HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A PATIENT/FAMILY CARE STUDY ON HYPERTENSION

BY

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

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PREFACE

The patient/family care study is a detailed written report of a comprehensive nursing care given to a patient with a particular condition which is done individually. This comprises of the complete assessment of potential and actual problem and the nursing care given to the patient to meet his /her physical, psychological, social and spiritual needs. Also it includes the interaction between the patient, his /her family, the community in which he/she stays and the health care team.

This study is a learning experience for the student nurse to prove his/her ability to use the theoretical knowledge and practical skills acquired during his/her period of training to plan and care for a particular patient and family. It helps the student nurse to know more about the disease condition of the selected patient and to sharpen his/her interactive and problem-solving skills. This study uses the nursing process, which is a systematic guide to client- centered care with five sequential steps which comprises of assessment, diagnosis, planning, implementation and evaluation of all care given to patient and family for effective nursing care. The patient /family care study is also a requirement as a partial fulfillment for an award as a Registered General Nurse honored by the Nurses' and Midwifery Council of Ghana to student pursing Diploma in Nursing in the country.

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The greatest thanks go to the Almighty God for giving me the strength and wisdom to embark on this care study successfully.

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INTRODUCTION

Patient/family care study is a written report of the care given to the patient/family which is required by the Nursing and Midwifery Council of Ghana in partial fulfillment for the award of License to practice as a Professional Registered General Nurse. This is an approach in nursing where a holistic nursing care is given to the patient/family from the time of admission to discharge and ensuring continuity of care through follow-ups or home visits before the care is terminated.

This patient/family care study was carried out on a 67year old woman who for the purpose of confidentiality will be referred to as Madam T.Y in this study. Madam T.Y was admitted to the Females Ward of the Sunyani Regional Hospital on 26th November, 2021 on account of hypertension and was discharged on 1st December 2021. Madam T.Y. spent six days in the hospital.

Data was collected from the patient/family through observations, interviews and other diagnostic procedures. Health problems such as, acute pain, activity intolerance and vomiting were identified and interventions made with patient and family's co-operation to achieve the set goals. Some of the following investigations were ordered , kidney function test , full blood count chest x-ray and some of the treatment given to the patient are intravenous Labetalol 40mg stat ,Tablet Nifedipine 40mg bid for 30days ,paracetamol 1gram tds for 48 hours .Due to the effective medical and nursing care given to her, she was discharged without any complications or referral.

Three home visits were made during admission and after discharge to identify predisposing factors of client's condition, to educate client's family on the condition and to ensure continuity of care. Madam T.Y and her family appreciated the care given to them by the health care team.

This script comprises of six chapters which include;

1. Assessment of patient/family.
2. Analysis of data collected.
3. Planning for patient/family care.
4. Implementation of patient/family care.
5. Evaluation of care rendered to patient/family.
6. Summary and conclusion.

Chapter one deals with assessment of client and family comprising client particulars, family medical history, socio-economic history, lifestyle and hobbies, past and present medical history, admission of client, her concept of illness, literature review and validation of data.

Chapter two deals with analysis of data involving comparison of data gathered with standard for literature, client and family strength, health problems and nursing diagnosis.

Chapter three deals with planning of care for the patient/family, setting of objectives and the nursing care plans for objectives set.

In chapter four, interventions of the nursing care plans were implemented thus; giving a summary of the actual nursing care plan, preparation of client and family towards discharge and rehabilitation and also follow-up home visit and continuity of care

Chapter five deals with evaluation of care consisting of statement of evaluation, amendment of the nursing care for partially met or unmet outcome, termination of care.

The chapter six deals with summary and conclusion followed by bibliography and appendix.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment is the systematic collection of data to determine the patient's health status and any actual or potential health problems (Hinkle & Cheever, 2014). It is the first stage and a vital tool in the nursing process. Assessment can be done through observations, interviewing and investigations such as laboratory results, x-ray reports and physical examination of the patient. It includes the patient's particulars, patient/family medical and surgical history, patient's socioeconomic history, patient's developmental history, patient's lifestyle and hobbies, patient past medical and surgical history, patient present medical and surgical history. It also includes admission of patient, patient and family concept of illness, literature review on the condition from which analysis will be made to identify the patient problems and validation of data. These help the nurse to determine the health status of the patient and her family in order to plan an effective nursing care towards recovery. All information was gathered from the patient and her relatives, as well as the patient's electronic-folder (e-folder).

1.1 Patient's Particulars

The name of the patient is Madam T.Y. She is a 67-year-old woman, born on 4th October, 1954. She comes from Drobo in the Jaman North of the the Bono Region, she currently resides at Penkwase a suburb of Sunyani in the Bono region of Ghana. She is fair in complexion, one hundred and sixty-six centimeters (166cm) tall and weighs sixty-two (62kg) with a Body Mass Index (BMI) of 22.5kg/m^2 which clearly indicates that she is not overweight or obese. Madam T.Y. is a Christian who worships with the Church of Pentecost. Her next of kin is her daughter Mrs. J.S.B. Madam T.Y is a retired teacher. She had her basic education at R/C primary and Junior High School,

Drobo. She speaks Twi and English. Madam T.Y. is a National Health Insurance beneficiary. She has no physical impairments or disabilities. Patient's hospital folder number is AAD6016

1.2 Family's Medical/Surgical History

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

Madam T.Y. from our conversation could tell that hypertension is a condition that exists in their family and according to her this is her first time of been diagnosed with hypertension. She confessed that their family members seek for medical care at the hospital whenever they are sick. Madam T.Y stated that there is no history of mental illness and other communicable diseases like tuberculosis in their family. There is no family history of inherited diseases like diabetes and sickle cell anemia. According to Madam T.Y, members of the family occasionally experience minor disorders like headache, abdominal pains, palpitations, etc. which are treated by the use of over-the-counter drugs. Education was given to client and family on the need to avoid over the counter medication and report to hospital promptly when they are sick. The family does not have any known allergies. Madam T.Y. indicated that with the exception of her father whom she could not tell the cause of his death, none of her siblings is dead. None of the family members has undergone surgery before.

1.3 Family Socio-economic History

Madam T.Y. has a very good relationship and cohesion with her family. Socially, the family is not noted for smoking or drinking alcohol. She revealed that most of her family members are into farming. Family members are always ready and willing to support each other in times of financial

hardships. Madam T.Y does not depend on her extended family for financial support but rather depends on her pension allowances and on the remittances from her children. Her family members are well known for their massive participation in religious activities, their kindness and generosity. In terms of religious believes she revealed that, all of her family members are Christians. The family members according to Madam T.Y depend on National Health Insurance Scheme (NHIS) for medical care. There are no taboos governing the family.

1.4 Patient's Developmental History

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

According to Madam T.Y, her mother who is dead had a spontaneous vaginal delivery at term without any difficulties or problems during pregnancy, delivery and throughout the period of breastfeeding the client.

Congenital abnormalities such as cleft lip and palate, congenital heart defect, hydrocephalous were absent when the client was born.

According to Madam T.Y, she did not received immunization against the vaccine preventable diseases such as poliomyelitis, whooping cough, diphtheria, measles, tetanus and tuberculosis.

Madam T.Y was breastfed well before she was introduced to complementary feeds like porridge and cereals such as sorghum and maize.

She went through a normal developmental milestone such as sitting, crawling, standing, walking and running between the ages of two and three years old. She developed the secondary sexual

characteristics such as development of breast, enlargement of hip and pubic hair around age fifteen (15). Client could not remember the exact age she started schooling.

According to Erik Erikson Theory of Psychosocial Development, there are eight stages of ego development that encompasses the life span. These stages are as follows;

(1) Trust versus Mistrust (Birth to 18months) Infancy

(2) Autonomy versus Shame and doubt (18 months to 3years) Early childhood

(3)Initiative versus Guilt (3 to 6years) Late Childhood

(4)Industry versus Inferiority (6 to 12years) School age

(5) Identity versus Role Confusion (12 to 20years) Adolescence

(6) Intimacy versus Isolation (20 to 35years) Early adulthood

(7) Generativity versus Stagnation (35 to 65years) Middle adulthood

(8) Intergrity versus Despair (65 to death)

Each stage is characterized by a distinct conflict, or crisis, relating to the person's physiologic maturation and to what society expects of a person at that age. In respect to patient's age (67), she falls under stage eight which is Integrity versus Despair. It is during this stage that the individual contemplates his or her accomplishments and if the person is able to develop integrity, the person sees himself or herself as a successful person in life. If the person sees himself or herself as unproductive or was not able to accomplish his or her goals, the person becomes dissatisfactory with life and develop despair often leading to depression and hopelessness. Upon this idea and interactions with the patient, I realized that the patient is successful because she said she was able to achieve all her goals in life by taking care of her children.

1.5 Obstetric History

According to patient, she had her menarche around the age of thirteen. Madam T.Y. has given birth to four children. All her pregnancies were carried to term and she delivered all the four spontaneously. Patient also stated that she always attends antenatal care till she gives birth. Madam T.Y. indicated that she had never committed an abortion before. She revealed that she has not had any family planning. She also added that she had a regular menstrual cycle and that she usually had her menses every twenty-nine days. But she no longer has her menses since she is in her menopausal age.

1.6 Patient's Lifestyle and Hobbies

Madam T.Y. usually goes to bed around 9:00 pm and wakes up at 6:00am and says her morning prayers. She maintains her oral hygiene with the use of yazz tooth brush and close up tooth paste which is her favourite. After that she empties her bowel and takes her bath with warm water. For breakfast, patient mostly takes porridge with bread and sometimes "milo" drinks with bread. Patient indicated that she usually takes mashed kenkey or Ampesi and stew for launch. Patient revealed that she usually goes to the market to buy foodstuffs to prepare supper. On Thursday evenings, she attends church meetings at 7:30pm and closes at 8:30pm. During Saturdays, she wakes up early in the morning and goes about her normal duties. She washes her clothes. On Sundays, she gets ready for church. Patient has no known allergy to food or drugs. Madam T.Y.'s favourite food is Fufu with Palm nut soup. She does not have any fixated habit such as drinking, smoking, gossiping etc. She described herself as an introvert but occasionally attends funerals and weddings. My personal impression about my patient is that, she is very calm, benevolent and generous.

