HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM.

A PATIENT/FAMILY CARE STUDY ON RIGHT LOBAR PNEUMONIA

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A PATIENT/FAMILY CARE STUDY SUBMITTED TO NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILLMENT FOR THE AWARD OF A LICENCE TO PRACTICE AS A PROFESSIONAL REGISTERED GENERAL NURSE

AUGUST, 2023

PREFACE

The profession of nursing as we know it today has developed over time. Nursing was practised instinctively and "untaught" in the prehistoric age out of compassion and a desire to aid others. Based on experience and observation, it was a woman's role to naturally care for the young, the ill, and the elderly. Later, it changed, and prisoners, religious orders of the Christian Church, and crusaders provided care while being trained on the job by more seasoned nurses. However, health did not significantly improve as enraged Protestants seized the assets of hospitals affiliated with Roman Catholicism. As a result, many nurses ran for their lives.

However, during the 19th and 20th centuries, nursing advanced due to numerous conflicts, a rise in social consciousness, more educational options for women, and the significant impact Florence Nightingale performed, which cannot be overstated. The training of nurses in diploma program, licensing of nurses, specialization of hospitals and diagnosis, development of baccalaureate and advance degree programs and scientific and technological development as well as social changes marked this period. More than ever, today’s nurses need to think critically, creatively, and compassionately to reach out to all.

The nursing process is a methodical approach to problem-solving used to address a person's nursing and health care needs. Assessment, diagnosis, result identification (using objective/outcome criteria), planning, implementation, and evaluation are the steps that make up this process. Assessment is the methodical gathering of information to ascertain the patient's health status and spot any present or possible health issues. Diagnosis is identification of actual, potential and collaborative patient problems whereas planning is the development of goals and outcomes, as well as a plan of care designed to assist the patient in resolving the diagnosed problems and achieving the identified goals and desired outcomes. Implementation is the actualization of the plan of care through nursing

interventions and evaluation is determination of the patient’s responses to the nursing interventions and the extent to which the outcomes have been achieved.

Every final-year student's evaluation includes the patient/family care study. Every candidate must complete it in order to partially fill the requirements for the Nursing and Midwifery Council of Ghana's licence to practise as a Registered General Nurse. The student has the chance to improve his or her talents for use in the future. The patient/family care study is a thorough description of all nursing care provided to the patient and family from the day of admission through the day of release, as well as review and follow-up visits.

The use of patient/family initials rather than their full names guaranteed the confidentiality of the patient and family.

The use of expertise and information from such fields as psychology, public health nursing, medical nursing, surgical nursing, pharmacology, nutrition, and dietetics to satisfy the requirements of the patient/family and the community at large enabled the provision of comprehensive care.

ACKNOWLEDGEMENT

Without the knowledge of some people, this study would not have been able to be finished. I feel compelled to express my sincere gratitude to them for making such a significant contribution to the success of this study.

My first gratitude goes to the Almighty God for keeping me safe and guiding me throughout the writing of this script. Is by his wisdom, grace and direction that has brought me this far.

I am incredibly grateful to Mister. E.K.T., the study's subject, and his family for their cooperation both in the hospital and during my home visits. God bless them abundantly.

The Holy Family Nursing and Midwifery Training College, Berekum personnel as a whole, and notably my supervisor, Mr. Emmanuel Ali, deserve special thanks for their dedication to the success of this care study.

I wish to also express my sincere gratitude to the staff of Holy Family Hospital, Berekum, especially to the Nurse In-Charge and staff of the Male's medical Ward for their support and the advice they gave me throughout the study. May God bless you all for your guidance and support. My heartfelt gratitude to Mr. Appau for his generous act of providing me with a laptop to do this care study.

I want to express my sincere gratitude to my parents, Mr. and Mrs. Amankwa for their prayers, advice and for their financial support and especially to my two elder sisters Gloria and Edith for their care, love and support and to the entire family for their support and encouragement.

Finally, to my friends Serwaa and Vida and all D23 students for their help, love and encouragement during my study. God richly bless you all.

My appreciation also goes to the authors and publishers of the various books from which I took valuable information to write this script.

I certify that, this patient/ family care study was done and written by me. I therefore take full responsibility of any errors or mistakes done in this study.

INTRODUCTION

Patient and family care study is an academic exercise carried out by final year student nurses. The patient and family care study uses the nursing process, which is a deliberate activity where by the practice of nursing, is performed in a systemic manner.

This care study is based and written on Mister E.K.T., a 59 year old man who comes from Nsoatre at the Bono Region. He was admitted on 17th March, 2023, at 4:00pm and diagnosed with Right Lobar pneumonia. I interacted with him the very day he was admitted.

He spent five days at the hospital and throughout his stay in the hospital, he had treatment and care geared towards complete recovery.

The medications prescribed for him during his stay on the ward included;

1. Intravenous Metronidazole 500mg tds x 48hours
2. Tab Azithromycin 500mg bd x 3days
3. Tab Paracetamol 1g tid x 3 days
4. Carbocistein syrup 15mls tid x 7 days
5. Intravenous infusions NS 1.5L for 24hrs

Diagnostic tests conducted include;

1. Full Blood Count.
2. Erythrocyte Sedimentation Rate.
3. Chest X- Ray.

During his stay at the hospital, seven (7) health problems were identified. These were;

1. Patient had labored respiration. (17/03/2023).
2. Patient experienced chest pains. (17/03/2023).

3. Patient had headache. (17/03/2023).

4. Patient had fever. (17/03/2023).

5. Patient had interrupted sleep. (17/03/2023).

6. Patient had cough. (17/03/2023).

7. Client/family was ignorant about the condition (18/03/2023).

Three home visits and a follow up/review in the hospital were made to ensure continuity of patient's care which took place on;

1. First home visit 20^{th} March, 2023.

2. Second home visit 25^{th} March, 2023.

3. Review day 27^{th} March, 2023.

4. Third home visit 2^{nd} April, 2023.

Mister E.K.T. was chosen for the study base on the fact that I wanted to gain more knowledge about the condition (Pneumonia) which I communicated to patient. Patient and family responded positively to the request as husband of patient said, she believe her wife will be cured of her illness soon looking at how she is being cared for.

The patient/family care study was organized under six (6) headings which are;

1. Assessment of Patient/Family.

2. Analysis of Data.

3. Planning of Patient/Family Care.

4. Implementation of Patient/Family Care Plan.

5. Evaluation of Care Rendered to Patient/Family.

6. Summary and Conclusion

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment is a gradual process that enables the nurse to identify patient's needs and problems (Taylor, 2019). Assessment is the first stage of the nursing process which comprises of collection of data, observation, medical records and interviews. This helps the nurse to detect, plan and manage individualized health problems. It is also use in periodic evaluation of how client is responding to care rendered. It entails the patient's particulars, family medical/surgical history, family socio-economic history, patient's developmental history, patient's lifestyle and hobbies, patient's past medical/surgical history and the present medical/surgical history of the patient, literature review and validation of data.

1.1 Patient's Particulars

Patient particular's refers to the biographical data of a client and also includes areas such as patient's name(initials),date of birth, sex, marital status, nationality, next of kin, address, occupation, hometown and others(Marilynn,2017).

Mister. E.K.T., is a 59years old man born on the 21st of September 1963. He is dark in complexion and has an oval face with a slender body. He is 1.7m tall and weighs 63kg on admission. His Body Mass Index is 21.8kg/m^2. He is a Ghanaian by nationality and hails from Nsoatre in the Bono region of Ghana but lives at Dormaa Ahenkro with his wife. He has two daughters who are 32 and 26 years old respectively .He is the first born among six siblings and was born to Madam D.A who is still alive and the Late Mister K.T. His last daughter is his next

of kin. He is a Christian who worships at the Methodist church. He is an Akan and speaks bono. He has no educational background. He is a National Health Insurance beneficiary. He has no physical impairments or disabilities.

1.2 Family Medical History

Per the words of Mister E.K.T. the only chronic and hereditary disease he knows of in his family is hypertension, he further explained that his aunt died of hypertension and father was also a known hypertensive. No other family member has ever been hospitalized except his aunty. There is no communicable diseases like leprosy in the family. The only food he is allergic to is fufu because he experiences severe stomachache when he eats it. Over the counter medications are used for the treatment of headaches, stomach pains but goes to the hospital for further treatment according to his wife, Mrs. M.K. His grandparents are both deceased, his mother is the only one alive who is a bit weaker due to old age and father is also deceased, but the rest of his siblings are all alive and fit. There is no mental illness in the family. Patient has not undergone any surgical procedures yet.

1.3 Socio economic history

Socio-economic history captures sources of support, coping styles, strengths, and fears (Bickley & Szilagyi, 2019).

Mister E.K.T. is a mechanic and owns a shop with six apprentices. He earns enough money to cater for himself and wife since they stay alone but their granddaughter comes to spend time with them most times. His two daughter's stay away from them. Mister E.K.T.'s wife sells foot wears and supports him in one way or the other. He is under the National Health Insurance Scheme. Some of the occupational hazards he can encounter as a mechanic are injuries to his hands by

tools and moving vehicles can also cause injuries or death. His family is on average financial status as their basic needs such as food, shelter and other family expenses are being met. His wife testified about how supportive he is to the family. His family is very united. Mister E.K.T. is a Christian and worships at Methodist Church together with his wife and is a member of the Men's fellowship. The family did not have any particular family traditions, taboos, norms, cultural practices.

1.4 Patient's Developmental History

Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Taylor, 2019). Maturation is the process of developing (Taylor, 2019). Growth is the progressive development a living thing, especially the process by which the body reaches its complete physical development (Taylor, 2019).

Mister E.K.T. said, the mother told him, she had spontaneous vaginal delivery at Nsoatre Health Centre. Mister E.K.T. was not exclusively breastfed. He went through a normal developmental milestone. This includes sitting up at the 5^{th} month, crawling at the 10^{th} month, walking, talking and running between the ages of one and three. He had tooth eruption at sixth month. He was not immunized against tetanus, measles, poliomyelitis, tuberculosis and all other childhood diseases. Mister E.K.T. hit puberty when he was thirteen years old, started with the breaking of voice and spurts of hair growth in the armpits and penis. He got married at the age of 27years. He started his first relationship with the opposite sex at the age of 21years. He never attended school but he acquired skills on mechanics.

According to Erik Erickson's Theory of Psychosocial Development (1959), there are eight different stages with each possible result thus either success or failure in personality.

Mister E.K.T. is in the seventh stage of this theory known as generativity vs stagnation (35 to 65) Middle adulthood. Generativity is the concern of guiding the next generation. During middle age the primary developmental is one of the contributing to society helping to guide future generations. When a person makes a contribution during this period, perhaps by raising a family or working toward the betterment of society, a sense of productivity and accomplishment results. In contrast a person who is self - centred and unable or unwilling to help society move forward develops a feeling of stagnation. From the above and base on the information gathered from my patient it is clear that my patient has succeeded in this stage of life as manifested by his matureness and hard work.

1.5 Patient's Lifestyle and Hobbies

Lifestyle is defined as a pattern of daily living that an individual develops (Taylor, 2019).

The first thing Mister E.K.T. does before going out of bed is say a word of prayer and the last and the last thing done before going to bed is watching of television. He wakes up at 7:00am and start the day by taking his bath with warm water, brushing of teeth and sometimes eat breakfast such as oats or tom brown before going to work and goes to work around 9:30am and closes around 10:00pm at his mechanic shop. He works from Monday to Saturday and rests on Sundays only. He mostly eats his lunch at the workplace around 1:00pm and takes supper at 8:00pm. Their source of drinking water is bottles filled with borehole water and sometimes sachet water. He bathes twice daily and brushes his teeth once or sometimes twice daily. His hobbies are listening to the radio, watching of news on the television and playing ludo with his wife. He attends social gatherings such as funerals and weddings at his spare time. He empties his bowel

once daily and urinates about 5 to 6 times at the end of the day. My personal impression of my patient is that, he is very soft spoken, calm and very responsible man.

