HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A PATIENT/FAMILY CENTERED NURSING CARE STUDY ON

SEVERE ANAEMIA

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

AUGUST, 2023

PREFACE

Patient and family care study involves the collection of data from patient by using the problem solving approach to find out patient's problems and to render a comprehensive and competent nursing care to the patient using the nursing process approach.

It involves detailed written account of the holistic nursing care rendered to the patient and family. It also involves and creates a good professional but cordial relationship between the patient, family community and health team.

The patient/family care study forms part of the assessment of every final year student. It is a prerequisite for every candidate in order to partially fulfil the award of diploma certificate in Registered General Nursing by the Nursing and Midwifery Council of Ghana. It affords the student the opportunity to develop his/her skills for future use. The patient/family care study is a comprehensive account of the comprehensive and competent nursing care rendered to the patient and family from the day of admission through the day of discharge, review and follow up visit. The study has equipped me with knowledge in 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 has been learnt theoretically. The study serves as a reference paper for other student nurses and qualified health personnel who may be interested in its content.

The confidentiality of the patient and family were ensured by the use of patient/family initials instead of their full names. The comprehensive care rendered was made possible by the employment of skills and knowledge in such disciplines as psychology, public health nursing, medical nursing, surgical nursing, pharmacology and nutrition and dietetics to meet the patient/family's needs and the community at large.

ACKNOWLEDGEMENT

My greatest gratitude goes to the Almighty God for His strength, knowledge, wisdom, protection, guidance and all the grace given to me.

I wish to state my profound appreciation to Mrs.A.K. and her family for their co-operation, patience, support and consent for permitting me to use them as my patient and family for this care study. I would also like to express my deepest gratitude to the staff of Holy Family Nursing and Midwifery Training College especially Mr. Osei Owusu Shardrack my supervisor for their guidance, corrections and the time they spent making this study become a reality. Again, my appreciation goes to the medical director, nursing administrator, the preceptor, the nurse in-charges and staffs of the Females ward in Holy Family Hospital, Berekum, who also gave me their support, time and guidance during the study.

I also express my profound gratitude to the Auditors and publishers whose work I selected to making this script. And to my mother Mrs.Konadu Theresah for her unconditional financial and emotional support she granted me during years of being in school. I also express my gratitude to my course mate Jordan for helping me during my care study, God bless him for everything he did for me.

May the Good Lord bless them all and grant them all their heart desires.

INTRODUCTION

Patient care study is an academic exercise carried out by final year student nurse. The care study uses the nursing process approach which is deliberate activity whereby the practice of nursing is performed in systematic manner. The nursing process has five components. These are assessment, analysis, planning, implementation and evaluation. Using the nursing process in the nursing care of the patient emphasis is placed on health promotion, maintenance and restoration of health or even enhancing a peaceful death depending on the patient's condition. The patient/family care study forms part of the requirements of the Nursing and Midwifery Council in the fulfilment of the award of Registered General Nurses' Certificate (Diploma). This study was carried out on Mrs. A.K., a 74years women who was admitted to the Females ward of Holy Family Hospital, Berekum, on the 6th December, 2022 at 12:40pm accompanied by her daughter and the outpatient department (OPD) nurse in a conscious state, with the diagnosis of severe anaemia Pre-admission preparations made included bed making, arrangement of infusion drip stand and setting of a tray for vital signs. The nurse in-charge took over the patient's particulars from the OPD nurse. Patient particulars were taken and patient and daughter assured that they were in the care of competent health team. A simple bed was offered to the client and her daughter was oriented at the ward. Visiting hours were explained to the daughter as well as the rules and regulations of the ward. Patient was reassured and made comfortable in bed. I introduced myself to patient and her daughter, assured them of my help and intention to use her for my care study to ensure her quick recovery. I told them I was interested in that condition (Severe Anaemia) and wanted to find out more about the condition and to nurse them holistically until they are discharged. IV line was accessed and secured and her blood sample was taken for grouping and cross matching at the laboratory. The result revealed that she is O positive and her haemoglobin level was 6.8g/dl.

The need for blood transfusion was explained to her and her daughter.

During the period of hospitalization, patient was put on the following medication;

1. IV N/S 500ml bid x 24hrs

2. Tablet Omeprazole 20mg bid x7

3. Suspension Nugel 15ml tid x7

4. Transfused 2 units of whole blood

5. IV Furosemide 10mg/ml OD x 2

6. Paracetamol 1mg tid x 7

During the period of hospitalization, patient was nursed for six (6) days. Three (3) home visits were made during the period of interaction with my patient. My first home visit was made on 9th December, 2022 and last home visit was made on 6th January, 2023. The nursing process was the tool adopted to determine the patient/family needs and problems for the appropriate nursing interventions to be carried out. At the time of discharge, her condition had tremendously improved. Care was terminated on the 6th January, 2023. The study was organized in six main chapters as follows;

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

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CHAPTER ONE

ASSESSMENT OF PATIENT/FAMILY

1.0 Introduction

It is a process that enables the nurse and the health team to identify the patient's needs. It is the process through which the patient and family information can be gathered. This is the initial phase of nursing process and it comprises collection of data from patient's particulars, family medical and socio-economic history, developmental history, lifestyle and hobbies. It is done through observations, interviews, physical examination and investigations. It takes into consideration patient's concept of illness, its causes as well as patient's concerns and expectations towards treatment. All these information were gathered starting from the day of admission.