1.7 Patient's Past Medical History

Past medical history provides information on patient state of health and illness before the present complains (Weller B., 2014).

According to Madam T.Y, she did not have any childhood illness like measles, whooping cough, diphtheria, etc. Client normally experiences minor symptoms like headache, diarrhea, common cold, cough and malaria which are always treated with drugs bought from the pharmacy shop and on out- patient basis at the hospital. Madam T.Y. had never experienced any allergies. According to client, she sometimes experiences certain minor injuries which she usually treats with traditional medicines and sometimes with over-the-counter medications as well. Client does not have any physical disability. Client has never had any surgical procedure before.

1.8 Patient's Present Medical History

History of present illness is a complete, clear, and chronologic account of the problems prompting the patient to seek care.

Client was in her usual state of health until 25th November, 2021 when she started feeling intense fatigue on minimal exertion, dizziness, palpitations, headache and loss of appetite. Client then decided to visit the Regional Hospital, Sunyani on that same day, 25th November, 2021at 02:57pm. She went through the Emergency Unit and she was attended to by a medical officer and after physical examination and laboratory investigations she was diagnosed of hypertension.

1.8 Admission of Patient

On the 26th November, 2021at exactly 1:50 pm, Madam. T.Y. was brought to the female medical ward of Regional Hospital from Emergency unit accompanied by student nurse per ambulatory with diagnosis of Hypertension. Client complained of headache, palpitation, was very anxious and her blood pressure was high. Patient was fully conscious. Happening to be at the nurses' station

with the nurse in-charge at the time of her arrival, I was charged with the responsibility to carry out her admission to the ward. It was a planned admission. The patient's identity was verified by mentioning her name for response. She was then welcomed and immediately admitted and made comfortable in an admission bed. Her vital signs were checked and recorded as;

- Temperature - 36.1°C
- Pulse - 80 beats per minute
- Respiration - 20cycles per minute
- Blood pressure - 210/120mmHg
- Oxygen saturation- 96%

She was introduced to the staffs present and was assured of the competency of the healthcare team. Her particulars such as name, sex, age, and residential address were recorded in the admission and discharge book and the daily ward state. Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained.

She and her relatives were oriented to the ward and its surroundings and welcomed to the ward. Patient was assured of a competent nursing care that everything about her will be done with much care to ensure delivery of quality health care. She was introduced to other patients at the ward and on observation patient was seen to be anxious.

Patient was to undertake the following investigations;

1. Kidney Function Test
2. Full Blood count

3. Human immunodeficiency (HIV) Screening

4. Chest X-ray

5. Blood Film for Malaria Parasites

6. Random Blood Sugar (RBS)

Medications prescribed were;

1. Tablet Paracetamol 1gram tds for 48 hours

2. Intravenous Labetalol 40mg stat

3. Tablet Nifedipine 40 mg bid x 30 days

4. Tablet Bendroflumethiazide 2.5 mg daily x 30 days

5. Tablet methyldopa 500mg bid x 14 days

6. Intravenous Normal Saline 2 litres for 48 hrs

There was two (2) hourly blood pressure monitoring for 24hours. Due medication was served and patient was assured of successful recovery with the help of competent and dedicated nurses.

Table 1: Blood Pressure Monitoring Chart

DATE	TIME	BP	INTERVENTION
26/11/2021	1:50pm	210/120mmHg	Intravenous labetalol 40mg stat was given
26/11/2021	3:50pm	190/105mmHg	Tablet Nifedipine 40mg / normal saline 500ml.
26/11/2021	5:50pm	170/90mmHg	No intervention was given
26/11/2021	7:50pm	150/88mmHg	No intervention was given

26/11/2021	9:50pm	149/88mmHg	No intervention was given
26/11/2021	11:50 pm	163/90mmHg	Intravenous paracetamol 1g
27/11/2021	1:50 am	150/89mmHg	No intervention was given
27/11/2021	3:50 am	145/73mmHg	No intervention was given
27/11/2021	5:50 am	130/73mmHg	No intervention was given
27/11/2021	7:50 am	140/79mmHg	No intervention was given
27/11/2021	9:50 am	156/90mmHg	Tablet Nifedipine 40mg
27/11/2021	11:50 am	145/86mmHg	No intervention was given
27/11/2021	1:50pm	139/80mmHg	No intervention was given

I reintroduced myself to patient as a final year student nurse of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take her and her family for my care study. Madam T.Y. was informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of license in Registered General Nursing. I explained to Madam T.Y. the concept of the patient/family care study and assured her of privacy and confidentiality of information. It was added that a report will be written after the entire event. Madam T.Y. agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to her. Discharge planning was initiated with Madam T.Y. and family; thus, they will continue the care at home once she is well. I decided

to choose this patient for the study because I wanted to know more about the diseases (Hypertension) that brings most clients around the age of Madam T.Y. to the hospital.

1.10 Patient's Concept of Illness

Madam T.Y. did not attribute her illness to any spiritual cause in spite of her spiritual believes as a Christian. She also said that some conditions like epilepsy and other mental disorders can have spiritual implications. She does not know the exact cause of her condition. Patient believes that, the treatment planned for her, in the hospital, will help treat her illness and prevent any complications.

1.10 Literature Review on Hypertension

Literature review of a condition gives a detailed insight into the condition. It talks about the established and laid down facts about the disease condition, which aids in the medical and nursing diagnoses and the appropriate management for that particular disease.

Basic anatomy and physiology of the heart and blood vessels

According to Weller, 2014 the size of the heart is like the owner's fist. The hollow, cone-shaped heart has a mass of betweenScreening 250 and 350 grams—less than a pound enclosed within the media sternum. The heart extends obliquely for 12 to 14 cm (about 5 inches) from the second rib to the fifth intercostal space. As it rests on the superior surface of the diaphragm, the heart lies anterior to the vertebral column and posterior to the sternum. The lungs flank the heart laterally and partially obscure it. Its apex points inferiorly toward the left hip. The heart is enclosed in a double-walled sac called the pericardium. The heart wall is composed of three layers. The superficial epicardium is the visceral layer of the serous pericardium. It is often infiltrated with fat, especially in older people. The middle layer, the myocardium ("muscle heart"), is composed

mainly of cardiac muscle and forms the bulk of the heart. It is the layer that contracts. The third layer, the endocardium, is a glistening white sheet of endothelium (squamous epithelium) resting on a thin connective tissue layer. It lines the heart chambers and covers the fibrous skeleton of the valves. The heart has four chambers-two superior atria and two inferior ventricles. The internal partition that divides the heart longitudinally is called the interatrial septum. Blood enters the right atrium via three veins: (1) The superior vena cava returns blood from body regions superior to the diaphragm; (2) the inferior vena cava returns blood from body areas below the diaphragm; and (3) the coronary sinus collects blood draining from the myocardium. Four pulmonary veins enter the left atrium, which makes up most of the heart's base. These veins, which transport blood from the lungs back to the heart, are best seen in a posterior view. Blood flows through the heart in one direction: from atria to ventricles and out the great arteries leaving the superior aspect of the heart. This one-way traffic is enforced by four valves that open and close in response to differences in blood pressure on their two sides.

The two atrioventricular (AV) valves, one located at each atrial-ventricular junction, prevent backflow into the atria when the ventricles are contracting. The right AV valve, the tricuspid valve has three flexible cusps. The left AV valve, with two flaps, is called the mitral valve because of its resemblance to the two-sided bishop's miter or hat. It is sometimes called the bicuspid valve. Attached to each AV valve flap are tiny white collagen cords called chordae tendineae "heart strings" which anchor the cusps to the papillary muscles protruding from the ventricular walls. The aortic and pulmonary (semilunar, SL) valves guard the bases of the large arteries issuing from the ventricles (aorta and pulmonary trunk, respectively) and prevent backflow into the associated ventricles. Each SL valve is fashioned from three pocket like cusps, each shaped roughly like a crescent moon (semilunar = half-moon).

The three major types of blood vessels are arteries, capillaries, and veins. The walls of all blood vessels, except the very smallest, have three distinct layers, or tunics ("coverings"), that surround a central blood-containing space, the vessel lumen. As the heart contracts, it forces blood into the large arteries leaving the ventricles. The blood then moves into successively smaller arteries, finally reaching their smallest branches, the arterioles "little arteries", which feed into the capillary beds of body organs and tissues. Blood drains from the capillaries into venules, the smallest veins, and then on into larger and larger veins that merge to form the large veins that ultimately empty into the heart. Because arteries carry blood away from the heart, they are said to "branch," "diverge," or "fork" as they form smaller and smaller divisions. Veins, by contrast, carry blood toward the heart and so are said to "join," "merge," and "converge" into the successively larger vessels approaching the heart. In the systemic circulation, arteries always carry oxygenated blood and veins always carry oxygen-poor blood. Of all the blood vessels, only the capillaries have intimate contact with tissue cells and directly serve cellular needs. Exchanges between the blood and tissue cells occur primarily through the gossamer-thin capillary walls.

Definition of Hypertension.

Hypertension is a chronically elevated arterial blood pressure with the systolic more than 140 and diastolic more than 90 Millimeters of mercury (It should be checked for at least three times). Is a major case of premature vascular disease leading to cerebrovascular events, ischemic heart disease and peripheral vascular disease. Blood pressure is a characteristic of each individual like weight and height with marked inter-individual variation and has a country's distribution. People with Hypertension may be suffering from other conditions such as Diabetes and hyperlipidemia. Therefore, it can be treated together with other conditions. The levels of blood pressure observed depend on the characteristics of the population studied in particular, the age or ethnic background.

Blood pressure in industrialized countries rises with age certainly up to the seventh decade. Hypertension is very common in the developed world. Hypertension is present in 20-30% of the adult population. Hypertension rates are much higher in black Africans (40-45% of adults). (Hinkle & Cheever, 2014).

Types of Hypertension

There are three (3) types of hypertension. (Hinkle & Cheever, 2014).

1. Primary or essential hypertension or Idiopathic
2. Secondary or non-essential hypertension
3. Malignant Hypertension

Primary or Essential Hypertension

This is a disorder characterized by blood pressure that persistently exceeds 140/90 mmHg. It occurs primarily in people between the ages of 25 and 55 and the cause is unknown. It accounts for about 80-90% of people suffering from Hypertension. It is also known as "silent killer".