1.6 Patient's Present Medical History

According to Mister E.K.T.'s, wife, his present or current condition started on 13th March, 2023 when he had diarrhea, productive cough and started experiencing chest pains. They thought it was a minor ailments but they was no progress so he was sent to Ampemkro hospital at Dormaa. He was given colodium and ORS for rehydration but no improvement was seen with the productive cough and chest pains. He was then rushed to Holy Family Hospital, Berekum for further treatment. On 17th March, 2023, he was attended to by Dr. C. A at the Out Patient Department (OPD), who admitted him to the General male's ward after he was diagnosed of Right Lobar Pneumonia. . They were welcomed and he was quickly put in a comfortable cardiac bed. Patient's vital signs were checked and recorded as follows;

Temperature - 37.9^{o}c

Pulse - 90 bpm

Respiration - 26 cpm

Blood Pressure - 118/90 mmHg

Weight was 63kg

1.7 Patient's Past Medical History

According to Mister E.K.T., growing up, he did not experience any vaccine preventable diseases like diphtheria, whooping cough, and measles even though was not immunised against all the

childhood killer diseases which are tetanus, diphtheria, polio, whooping cough, measles, tuberculosis. Patient has been hospitalized at Holy Family Hospital, Berekum for the same condition (pneumonia) and was hospitalized for six days. He revealed that he sometimes suffers from minor ailments such as headaches, constipation, and diarrhea and treats them with over the counter medications. He has no known allergies to drugs, animals but except fufu. My patient has no physical disabilities and does not go for regular checkups. My patient has easy access to health care because he stays closer to a hospital and is a registered member of the NHIS. He has not done any surgical procedures and has no physical disability. My patient has not experienced any accidents before.

1.8 Admission of Patient

On the 17th of March, 2023, around 4:00pm, Mr. E. K. T. was admitted into the General male's ward at Holy Family Hospital, Berekum in a conscious state. Client and his wife were warmly welcome and offered a sit at the nurses' station. The staff and I introduced ourselves to them. I mentioned the name of the patient for the wife to respond in order to ensure that the right patient is admitted. He came with the complaints of severe dyspnoea, headache, cough, chest pain, fever and chills. Client and wife were reassured that necessary measures will be carried out with their cooperation by competent health workers in order to stabilize the condition. Patient's particulars were collected and documented accordingly into the admission and discharge book, daily ward state, nurse's notes and report books. All other necessary documentations according to the hospital protocol were also done. He was diagnosed of Right Lobar Pneumonia. He was oriented to time, place and person. They were welcomed and he was quickly put in a comfortable cardiac bed**.** On admission patient had difficulty in breathing, patient and his wife were also anxious. His vital signs were checked and recorded on admission.

My patient and his wife were reassured that everything would be done for his early recovery with their co-operation. He was also introduced to other patients in the ward. Patient and relative were oriented to the ward, it annexes, and visiting hours.

Patient was placed on the following medication

1. Intravenous Metronidazole 500mg tds x 48hours
2. Tab Azithromycin 500mg bd x 3days
3. Tab Paracetamol 1g tid x 3 days
4. Carbocistein syrup 15mls tid x 7 days
5. Intravenous infusions NS 1.5L for 24hrs

The following laboratory investigations were requested as follows;

1. Complete Blood Count (Haemoglobin,white blood cell and platelet).
2. Erythrocyte Sedimentation Rate (ESR).
3. Chest X-ray

He was also given general care such as oral care; feeding and drug administration and all were documented into the nurse's note. Drugs were collected from the ward pharmacy since patient is a national Health Insurance Scheme (NHIS) holder and treatment started as requested. As part of the admission process, I reintroduced myself to him as a student nurse in the Nursing and Midwifery Training College, Berekum who would like to use him for my care study to enable me to render a holistic nursing care to him and the family. They accepted with great joy and thanked me for showing care to him and the family. He promised to give me his maximum cooperation. I also made them to understand that it is a partial requirement by the Nursing and

Midwifery Council of Ghana towards the award of license to practice as a registered general Nurse.

Discharge plan was communicated to patient and wife including possible duration of hospitalization and after care. My reason for choosing this condition was for the fact that, it is an interesting condition which will help me learn and gain more knowledge on this condition. I assured patient and family of confidentiality of the information obtained through our interaction for example by using initials to represent their names. Patient relatives cooperated fully during the care.

1.9 Patient/Family Concept of the Illness

Patient and family do not know the cause of the illness and did not attribute the illness to any spiritual cause. Wife expressed hope in her husband getting well soon while patient also believe in the chances for him to improve in his condition as far as treatment continued.

1.10 Literature Review on Lobar Pneumonia.

The literature review condition will be discussed under the headings below.

1. The definition/description of Pneumonia
2. Incidence of Pneumonia
3. Causative organisms Pneumonia
4. Mode of spread of Pneumonia
5. Risk factor of Pneumonia
6. Pathophysiology of Pneumonia
7. Diagnostic Investigation of Pneumonia
8. Signs and symptoms of Pneumonia

9. Medical treatment of Pneumonia

10. Standard Nursing intervention of Pneumonia

11. Prevention of Pneumonia

12. Complication of Pneumonia.

Anatomy and Physiology Review of the Respiratory System

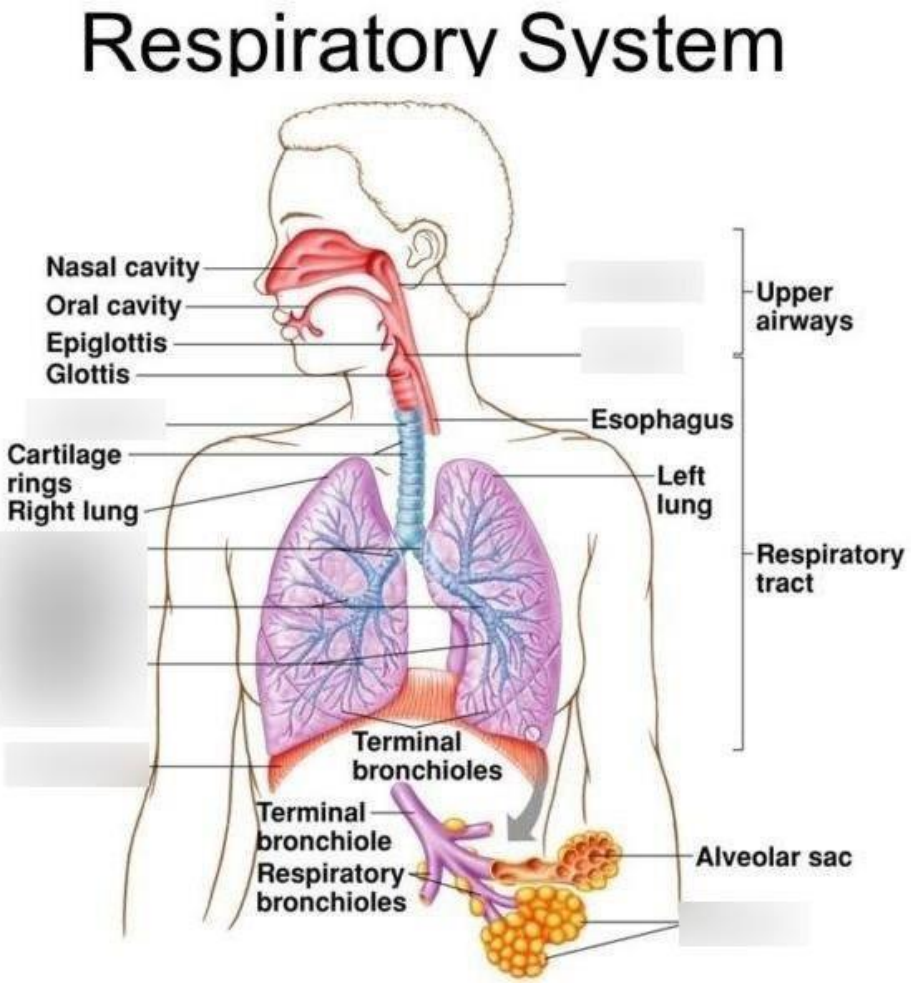

Figure 1. Anatomy of the Respiratory System

There are two lungs, one lying on each side of the midline in the thoracic cavity. They are cone-shaped and are described as having an apex, a base, costal surface and medial surface. The lungs are composed of the bronchi and smaller air passages, alveoli, connective tissue, blood vessels, lymph vessels and nerves. The left lung is divided into two lobes and the right, into three. Each lobe is made up of a large number of lobules. Within the lungs each pulmonary artery divides into many branches which eventually end in a dense capillary network around the walls of the

alveoli. The walls of the alveoli and those of the capillaries each consist of only one layer of flattened epithelial cells. The exchange of gases between air in the alveoli and blood in the capillaries takes place across these two very fine membranes (Grant & Waugh, 2022).

INTRODUCTION TO PNEUMONIA

Pneumonia is a form of acute respiratory infection that affects the lungs and bronchus (WHO, 2013)**.** Pneumonia is an inflammation of the lung parenchyma caused by various microorganisms, including bacteria, mycobacteria, fungi, and viruses. Pneumonitis is a more general term that describes an inflammatory process in the lung tissue that may predispose or place the patient at risk for microbial invasion (Hinkle, Cheever & Overbaugh, 2021). commonly other microorganisms, certain drugs and other conditions such as autoimmune diseases. When an individual has pneumonia, the alveoli are filled with pus and fluid, which makes breathing painful and limits oxygen intake. The area of the involved lung is said to have undergone consolidation.

Types of Pneumonia

Pneumonia is subdivided into two main type based on the anatomical position. They are lobar pneumonia and Bronchopneumonia.

Bronchopneumonia

This is a less dramatic form of Pneumonia but more prevalent than Lobar Pneumonia. The area affected is usually smaller than in the lobar type. The inflammation is localized in or around the bronchi and causes the lungs to be spotted or patched with clusters of infected tissue. It is mostly caused by organisms like streptococcus, influenza and infections which are present in the upper

respiratory tract (URT), travels down to infect the terminal bronchi (Hinkle, Cheever & Overbaugh, 2021).

Lobar pneumonia

Lobar Pneumonia a segment or the entire lobe of the lung may be affected. When both lungs are affected the disease is called double or bilateral Lobar Pneumonia. It is most frequently caused

by Pneumococcal and Klebsiella pneumonia. Others include Staphylococcus aureus, Streptococcus and viruses like influenza and adenovirus.

In this condition, a whole or part of the lung becomes solidified by inflammatory material. (Hinkle, Cheever & Overbaugh, 2021).

Epidemiology

Pneumonia is the single largest cause of death in children worldwide. Every year, it kills an estimated 1.2 million children under the age of five years, accounting for 18% of all deaths of children under five years old worldwide. Pneumonia affects children and families everywhere, but is most prevalent in South Asia and sub-Saharan Africa (WHO, 2013).

Pneumonia and influenza are the most common causes of death from infectious diseases in the United States. Together they account for nearly 60,000 deaths annually and rank as the eighth leading cause of death in the United States. The condition is common among the following people;

1. It is common in patients with suppressed immunity.
2. Patient undergoing radiation therapy
3. It is prevalent in patient with respiratory disease and respiratory malfunction

4. Elderly patients are highly affected because of depression of cough and glottis reflex.
5. People who smoke cigarette are highly affected and (90%) of cigarette smokers die as a result of pneumonia every year which is due to disruption in both mycociliary and macrophage activity.
6. People in overcrowded places and areas with poor environmental hygiene

Causative Organism

Pneumonia is caused by a number of infectious agents, including viruses, bacteria and fungi. The most common are:

1. Bacteria**:** *Streptococcus pneumoniae* – the most common cause of bacterial pneumonia in children;
2. *Haemophilusinfluenzae* type b (Hib) – the second most common cause of bacterial pneumonia;(WHO, 2013)
3. Viral: Respiratory syncytial virus is the most common viral cause of pneumonia; in infants infected with HIV, *Pneumocystis jirovecii*is one of the commonest causes of pneumonia, responsible for at least one quarter of all pneumonia deaths in HIV-infected infants. (WHO, 2013)
4. None microorganism causes include radiation, ingestion of chemicals and aspiration of gastric secretions, food or fluids (aspirated pneumonia) and retention of secretions which occurs in the mostly elderly people (Hypostatic Pneumonia) (Hinkle, Cheever & Overbaugh, 2021).

