened to ensure adequate ventilation.

On 25th November, 2021 at 8:30am, evaluation of the set objective on 24th November, 2021 to help patient achieve optimal sleep and rest within 24 hours was done and goal was met as patient verbalized her sleeping hours has returned to normal and nurse visualized patient having a sound uninterrupted sleep for at least 6-8 hours.

F. Patient and relatives gained adequate knowledge on disease condition

On 26th November, 2021 at 9:25am, evaluation of the set objective on 25th November, 2021 to help patient and relatives gain understanding on condition within 24 hours was done and goal was fully met as patient verbalized understanding of what she has been educated on and nurse observed that patient adhered to therapy and nutritional advice.

5.2 Amendment of Nursing Care

The objectives and goals that were set during the nursing care of patient were fully met hence no amendments were made.

5.3 Termination of Care

This is the time in which the nurse brings to an end the therapeutic treatment and nursing care with the patient and family. Every nurse-patient relationship at the hospital needs to be terminated. 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. Termination of care for patient and the family

started on the day of admission, 23rd November, 2021. Patient and family were given a gradual psychological preparation; they were told that, our relationship was a therapeutic one and was temporal, which would last for a reasonable period.

During my visit to her home especially the third time, I observed that her general condition was encouraging and therefore terminated my care with her on 14th December, 2021 by finally advising her on eating balanced meals and having enough rest and officially handed over to a public health nurse on 14th December, 2021. I wished her the best in life and told her to report to the hospital whenever she is feeling ill.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation, or compendium of previously stated facts or statements. Conclusion is something that you decide when you have thought about all the information connected with the situation (Weller, 2014). This is the last step of the patient/family care study which entails the student's personal appreciation of the therapeutic relationship with the patient as well as the use of the nursing process.

6.1 Summary

Patient arrived on the Female Medical Ward on 23rd November,2021 at around 1:00pm per wheel chair accompanied by a staff nurse, rotational nurse and her mother. On arrival patient was fairly ill, weak and with an unsatisfactory level of hydration. Patient was fully conscious and alert. Patient had been detained at the Accident and Emergency unit for one day with the diagnosis of Severe Anaemia with history of dizziness, headache and weakness. Patient was trans-out from the E/R to the female medical ward. With the use of nursing process, the problems identified were developed into nursing diagnosis with nursing orders which were implemented to help solve these problems and promote recovery.

Using the nursing care plan, effective nursing care was carried out on the patient to ensure full recovery of patient. Among the care provided to her were bed making, monitoring of vital signs (temperature, pulse, respiration, and blood pressure), proper positioning in bed, administration of medication, and patient/family education on personal hygiene was done. She was discharged on 27th November, 2021 when her condition had improved and was declared fit to go home with no complains. Goals were fully met during evaluation of care. Three home

visits were paid to her to assess progress of her condition at home. She reported to the hospital for review on the 6th December, 2021. Care was terminated on 14th December, 2021.

6.2 Conclusion

The patient care study has helped me gain knowledge about nursing care rendered to patients, this study has also helped me to know how to collect relevant information from patients, identify health problems, analyze and formulate a nursing care plan using the nursing process approach. Recommendations of patient/family, medical team, opinions and appraisal of their co-operation towards the achievement of goals which promoted the well-being of patient and family physically, psychosocially and spiritually.

This study has enabled me to put into practice the knowledge acquired during my three years training in the institution, it has helped me to be prepared to nurse patients effectively in the near future regardless of their condition with the help of nursing process adopted.

I therefore recommend that the patient and family case study should be maintained as a facade of the nurse trainee and fully establish in the country health care delivery system to aid in the improvement of health for the country.

APPENDIX

Table 7: Vital signs chart for patient

Date	Time	Temperature (°C)	Pulse (bpm)	Respiration (cpm)	Blood Pressure (mmHg)
23/11/21	1:00pm	37.4	128	22	100/60
	2:00pm	37.1	118	20	110/60
	6:00pm	36.7	120	24	100/80
	10:00pm	36.9	122	19	110/80
24/11/21	6:00am	36.2	118	20	120/70
	10:00am	36.3	120	20	110/80
	2:00pm	36.5	110	21	110/70
	6:00pm	36.6	112	21	110/80
	10:00pm	36.8	108	20	110/70
25/11/21	6:00am	35.9	110	20	100/60
	10:00am	36.2	94	21	120/80
	2:00pm	35.7	99	21	100/70
	6:00pm	36.5	88	20	110/60
	10:00pm	36.4	90	17	120/70
26/11/21	6:00am	36.1	86	22	110/60
	10:00am	36.3	88	20	100/60
	2:00pm	36.4	84	23	110/80
	6:00pm	36.1	86	21	110/70
	10:00pm	36.4	84	20	100/60
27/11/21	6:00am	36.2	86	24	110/80
	11:00am	36.5	88	22	100/80

Vital signs chart for pre and post transfusion for patient.

23/11/21 4: 00pm Pre-trans.	Temperature (℃)	Pulse (bpm)	Respiration (cpm)	Blood Pressure (mmHg)
	36.0	72	22	110/60
23/11/21 8:20pm Post trans.	36.8	70	21	120/70
24/11/21 5:20pm Pre-trans.	36.0	72	22	110/60
24/11/21 9:40pm Post trans.	36.7	70	22	110/60

Vital signs chart for Patient's review

6/12/21 9: 00am	Temperature (℃)	Pulse (bmp)	Respiration (cpm)	Blood Pressure(mmHg)
	35.9(℃)	74	22	110/70

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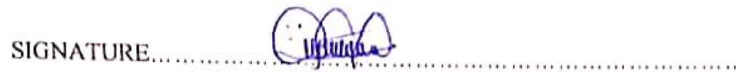
SIGNATORIES

1. THE STUDENT NURSE

NAME: AWINPOKA VICTORIA



DATE: 6TH OCTOBER, 2022.

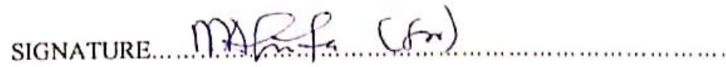
2. THE SUPERVISOR, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE BEREKUM

NAME: MISS GRACE ASANTEWAA

DATE...11/10/2022...

3. THE WARD IN-CHARGE, REGIONAL HOSTPITAL SUNYANI

NAME: MISS BARBARA ASANTE YEBOAH



DATE...11/10/2022...

4. THE PRINCIPAL, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

NAME: MONICA NKUMAH