Secondary or Non-Essential Hypertension

This refers to elevated blood pressure resulting from some underlying cause. It accounts for the remaining 10% of the people suffering from Hypertension. The most common causes of secondary hypertension include estrogen use (long-term use of oral contraceptives), renal disease, vascular disease, endocrine disorders, and coarctation of the aorta, stress and pregnancy.

Malignant Hypertension

It occurs when there is a sudden and severe blood pressure elevation. It occurs mainly in males in their third and fourth decades. The prognosis is very poor.

Other forms of Hypertension

a. **Benign Hypertension:** There is the presence of high blood pressure for years with no symptoms manifesting in the individual.

b. **Labile Hypertension:** There is intermittent rise and fall in the blood pressure.

c. **Malignant Hypertension:** It is relatively a rare condition occurring in less than 1% of individuals with diagnosed hypertension. The most common etiology of malignant hypertension is poorly controlled primary hypertension.

d. **Gestational Hypertension:** It indicates a hypertensive disorder in a woman who is previously not hypertensive but rather due to pregnancy and it disappears after delivery (Hinkle & Cheever, 2014).

Etiology of Secondary Hypertension

Secondary hypertension may be caused by any of the following;

1. Heart diseases
    1. Coarctation of the aorta
    2. Myocardial infaction
    3. Stenosis of the cardiac valve
    4. Pulmonary disease
2. Endocrine disorders
    1. Thyrotoxicosis which increases heart rate
    2. Cushing syndrome leading to formation of atherosclerosis
    3. Phaeochromocytoma leading to increased cardiac output

4. Diabetes mellitus

3. Renal conditions

1. Acute glomerulonephritis
2. Renal tumors

4. Pregnancy related disease

1. Pregnancy induced hypertension (Hinkle & Cheever, 2014).

Incidence

It affects more females than males according to health records because most men who have the condition do not visit the hospital. Most especially black males are less able to tolerate the condition. It also affects more blacks than whites (Hinkle & Cheever, 2014).

Predisposing Factors of Primary Hypertension

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

1. Genetic (non-modifiable) factors

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

a) Family history: Individuals whose parents have high blood pressure have a high risk of developing this condition at a younger age.

b) Gender: High blood pressure increases in both men and women but women record the highest number in our hospitals meanwhile most of the men that suffer from hypertension do not visit the hospital.

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

2. Environmental (modifiable) factors.

These are environmental factors or stimulations which one can do away with. These factors are stress profile, occupation socio-economic status, nutrition, obesity, life-style habits e.g. excessive smoking, alcohol consumption and physical activity.

a) Stress profile

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

b) Occupation

There are certain occupations which are hypertension prone because of the stress level involved in them. Example, theatre and emergency nursing.

Socio-economic status

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

d) Nutrition

High blood pressure is a disease of excessive salt, calories and alcohol intake. It has been found that high levels of cholesterol in blood forms deposit on the arteries causing hypertension.

e) Obesity

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

f) Life-style habits

1. Alcohol consumption: It increases blood pressure but the exact mechanism is not known. However, increased cardiac output, calcium levels and cortical secretions are mentioned as possible explanations.
2. Excessive smoking: Nicotine is a vasoconstrictor which increases peripheral resistance thereby increasing blood pressure.
3. Physical Activity: Those who do not do physical exercise have increased risk of about 1.5% for developing high blood pressure as compared to those who do exercise. This is because exercise increases endorphins in the brain cells which contribute to one's sense of wellbeing and also increases high density lipoproteins, which protects against cardiovascular disease. (Hinkle & Cheever, 2014).

Pathophysiology

The pathophysiology of essential hypertension remains unclear. In some young hypertensive patients, there is an early increase in cardiac output in association with increased pulse rate and circulating catecholamine's. This result in changes in baroreceptor sensitivity which would then

operate at a higher blood pressure level. Left ventricular hypertrophy which results from increased peripheral vascular resistance and increased left ventricular load is a significant prognostic indicator of future cardiovascular events. (Hinkle & Cheever, 2014).

Arterial blood pressure is regulated by chemicals such as catecholamine, renin, aldosterone and other neurotransmitters. These chemicals affect the structural and functional state of the heart and blood vessels. An increase in vascular ions initially results in increased peripheral resistance. As the disease progresses, the smaller arteries lose their ability to contract and may breakdown to narrow their lumen. This leads to an increase deposition of lipids in even the longer arteries which leads to narrowing of the blood vessels. (Hinkle & Cheever, 2014).Consequently, the heart, especially the left ventricle enlarges. With the help of the nervous system, the sympathetic flow release catecholamine, the parasympathetic nerves also release catecholamine which grossly affects the blood vessels.

A reduced blood circulation decrease pressure in the afferent arteriole in the glomerular capsule. This leads to a release of renin and consequently the release of angiotensin and aldosterone. The presence of aldosterone brings about sodium retention. Sodium retention results in increased blood volume. The blood pressure increases rapidly and produces all forms of edema, left ventricular failure, severe renal damage, retina hemorrhage and papilla edema (swelling of the optic nerve) which are found in malignant hypertension.

Clinical Features

According to Hinkle and Cheever (2014), the clinical features of hypertension include;

1. There is palpitation
2. There is dizziness

3. There is a rise in blood pressure when blood pressure is checked
4. There is headache
5. The patient may complain of breathlessness or dyspnea.
6. The patient may complain of chest pain
7. Insomnia may be present
8. The patient becomes tired easily on slight exercise (fatigue)
9. Confusion and restlessness occurring in severe conditions.
10. Weak peripheral pulse
11. Epistaxis

Diagnostic Investigations

According to Hinkle and Cheever (2014), the diagnostic measures of hypertension include;

1. Previous medical history and physical examination will help in the diagnosis.
2. Electrocardiograph to assess the size and function of the heart.
3. Echocardiography to assess left ventricular hypertrophy.
4. Blood urea and creatinine and electrolyte analysis
5. Urine analysis to identify renal disease
6. Angiography to assess veins
7. Chest x ray
8. Kidney Function Test

Medical Treatment for Hypertension

According to Hinkle and Cheever (2014), if the condition is secondary hypertension, the treatment of the underlying cause is usually done to relief the patient the patient of the condition. In the

malignant hypertension, the treatment is aimed at lowering the blood pressure in order to prevent complications. Drug treatment includes:

1. Calcium channel blockers e.g. Nifedipine
2. Diuretics e.g. Hydrochlorothiazide (Esidrex)
3. Adrenergic inhibitors such as Atenolol and Propranolol (Inodera)
4. Vasodilators e.g., Hydralazine, (Apresoline). It increases peripheral resistance.
5. Beta blockers e.g., Labitalol
6. ACE inhibitors, e.g., Lisinopril and Captopril.
7. Centrally alpha 2 agonists, e.g., methyldopa (aldomet).

Nursing Management for Hypertension

The nursing care of the hypertensive patient begins with reassurance and explanation of the condition to the patient about causes, prevention, predisposing factors and side effects of drugs. Knowledge of the disease condition allays anxiety, thereby reducing the high blood pressure. Nursing management focuses on rest, diet, observation, modification of lifestyle, elimination medication and exercise (Hinkle & Cheever, 2014).

Psychological Care

Reassure the client and relatives that all will be well since the client is in competent hands to allay fear and anxiety also to relax the client and to win her co-operation.

Position

Client is placed in a comfortable position e.g., Semi-fowlers position. The position must not be contraindicated with client's condition to help prevent complication such as bed sore.

Observation

Client's mental status was assessed to know whether she is oriented to time, place and person. Observe patient's vital signs and record them accurately. The signs and symptoms of the condition must be observed to know whether patient's condition is improving or deteriorating. Observe possible complication of the condition so that preventive measures can be observed. The intravenous site must be observed for patency of line and the flow of infusion. Desired effects, side effects and contraindications of drugs to be administered should be observed. Pain should be observed from facial expressions.

Modification of Life Style

Obesity: Advise obese patients to maintain normal body weight (thus body mass index of 18.5-24.9kg/m^2

Stress: Identify stress producing situation in the patient's life and seek means to reduce them. Patient should be referred for training in stress management where necessary.

Smoking: Smoking should be avoided since cigarette contains nicotine and this can raise arterial blood pressure.

Alcohol: Avoidance or reduced alcohol intake helps reduce hypertension.

Rest and Sleep

Rest and sleep is ensured to enhance the comfort of the patient and to prevent further complications. Rest also helps to avoid over secretion and possible worsening of symptoms.

A quiet and restful environment is to be ensured to enable patient have a maximum rest and sleep he/she needs. A comfortable bed is made and also noise on the ward should be minimized.

Personal Hygiene

The client is given bed bath twice a day to remove dirt, improve circulation and induce sleep. The perineum must be washed to prevent any infection. Pressure areas must be treated to prevent patient from developing pressure sores. Finger and toe nails should be trimmed and washed to prevent client from harboring organisms.

Nutrition

There must be reduction of dietary saturated fats and cholesterol. Adequate intake of balanced diet is encouraged which include carbohydrates to provide energy, protein to repair worn out tissues.

Low salt diet should be encouraged, vitamin supplement to increase the body's immune system. When the client is obese, carbohydrate foods should not be eaten too much. There should be avoidance of coffee as well as smoking and alcohol. Client should be involved in planning of his/her diet.

Exercise

Client is encouraged to undergo mild to moderate exercise as his or her condition allows. This helps to improve circulation, prevent joint stiffness, etc. client is assisted to sit up in bed, walk around in bed and gradually walk around the ward.

Elimination

Bladder elimination is ensured by serving urinal on client's request. When client is not able to pass urine, nursing measures such as opening of taps, application of warm compresses or catheterization is carried out.

Bowel elimination is also ensured by serving bed pan on client's request. More fluids and roughage are given to soften the stool.

Health Education

Client is educated on the causes, signs and symptoms as well as complications of the condition. Client is educated on the need to conform to drug regiment and periodic checkups. Client is also educated on the need for regular monitoring of the blood pressure.

Client is educated to restrict salt intake, fat intake and coffee intake as well as smoking and alcohol.