5. **Risk Factors**

According to (Hinkle, Cheever & Overbaugh, 2021), certain groups of people are at a higher risk for developing pneumonia. These risk factors include;

1. Age above 65years and below 2years.
2. Alcoholism
3. Smoking
4. Beta-lactam therapy (e.g., cephalosporins) in past 3 months
5. Immunosuppressive disorders
6. Multiple medical comorbidities
7. Exposure to a child in a day care facility.
8. Structural lung disease (e.g., bronchiectasis)
9. Corticosteroid therapy Broad-spectrum antibiotic therapy (>7 days in the past month)
10. Malnutrition.
11. Residency in a long-term care facility
12. Underlying cardiopulmonary diseases.

Mode of Transmission

Pneumonia can be spread in a number of ways. The viruses and bacteria that are commonly found in a patient's nose or throat can infect the lungs if they are inhaled or aspirated. They also spread via air-borne droplets from a cough or sneeze.

Pathophysiology

Normally, the upper airway prevents potentially infectious particles from reaching the sterile lower respiratory tract. Pneumonia arises from normal flora present in patients whose resistance has been altered or from aspiration of flora present in the oropharynx; patients often have an acute or chronic underlying disease that impairs host defenses. Pneumonia may also result from blood borne organisms that enter the pulmonary circulation and are trapped in the pulmonary capillary bed. Pneumonia affects both ventilation and diffusion. An inflammatory reaction can occur in the alveoli, producing an exudate that interferes with the diffusion of oxygen and carbon dioxide. White blood cells, mostly neutrophils, also migrate into the alveoli and fill the normally air-filled spaces. Areas of the lung are not adequately ventilated because of secretions and mucosal edema that cause partial occlusion of the bronchi or alveoli, with a resultant decrease in alveolar oxygen tension. Bronchospasm may also occur in patients with reactive airway disease. Because of hypoventilation, a ventilation–perfusion (V. /Q.) mismatch occurs in the affected area of the lung. Venous blood entering the pulmonary circulation passes through the under ventilated area and travels to the left side of the heart poorly oxygenated. The mixing of oxygenated and unoxygenated or poorly oxygenated blood eventually results in arterial hypoxemia. Distribution of lung involvement in bronchial and lobar pneumonia. In bronchopneumonia (left), patchy areas of consolidation occur. In lobar pneumonia (right), an entire lobe is consolidated. If a substantial portion of one or more lobes is involved, the disease is referred to as lobar pneumonia. The term bronchopneumonia is used to describe pneumonia that is distributed in a patchy fashion, having originated in one or more localized areas within the bronchi and extending to the adjacent surrounding lung parenchyma. Bronchopneumonia is more common than lobar pneumonia. (Hinkle, Cheever & Overbaugh, 2021).

Clinical Manifestations

Symptoms can develop gradually or suddenly. Viral bronchopneumonia may initially present with flu-like symptoms, but progress in a few days. Symptoms of bronchopneumonia include:

1. Fever and chills
2. Cough unproductive cough from onset and latter productive
3. Shortness of breath
4. Wheezing and crackling
5. Chest pain
6. Rapid breathing
7. Sweating
8. Anorexia
9. Increase in the pulse rate
10. General malaise
11. Headache
12. Elevation is leukocyte count

Diagnostic Investigation

1. Proper history taking and physical examination is conducted to assess for the presence of fever, crackling or wheezing etc.

2. Complete Blood Count (CBC) indicates an elevated number of white blood cells.

3. A chest X-ray is one of the best ways to diagnose this condition. This test uses electromagnetic radiation to create a picture of the lungs and chest, which can allow the doctor to locate areas that are affected by lobar pneumonia.

4. Erythrocyte Sedimentation Rate (ESR) to assess the level of inflammation

5. A computed tomography (CT) scan produces a picture similar to an X-ray but in more detail. This will tell the doctor where the infection is occurring in your lungs specifically.

6. A sputum culture tests a sample of mucus from your lungs to determine the cause of the infection.

7. A bronchoscope involves putting a camera down your throat to look at your bronchial tubes. This can be done to determine if there are other factors causing your bronchopneumonia.

8. The doctor may order a pulse oximetry. This test requires you to put a sensor on your finger and measures the amount of oxygen in your blood. The results of this test can tell the doctor the extent or severity of the infection and its effect on your ability to absorb oxygen.

Medical Treatment

Pneumonia is treated with antibiotics. Most cases of pneumonia require oral antibiotics for treatment. Hospitalization is recommended only for severe cases of pneumonia, and for all cases of pneumonia in infants younger than two months of age. Below is the treatment modality for pneumonia;

1. Antibiotic such as, gentamycin, cefuroxime and azithromycin to combat infections
2. Cough mixtures such carbocistein syrup is given to relief cough.
3. Analgesics and antipyretic such as paracetamol care given for pain and pyrexia
4. Anti-inflammatory such as diclofenac for pain and to reduce inflammation
5. Nitriomidazoles such as metronidazole to combat the infection.
6. Intravenous fluid 3 to 4 liters may be given daily to hydrate the client

Other non-pharmacological therapies include;

7. Patients who are hypoxemic are given humidified oxygen.
8. Respiratory measures such as endotracheal intubation and mechanical ventilation can be done.

Nursing Management

With reference to Kumar and Clark (2020), Hinkle, Cheever and Overbaugh (2021). the nursing management of pneumonia can be carried out under the following headings:

Psychological care

1. Reassure client that she/he in the hands of competent health workers who are willing to take care of him/her.
2. Educate client and family on the condition and allow them to ask question and answer them tactfully
3. Introduce client to other patients who had the same condition but have recovered successfully.

All these are done to allay fears and anxiety of client and for the client to have confidence in the staff.

Observation

1. Observe client for signs and symptoms of respiratory distress.
2. Check and record vital signs such as blood pressure, pulse, respiration and temperature accurately to check whether client's condition is improving or deteriorating.
3. Monitor intake and output chart and observe the site for swelling or dislodgement of the needle if client is on intravenous infusion.

4. Observe for effects and side effects of medication and report any abnormalities for measures to be taken.

Position

1. Put patient in a semi- fowler's position supported with pillows at the back to facilitate smooth and effective breathing.
2. Change position frequently to prevent client from developing pressure sores and improve proper circulation of blood.

Maintenance of Airway

1. Change the patient position every two hours to prevent pooling of secretions.
2. Encourage patient to do deep breathing exercise.
3. Where client is child and unable to cough sputum out, oropharyngeal suction is done to clear the airway. This is done with care in order not to introduce foreign substance into the pleural cavity.

Nutrition

1. Client must be encouraged to take in fruit and fluid (about 3-4litres daily should be given) to thin secretions and facilitate breathing and also avoid constipation.
2. If client experiences dyspnea, liquid diet is more preferable to avoid chocking.
3. A pleasant environment should be provided during meal time.
4. More protein, vitamins, mineral salt and carbohydrate meal are served to help in fighting infection and enhancing worn-out tissue repair. Vitamins and mineral salts diet must be

encouraged to build client's immunity. Foods rich in protein such as fish and eggs must be encouraged to repair worn out tissues.

Medication

1. Drugs prescribed by the physician must be administered as prescribed and documented.
2. During drug administration, the rights of drug administration must be observed, that is right patient, right drug, right dose, and right time.
3. Do not place drugs at patient's bedside to prevent him/her from taking overdose

Personal Hygiene

1. Bed linen and clothing's should be changed as soon as it is soiled.
2. Client should be given water to rinse mouth after coughing out sputum due to unpleasant taste of the sputum.
3. Patient should be bathed twice daily to maintain personal hygiene, improve circulation and to induce sleep.
4. Care of the mouth must be done at least twice daily to stimulate client's appetite
5. Care of hands feet must be done when necessary to prevent harboring of microorganisms
6. Mouth care should be given regularly to combat dryness or cracking of the lips and infections in the mouth.

Exercise

1. Engage patient in passive exercise as condition permits to improve circulation.
2. Breathing exercises can be done to loosen and mobilize secretions.

Elimination

1. Bedpan must be given promptly on demand to prevent patient from soiling himself/herself.
2. Monitor patient bowel movement and assess patient for any abnormality
3. Patient must be catheterize to help him/her micturate if cannot

Rest and Sleep

1. A comfortable bed free from creases and crumps must be prepared for client to prevent him from developing pressure sores.
2. A quiet environment must be ensured by asking other patient to communicate in low tones and also keep volumes of television and radio sets low.
3. Encourage client to rest and remain in bed to avoid exertion and relief symptoms.
4. Warm bath and warm drinks may be given to induce sleep.
5. Patient must be nursed in a well-ventilated room and quiet environment.
6. Temperature is controlled by tepid sponging to provide comfort.
7. Plan and carry out care in such a way that the client's resting time will not be interrupted.

Health Education

1. Educate the patient and family on the disease condition so that they can prevent any complication.
2. Educate on the need for follow-up and treatment regimen of antibiotics.
3. The patient should be taught coughing and breathing exercise.

4. Educate on the need to avoid sleeping directly under fans but rather should open windows for ventilation.
5. Educate patient on the avoidance of alcohol, smoking and strenuous exercises.
6. Educate patient to avoid dust and cold environment because this can predispose one to getting pneumonia.
7. Teach client and his mother to avoid passive smoking which can increase an individual susceptibility.

Prevention of Pneumonia

According to Bare and Smeltzer, (2017). , pneumonia can be prevented in the following ways.

1. Educate on proper environmental and personal hygiene.
2. Sudden change of body temperature should be reported to the appropriate health facility.
3. Avoid excessive intake of alcohol, smoking and environmental pollution (dusty or smoky environment).
4. The patient should sleep in a well-ventilated room.
5. Disease of the Upper Respiratory Tract should be treated quickly to avoid organism descending into the Lower Respiratory Tract
6. Educate patient on the avoidance of indiscriminate use of antibiotics for infections.
7. Sleeping in cold environment should be avoided.
8. Frequent suctioning of secretion in patients who are unconscious or have poor cough reflex
9. Vaccination against pneumococcal and influenza viral infection called pneumovax 23 has been recommended for debilitated patients.

Complications

According to Kumar and Clark (2020), there may be

Complications such as;

1. Emphysema: as a result of the invasion of bacterial in the lungs or pleuritic cavity, the infection and inflammation may lead to pus formation in the lungs.

2. Pleural effusion: This is due to the inflammation of the lung tissue, necrosis may occur forming pus in the pleural cavity leading to pleural effusion.

3. Bacteremia: due to the haematogous spread of bacterial from the lung in to the blood.

4. Respiratory failure: This is failure of the respiratory organ to perform its function, due to lungs (bronchial tree) been infected and inflamed. Therefore cannot carry oxygen to other parts of the body.

5. Cardiac failure: Pneumonia can complicate to cardiac failure and this is due to deprivation of oxygen to the lungs making it difficult for the heart to get enough oxygen causing ischemia to the heart muscles.

1.11 Validation of Data

Validation is the act of measuring or indicating the quality of a data collected as far as it can judge. This is to ensure that, data compiled on client and relatives are free from biases, misinterpretation and errors as possible. Physical assessment and diagnostic investigations (laboratory and radiology) carried out on the patient were compared with standard features and measurement. Also information gather on client was cross checked with her family, the medical officer and that from records. Patient's family were asked several questions needed for the

validation of data collected during home visit and answers provided were genuine to validate the collected data. All information collected on client indicates lobar pneumonia. These checks were done to ensure the ascendancy of the validity of data as possible and can therefore be affirmed that the data is suitable for this study.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis is the act of determining the component of parts of a substance (Chernyak, 2018). Analysis is the arranging and grouping of identical materials meaningfully for the purpose of identification and comparison. Analysis is the second phase of the nursing diagnosis that deals with comparing data gathered on the patient with the standard to help determine any deviation from normal functions of the body. This enables the nurse formulate appropriate individualized nursing care.

2.1 Comparison of Data with Standard

Information which were obtained from patient are compared to what is standardized in literature in other to solicit for more understanding about patient course of treatment and their effectiveness in patient's improvement.

This deals with comparing the data obtained with that of the standards. These includes

1. Diagnostic investigations
2. Causes
3. Clinical features
4. Treatment
5. Complications.

A. Diagnostic Investigation/Test

Diagnostic investigation is a study conducted on a patient to confirm the condition he/she suffering from and to find the causes of a disease to guide treatment plan.

To help in the diagnosis and treatment of Mister E.K.T, the following investigations were carried out on him during his period of hospitalization;

1. Complete Blood Count (CBC) to detect infection and rule out anaemia.
2. Erythrocyte Sedimentation Rate (ESR) to check the extent of inflammation.
3. Plain Chest radiography (x-ray) to indicate inflammation.

Table 1: Comparison of Diagnostic Investigation carried out on Patient with Literature review.

Diagnostic Investigation in the Literature Review	**Diagnostic Investigation carried out on my Patient**
1. Full blood count(White blood cell and haemoglobin and platelet)	1.White blood cell haemoglobin and platelet count was done
2.Chest x-ray	2.Chest x-ray was done
3.Computed tomography scan	3.Computed tomography scan was not done
4.Sputum culture	4.Sputum culture was not done
5.Bronchoscopy	5.Bronchoscopy was not done
6. Erythrocyte Sedimentation Rate	6. Erythrocyte Sedimentation Rate was done

7. Pulse oximetry	7. Pulse oximetry was not done

The following diagnostic investigations were performed on my client: physical assessment, Chest x-ray, Erythrocyte Sedimentation Rate and Full Blood Count (White blood cell and haemoglobin estimation and platelet count) were done. All the investigations conducted on my client are found in the literature review. Computed tomography scan, Sputum culture, Bronchoscopy, are all part of the literature review but were not requested.

Table 2: Result of Diagnostic Investigation/Test conducted on client compared;

Date	Specimen	Investigation	Results	Normal Value	Interpretation	Remarks
17/03/2023	Full Blood Count					
	Blood	Haemoglobin level estimation	14.2g/dl	Males:13.0-18.0g/dl Female:12.0-16.0g/dl	Results fell within normal limits.	No treatment was given
		White blood cell count	12.3 x 10^3/l	4x10^9/l -11x10^9/l	Client had infection.	Antibiotics such as azithromycin 500mg was prescribed and administered
		Platelet count	160 x 10^3/ul	150-400 x 10^3	Normal	No treatment was given
17/03/2023	Blood	Erythrocyte Sedimentation Rate	39mm/hr	Male**:** 0- 15mm fall in 1 hour.	Client had infection	Tab Azithromycin was given.

				Female**:**0- 20mm fall in 1 hour		
18/03/2023	Chest	Chest x-ray	Distributed clouds in the lungs	Lungs should be clear without any clouds and patchy areas	Indicating patchy consolidation due to inflammation as a result of infection	Tab Azithromycin was prescribed and administered

B. Causes of client's Illness

Comparing client's laboratory and chest x-ray with in the literature review and as confirm by the medical officer, it was indicated that, client's condition was as a result of infection.

C. Clinical manifestation/ Sign and Symptoms

Clinical feature is a term used to describe the feeling that is experienced by the individual affected or that which can be detected by someone else (Webster, 2018). These are the clinical features exhibited by my client.

Comparison of clinical features exhibited by client with those listed in the literature review. Table 3 below shows comparison of clinical features

Table 3: Comparison of Clinical Manifestations Exhibited by My Patient to those in the Literature Review

Clinical Features from the Literature Review	C**linical Features Exhibited by Client**
1. Fever and chills	1. Patient had fever
2. cough that brings up mucus and may be painful	2.Patient experienced cough with mucus
3. shortness of breath	3. Patient experienced shortness of breath
4 .Chest pains	4. Patient experienced chest pain
5. Sweating	5. Patient experienced sweating

6 .Anorexia	6.Patient had no anorexia
7. Increase in pulse rate	7.There was increased pulse rate
8. General malaise	8. Client experienced general malaise
9. Headache	9. Client experienced headache
10. Elevation of leucocyte count	10.There was no increased in leucocyte count
11. Rapid breathing	11. Patient had rapid breathing
12. Wheezing	12. Wheezing was present on examination

From the table, my client exhibited most of clinical manifestation as indicated in the literature review hence diagnosis confirmed that patient had lobar pneumonia.

D. Treatment given to my client

According to Taylor (2019), Treatment refers to the mode of dealing with a particular properties with the use of chemical, physical, or biological means. The following were the treatment given to my patient

With reference to literature review for the treatment of lobar pneumonia, client was given the following treatment

1. Intravenous Metronidazole 500mg tds x 48hours
2. Tab Azithromycin 500mg bd x 3days
3. Tab Paracetamol 1g tid x 3 days

4. Carbocistein syrup 15mls tid x 7 days

5. Intravenous infusions NS 1.5L for 24hrs

Table 4: Comparison of Drugs given to Patient to those in Literature Review.

Treatment outlined in the literature review	**Treatment given to my client**
1. **Antibiotics** a. Cefuroxime, b. Gentamycin c. Azithromycin	**1. Antibiotics** a. Cefuroxime was not administered b. Gentamycin was not administered c. Azithromycin was administered for my patient
2. Anti-pyretic and Analgesics a. Paracetamol (Acetaminophen) b. Diclofenac	**2. Anti-pyretic and Analgesics** a. Paracetamol was administered for my patient b. Diclofenac was not administered for my patient
3.Nitroimidazole a. Metronidazole	**3.Nitroimidazole** a. metronidazole was administered for my patient
4. Crystalloid isotonic solution a. Intravenous normal saline	**4.Crystalloids isotonic solution** a. Intravenous normal saline was administered for my patient
5. Expectorant a. Carbocistein	5.**Expectorant** a. Carbocistein was administered for my patient

Intravenous infusions was given, all treatment given conform to the literature review.

Table 5: Pharmacology of Drugs Administered to Mister E.K.T

Date	Drug	Dosage/Route of Administration in Literature Review	Dosage/Route of Administration Given to Client	Classification	Action/Desired Effect	Actual Action Observed	Side Effects
17/03/2023	Iv Metronidazole (Flagyl)	Dosage: Oral 400mg tid daily. IV:500mg every 8hours x 7days Adults:500mg IV x tid daily for 5 to 10days Children:22.5g to 40mg/ kg/ day, IV divided every 8 hours	500mg tid x 48hours. Route Intravenously	Nitroimidazole	Metronidazole is an antimicrobial drug with high activity against anaerobic bacteria and protozoa. Metronidazole works by entering bacterial and protozoal cells	Patient was treated from any bacterial infection.	Ataxia, darkening of urine, arthralgia, dizziness, erythema, headache None of these side effects was observed

					interfering with their DNA		

Table 5; Cont'd

Date	Drug	Dosage/Route of Administration in Literature Review	Dosage/Route of Administration Given to Client	Classification	Action/Desired Effect	Actual Action Observed	Side Effects
17/03/2023	Tablet Azithromycin	**Dose; Adult** 500mg once daily **Children:** 10mg/kd/dose PO for 1 day,5mg/kg/dose PO for 4 days **Route;** intravenous,	Dose; 500mg once daily for 3 days **Route; orally**	Antibacterial (Macrolides)	To combat infection by inhibiting bacteria protein synthesis.	Client was relieved of signs and symptoms of infection.	Nausea, vomiting, diarrhea, dyspepsia, flatulence, constipation, pancreatitis, hepatitis. None was present.

		intramuscular, oral					
17/03/2023	Tablet paracetamol	**Dose; Adult**:1g 3-4 times daily **Children**: 5mls to 10 mls 4 times daily. **Route**: Oral, rectal.	Dose; 1g tid x 3 days **Route**; oral	Analgesics and antipyretic	Block pain impulse by inhibition of prostaglandins synthesis; antipyretic action results from inhibition of prostaglandins in the central nervous system.	Temperature reduced to within normal range (36.2^{o}c-37.2^{o}c).	Drowsiness, hepatoxicity, skin reaction. None was observed on the patient
17/03/2023	Carbocistein syrup	**Dose;** 10-20ml **Adults**:10- 20mls x 3 times a day	**Dose;** 15mls x tid for 7 days **Route;** Oral	Cough suppressant	To suppress the cough reflex by direct action on the cough center in	Patient was relieved of cough.	Gastrointestinal irritation, rashes. None was observed on client.

		Children: 5mls to 10mls x 3 times daily. Route; Oral			the medulla of the brain. .		

E. Complications of Lobar pneumonia

Complication is difficult factor or issue often appearing unexpectedly and changing exiting plans, methods, or attitudes (Taylor, 2019).

Table 6: Comparison of Complications in Literature Review with Complication exhibited by patient

Complication in the Literature Review	Complication Mister E.K.T. exhibited
Emphysema	Emphysema was not present
Pleural effusion	Pleural effusion was not present
Bacteraemia	Bacteraemia was not present
Respiratory failure	Respiratory failure was not present
Cardiac failure	Cardiac failure was not present

On account of efficient nursing and medical care, patient did not experience any form of complication as outlined in the literature review of the disease condition.

2.2 Patient / Family Strengths

Patient/family strength involves those activities that the patient and family could do to help the patient towards recovery. (Taylor, 2019)

Strength is factor or activity that can be identified on a patient irrespective of his/her illness that can help the nurse to plan an individualized care for the patient

Below includes the strength of patient and family;

1. Patient could breathe when in upright position.
2. Patient could verbalize the intensity of the pain.
3. Patient could verbalize the intensity and duration of headache.

4. Patient could tolerate tepid sponging.
5. Patient can sleep continues uninterrupted for about 30 minutes at night.
6. Patient's cough subsides when sitting in an upright position .
7. Patient/wife expressed their willingness to know more about the condition.

2.3 Patient/family Health Problems

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

To give effective nursing care to the patient, it is essential for the health problems of my client to be identified through assessment, observation and data collection. These problems include actual and potential health problems. Patient and his family were nervous about the outcome of the condition. During observation, the following problems were identified;

3. Patient had labored respiration (17/03/2023).
4. Patient experienced chest pains (17/03/2023).
3. Patient had headache. (17/03/2023).
4. Patient had fever (37.9℃). (17/03/2023).
5. Patient had interrupted sleep. (17/03/2023).
6. Patient had cough. (17/03/2023).
7. Client/family was ignorant about the condition. (18/03/2023).

2.4 Nursing Diagnosis

According to Hinkle, Cheever and Overbaugh (2021), nursing diagnosis is the organization, analysis, synthesis and summarization of data collected and determines the patient's need for care. Nursing diagnosis are developed based on data obtained during nursing assessment

1. Dyspnoea related to congestion in the lungs. (17/03/2023).
2. Chest pains related to accumulation of fluid in the pleural cavity of the lungs. (17/03/2023).
3. Headache related to infectious process in the lungs. (17/03/2023).
4. Pyrexia related to infectious process in the lungs. (17/03/2023).
5. Sleep pattern disturbance related to intermittent cough. (17/03/2023).
6. Cough related to irritations in the airway. (17/03/2023).
7. Knowledge deficit related to inadequate information on condition. (18/03/2023).

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 Introduction

According to Hinkle, Cheever and Overbaugh (2021), planning is the development of goals and outcomes, as well as a plan of care designed to assist the patient in resolving the diagnosed problems and achieving the identified goals and desired outcomes.