There is the need to educate client on good personal hygiene, exercise, elimination, good nutrition and rest and sleep. Because condition is hereditary, other members of the family should be educated to go for regular checking of the blood pressure.

Medication

Anti-hypertensive drugs need to be taken regularly for long periods to control the blood pressure.

Complications

According to Hinkle and Cheever (2014), if a patient with hypertension is untreated, the following complications can result;

(a) The cardiovascular system

1. Myocardial infarction
2. Congestive heart failure
3. Left ventricular failure

(b) The central nervous system

1. Hypertensive encephalopathy
2. Cerebrovascular accidents

(c) Renal system

1. Renal failure

(d) The Eye

1. Retinopathy; This can lead to blindness

Prevention

(a) **Primary Prevention**

1. Educate patient on the need for adequate exercise.

2. Low salt intake and low-fat diets should be encouraged.

3. Obese people should join keep fit clubs if possible

(b). **Secondary Prevention**

1. Report signs and symptoms early.

2. Advise patient on the need for adequate rest.

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

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

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

(c) **Tertiary**

1. Educate patient to engage in less stressful activities.

2. Restrict salt intake and fatty diet.

3. Recommend that people with high blood pressure, check and monitor their blood pressure regularly and record.

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

Prognosis

The prognosis of hypertension is good if one seeks early medical attention but may worsen if left untreated for a long time.

1.11 Validation of Data

The information for this study was gathered from Madam T.Y., her relatives, nurses and medical records, personal observation and laboratory investigations. To prevent doubt and misinterpretation of information, they were cross-checked with Madam T.Y. and relatives. This indicated that data collected was valid since information gathered from patient was the same as information gathered from relatives.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis of data is the second phase of the nursing process, which involves careful comparison of the patient's problems or the information gathered from patient and relatives with standards and then putting these problems in order of priorities to plan for the care of the patient and family. This section covers the under listed areas; comparison of data with standards, patient and family's strength, patient's health problems and nursing diagnoses

2.1 Comparison of Data with Standards

Comparison is the process of comparing the information collected from patient/family and the care given, with standards set in the textbooks. This includes diagnostic investigations, causes, signs and symptoms, treatments and complications found in the literature review.

2.1.1Diagnostic Investigation/Test

Diagnosis is the determination of the nature of a disease and Test is defined as an examination or trial. Investigation refers to procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatment **Invalid source specified.**.

From the literature review, electrocardiograph, echocardiograph and angiography are done to determine hypertrophy of the heart, serum potassium level and blood urea, nitrogen level to determine a defect in the renal function, but were not done because she was a known hypertensive patient. The following are list of investigations which were carried out on Madam T.Y. during her period of hospitalization;

1. Kidney Function Test
2. Full Blood count

3. Human immunodeficiency (HIV) Screening
4. Chest X-ray
5. Blood Film for Malaria Parasites
6. Random Blood Sugar(RBS)

Table 2: Comparison of Test Done on Madam T.Y to Literature

Investigations According to Literature	**Investigations Done on Patient**
Previous medical history and physical examination will help in the diagnosis.	Medical history was considered.
Electrocardiograph to assess the size and function of the heart.	Electrocardiograph was not done.
Blood urea and creatinine and electrolyte analysis.	Blood urea and creatinine and electrolyte analysis was not done.
Echocardiography to assess left ventricular hypertrophy.	Echocardiography was not done.
Urine analysis to identify renal disease.	Urine analysis was not done
Angiography to assess veins.	Angiography was not done.
Chest x ray	Chest x ray was done
Kidney Function Test	Kidney function test was carried out
Random blood sugar (RBS), to determine blood glucose level.	Random blood sugar was tested .

With reference to the table above, Kidney function test, Physical examination and Chest x ray were found in literature and carried out on my patient. Human immunodeficiency (HIV) Screening, Full

blood count, Random blood sugar, and Blood Film for Malaria Parasites (not part of literature) were carried out to detect the presence of the human immunodeficiency virus and malaria parasites respectively and because of this, I can strongly conclude that the right investigations were carried out on my patient. From the literature review, electrocardiograph, echocardiograph and angiography are done to determine hypertrophy of the heart, serum potassium level and blood urea, nitrogen level to determine a defect in the renal function, but were not done because her diagnose was arrived based on the test performed on her.

Table 3: Results of Diagnostic Investigations Carried Out On Patient

Date	Specimen	Investigations		Normal Values	Interpretations	Remarks
26/11/2021	Blood	**Kidney function test** Sodium Potassium Chloride Creatinine (SI)	145.2mmol/l 4.2mmol/l 110mmol/l 121.1mmol/l	135-148mmol/l 3.5-5.4mmol/l 94-112mmol/l Male:55-138umol/l Female:55-127umol/l	The values obtained fell within the normal range. This means the patient's kidney is functioning well.	No treatment was given
26/11/2021	Blood	<u>**Full Blood Count**</u> Hemoglobin level estimation	12.4g/dl	Male:12.0-18.0g/dl Female:11.3-14.0g/dl	Values fell within the normal range indicating absence of anemia.	No treatment was given.
		White blood Cell count (WBC)	5.9(10^3/ul)	(2.60-8.50) x10^3/ul	Value fell within normal range indicating absence of infection.	

Table 3: Results of Diagnostic investigations carried out on patient cont'

Date	Specimen	Investigations	Results	Normal Values	Interpretations	Remarks
26/11/2021	Blood	**Human Immunodeficiency (HIV) Screening**				
		First response HIV ½	Non-reactive	Non-reactive	No evidence of HIV infection	No treatment was given
		Overall results	Negative	Negative	Absence of HIV infection	No treatment was given
26/11/2021	Chest	Chest X-ray	Enlarged heart	The size should be of ones tightly clinched fist.	Abnormal indicating enlargement of heart.	Further investigations were carried out and Tab.

						Nifedipine 30mg was given.
26/11/2021	Blood	Random	7.8mmol/L	Females(5.6-11.1mmol/L	Madam T.Y is not diabetic.	No treatment was given since the RBS was within normal range

2.1.2 Causes of Client's Condition

With regards to the data collected, the cause of the primary hypertension is not known and it forms 90% of all hypertension cases. Secondary hypertension forms 10% and can be related to specific causes such as certain medications, pregnancy and coarctation of the aorta. The client's condition is a primary hypertension. The cause is unknown but predisposing factors such as stress and familiar factors might have predisposed her to it.

2.1.3. Clinical Manifestation/Signs and Symptoms of Madam T.Y.

Table 4: Comparison of Signs and Symptoms of Patient to That of Literature Review

All the signs and symptoms exhibited by my patient were all found in the literature review which

Signs And Symptoms Outlined In Literature	Signs And Symptoms Exhibited By Client
Palpitation	There was palpitation
Dizziness	She was feeling dizzy
High blood pressure	Her blood pressure was high
Severe headache	Client experienced severe headache
Breathlessness	Breathlessness was not present
Chest pain	Chest pain was not present
Insomnia	There was insomnia
Fatigue	There was no fatigue
Confusion and restlessness	There was confusion and restlessness
Weak peripheral pulse	She did not have a weak peripheral pulse
Epistaxis	Patient did not experience epistaxis

clarifies that she is suffering from Hypertension.

2.1.4 Treatment Given to Client

This is the type and dosage of drug that the physician has prescribed for the patient to make her recover from her condition. The drugs are also compared to the drugs used for the treatment of Hypertensive patients in the literature review.

1. Intravenous Labetalol 40mg stat.
2. Tablet Nifedipine 40mg twice daily per 30 days.
3. Tablet Bendroflumethiazide 2.5mg daily for 30 days.
4. Tablet Methyldopa 500mg Twice daily for 14 days.
5. Intravenous paracetamol 1g stat.

Table 5: Treatment Given to Client as Compared with Literature Review

Treatment as in literature review	**Treatment given to my patient**
Beta blockers such as Labetalol	Intravenous labetalol 40mg stat, then 20mg tid for 1days
Calcium channel blockers e.g. Nifedipine	Tablet Nifedipine 40mg bid for 30 days.
Diuretics e.g. Hydrochlorothiazide	Tablet Bendroflumethiazide 2.6mg daily for 30 days.

Table 5: Treatment Given to Client as Compared with Literature Review cont.

Treatment as in literature review	**Treatment given to my patient**
Adrenergic inhibitors e.g. Atenolol	Was not given to patient
Vasodilators e.g. Hydralazine	Was not given to patient
ACE inhibitors e.g. Lisinopril and Captopril	Was not given to patient
Centrally alpha 2 agonist e.g. methyldopa	Tablet Methyldopa 500mg Twice daily for 14 days

From the above table, the treatments given to client were in line with the literature and it can be concluded that, the treatment given to Madam T.Y. was in line with the standard treatment for hypertension. Intravenous paracetamol which is not a drug used in the management of hypertension was given because client presented with severe headache.

Table 6: Pharmacology of Drugs Administered to Patient

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effects/ Remedies
26/11/2021	Labetalol	**Dosage:** **Intravenous:**20-80 mg, not to exceed 300mg/day **Route:** Oral and Intravenous.	**Dosage:** 40mg stat **Route:** Intravenous.	Beta Blocker	Labetalol works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure	Blood pressure reduced gradually	Shortness of breath, swelling, rapid weight gain, severe headache, blurred vision, loss of appetite, dark urine, Jaundice None was observed.

Table 6: Pharmacology of Drugs Administered to Patient cont.

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effects/ Remedies
26/11/2021	Nifedipine	**Dosage:** Dose; 30 to 60mg once per day. Dosage can be gradually increased every 7 to 14 days. Maximum dose is 90mg/ day **Route**: orally	**Dosage:** 40mg bd x 30 days **Route**: Oral	calcium channel blocker	Decrease cardiac work and energy consumption. Decrease delivery of myocardium consolidating effect on coronary and pericardial arteriole to reduce blood pressure to the normal range.	Patient's Blood pressure reduced from 200/130mmHg to 130/90 mmHg.	Headache, dizziness, syncope, peripheral oedema. None was observed.

Table 6: Pharmacology of Drugs Administered to Patient cont.