This chapter is the third phase of the patient and family care study that deals with planning the nursing care and it is third stage of the nursing process. It contains the process of developing nursing strategies to help face the client/family's health problems which were notified at the analysis stage.

To help accomplish a positive results, setting of clear objectives or outcome criteria and the corresponding of specific nursing intervention are essential to achieve our aim. After every nursing measure, the nurse evaluates the implemented measure to ensure the desired outcomes achieved or unmet.

3.1 Nursing Objectives/Outcome Criteria

After the problem and needs have been identified, objectives are set for specific nursing orders to enable the nurse achieve a positive outcome.

The objectives set for client E.K.T. and family are as follows;

1. Patient can breathe without difficulties within 48hrs as evidenced by;
   a. The nurse observing client breath normal and respiration rate is within limit (16-20cpm).
   b. The patient verbalizing that he can breathe without difficulties.

2. Patient's chest pains will resolve within 48 hours as evidenced by;

a. The nurse observing that the patient has a relaxed facial expression.

b. Patient's verbalizing the absence of chest pains.

3. Patient's headache will resolve within 24 hours as evidenced by;

a. The nurse observing that patient has a relaxed facial expression.

b. Patient's verbalizing the absence of pain.

4. Patient's body temperature will reduce to normal (36.2^{o}C to 37.2^{o}C) within 24 hours as evidenced by;

a. Thermometer readings indicating a reduction in client's body temperature. (36.2^{o}C to 37.2^{o}C)

b. Patient verbalizing that he is not warm to touch.

5. Patient will sleep uninterruptly for (6-8hours during the night and 2 hours during the day) as evidenced by;

a. Nurse observing client slept uninterruptly for 8hours in the night.

b. Patient verbalizing that he was able to sleep soundly in the night.

6. Patient's cough will subside within 48hours as evidenced by;

a. Patient verbalizing that cough has subsided.

b. Nurse observing that patient's cough has subsided.

7. Patient/family will get insight into the condition throughout the period of hospitalization as evidence by;

a. Patient/wife verbalizing that she now understands the cause, signs and symptoms, risk factors and management of the condition.

b. Patient/wife answering correctly questions posed by the nurse.

Table 6: Nursing Care Plan for Mister E.K.T.

Date and Time	Nursing Diagnosis	Nursing Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	Sign
17/03/23 @ 4:30pm	Dyspnea related to congestion in the lungs.	Patient can breathe without difficulties within 48hours as evidenced by; 1. The nurse observing patient can breathe normal and respiration is normal (16-20cpm). 2. The patient verbalizing that he can breathe without difficulties.	1. Put patient in the Fowler's position. 2. Remove tight clothing around patient chest. 3. Assess respiratory depth and breathe sound every 30 minutes . 4.Open nearby windows. 5.Administer prescribed drugs. 6.Assess for signs and symptoms of ineffective breathing pattern.	1. Patient was put in a semi-fowlers position and supported with pillows at the back to facilitate breathing. 2. Tight pullover was removed to ensure smooth respiration. 3. Patient's respiration was assess by counting, breath sounds by auscultating whilst the depth rate and rhythm were assessed at the same time. 4. Nearby windows were opened and fan was switched on to ensure adequate ventilation. 5. Prescribed drugs such as IV metronidazole and Tab azithromycin were administered to combat infections. 6. Signs and symptoms of ineffective breathing pattern such	19/03/23@ 4:30 pm	Goal fully met as; The nurse observed that patient breathed without difficulties and the client was observed to have normal chest expansion on assessment.	P.A

			7.Instruct client to deep breath or use incentive spirometer every (1-2 hours).	as shallow respiration, dyspnea and nasal flaring were assessed. 7.Client was instructed to breath deep or use incentive spirometer every (1-2 hours)			

Table 6: Nursing Care Plan for Mister E.K.T. CONT.

Date and Time	Nursing Diagnosis	Nursing Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	Sign
17/03/23 @ 4:45pm	Chest pain related to accumulation of fluid in the pleural cavity of the lungs.	Patient's chest pains will resolve within 48hours as evidenced by; 1. Patient verbalizing the absence of chest pain. 2. Nurse observing the relaxed facial expression of patient.	1.Reassure patient that chest pains will subside and also show other patients who had recovered from the same condition 2. Apply warm compress to the patient chest. 3. Put patient in the Fowler's position. 4. Encourage patient to sit upright when coughing. 5.Assess patient pain level using pain rating scale.(0-10). 6.Engage patient in diversional activity.	1. Patient was reassured that chest pains will subside and he was shown to other patients who have recovered from the same condition. 2. Warm compress such as towel dipped in hot water and squeezed out of excess water was applied to the patient's chest reduce pains. 3. Patient was put in the Fowler's position to facilitate breathing. 4. Patient was encouraged to sit up right when coughing to help reduce chest pains. 5. Patient pain level was assessed using pain rated scale and patient chose 7 as his pain level. 6. Patient was engaged in diversional activity such as watching of television.	19/03/23 @ 4:45pm	Goal was fully met as; Patient verbalized that chest pain has subsided. and nurse observed relaxed facial expression of patient.	P.A

			7.Serve prescribed antibiotics.	7. Tablet azithromycin 500mg and tablet paracetamol 1g were served.			

Table 6: Nursing Care Plan for Mister E.K.T. CONT.

Date and Time	Nursing Diagnosis	Nursing Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	Sign
17/03/23 @ 5:00pm	Headache related to infectious process in the lungs.	Patient's headache will resolve within 24hours as evidenced by; 1. Nurse observing that patient has a relaxed facial expression. 2. Patient verbalizing the absence of pain.	1. Reassure patient and family. 2.Assess patient's level and intensity of pain. (0-10). 3.Provide a calm environment for patient. 4.Teach patient relaxation techiques that will lessen the pain. 5. Provide patient with diversional activities. 6.Administer prescribed antipyretics.	1. Patient and family were reassured that measures are being taken to relieve patient of pain. 2. Patient's level and intensity of pain was assessed using the numerical rating scale (0-10), he chose 7. 3. Patient was provided with a calm environment by restricting visitors so that he can have a good rest. 4.Patient was taught relaxation technique such as breathing exercises to lessen his pain 5. Diversional activities such as watching of television was provided. 6. Prescribed antipyretics such as paracetamol 1g was administered	18/03/23 @ 5:00pm	Goal was fully met as nurse observed that patient has a relaxed facial expression and patient verbalized the absence of pain.	P.A

Table 6: Nursing Care Plan for Mister E.K.T. CONT.

Date and Time	**Nursing Diagnosis**	**Nursing Objective/outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	Sign
17/03/23 @ 5:20pm	Pyrexia related to infection in the lungs.	Patient 's body temperature will reduce to normal(36.2^{o}C-37.2^{o}C) within 24hours as evidenced by; 1. Thermometer readings indicating a reduction in patient's body temperature.(37.3^{o} C). 2. Patient verbalizing that his temperature has subsided and body is not warm to touch.	1. Check patient body temperature every 30 minutes. 2. Serve cold drinks to reduce temperature. 3.Remove patient's clothing. 4. Ensure adequate ventilation. 5. Remove extra beddings from patient 6. Tepid sponge patient. 7.Serve prescribed antipyretics and antibiotics.	1. Patient body temperature was checked every 30minutes. 2. Cold drinks such as orange juice were served to patient bring the temperature within normal range (36.2-37.2°C). 3. Patient's pullover was removed. 4. All nearby windows were opened and fan switch on to improve ventilation. 5. Extra beddings such as blankets and counterpane were removed from patient. 6. Patient was tepid sponged to reduce temperature. 7. Tablet paracetamol 1g and Tablet azithromycin 500mg were given orally to help reduced fever.	18/03/23 @ 5:20pm	Goal fully met as; Thermometer readings indicated a reduction in patient's body temperature (36.6°C) and patient verbalizing that his temperature has subsided and is not warm to touch.	P.A

Table 6: Nursing Care Plan for Mister E.K.T. CONT.

Date and Time	**Nursing Diagnosis**	**Nursing Objective/outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	Sign
17/03/23 @ 5:35pm	Sleeping pattern disturbance (insomnia) related to intermittent cough	1. Patient will sleep uninterrupted for(6-8hours during the night and 2hours during the day) within 24 hours as evidenced by; 1. Nurse observing patient sleep uninterrupted for 6-8 hours in the night. 2. Patient verbalizing that he was able to sleep soundly in the night.	1. Reassure patient that he will be able to sleep uninterrupted. 2.Make patient's bed comfortable to help induce sleep. 3.Monitor her vital signs regularly 4.Give patient warm drink and a warm bath to induce sleep. 5.Provide a well-ventilated and quite environment. 6.Serve prescribed drugs such as cough syrup	1. Patient was reassured will have enough sleep since proper nursing intervention have been out instituted. 2. Patient's bed was made free from creases and crumbs to enable him get a sound sleep. 3. Patient's vital signs were monitored every 4 hourly to know the progress of the patient. 4. Patient was given a warm bath and drink to dilate peripheral blood vessels to induce sleep. 5. Adequate ventilation was provided by opening nearby windows to allow fresh air into the ward. 6. Prescribed drugs such as cough mixtures and antibiotics were	18/03/23 @ 5:35pm	Goal fully met as Nurse observed patient slept uninterrupted for 8hours in the night and 2hours during the day and patient verbalized that he was able to sleep in the night.	PA

				served to relieve pain, persistent cough and to combat infection.			

Table 6: Nursing Care Plan for Mister E.K.T. CONT.

Date and Time	**Nursing Diagnosis**	**Nursing Objective/outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	Sign
17/03/23 @ 5:50pm	Cough related to irritations in the airways.	Patient's cough will subside within 48hours as evidenced by ; 1. Patient verbalizing that cough has subsided. 2.Nurse observing that patient's cough has subsided	1. Reassure the patient. 2.Elevate the head of patient's bed. 3.Put patient in an upright position. 4.Encourage deep breathing and relaxation techniques. 5.Monitor Patient's vital signs. 6.Administer prescribed expectorant.	1. Patient was reassured that all necessary measures will be taken to make cough subside. 2. The head of patient's bed was elevated to ease tension on the chest. 3. Patient was put in an upright position to allow expansion of the lungs and ensure enough breathing 4. Deep breathing and relaxation technique were encouraged to enable more air to flow through the body and help calm patient nerves. 5. Patient's vital signs such as respiration and SPO^2 were monitored to know the progress of my patient. . 6. Prescribed expectorant such as carbocistein 15mls was given to patient to relieve his cough.	19/03/23 @ 5:50pm	Goal was fully met as evidenced by; Patient verbalizing that cough has subsided and nurse observing that patient's cough has subsided.	P.A

Table 6: Nursing Care Plan for Mister E.K.T. CONT.

Date and Time	**Nursing Diagnosis**	**Nursing Objective/outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	Sign
18/03/23 @ 10:30am	Knowledge deficit related to inadequate information on condition	Patient/family will get insight into the condition throughout the period of hospitalization as evidenced by; 1. Patient verbalizing the cause, signs and symptoms, risk factors and management of the condition. 2. Patient answering correctly questions posed by the nurse.	1. Reassure patient and wife. 2. Assess patient/mother level of awareness of the condition. 3. Maintain a quiet and calm environment. 4. Educate patient/wife on the disease condition. 5. Allow patient/wife to ask questions. 6. Provide diagrammatic pamphlet to patient and wife. 7. Provide answers in simple clear language avoiding the use	1. Patient/family was reassured that the disease can be cured and complications can be prevented from occurring. 2. They were asked about what she knows about the disease condition that is causes, signs and symptoms and its prevention. 3. A quiet and calm ward was ensured by reducing noise on the ward, restricting visitors. 4. Patient/wife were educated on the causes, signs and symptoms risk factors, treatment and the prevention. 5. Patient/wife was allowed to ask questions bothering her and answers were provided in clear simple terms to allay her fears. 6. Diagrammatic pamphlets was provided to patient and wife. 7. Answers were provided in simple clear language.	21/03/23 @ 9:00am	Goal fully met as; Patient/wife verbalized the cause, signs and symptoms, risk factors and management of the condition and patient/wife answered correctly questions posed by the nurse.	P.A

			of professional or medical jargons.				