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effects/ Remedies**
26/11/2021	Bendrofluthiazide	**Dosage:** Dose;2.5 – 5.0 mg bid. **Route**: orally	Dosage; Dose; 2.5 mg bid x 30 days **Route**: Oral	Thiazide diuretic	It inhibits sodium reabsorption at the beginning of the distal convoluted tubule to reduce blood pressure	Madam A.C. sodium reabsorption at the distal convoluted tubule were inhibited hence blood pressure reduced from 200/130mmHg to 130/90 mmHg	Impotence (in males), hypokalemia, hypercalcemia, gout, thrombocytopenia and postural hypotension. None was observed.

Table 6: Pharmacology of Drugs Administered to Patient cont.

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effects/ Remedies
26/11/2021	Methyldopa	**Dosage** 250mg tid for 2 days for oral and 250-1000mg infusion over 30-60 minute 6-8hr PRN; not more than 4g/day. **Route:** Oral , IV	**Dosage:** 500mg bd x 14 days **Route**: Oral	Alpha – 2 receptor agonist.	It relaxes and dilates (widens) blood vessels. Blood flows more freely and at a lower pressure.	Patient's blood pressure was reduced to 130/90 mmHg.	Dizziness, drowsiness, dry mouth, headache, and weakness. No side effect was observed.

Date	Drug	Dosage/Route of Administration (Literature)	Dosage /Route of Administration given to patient	Classification	Desired Effect	Actual action observed	Side Effect
26/11/2021	Paracetamol (acetaminophen)	**Dosage:** 325mg to maximum dose of 4mg daily that is QID when the need emerges Route: orally	**Dosage**: 1g tds for 48 hours **Route**: intravenous	Analgesic/ antipyretic effect	To relieve pain by blocking generation of pain impulses, probably by inhibiting prostaglandin synthesis in the central nervous system.	Patient's headache was relieved.	**Side Effect** Renal failure, constipation Skin rashes, dizziness, urticarial, hypotension **Remarks** None of the above effects was experienced.

2.1.5. Complications

With reference to the complications indicated in the literature review such as Myocardial infarction, Congestive heart failure, Left ventricular failure, Hypertensive encephalopathy, Cerebrovascular accidents, renal failure, Retinopathy, Angina pectoris, etc. Madam T.Y. did not experience any complication of hypertension due to effective medical and nursing care given during hospitalization.

2.2 Patient/Family Strength

Strength refers to the physical power and energy that makes an individual determined in dealing with difficult or unpleasant situations **Invalid source specified.**. This is what the patient can do aside all that she is going through.

1. Patient could express the intensity of pain.
2. Patient could breathe when propped up in bed.
3. Patient could verbalise the level of anxiety.
4. Patient is able to tolerate daily activities.
5. Patient could tolerate fluids.
6. Patient expressed interest in knowing more about her condition by asking question**.**

2.3 Patient Health Problems

Problem is defined as a situation, person that needs attention and needs to be dealt with or solved **Invalid source specified.**. To provide effective nursing care to the patient, it is essential for the health problems of the patient to be identified through assessment, observation and data collection. These problems include actual and potential health problems. The following problems were identified;

1. Patient complained of severe headache. (26/11/2021)
2. Patient experience difficulty in breathing. (26/11/2021)
3. Patient was anxious of the outcome of her condition. (26/11/2021)

4. Patient complained of body weakness. (27/11/2021)
5. Patient is vomiting. (28/11/2021)
6. Patient had less knowledge of her current disease condition. (28/11/2021)

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY NURSING CARE

3.0 Introduction

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan (Weller, 2014). Following assessment and analysis of data, the nursing care is marked by a sequence of activities that nurses use to meet the individual health needs of the client.Planning is necessary as it serves as a logical system that permits the nurse and relatives to set objectives considering the patient and family strength that can be utilized in the nursing activities.

Nursing Objective/Outcome Criteria

A nursing outcome refers to a measurable behavior or perception demonstrated by an individual, a family, a group, or a community that is responsive to nursing intervention (Herdman & Kamitsuru, 2018).

1. Patient would be relieved of headache within twenty-four hours as evidenced by:
   a. The patient verbalizing relief of pain.
   b. The nurse observing patient has relaxed facial expression and increased participation in activities.
2. Patient would regain her normal breathing pattern within 24 hours as evidenced by;
   a. Patient verbalizing that she can now breathe without difficulties.

b. Nurse observing and recording a respiratory rate between 14- 20 cycles per minute.

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

   a. Patient co-operating with the health staff fully during provision of care

   b.The nurse observing patient and family have cheerful facial expressions.

4. Patient will be relieved of fatigue within 48 hours as evidenced by;

   a. Patient verbalizing that she no longer feels weak.

   b. Nurse observing patient performing activities of daily living example; washing, grooming etc.

5. Patient will maintain normal fluid volume within 24 hours as evidenced by;

   a. Nurse visualizing resolution of vomiting.

   b. Patient having good skin turgor, moist skin and mucus membrane, absence of thirst and normal urine output.

6. Patient and relatives will have adequate knowledge on her condition within period of hospitalizationas evidence by;

   a. The patient verbalizing a basic understanding of the causes, management and

prevention of hypertension.

b. The nurse observing patient and relatives give accurate answers to questions posed on hypertension

Table 7: Nursing Care Plan

Date/ Time	Nursing diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
26/11/21 1:50pm	Acute pain (Headache) related to Increased pressure in the cerebral arteries of the brain.	Patient would be relieved of Headache within 24 hours as evidenced by; 1. Patient verbalizing that she does not feel any pain. 2.Nurse observing patient has relaxed facial expression and increased participation in activities	1. Assess patient level and intensity of pain on the numerical rating scale 0-10. 2. Assess verbal complaints of discomfort. 3.Assess for factors that aggravate the pain. 4.Monitor vital signs. 5. Administer prescribed	1. Pain assessment was done using the numerical rating scale and Madam T.Y. chose 7 to note her pain intensity. 2. Patient's verbal complaints of discomfort were assessed. 3. Factors that aggravate pain were assessedand it was detected that stress aggravates Madam T.Y.'s pain. 4. Vital signs were checked and recorded. 5. IV labetalol 40mg and IV Paracetamol	27/11/21 1:50pm	Goal was fully met as patient verbalized that she does not feel any pain and nurse observed patient has arelaxed facial	

			Antihypertensives and Antipyretics	1g administered.		Expression and increased participation in activity	

Date/ Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
26/11/21 1:50pm	Ineffective Breathing Pattern (dyspnea) related to chest pain.	Patient will regain her normal breathing pattern within 24 hours as evidence by; 1. Patient verbalizing that she can now breathe well. 2. Nurse observing and recording a respiratory rate between 14 to 20 cycles per minutes.	1.Reassure client that respiration will normalize with proper interventions. 2. Assess for impaired respiration function. 3. Loosen tighten cloths around the neck and chest. 4. Prop patient up in bed and support her with pillows.	1.Patient was assured that her normal respiration will be normal 2. Patient was assessed for shallow and rapid respirations function to enhanced breathing. 3.Tight clothing around neck and chest were loosened. 4.Patient was propped up in bed and supported with pillows to enhance	27/11/21 1:50pm	Goal fully met as; 1. Patients respiratory rate within normal range (24 cycles per minute). 2. Patient verbalized .	

			5.Teach patient deep breathing exercise.	breathing. 5.Patient was taught deep breathing exercise			

Date/ Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
26/11/21 2:10pm	Anxiety related to unknown outcome of the condition .	Patient will be relieved of anxiety Within 24 hours asevidence by; 1. Patient verbalizing that she no longer feels anxious. 2. Nurse observing relaxed facial expression of the patient.	. Assure patient of competent nursing team and nursing care. 2. Assess for signs and symptoms of anxiety. 3. Allow patient to voice out her fears andask questions. . . 4.Introduce other patients who have been relieved from same condition to patient and allow her to interact with them.	1. Patient was assured that shewill be relieved of her symptoms through competent nursing care. 2. Patient's anxiety level was assessed by asking her of her fearsand worries. 3. Patient was allowed to voice out her feelings and questions were tactfully answered. 4.Patient was allowed to interact with other patients with the same condition.	27/11/21 2:10pm	Goal fully met as; 1. Patient verbalized that she feelsless anxious. 2. Nurse observed a relaxed facial expression of the patient.	

			5. Introduce health team members to her.	5. Health team members were introduced to patient.			

Date/ Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
27/11/21 8:30am	Activity intolerance related to fatigue.	Patient will be relieved of fatigue within 48 hours as evidence by; 1. Patient verbalizingthat she doesn't feel weak. 2. Nurse observing patient performing activities of daily Living example ; washing and grooming.	1. Assure patient that she will be relieved of her weakness. 2. Assist patient in some of herdaily activities example washing. 3. Raise side rails to prevent patient from falling. 4.Help patient assume a comfortable position in bed. 5.Restrict visitors to prevent	1. Patient was assured of competent nursing care that her weakness will be relieved. 2. Patient was assisted in some of her daily activity performance. 3. Side rails were raised to prevent her from falling. 4. Patient was helped to assumea comfortable position in bed. (semi-fowlers) 5. Visitors were restricted	29/11/21 8:30am	Goal fully met as evidence by; 1. Patient verbalized that she no longer feels weak. 2. Nurse observed patient perform activities of	

			interruptions during sleeping hours.	to prevent interruptions in resting periods of the patient.		daily living example washing and grooming.	

Date/ Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
28/11/21 11:34am	Risk for fluid volume deficit as evidenced by frequent vomiting	Patient will maintain normal fluid volume within 24 hours as evidenced by; 1. Patient verbalizing resolution of vomiting. 2. Patient having good skin turgor, moist skin and mucus membrane, absence of thirst and	1. Assure patient that normal fluid volume will be maintained. 2. Monitor and record vital signs. 3. Assess for signsand symptoms of dehydration. 4. Encourage the intake of oral fluids. 5. Administer prescribed IV	1. Patient was assured of competent nursing care. 2. Vital signs were checked and recorded four hourly. 3. Clinical features of dehydration were assessed as patient has good skin turgor, moist skin and mucus membrane and reported of no thirst. 4. Patient was encouraged to take oral fluids. 5. Prescribed IV fluids were administered example IV Ringers	29/11/21 11:34am	Goal fully met as; 1. Patient verbalizing resolution of vomiting. 2. Patient having goodskin turgor, moist skinand mucus membrane, absence of thirst and normal urine output.	

		normal urine output.	fluids.	Lactate.			