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.1 Introduction

This aspect of the study deals with a description of the actual nursing care rendered to Mister E.K.T. and family during the period of hospitalization. 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 & Overbaugh 2021). 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

The actual nursing care of Mister E.K.T. began right from admission on the 17/03/ 2023 and continued until discharge on the 21/03/ 2023. During the period of admission, daily routine nursing care such as bed making, mouth care, bathing and serving of prescribed medication were carried out. Also specific care was rendered according to patient's needs.

First Day of Admission (17/03/2023).

On the 17th of March, 2023, around 4:00pm, Mr. E. K. T. was admitted into the General male's ward at Holy Family Hospital, Berekum in a conscious state. Patient and his wife were warmly welcome and offered a sit at the nurses' station. The staff and I introduced ourselves to them. I mentioned the name of the patient for the wife to respond in order to ensure that the right patient is admitted. He came with the complaints of severe dyspnoea,

headache, cough, chest pain, fever and chills. Patient and wife were reassured that necessary measures will be carried out with their cooperation by competent health workers in order to stabilize the condition. Patient's particulars were collected and documented accordingly into the admission and discharge book, daily ward state, nurse's notes and report books. All other necessary documentations according to the hospital protocol were also done. He was diagnosed of Right Lobar Pneumonia. He was oriented to time, place and person. They were welcomed and he was quickly put in a comfortable cardiac bed**.** On admission patient had difficulty in breathing, patient and his wife were also anxious.

His vital signs were checked and recorded on admission as follows;

Temperature - 37.9 ^{o}C

Pulse - 90 bpm

Respiration - 26 cpm

Blood Pressure - 118/90 mmHg

My patient and his wife were reassured that everything would be done for his early recover with their co-operation. He was also introduced to other patient in the ward. Patient and relative were oriented to the ward, it annexes, and visiting hours.

Patient was placed on the following medication

1. Intravenous Metronidazole 500mg tds x 48hours
2. Tab Azithromycin 500mg bd x 3days
3. Tab Paracetamol 1g tid x 3 days
4. Carbocistein syrup 15mls tid x 7 days
5. Intravenous infusions NS 1.5L for 24hrs

The following laboratory investigations were requested as follows;

6. Complete Blood Count (White blood cell and platelet).
7. Erythrocyte Sedimentation Rate (ESR).
8. Chest X-ray.

He was also given general care such as oral care; feeding and drug administration and all were documented into the nurse's note. Drugs were collected from the ward pharmacy since patient is a national Health Insurance Scheme (NHIS) holder and treatment started as requested. As part of the admission process, I reintroduced myself to him as a student nurse in the Nursing and Midwifery Training College, Berekum who would like to use him for my care study to enable me to render a holistic nursing care to him and the family. They accepted with great joy and thanked me for showing care to him and the family. He promised to give me his maximum cooperation. I also made them to understand this is a partial requirement by the Nursing and Midwifery Council, Ghana.

Discharge plan was communicated to patient and wife including possible duration of hospitalization and after care. My reason for choosing this condition was for the fact that, it is an interesting condition which will help me learn and gain more knowledge on this condition. I assured patient and family of confidentiality of the information obtained through our interaction for example by using initials to represent their names. Patient relatives cooperated fully during the care.

I went ahead and identified the following health problems based on complains and assessment on client;

At 4:30pm, a nursing care plan was done to manage patient difficulty in breathing. A nursing diagnosis of dyspnea related to congestion in the lungs was formulated. Nursing objective to enable patient breathe within 48 hours was set. Patient was put in a semi-fowlers position and supported with pillows at the back to facilitate breathing. Tight pullover was removed to ensure smooth respiration. Patient's respiration was assess by counting, breath sounds by auscultating whilst the depth rate and rhythm were assessed at the same time. Nearby windows were opened and fan was switched on to ensure adequate ventilation. Signs and symptoms of ineffective breathing pattern such as shallow respiration, dyspnea and nasal flaring were assessed. Client was instructed to breath deep or use incentive spirometer every (1-2 hours). Prescribed drugs such as IV metronidazole and Tab azithromycin were administered to combat infections.

Also, at 4:45pm, a nursing diagnosis of chest pain related to accumulation of fluid in the pleural cavity of the lungs was made. An objective to relief patient of chest pains within 48hours was set. Nursing interventions implemented included; patient was reassured that chest pains will subside and he was shown to other patients who have recovered from the same condition. Warm compress such as towel dipped in hot water and squeezed out of excess water was applied to the patient's chest reduce pains. Patient was put in the Fowler's position to facilitate breathing. Patient was encouraged to sit up right when coughing to help reduce chest pains. Tablet azithromycin 500mg and Tablet paracetamol 1g were served. Patient pain level was assessed using pain rated scale and patient chose 7 as his pain level. Patient was engaged in diversional activity such as watching of television.

Again, at 5:00pm, a nursing diagnosis of headache related to infectious process in the lung was made. An objective to relieve patient of headache within 24hours was set. The following interventions were implemented to relieve patient of headache. Patient and family were reassured that measures are being taken to relieve patient of pain. Patient's level and intensity

of pain was assessed using the numerical rating scale (0-10), he chose 7. Patient was provided with a calm environment by restricting visitors so that he can have a good rest. Patient was taught relaxation technique such as breathing exercises to lessen his pain. Diversional activities such as watching of television was provided. Prescribed antipyretics such as paracetamol 1g was administered.

More so, at 5:20pm, Pyrexia related to infection in the lungs was the nursing diagnosis made. An objective to resolve patient's temperature within 24hours was set. Nursing interventions implemented included, patient body temperature was checked every 30minutes. Cold drinks such as orange juice were served to patient bring the temperature within normal range (36.2-37.2°C). Patient's pullover was removed. All nearby windows were opened and fan switch on to improve ventilation. Extra beddings such as blankets and counterpane were removed from patient. Patient was tepid sponged to reduce temperature. Tablet paracetamol 1g and Tablet azithromycin 500mg were given orally to help reduced fever.

Around 5:35pm, my patient was finding it difficult to sleep, a nursing diagnosis of sleeping pattern disturbance related to intermittent cough was generated. A nursing intervention was implemented to aid my patient to sleep. Patient was reassured will have enough sleep since proper nursing intervention have been out instituted. Patient's bed was made free from creases and crumbs to enable him get a sound sleep. Patient's vital signs were monitored every 4 hourly to know the progress of the patient. Patient was given a warm bath and drink to dilate peripheral blood vessels to induce sleep. Adequate ventilation was provided by opening nearby windows to allow fresh air into the ward. Prescribed drugs such as cough mixtures and antibiotics were served to relieve pain, persistent cough and to combat infection

In addition, at 5:50pm, a care plan was made on cough and the nursing diagnosis generated was cough related to irritations in the airways. A nursing objective of cough subsiding within 48hours was set. The nursing interventions implemented were as follows; Patient was reassured that all necessary measures will be taken to make cough subside. The head of patient's bed was elevated to ease tension on the chest. Patient was put in an upright position to allow expansion of the lungs and ensure enough breathing. Deep breathing and relaxation technique were encouraged to enable more air to flow through the body and help calm patient nerves. Patient's vital signs such as respiration and SPO^2 were monitored to know the progress of my patient. Prescribed expectorant such as carbocistein 15mls was given to patient to relieve his cough.

At 6:00pm, vital signs was checked and recorded as in the appendix. Patient was served with rice and stew.

At 10:00pm, patient received his medications which included; IV Metronidazole 500mg, Tablet paracetamol 1g, Tablet Azithromycin 500mg, Syrup Carbocistein 15mls and 500mls of IV Normal saline.

Second Day of Admission on 18th March, 2023

On the second day of admission around 7:30am, I went to the ward to nurse my patient. Patient's vital signs that were checked and recorded at 6:00am as in the appendix.

Patient was assisted to perform personal hygiene activities such as brushing of teeth and bathing. Patient was served with tea and bread with boiled eggs in the morning. Around 9:36 am patient was reviewed by the doctor during ward rounds. All due medications were served. After the rounds, 10:00am vital signs were checked and recorded as in the appendix.

After checking of vitals, I inquired from the patient and wife about their understanding of the condition and realized they had inadequate knowledge on the condition.

At 10:30am, a nursing diagnosis of Knowledge deficit related to inadequate information on condition was made and an objective to enable patient and relatives get insight into the condition throughout the period hospitalization. Nursing interventions made includes: Patient/family was reassured that the disease can be cured and complications can be prevented from occurring. They were asked about what she knows about the disease condition that is causes, signs and symptoms and its prevention. A quiet and calm ward was ensured by reducing noise on the ward, restricting visitors. Patient/wife were educated on the causes, signs and symptoms risk factors, treatment and the prevention. Patient/wife was allowed to ask questions bothering her and answers were provided in clear simple terms to allay her fears. Diagrammatic pamphlets was provided to patient and wife. Answers were provided in simple clear language

At 2:00pm, after Mister E.K.T. had taken rice with tomato stew and chicken, his vital signs were checked and recorded as in the appendix. All nursing activities were documented appropriately on the vital signs sheet, medication and nurse's notes respectively.

I arranged for my first home visit with the client on the coming Sunday which is 20th March, 2023. In the afternoon patient was served with Malt drink with meat pie. Patient slept around 2:45pm after these nursing procedures and woke up at 5:10pm.

At 5:00pm, I evaluated the objective I set on 17th March, 2023 to relieve patient's headache and goal was fully met as nurse observed that patient has a relaxed facial expression and patient verbalized the absence of pain.

At 5:20pm, I evaluated the objective set on 17th March, 2023 to relieve patient's fever and goal was fully met as thermometer readings indicated a reduction in patient's body temperature (36.6°C) and patient verbalizing that his temperature has subsided and is not warm to touch.

At 5:35pm, I evaluated the objective I set to help my patient with sleeping pattern disturbance, my goal was fully met as nurse observed patient slept uninterrupted for 8hours in the night and 2hours during the day and patient verbalized that he was able to sleep in the night.

At 6:00pm, vital signs were checked and everything was within its range as in appendix. Patient was served with boiled yam and kontomire stew with pear at 6:30pm. He took his bath with assistance and his bed was made free from creases and crumbs. At 6:50pm, patient was assessed on his dyspnoea and patient verbalise that he can breathe a little bit well. Assessment was done on my patient's chest pain and patient verbalise that the pain has reduced from 7 to 5, using the pain rating scale. His cough was also assessed and cough seem to have been subsided a little. Patient and wife was assessed about their knowledge on the education given and they were able to repeat somethings which were taught.

At 10:00pm, vital signs were checked and everything was within its range as in appendix. All due medications were administered and documented appropriately after which patient slept soundly. Interventions for all other unevaluated goals were continued.

Third Day of Admission on 19th March 2023

On the third day of admission, I came on duty around 7:05am. Client vital signs were checked and recorded at 6am as in the appendix.

Mister E. K.T. was assisted to brush his teeth and take his bath. He was served with oats and wheat bread with milk for breakfast. All due medications were served. I continued the education on the condition. They were allowed to ask questions on the former and latter education and all questions were answered accordingly. Patient was served with rice and chicken soup in the afternoon and he was given bananas as well. He requested to walk around for a bit which permission was granted and I assisted him through it.

At 4:30pm, I evaluated the objective set on 17th March, 2023 to relieve patient of difficulty in breathing and my goal was fully met as the nurse observed that patient breathed without difficulties and the client was observed to have normal chest expansion on assessment.

At 4:45pm, I evaluated the objective I set on the 17th March, 2023 to relieve patient of chest pains within 48hours and my goal was fully met as patient verbalized that chest pain has subsided and nurse observed relaxed facial expression of patient.

At 5:50pm, I evaluated the objective I set on the 17th March, 2023 to relieve patient of cough within 48hours and my goal was fully met as patient verbalized that cough has subsided and nurse observed that patient's cough has subsided.