Date/ Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
28/11/21 12:55pm	Knowledge deficit related tolack of adequate information about the condition.	Patient will have adequate knowledge on her condition within period of hospitalization as evidence by; 1. The patient verbalizing a basic understanding of the causes,	1. Assure patient that she will get knowledge on the condition. 2. Ensure a quiet and conducive environment for education. 3. Assess patient and family's level of knowledge.	1. Patient and family were assured that the necessary information about the condition will be made known to them. 2. Conducive environment was ensured during the education section. 3. Patient and relative were asked about the knowledge they had on hercondition.	1/12/21 9:30am	Goal fully met as patient and relatives answered questions well.	

		management and prevention of hypertension. 2. Nurse observing that client and relatives give accurate answers pose tothem on hypertension.	4. Educate patient and family on the disease condition. 5. Encourage patient and family to ask questionsand answer tactfully.	4. Education on disease condition, desired and adverse effects of drugs were provided to patient and relatives 5. Questions were tactfully answered.			

CHAPTER FOUR

IMPLEMENTATION OF CLIENT/FAMILY CARE PLAN

4.0 Introduction

The implementation phase of the nursing process involves carrying out the proposed plan of nursing care. The nurse assumes responsibility for the implementation and coordinates the activities of all those involved in implementation, including the patient and family, other members of the nursing team, and other members of the health care team, so that the schedule of activities facilitates the patient's recovery (Hinkle & Cheever, 2014). This aspect of study deals with a description of the actual nursing care rendered to Madam T.Y and family during the period of hospitalization. It further describes the preparation made towards discharge and follow ups including the home visits made to the patient's home and community while she was on admission and after discharge.

4.1 Summary of Actual Nursing Care Rendered to Madam T.Y

Management of the patient was aimed at a successful medical treatment and nursing care to relieve Madam. T.Y. of all problems she had as well as maintaining optimal physiological function of patient so that she could return to normal health. Nursing care rendered to Madam T.Y started on the day of her admission, on 26th November, 2021 until she was discharged on the 1st December, 2021. During admission, daily routine nursing care were carried out such as bed making, bathing, mouth care, and serving of prescribed medications. Vital signs especially the blood pressure was monitored and recorded accordingly. Specific care was rendered according to patient's needs.

First Day of Admission (26th November 2021)

On the 26th November, 2021 at exactly 1:50 pm, Madam. T.Y. was brought to the female medical ward of Regional Hospital from Emergency unit accompanied by student nurse per ambulatory

with diagnosis of Hypertension. Client complained of headache, palpitation, was very anxious and her blood pressure was high. Patient was fully conscious. Happening to be at the nurses' station with the nurse in-charge at the time of her arrival, I was subsequently charged with the responsibility to carry out her admission to the ward. It was a planned admission. The patient's identity was verified by mentioning her name for response. She was then welcomed and immediately admitted and made comfortable in an admission bed. Her vital signs were checked and recorded as;

- Temperature - 36.1oC
- Pulse - 80 beats per minute
- Respiration - 20 cycles per minute
- Blood pressure - 210/120mmHg
- Oxygen Saturation -96%

She and her relatives were introduced to the staffs present and was assured of the competency of the healthcare team. Her particulars such as name, sex, age, and residential address were recorded in the admission and discharge book and the daily ward state. Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained.

She was oriented to the ward and its surroundings and welcomed to the ward. Patient was assured of a competent nursing care that everything about her will be done with much care to ensure delivery of quality health care. She was introduced to other patients at the ward and on observation patient was seen to be anxious.

Patient was to undertake the following investigations;

1. Kidney Function Test
2. Full Blood count
3. Human immunodeficiency (HIV) Screening
4. Chest X-ray
5. Blood Film for Malaria Parasites
6. Random Blood Sugar

Medications prescribed were;

1. Intravenous Labetalol 40mg stat
2. Tablet Nifedipine 40 mg bid x 30 days
3. Tablet Bendroflumethiazide 2.5 mg daily x 30 days
4. Tablet methyldopa 500mg bid x 14 days
5. Intravenous Normal Saline 2 liters
6. Intravenous Paracetamol 1g tds for 48 hours

There was two (2) hourly blood pressure monitoring. Due medication was served and patient was assured of successful recovery with the help of competent and dedicated nurses.

BLOOD PRESSURE MONITORING CHART

DATE	TIME	BP	INTERVENTION
26/11/2021	1:50pm	210/120mmHg	Intravenous labetalol 40mg stat was given

26/11/2021	3:50pm	190/105mmHg	Tablet Nifedipine 40mg / normal saline 500ml.
26/11/2021	5:50pm	170/90mmHg	No intervention was given
26/11/2021	7:50pm	150/88mmHg	No intervention was given
26/11/2021	9:50pm	149/88mmHg	No intervention was given
26/11/2021	11:50 pm	163/90mmHg	Intravenous paracetamol 1g
27/11/2021	1:50 am	150/89mmHg	No intervention was given
27/11/2021	3:50 am	145/73mmHg	No intervention was given
27/11/2021	5:50 am	130/73mmHg	No intervention was given
27/11/2021	7:50 am	140/79mmHg	No intervention was given
27/11/2021	9:50 am	156/90mmHg	Tablet Nifedipine 40mg
27/11/2021	11:50 am	145/86mmHg	No intervention was given
27/11/2021	1:50pm	139/80mmHg	No intervention was given

I reintroduced myself to patient as a final year student nurse of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take her and her family for my care study. Madam T.Y. was informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of license in Registered General Nursing. I explained to Madam T.Y. the concept of the patient/family care study and assured her of privacy and confidentiality of information. It was added that a report will be written after the entire event. Madam T.Y. agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to her. Discharge planning was initiated with Madam T.Y. and family; thus, they will continue the care at home once she is well. I decided

to choose this patient for the study because I wanted to know more about the diseases (Hypertension) that brings most clients around the age of Madam T.Y. to the hospital.

At 1:50pm, patient complained of headache and on observation she was very anxious of the outcome of her condition. A nursing diagnosis of acute pain (Headache) related to increased pressure in the cerebral arteries of the brain was made. A goal was set to help relieve Madam T.Yof headache within 24 hours. Nursing interventions implemented include; pain assessment using the numerical rating scale and Madam T.Y chose 7 to note her pain intensity, patient's verbal complaints of discomfort were assessed, factors that aggravate pain were assessed and it was detected that stress aggravates Madam T.Y's pain, patient's vital signs were checked and recorded, prescribed antihypertensive and antipyretic medication such as; IV labetalol 40mg and IV Paracetamol 1g tds for 48 hours were administered and documented.

At 1:50pm, patient complained of difficulty in breathing so a nursing diagnoses of ineffective breathing pattern (dyspnea) related to chest pain was formulated and objectives was set to help patient to breath well within 24 hours. The following interventions were carried out to help meet the set objectives; patient was assured that respiration will normalize with proper interventions, patient was assessed for impaired respiratory function, and patient's tight cloths around the neck and chest were loosened and also propped up in bed and supported with pillows to enhance breathing. Patient was also taught deep breathing exercise.

At 2:10pm, patient looked anxious and was confirmed by her. A nursing diagnose of anxiety related to unknown outcome of the condition (hypertension) and its treatment was formulated and to be evaluated within 24 hours. The interventions done were; Patient was assured that she will be relieved of her symptoms through competent nursing care, patient's anxiety level was assessed by asking her of her fears and worries, patient was allowed to voice out her feelings and questions

were tactfully answered. Patient was allowed to interact with other patients with the same condition and health team members were introduced to patient.

At 6pm, her vital signs were checked and recorded. She ate rice with “kontomire” stew. Patient slept around 9pm. I handed over to the night nurses and departed the ward.

Second Day of Admission (27th November 2021)

On the second day of admission, at 7:00am I went to the ward to continue with my nursing care for Madam T.Y., her morning vital signs were checked at 6am and recorded as Temperature 36.10C, Pulse 79bpm, Respiration 19cpm and Blood Pressure 150/90mmHg. Patient ate oats and bread.

At 8:30am, patient complains of being weak. A nursing diagnosis of activity intolerance related to fatigue was formulated to be evaluated within 48 hours. The interventions made were patient was assured of competent nursing care that her weakness will be relieved, patient was assisted in some of her daily activity performance, side rails were raised to prevent her from falling, patient was helped to assume a comfortable position in bed (semi-fowlers) and visitors were restricted to prevent interruptions in resting periods of the patient.

At 1:50 pm, evaluation on the goal set on the previous day to relief patient’s headache was done. Goal was fully met as patient verbalized a relief of pain and patient had a relaxed facial expression.

At 1:50pm, an evaluation on the goal to help Madam T.Y regain her normal breathing pattern was evaluated. Goal fully met as patient’s respiratory rate were within normal range (19 cycles per minute) and patient verbalized that she is relaxed.

At 2:10 pm, evaluation was done on goal set to relieve Madam T.Y. of anxiety the previous day. Goal was fully met as patient co-operated with health staff fully during provision of care and patient had cheerful facial expressions.

Due medications were served at 6pm, her vital signs were checked and recorded at 6pm and 10pm. Patient slept around 10pm that day. I handed her over and departed to my house.

Third Day Of Admission (28th November 2021)

On the third day of admission, patient was fairly well, she brushed her teeth, had her bath and emptied her bowel. Her vital signs were checked and recorded as Temperature 36.20C, Pulse 88bpm, Respiration 21cpm and Blood Pressure 140/70mmHg. Due medications such as Tablet Nifedipine 40mg, Tablet Bendroflumethiazide 2.5mg daily and Tablet Methyldopa were administered and recorded at 6am. Patient ate wheat and 4 slices of bread around 7:40am.

At 12:55pm patient was engaged in an interaction and it was realized that patient had less knowledge on her condition (Hypertension). The nursing diagnosis formulated was knowledge deficit related to lack of adequate information about the condition (Hypertension). An objective was set to help patient and family gain adequate knowledge on hypertension throughout the period of hospitalization. Interventions carried out were.