In the Evening at 6:00pm, vital signs were checked and recorded in the appendix

Patient was served with Rice ball and groundnut soup for supper, and all due medication were served accordingly in the evening. At 7:00pm, Patient and wife was assessed about their knowledge on the education given and they were able to repeat somethings which were taught and they were able to mention two causes of pneumonia.

At 10:00pm, vital signs were checked and everything was within its range as in appendix. Due medications were served and documented appropriately after which patient slept

soundly.The previous measures instituted to help client sleep were implemented again and he was able to sleep. Interventions for all other unevaluated goals were continued.

Fourth Day of Admission on 20th March 2023

On this day, the patient general condition had improved appreciably and patient looked cheerfully. He took his bath, brushed his teeth and groom himself. His bed linens were straightened and he took his breakfast. At 6:00am, vital signs were checked and recorded as in the appendix. Due medications were administered. Discussions were made with the patient and permission was sought to visit patient's home. Patient agreed and appropriate time was scheduled which was at 10:00am. I went to their house following the direction given to me by patient's wife. At 2:00pm, vital signs checked were within their normal ranges as indicated in the appendix. Prescribed medications were served and documented as well. Patient ate banku and okro soup with fish for lunch. Patient took his bath and watched television. At 4:00pm, patient and wife was assessed about their knowledge on the education given and they were able to mention at least one sign hence the interventions continued.

At 10:00pm, vital signs were checked and everything was within its range as in appendix. Due medications were served and documented appropriately after which patient slept soundly were continued.

Fifth Day of Admission on 21st March 2023 (Day of Discharge)

Around 6:00am, Mister E.K.T. was visited and all personal hygiene activities were performed such as bathing and grooming. Tea with toasted bread and egg were served for breakfast and he enjoyed it very well. His vital signs were checked and recorded in

appendix without any abnormality detected. Patient and wife were seen communicating very well with the other patients.

At 9:00am, evaluation on patient inadequate knowledge on his condition was made. Goal fully met as patient verbalizing that patient/family now know the causes, signs and symptoms and prevention of the condition and nurse observing patient answering questions posed him on the condition correctly.

Ward rounds began around 9:20am. By 9:45am, patient and family were discharged by Dr C.A, Patient and family were happy on hearing of their discharge such that, by the time patient could be discharged from the Admission and Discharge book as well as from the ward state, patient's wife had begun packing his belongings. Patient/family were showed the dosages to his medications. Also, they were educated on good hygiene practices, eating balance diet and to seek immediate medical attention in case of any deviation in health. Also, to ensure that the goal on the education of the condition was met, they were asked questions on what they have learned and the responds was satisfactory and also asked to give a summary of the whole education, which was done well. My patient bills were settled. Patient was reminded to come for review as stated which was on 27th March, 2023. Mister E.K.T. and the family members thanked the staff and friends in the ward and showed appreciation for the proper care and hospitality being rendered. He bid the other patient's good bye. They left the hospital at about 12:20pm for their home. The bed linen was put in the dirty linen bid for washing and mattress decontaminated with 0.5% bleach solution including the bedside locker and cardiac table.

4.2 Preparation of patient/family towards discharge and rehabilitation.

This is where measures are put in place in advance to prepare patient and family towards discharge when he is clinically fit as deemed by the medical officer and it starts on the day of admission on 17th March, 2023. Patient and family were made to understand that with continuous care, client's condition would improve and would be discharged home. From that day, patient and family were given series of education from the health team to help improve patient's condition. Patient and family were educated under the following;

Personal and Environmental Hygiene

Strict practice on personal and environmental hygiene were emphasized on in the prevention of subsequent infections. Patient was educated on cutting of fingernails to prevent harbouring of microorganisms and proper self-care. Patient was encouraged to in proper handwashing with soap and running water. They were also educated to dispose of refuse when it's near full and also clear bushy areas around their house, washing patient's clothing. Patient was advised to sleep under treated mosquito net.

Diet

Patient was educated on the need to eat nutritious or balanced diet. Patient was advised to eat high – calorie diet and high protein diet such as milk, fruit drinks, fish, meat, eggs and beans with the requisite energy, prevent weight loss, help to heal her and also promote a healthy immune system. Patient was also educated on the importance of well-balanced diet, was encouraged to ensure client take enough fluids and fruits to prevent constipation and dehydration.

Drugs

Patient was advised to continue the drug treatment regimen at home as prescribed and was also educated on how to take her medication at home. The side effects as well as the desired effects of the medications were explained to the family.

Education on prevention.

Patient was educated on preventive measures against pneumonia like getting vaccinated against pneumonia, patient should avoid smoking, prevent sleeping directly under the fan. Patient was educated to keep fingernails short and clean to prevent harbouring microorganisms which can cause pneumonia.

4.3 Follow Up/Home Visit/Continuity of Care

Home visit is a visit made by a health professional to a patient's home. Follow up is an important aspect in the care of the client in nursing after discharge. This is to ensure continuity of care by preventing diseases, promoting and maintaining health and prolonging life through health education, counselling, nursing care and rehabilitation.

First Home Visit (20TH MARCH, 2023).

I went for my first home visit on 20th March, 2023 at Dormaa while my patient was at the ward. My mission for embarking on this visit was to know my patient's house, his surroundings in which he lives, verify the information given me as well as to identify environmental factors that triggered my patient's condition. My patient's wife gave me the direction to their house which she stated was opposite to Dormaa Hospital. She gave me the house number and landmarks to notify the house which helped in easier access to their house. I set off around 10:00am, upon arrival at Dormaa town, I set off to locate the house. When got to the house, I greeted the first tenant I saw and explained my purpose for coming, she

was a bit reluctant but I reassured her and showed her my student ID and told her I am the one caring for Mister E.K.T. at Holy Family Hospital, Berekum. I was warmly welcomed. The house has a wall around it and has a black metal gate, the house is painted with cream and light brown color. The house is very big and is made up of 8 bedrooms with three chamber and hall with two rooms facing outside of the front view and is in a rectangular shape. Mister E.K.T. and his wife occupies one of the chamber and halls with a little veranda in front which serves as a cooking area for his wife and has a little door at the end. Since my patient and wife were still at the hospital, my reason for visiting was explained to the tenant I met and she even thanked me for coming and even showed me my patient's room. The house is built with blocks and roofed with iron sheets. They have four bathrooms which was made with broken tiles and three toilets which is a water closet. A borehole situated at the corner of the house is the source of drinking water for my patient and wife and a standing pipe is available as well. The compound was neatly swept. They have electricity in the house and their windows net had a little tears which I advised them to change it but can put paper in the holes for the time being.

I saw a bin for the collection of refuse which had no lid and I advised them to get one with a lid to minimize flies and pollution. During my visit, I noticed how neat their environment were, so I took the opportunity to congratulate them for doing that and also advised them to clear a small bushy area in front of the house and a little stagnant water. I informed them of my next visit which will be after discharge. After staying with patient's tenants for a while, I asked permission to leave of which permission was granted. I thanked them for their kindness and warm reception and again promised them of my next visit after patient's discharge. I left around 2:45pm, I exchanged goodbyes with the tenants and told them I will be back.

No vulnerable, such children under 5, the aged and pregnant women were found at patient home during my visit.

Second Home Visit (25th March, 2023)

My second home visit was made on 25th March, 2023, my reason for making that visit was to make enquiries about my patient's wellbeing, response to treatment and remind him of his upcoming review(27th March, 2023) and if there is any experience of adverse effect or not. As soon as my patient's wife saw me she gave me a warm hug and offered me a seat. My patient's wife told me her husband is going to be with me shortly because he just finished taking his bath. I used this opportunity to ask her whether my patient's health is improving or deteriorating and she confirmed that his health has really improved for the better since she makes sure he follows the drug regimen given. My patient joined us at the veranda and he was so happy to see me, I asked him how he was faring and he confirmed he is doing tremendously well. He emphasized on even resuming his work at the mechanic shop and I advised him on the importance of rest at the time being. I educated him that even though he seems strong he is still in the process of healing and it takes sleep and rest to make it faster so he should wait for the doctor's approval during his upcoming review.

I made them aware that in my next visit they will be handed over to a community health nurse if there is the need for continuity of care to be rendered to them. I went over on the education given to them and also asked patient to bring his medications to check whether patient was following the medication regimen that was given on his discharge and first home visit.

Finally, I told them they should not hesitate to report to the hospital if any complication arises before the review date. Before leaving the house, I wished them all the best and asked them

to stay healthy. They escorted me to the roadside, I bid them goodbye and left them at 12:40pm.

Review Day (27th March, 2023)

On this day, I met Mister E.K.T. and wife at the Out Patient Department at 8:30am at Holy Family Hospital, Berekum for review. He looked energetic and happy. I went with them to re-activate his card at the Records office. He then joined the queue for the checking of his vital signs and are as follows;

BP - 126/80 mmHg

Temp- 36.6 ^{O}C

Resp- 20cpm

Pulse- 80bpm

I took my client to the consulting room for the review when it got to his turn. Patient had no complains and was encouraged to ensure strict adherence to drug regimen and report to the hospital anytime he falls sick. Client was also educated on the need to ensure proper personal and environmental hygiene and also avoid dusty areas which can predispose him to the condition again. Client went ahead to confirm from the doctor if he can resume work, he was given the go ahead and advised not to over stress himself. After the consultation, client and wife were accompanied to the road side to board a tricycle to the station. They bid me good bye and left the hospital around 11:55am.

Third Home Visit (2nd April, 2023).

This was my last home visit that I went on 2nd April, 2023. My main motive was to see how Mister E.K.T. was doing at home, to see the general condition of the entire family, to reinforce on the education that had been given to them and to finally terminate care. I got there around 10:34 am with Nurse B.K. who is a community health nurse at Dormaa Hospital. When we arrived, Mister E.K.T. was prepared and ready to leave for work, he greeted us with a smile and offered us seats. I asked him about how he is doing and his wife and he told me everyone was good but his wife has gone to the market to sell her foot wears. I introduced Nurse B.K. to him as the one taking up in continuity of care from me. I noticed that their surroundings were still clean and I told him to keep it up. Education on nutrition, personal and environmental hygiene was given. Again I elaborated on the need to report to the hospital in case of any illness rather than self-medication. The community health nurse also assured Mister E.K.T.'s family of her readiness to help them achieve the best health status. They expressed their gratitude for my support and help. My client said he was sincerely grateful that I dedicated my time to support them when he was ill.

I also thanked them for their co-operation which all contributed in making the care of Mister E.K.T a success. I asked permission to leave which was granted and he saw me off to the road side where we bid each other goodbye 12:25pm.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO THE CLIENT/FAMILY

5.0 Introduction

Evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process (Hinkle, Cheever & Overbaugh, 2021).

The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to patient and family.

5.1 Statement of Evaluation

Evaluation is the final phase of the nursing process. It is the process of assessing and comparing the outcome of nursing orders and intervention against previously stated goals and objectives. Mister E.K.T was admitted on the 17th of March 2023,during his admission seven problems were identified which were then formulated into nursing diagnosis with their various goals set and nursing interventions carried out on them as well. Below are the outcomes or the result to these goals and objectives;

1. Patient was relieved of difficulty in breathing on 19/03/23 at 4:30pm

On 17/3/2023, a nursing objective to enable patient breathe within 48 hours was set with a formulation of nursing diagnosis of dyspnea related to congestion in the lungs at 4:30pm. . Patient was put in a semi-fowlers position and supported with pillows at the back to facilitate breathing. Tight pullover was removed to ensure smooth respiration. Patient's respiration was assess by counting, breath sounds by auscultating whilst the depth rate and rhythm were assessed at the same time. Nearby windows were opened and fan was switched on to ensure adequate ventilation. Signs and symptoms of ineffective breathing pattern such as shallow

respiration, dyspnea and nasal flaring were assessed. Client was instructed to breath deep or use incentive spirometer every (1-2 hours). Prescribed drugs such as IV metronidazole and Tab azithromycin were administered to combat infections.

On 19/03/23 at 4:30pm, I evaluated the objective set on 17th March, 2023 to relieve patient of difficulty in breathing and my goal was fully met as the nurse observed that patient breathed without difficulties and the client was observed to have normal chest expansion on assessment.

2. **Patient was relieved of chest pain on 19/03/23 at 4:45pm**

At 4:45pm, nursing diagnosis of chest pain related to accumulation of fluid in the pleural cavity of the lungs was made. An objective to relief patient of chest pains within 48hours was set. Nursing interventions implemented included; patient was reassured that chest pains will subside and he was shown to other patients who have recovered from the same condition. Warm compress such as towel dipped in hot water and squeezed out of excess water was applied to the patient's chest reduce pains. Patient was put in the Fowler's position to facilitate breathing. Patient was encouraged to sit up right when coughing to help reduce chest pains. Tablet azithromycin 500mg and Tablet paracetamol 1g were served. Patient pain level was assessed using pain rated scale and patient chose 7 as his pain level. Patient was engaged in diversional activity such as watching of television

On 19/03/23, at 4:45pm, Goal fully met as patient verbalized that chest pain has subsided and nurse observed relaxed facial expression of patient.

3. **Patient was relieved of headache on 18/03/23 at 5:15pm**

At 5:00pm, a nursing diagnosis of headache related to infectious process in the lung was formulated on 17/03/2023. An objective to relieve patient of headache within 24hours was set. The following interventions was implemented to relieve patient of headache; Patient and family were reassured that measures are being taken to relieve patient of pain. Patient's level and intensity of pain was assessed using the numerical rating scale (0-10), he chose 7. Patient was provided with a calm environment by restricting visitors so that he can have a good rest. Patient was taught relaxation technique such as breathing exercises to lessen his pain. Diversional activities such as watching of television was provided. Prescribed antipyretics such as paracetamol 1g was administered.

On 18/03/23, at 5:00pm, Goal fully met as nurse observed that patient has a relaxed facial expression and patient verbalized the absence of pain.

4. **Patient was relieved of fever on 18/03/23 at 5:20pm**

At 5:20pm, Pyrexia related to infection in the lungs was the nursing diagnosis made. An objective to resolve patient's temperature within 24hours was set. Nursing interventions implemented included, patient body temperature was checked every 30minutes. Cold drinks such as orange juice were served to patient bring the temperature within normal range (36.2-37.2°C). Patient's pullover was removed. All nearby windows were opened and fan switch on to improve ventilation. Extra beddings such as blankets and counterpane were removed from patient. Patient was tepid sponged to reduce temperature. Tablet paracetamol 1g and Tablet azithromycin 500mg were given orally to help reduced fever.

At 5:20pm, evaluation on body temperature was done, goal was fully met as thermometer reading showing a reduction in body temperature within 36.2°C – 37.2°C and as patient verbalized that temperature has subsided and he is not warm to touch.

5. **Patient slept throughout the night and for 2hours during the day on 18/03/23 at 5:35pm**

Around 5:35pm, my patient was finding it difficult to sleep, a nursing diagnosis of sleeping pattern disturbance related to intermittent cough was generated. A nursing intervention was implemented to aid my patient to sleep. Patient was reassured will have enough sleep since proper nursing intervention have been out instituted. Patient's bed was made free from creases and crumbs to enable him get a sound sleep. Patient's vital signs were monitored every 4 hourly to know the progress of the patient. Patient was given a warm bath and drink to dilate peripheral blood vessels to induce sleep. Adequate ventilation was provided by opening nearby windows to allow fresh air into the ward. Prescribed drugs such as cough mixtures and antibiotics were served to relieve pain, persistent cough and to combat infection

On 18/ 03/23 at 5:35pm, I evaluated the objective I set to help my patient with sleeping pattern disturbance, my goal was fully met as nurse observed patient slept uninterruptly for 8hours in the night and 2hours during the day and patient verbalized that he was able to sleep in the night.

6. Patient was relieved of cough on 19/03/23 at 5:50pm.

At 5:50pm, a care plan was made on cough and the nursing diagnosis generated was cough related to irritations in the airways. A nursing objective of cough subsiding within 48hours was made. The nursing interventions implemented were as follows;

Patient was reassured that all necessary measures will be taken to make cough subside. The head of patient's bed was elevated to ease tension on the chest. Patient was put in

an upright position to allow expansion of the lungs and ensure enough breathing. Deep breathing and relaxation technique were encouraged to enable more air to flow through the body and help calm patient nerves. Patient's vital signs such as respiration and SPO^2 were monitored to know the progress of my patient. Prescribed expectorant such as carbocistein 15mls was given to patient to relieve his cough.

On 19/03/23, at 5:50pm, Goal fully met as patient verbalized that cough has subsided and nurse observing that patient's cough has subsided.

7. Patient gained enough knowledge on the condition on 21/03/23 at 9:00am

At 10:30am, a nursing diagnosis of Knowledge deficit related to lack of access to information on condition was made and an objective to enable patient and relatives get insight into the condition throughout the period hospitalization. Nursing interventions made includes; Patient/family was reassured that the disease can be cured and complications can be prevented from occurring. They were asked about what she knows about the disease condition that is causes, signs and symptoms and its prevention. A quiet and calm ward was ensured by reducing noise on the ward, restricting visitors. Patient/wife were educated on the causes, signs and symptoms risk factors, treatment and the prevention. Patient/wife was allowed to ask questions bothering her and answers were provided in clear simple terms to allay her fears. Diagrammatic pamphlets was provided to patient and wife. Answers were provided in simple clear language

At 9:00am, evaluation on patient inadequate knowledge on his condition was made. Goal fully met as Patient/family verbalized the cause, signs and symptoms, risk factors and management of the condition and patient/wife answered correctly questions posed by the nurse.

5.2 Amendment of Nursing Care Plan for Partially Met and Unmet Outcome Criteria

With the support from other members of the health team and participation of the patient/family, all the goals set were fully achieved. The care plan was therefore not amended.

5.3 Termination of Care

Termination of care is difficult because of the special bond formed with your patient and relatives, the gradual withdrawal becomes an emotional path to take. My last home visit to Mister E.K.T. and his family occurred on 2/04/2023. The purpose of the visit was to know whether my client condition had improved after review and to finally terminate care. During the period of admission, seven (7) problems were identified and efficient nursing interventions were implemented so all goals were achieved. The family was educated on causes, risk factors, clinical presentations, treatment and preventive measures of bronchopneumonia. They were also educated on balanced diet, personal and environmental hygiene, and to seek immediate medical attention in case of any illness. During the third home visit, I told my client and family that I may not be able to visit them again because I will be going back to school. I thanked Mister E.K.T. and wife for their maximum cooperation and patience. I handed over Mister E.K.T. to the community health nurse I chose to continue the care.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

This chapter draws the curtains on the patient/family care study where all information and care rendered are summarized. This chapter also serves as a means where the student nurse uses in showing appreciation for the nursing process and how beneficial it has been to him or her.

6.1 Summary

On the 17th March, 2023, Mister E.K.T., a 53years old man who stays at Dormaa was admitted at the Holy Family Hospital, Berekum and was diagnosed of Right lobar pneumonia. His vital signs read; Temperature – 38.9 º C, Pulse - 101bpm, Respiration - 29cpm and blood pressure- 130/90mmHg. During his stay at the hospital, seven (7) health problems were identified. These were;

1. Dyspnea related to congestion in the lungs. (17/03/2023).
2. Chest pains related to accumulation of fluid in the pleural cavity of the lungs. (17/03/2023).
3. Headache related to infectious process in the lungs. (17/03/2023).
4. Pyrexia related to infectious process in the lungs. (17/03/2023).
5. Sleep pattern disturbance related to intermittent cough. (17/03/2023).
6. Cough related to inflammatory process in the lungs. (17/03/2023).
7. Knowledge deficit related to inadequate information on condition. (18/03/2023).

Routine nursing activities such as; personal hygiene, monitoring of patient's vital signs, education, tepid sponging and drug administrations helped in the achievement of goals that were set. Treatments given to my patient includes;

1. Intravenous Metronidazole 500mg tds x 48hours
2. Tab Azithromycin 500mg bd x 3days
3. Tab Paracetamol 1g tid x 3 days
4. Carbocistein syrup 15mls tid x 7 days
5. Intravenous infusions NS 1.5L for 24hrs

The above medications were administered and prescribed by the doctor and were monitored to ensure that patient recovers successfully without complications setting in.

No complications were encountered. Patient was also made to do the following laboratory investigations;

1. Full blood count (Blood for Hemoglobin level (Hb) estimation, White Blood Cell count (WBC) and Platelet count)
2. Erythrocyte Sedimentation Rate. (ESR)
3. Plain Chest radiography (x-ray).

There were three home visits and a follow up/review in the hospital was made to ensure continuity of patient's care which took place on;

1. First home visit 20th March, 2023
2. Second home visit 25th March 2023
3. Review day 27th March, 2023
4. Third home visit 2nd April, 2023

During the home visits, Patient and family were educated on condition and its management, personal and environmental hygiene was done. He was discharged on the 21st March, 2023. Follow-up visits were made to ensure continuity of care. On my last home visit, the care I rendered to my client and family was finally terminated.

6.2 Conclusion

This care study has enlightened and broadened my knowledge and understanding I had about Right lobar pneumonia, its management and understanding on how individual nursing care is rendered through the use of the nursing process. It has also offered me a great chance to know how to nurse patients with right lobar pneumonia and apply the skills taught in the class practically. It is going to be a research guide for other students at Holy Family Nursing and Midwifery College, Berekum who will take the work, which will be very beneficial to them. The hospital, that is Holy Family Hospital, Berekum has also benefited from this by my patient testifying about their good deeds to the community at large. Mister E.K.T. and family has also benefited from these holistic and comprehensive care that was rendered to them without encountering any complications and it's my hope to continue to give these care to other patients as well and the hospital as a whole.

To end with, I have learnt how to develop good interpersonal relationship between I and my patient and family and I will continue to practice these good attribute. It is my silent wish that all students nursing students will be able to gain these knowledge, skills and practices which will benefit them in rendering holistic care to their patients

APPENDIX

Table 7: Vital Signs Chart of Mr. E.K.T throughout Period of Hospitalization.

Date	Time	Temperature (ºC)	Pulse (bpm)	Respiration (cpm)	Blood Pressure(mmHg)	SPO^2 (%)
17/03/2023	4:00pm	37.9	90	26	118/90	95
	6:00pm	37.5	95	23	120/68	97
	10.00pm	37.4	97	23	130/90	99
18/03/2023	6:00am	37.3	80	20	110/80	98
	10:00am	36.7	80	20	130/80	98
	2:00pm	37.2	81	21	130/90	97
	6:00pm	36.5	75	20	125/79	99
	10:00pm	36.7	80	22	123/80	98
19/03/2023	6:00am	37.1	83	20	136/74	98
	10:00am	36.6	72	18	132/70	99
	2:00pm	36.5	95	24	118/69	97
	6:00pm	36.5	79	22	121/70	99
	10:00pm	36.7	69	20	123/81	99
20/03/2023	6:00am	37.1	85	23	128/93	98
	10:00am	36.5	69	21	132/80	99
	2:00pm	37.3	70	22	126/84	97
	6:00pm	36.6	74	17	120/81	99
	10:00pm	36.8	87	21	129/80	99
21/03/2023	6:00am	36.6	78	18	118/79	98
	10:00am	36.4	66	21	121/80	98

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SIGNATORIES

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SIGNATURE.....

DATE...11th July, 2023.....

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

NAME: MR. EMMANUEL ALI

SIGNATURE.....

DATE.....11th July, 2023.....

THE NURSE IN- CHARGE OF THE MALE'S WARD (HOLY FAMILY HOSPITAL, BEREKUM)

NAME: MR. DODOVI MARK

SIGNATURE.....

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