Patient and family were assured that all the necessary information about the condition will be made known to them, patient level of knowledge on the the condition was assessed, patient was educated on condition and questions were asked by the patient.

Around 11am, she ate banku and groundnut soup. Patient vomited the food eaten at exactly 11:34am. A nursing diagnosis was formulated as risk for fluid volume deficit as evidenced by frequent vomiting which was to be evaluated in 24 hours. These interventions were formulated to

meet the goal: Patient was assured of quality care, vital signs were checked and recorded four hourly, clinical features of dehydration were assessed as patient has good skin turgor,moist skin and mucus membrane and reported of no thirst ,patient was encouraged to oral fluids and prescribed IV fluids were administered example IV Ringers Lactate.

At 2:10pm, I left for my first home visit whiles patient was still on admission. I met Madam T. Y's granddaughter in which we had interactions.

Her vital signs were checked recorded at 2pm, 6pm and 10pm. Due medications were also administered at 6pm. She took tea and biscuits for supper and retire to bed around 8pm.

Fourth Day of Admission (29th November 2021)

She observed her personal hygiene needs and vital signs checked and recorded as follows; Temperature 36.40C, Pulse 80bpm, Respiration 24cpm and Blood Pressure 130/80mmHg. She was reassured that everything necessary will be done in caring for her. Bed linens were straightened to provide comfort, medications were administered as ordered and documented. Her breakfast was attractively served and encouraged to eat at 7:00am before rounds. At 8:00am doctor came for in-patient review and patient expressed her happiness about the care being rendered to her. On rounds, no new orders were made but to continue treatment.

At 8:30am, I evaluated the goal to help relieve patient of fatigue. Goal was fully met as evidence by; patient verbalized that she no longer feels weak and nurse observed patient perform activities of daily living.

I also evaluated the goal to help maintain normal fluid volume of the patient at 11:34am. Goal was fully met as; nurse verbalizing resolution of vomiting and patient having good skin turgor, moist skin and mucus membrane, absence of thirst and normal urine output.

All routine nursing actions were carried out and documented for references and to ensure quality care as well. We later had conservation regarding her work and activities that will promote her health. Patient was made comfortable in bed after evening medications were served and she slept around 10:20pm.

Fifth Day of Admission (30th November 2021)

On the fifth day of admission, patient was fairly well, she brushed her teeth, had her bath and emptied her bowel. Her vital signs were checked and recorded at 6am as Temperature 36.60C, Pulse 80bpm, Respiration 24cpm and Blood Pressure 135/80mmHg.Tablet Nifedipine 40mg, Tablet Bendroflumethiazide 2.5mg daily were administered as ordered and documented. She took her breakfast and made comfortable in bed.

At 8:00am doctor came for in-patient review and no new orders were made but to continue treatment. All routine nursing actions were carried out and documented for references and to ensure quality care as well. After all these, patient/family was informed about her possible discharge the next day as said by doctor and she was very happy about that. We later had conservation regarding her work and activities that will promote her health. Patient was made comfortable in bed after evening medications were served and she slept around 10:20pm.

Day of Discharge/Sixth Day of Admission (1st December 2021)

On 1st December 2021, patient looked very healthy, had no complaints and blood pressure was stabilized. At 6am, the blood pressure was checked and recorded as 130/90mmHg, temperature 36.70C, pulse 76 beat per minute and respiration 24 cycle per minute.

At 8:30am, evaluation on the goal set to help madam T.Y have adequate knowledge on the disease within 24 hours was done. Goal was fully met as patient and relatives answered questions well.

The medical team informed her of her discharge on their usual daily in-patient review. She was encouraged to do exercises, maintain personal hygiene, avoid stressful activities, and continue with the intake of low sodium diets. She was informed not to hesitate to come to the hospital if she is not feeling well even before the review date. Enquires were made about the bills and she was to pay an amount of GH¢ 250.00 for medications which were not covered by National Health Insurance Scheme.

Patient was discharged with Tablet Nifedipine 40mg, Tablet Methyldopa 500mg and Tablet Bendrofluazide 2.5mg. Patient was informed to come for review on 8th December 2021 at the Out Patient Department. Education was given to patient on how medications should be taken and prevention of predisposing factors such as stress. Patient's discharge was documented in the admission and discharge book and daily ward state. I helped patient to pack her belongings after which I escorted her to the entrance. Patient boarded a taxi and left around 11am. I bid patient a goodbye and returned to the ward. After the patient had been discharged, the bedside locker and the bed were disinfected. All dirty articles were removed. This was done to ensure cleanliness of the ward and to prevent cross infection.

4.2 Preparation of Patient and Family for Discharge/Rehabilitation

Preparation for discharge commenced from the time of admission at the hospital on 26th November, 2021 till the last day of hospitalization, 1st December, 2021. The patient and family were informed that staying in the hospital was for a temporal period of time. Patient was assured that they are in competent hands and with full cooperation, patient's health was going to be restored very soon.

During in-patient review on the 1st December, 2021 the health team declared their intention of discharging her. Patient was informed about her discharge and was also educated to report to the

hospital if she fell ill. Education on the need to honor review on the 8th December, 2021. After patient's bills were settled, I helped patient to pack her belongings. The review date (8th December, 2021) was re-echoed to her and the need to comply with drug therapy was also emphasized. Education was given to patient on how medications were to be taken. Prevention of predisposing factors such as stress etc. were made known once again. The date of discharge was entered into the admission and discharge book as well as the daily ward state. Patient was allowed to say goodbye to the staff and other patients on the ward after which she was escorted to the car park to board a car home.

4.3 Follow Up / Home Visit / Continuity of Care

Home visit is a visit made by a health professional to a patient's home, usually with face-to-face contact between the health professional and the patient, less commonly between health professional and the patient's family.

Home visits were done before and after patient's discharge. It is friendly but a purposeful visit to patient home. Health educations were given and the need for the prevention of complication was reemphasized. It provided a good account on the causes and predisposing factors of patient's illness.

First Home Visit (28th November 2021).

My first home visit was made on 28/11/2021, thus; the third day of admission to Penkwase, about 1km journey from Bono Regional Hospital, Sunyani. It was agreed to visit their home on this day, while patient was on admission, on the day of admission as I explained to her that it is a requirement and part of the care. The purpose of this visit was to assess the home environment of the patient and to give appropriate health educations to her family before her discharge on general cleanliness and safeguard methods to prevent themselves from injury. I left Bono Regional

Hospital, Sunyani around 2:10pm and safely arrived at the patient's house at around 2:30pm with patient's granddaughter where I was warmly welcomed, offered a comfortable seat and water as tradition demands. I was asked of my mission so I introduced myself to them as a final year nursing student as said above and the need for the visit. The patient lives in a three-bedroom house built with blocks and roofed with aluminum sheets with kitchen with digital address Bs-0081-8310.

During my interactions with her granddaughter, she revealed to me that their place of convenience was not a problem because there was a toilet in the house. On observation refuse in the home is disposed-off in a well-covered dustbin provided by Zoom lion Domestic Waste Limited and emptied regularly and source of water from a tap at the house. I also realized that water containers were covered.

Based on the above findings, I reinforced on the need to continue to cover water containers and also food to prevent contamination. The need to ensure proper ventilation was also stressed on. Hand washing with soap under running water before eating and after visiting toilet.

Finally, she was encouraged to ask questions and answers were provided in simple terms to enhance her understanding. I thanked her for the hospitality and she thanked me too. I left the house around 4:00pm.

Second Home Visit (2ndDecember 2021)

A second visit was made on the 2nd December 2021 thus, a day after Madam T.Y. was discharged to assess patient's health status and to offer necessary education. I arrived at patient's home exactly 9:00am on Thursday. On observation i noticed that Madam T. Y's condition had improved well. I went along with the blood pressure apparatus and checked Patient's blood pressure and pulse which read as 130/80millimeters of mercury and pulse 79 beat per minute respectively. This was

as a result of her compliance with drug therapy and also because she incorporated into her life what was taught to her at the hospital. Some relatives available were also encouraged to check theirs and they did same. Her granddaughter confirmed that patient took all her drugs as prescribed and when I inspected the drugs it indicated she took them as prescribed. Emphasis was further made on the need for enough rest and sleep and also the need to avoid high sodium meals. Stress management and performance of exercise was emphasized. I prepared patient and family psychologically towards the intended handing over to the public health nurse for continuity of care during my next visit. Patient and family were thankful for my visit and they were also reminded of the review date which was 8th December 2021. I bade patient and her family fare-well and left there around 11:00am

Day of Review /Follow up (8th December 2021)

On 8thDecember 2021 Madam T.Y. and daughter were met at the Out- Patient Department of the Bono Regional Hospital, vital signs checked and recorded as follows; Temperature - 36.80C, Pulse – 67 beat per minute, Respiration - 14 cycle per minute, blood pressure - 130/90millimeters of mercury. On review client gave no new complaints and was educated to continue with her medications. She was also encouraged to visit the hospital anytime she is not well. Madam T.Y. was escorted to the hospital gate where she boarded a taxi home.

Third Home Visit (20th December 2021)

The main reason for conducting the third home visit were to: Assess the general condition of patient and family, reinforce the need to comply with treatment regimen and finally terminate care.

On the said date, I set off early Monday afternoon around 2:30pm with a taxi. I got to her house at around 02:45pm. Patient and granddaughter were doing well as they looked cheerful and had no

complains. The environment was tidy as there were no rubbish nor stagnant water around. I handed over patient to one of her daughters who is nurse to continue with care at home after giving her enough education. Madam T. Y's daughter commended me for a good work done and accepted to continue the care of Madam T.Y at home. I however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick and rather than relying on self-medication. After interacting with patient and family for a while, I reemphasized on health educations that had been given to them already. Since it happened to be my last day of therapeutic relationship with patient and family, I terminated my care and thanked them for their cooperation which made my study a success. Again, patient and her daughter expressed their gratitude by showing how grateful they were to me for the support and care given to them. I eventually sought permission to leave and bid them the final farewell. I board a taxi to my house at 4:50pm.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND 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, 2014).The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to the patient and family.

5.1 Statement of Evaluation

Throughout the period of admission, six health problems were recorded and objectives were set to solve them. Using the nursing process approach, all the goals set were met within the scheduled period. Below is the summary of the interventions carried out and to what extent the goals were met.

Madam T.Y was relieved of headache

On 26th November, 2021 at 1:50pm, patient complained of headache and on observation she was very anxious of the outcome of her condition. A nursing diagnosis of acute pain (Headache) related to increased pressure in the cerebral arteries of the brain was made. A goal was set to help relieve Madam T.Y. of headache within 24 hours.

Nursing interventions implemented include; pain assessment using the numerical rating scale and Madam T.Y. chose 7 to note her pain intensity, patient's verbal complaints of discomfort was assessed, factors that aggravate pain were assessed and it was detected that stress aggravates Madam T.Y's pain, patient's vital signs were checked and recorded, patient was encouraged to take in copious fluids adequately to correct dehydration, prescribed antihypertensive and

antipyretics medication such as; IV labetalol 40mg and IV Paracetamol 1g tds for 48 hours were administered and documented.

On 27thNovember2021 at 1:50 pm, evaluation on the goal set on 26thNovember2021 to relieve patient's headache was done. Goal was fully met as patient verbalized a relief of pain and patient had a relaxed facial expression.

Madam T.Y was relieved of difficulty breathing

On 26th November, 2021at 1:50pm, patient complained of difficulty in breathing so a nursing diagnosis of ineffective breathing pattern (dyspnea) related to chest pain was formulated and objectives were set to help patient to breath well within 24 hours. The following interventions were carried out to help meet the set objectives; patient was reassured that respiration will normalize with proper interventions, patient was assessed for impaired respiratory function, patient's tight cloths around the neck and chest were loosened and also propped up in bed and supported with pillows to enhance breathing. Patient was also taught deep breathing exercise.

On 27thNovember2021 at 1:50pm, an evaluation on the goal to help Madam T.Y regain her normal breathing pattern was evaluated. Goal fully met as patient's respiratory rate were within normal range (19 cycles per minute) and patient verbalized that she is relaxed.

Madam T.Y was relieved of anxiety

On 26th November, 2021 at 2:10pm, patient looked anxious and was confirmed by her. A nursing diagnoses of anxiety related to unknown outcome of the condition was formulated and to be evaluated within 24 hours. The interventions done were; Patient was assured that she will be relieved of her symptoms through competent nursing care, patient's anxiety level was assessed by asking her of her fears and worries, patient was allowed to voice out her feelings and questions

were tactfully answered. Patient was allowed to interact with other patients with the same condition.

On 27th November2021 at 2:10 pm, evaluation was done on goal set to relieve Madam T.Y. of anxiety the previous day. Goal was fully met as patient co-operated with health staff fully during provision of care and patient had cheerful facial expressions.

Madam T.Y was relieved of fatigue

On 27th November,2021 at 8:30am, patient complains of being weak. A nursing diagnosis of activity intolerance related to fatigue was formulated to be evaluated within 48 hours. The interventions made were patient was assured of competent nursing care that her weakness will be relieved, patient was assisted in some of her daily activity performance example washing and grooming, side rails were raised to prevent her from falling, patient was helped to assume a comfortable position in bed (semi-fowlers) and visitors were restricted to prevent interruptions in resting periods of the patient.

On 29th November2021at 8:30am, I evaluated the goal to help relieve patient of fatigue. Goal was fully met as evidence by; patient verbalized that she no longer feels weak and nurse observed patient perform activities of daily living example washing and grooming.

Madam T.Y was relieved of vomiting

On 28th November2021around 11am, she ate banku and groundnut soup. Patient vomited the food eaten at exactly 11:34am. A nursing diagnosis was formulated as risk for fluid volume deficit related to vomiting which was to be evaluated in 24 hours. These interventions were formulated to meet the goal: Assure patient of competent nursing care, monitor and record vital signs, assess for signs and symptoms of dehydration, encourage the intake of oral fluids and administer prescribed IV fluids.

On 29th November2021, I also evaluated the goal to help maintain normal fluid volume of the patient at 11:34am. Goal was fully met as; nurse verbalizing resolution of vomiting and patient having good skin turgor, moist skin and mucus membrane, absence of thirst and normal urine output.

Madam T.Y and family gained knowledge on hypertension

On 28th November2021at 9:30am patient was engaged in an interaction and it was realized that patient and family had less knowledge on her condition (Hypertension). The nursing diagnosis formulated was knowledge deficit related to lack of adequate information about the condition (Hypertension). An objective was set to help patient and family gain adequate knowledge on hypertension throughout the period of hospitalization. Interventions carried out were; Patient and family was assured that all the necessary information about the condition will be made known to her, patient level of knowledge on the the condition was assessed, patient and family were educated on condition and questions were asked by the patient.

On 1st December 2021 at 8:30am, evaluation on the goal set to help madam T.Y have adequate knowledge on the disease within 24 hours was done. Goal was fully met as patient and relatives answered questions well.

5.2 Amendment of the Nursing Care Plan

Despite the numerous problems identified, with the individualized comprehensive nursing care and support from other members of the health team and co-operation from Madam T.Y and family, all of the goals set were fully met. The care plan was therefore not amended.

5.3 Termination of Care

Care of patient and family ended on the 20th December, 2021which was my last home visit. This ended the interaction between the health team and Madam T.Y and her family. The preparation for termination started on day of admission through discharge, review to the third home visit. During these periods, patient and family were educated on various topics. I congratulated the family for the care they had rendered to Madam T.Y. They were thanked for their co-operation and patient was handed over to a community health nurse to continue with care at home. They were told now that Madam T. Y's health had been restored, the care for her has officially ended. I informed them of my desire to visit them unofficially whenever I had the opportunity. They were happy and indicated that they would miss my care and would strictly adhere to all instructions given to them. It was a moment to remember when I told them of my intention to leave. There was no separation anxiety as patient and the relatives had enough psychological preparations from the day of admission till discharge but it was still difficulty bidding them farewell.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

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

6.1 Summary

Madam T.Y a 67-year-old woman was admitted to the female medical ward through the Emergency Unit of the Bono Regional Hospital, Sunyani on the 26th of November, 2021 at 01:50pm with the diagnose of hypertension. On admission, she presented with severe headache, difficulty in breathing and anxiety and was discharged on 1st December, 2021. Patient was educated on hypertension. On the 8thDecember, 2021 patient reported for review as scheduled. Three home visits were embarked on. The first home visit was done while patient was still on admission on 28th November, 2021, second home visit was on the 2nd December, 2021 and third home visit was on the 20th December, 2021. The care of Madam T. Y and her family care were terminated on the20th December, 2021, during the third home visit when patient had had her blood pressure being in the normal values.

6.2 Conclusion

The study has equipped me with knowledge on how to care for a patient as an individual. Through this study, I have been able to put into practice actual and holistic nursing care as has been learnt theoretically. The study provided a therapeutic environment for nursing patient as an individual and has promoted a good nurse-patient (family) relationship as well as broadened my knowledge on hypertension. It has also helped me to practice my skills acquired in the classroom theoretically.

It has deepened my relationship with patients, families and the people in a given community as a whole.

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

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APPENDIX

Date	Time	Temperature (ºC)	Pulse (Bpm)	Respiration (Cpm)	Blood pressure (mmHg)	SPO2 %
26/11/21	01:50pm	36.1	80	20	210/120	96
	02:00pm	36.1	80	20	210/120	95
	06:00pm	36.0	88	21	170/90	96
	10:00pm	36.3	94	20	149/88	97
27/11/21	06:00am	36.1	79	19	150/90	97
	10:00am	36.2	90	21	156/90	96
	02:00pm	36.3	86	21	148/80	95
	06:00pm	36.4	91	20	150/85	97
	10:00pm	36.0	97	23	140/77	96
28/11/21	06:00am	36.2	88	21	140/70	98
	10:00am	36.5	93	22	145/75	97
	02:00pm	36.6	93	23	147/70	96
	06:00pm	36.5	91	21	140/80	98
	10:00pm	36.3	86`	20	140/79	98
29/11/21	06:00am	36.1	86	22	130/80	97
	10:00am	36.4	96	21	135/85	97
	02:00pm	36.1	93	22	140/80	96
	06:00pm	36.7	94	21	143/70	98
	10:00pm	36.4	89	20	140/75	98
30/11/21	06:00am	36.5	91	21	145/70	97
	10:00am	36.6	88	20	140/80	97
	02:00pm	36.5	90	21	139/75	95
	06:00pm	36.5	89	23	140/80	99

	10:00pm	36.6	91	22	145/85	96
01/12/21	06:00am	36.7	76	24	130/90	98
	10:00am	36.6	80	20	135/75	99

SIGNATORIES

1. THE STUDENT NURSE

NAME: ASARE FELICITY

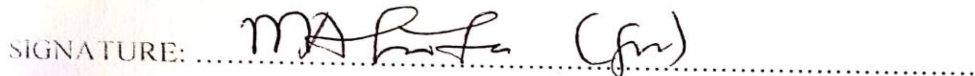
SIGNATURE: ....

DATE: 7TH, OCTOBER, 2022

2. THE NURSE-IN-CHARGE OF FEMALES' WARD (BONO REGIONAL HOSPITAL, SUNYANI).

NAME: MISS BARBARA Y. ASANTE

SIGNATURE: ....

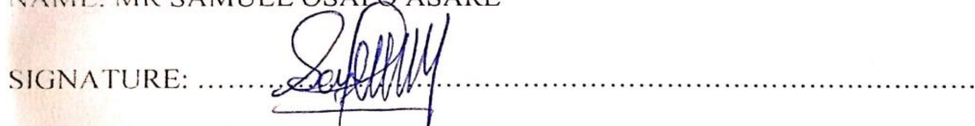


DATE: 07/10/2022

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

NAME: MR SAMUEL OSAEQ ASARE

SIGNATURE: ....

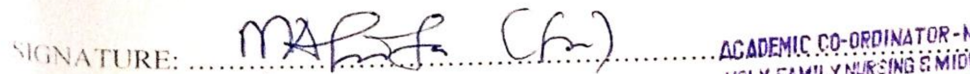


DATE: 07-10-22

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

NAME: MONICA NKRUMAH

SIGNATURE: ....



DATE: 10/10/2022