1.1 Patient's Particulars

Patient particulars are facts or details such as; name, sex, religion, ethnicity, date of birth etc. about the patient which are written down and kept as recorded (Wang and Peura, 2015) Mrs.A.K.is a 74 year old woman born on the 2nd of February,1948 to the late Mr.K.B and Mrs.A.M at Biadan in the Bono Region of Ghana. She is dark in complexion and weighs 58kilograms and height 5 feet tall. The family current town of residence is Senase in the Berekum East Region and her house number is FA/8. She is an Ashanti who speaks Asante Twi and a Ghanaian by nationality. She did not have any formal education and she is currently a farmer. Patient did not have any formal education due to financial problems. Mrs.A.K. is the first born among three children. She got married to Mr.K.M but lost him two years ago. She is a mother to 5 children of which two are males and the rest are females. She is a Christian and attend church at The Church of Pentecost at Senase. Patient lives in a boys quarters, which is built with blocks, iron

sheet and others coloured with brown paint. She has a good supply of pipe borne water and electricity. Patient next of kin is her first son, who also stays at Senase.

1.2 Family's Medical History

On interaction with Mrs.A.K, she confirms that there is no known member in the family suffering from asthma and diabetes, mental illness such psychosis and epilepsy, communicable diseases such as tuberculosis. She however mentions that, she is a known hypertensive patient. Their family occasionally suffer from malaria, cough and headache which treatments are taken from the hospital. She says they do not rely on over the counter drugs unless prescribed by the Doctor and they sometimes rely on the traditional herbalists for treatment when any of the family members suffer from any of them. Socially, patient family members are not known to be drug addict and also do not exhibit any form of social vices. She also said that his family had no known allergies. Patient family are known because of their good conduct and are respected in their community.

1.3 Family's Socio-Economic History

Mrs.A.K. has a very good relationship and cohesion with her family. Family members are willing to support each other in times of financial hardships despite the low economic status of most family members. She said most of her family members are farmers. She being a farmer predisposes her to cuts from cutlass and snake bites, she has had a cut from cutlass but no snake bite as at the time of interaction. Mrs.A.K. does not depend much on her family for financial support. She depends on her own income generated by selling her farm produce. She informed me that going to farm on Friday, is the only taboo in their family and the entire community. Family members are known for their kindness and generosity despite their economic status. They also involve themselves in

religious activities, family members attend different churches. She said all of her family members depend on the National Health Insurance Scheme (NHIS) for medical care.

1.4 Patient's Developmental History

Development history is an account of how and when a person met developmental milestones such as; walking and talking (Shiel, 2016).

Growth is the progressive development of living thing, especially the process by which the body reaches its complete physical development (Weller, 2014)

According to patient, her mother had a normal pregnancy of nine months and a spontaneous vagina delivery at term. She was delivered at home by the help of her grandmother who was a traditional birth attendance and was very healthy. There was no problem with puerperium and no congenital abnormalities like cleft lip, cleft palate, hydrocephalus and other were found on her. Mrs.A.K. was breastfed alongside given some local dishes like porridge and rice porridge. Patient did not receive any immunization during childhood and went through the normal developmental milestone which started from sitting, crawling, standing, taking steps, walking and gradually running which she stated that she cannot actually tell the time she started all these. She engaged in farming and trading through which she was able to cater for her children. According to patient, she experienced certain secondary characteristics such as development of breast, growth of pubic hair in the axilla and genital areas at age seventeen. She had her menarche at age of eighteen and it was 30 days menstrual cycle. Patient had her menopause at the age of fifty.According to patient, she had no formal education so farming is what she does for a living. She got married at the age of 26 years and gave birth to 5 children and went through the normal pregnancy of nine months and a spontaneous vagina delivery at term. Her ambition is to take care of all her children before death.

According to Erikson's theory of psychosocial development (1959), there are eight distinct stages with each possible result, this either success of failure personality. These stages are;

1. Trust verses mistrust (from birth to 18 months)
2. Autonomy verses shame and doubt (2 to 3 years)
3. Initiative verses guilt (3 to 6 years)
4. Industry verses role inferiority (6 to 12 years)
5. Identify verses role confusion (12 to 18 years)
6. Intimacy verses isolation (20 to 40 years)
7. Generatively verses stagnation (40 to 65 years)
8. Integrity verses despair (65years to death).

According to Eric Erikson theory of development, patient falls under integrity versus despair (65 years to death).This stage includes, "a retrospective accounting of one's life to date; how much one embraces life as having been well lived, as opposed to regretting missed opportunities". Those in late adulthood need to achieve both the acceptance of their life and the inevitability of their death (Barker, 2016).This stage includes finding meaning in one's life and accepting one's accomplishments, but also acknowledging what in life has not gone as hoped. It is also feeling as sense of contentment and accepting others' deficiencies. This acceptance will lead to integrity, but if elders are unable to achieve this acceptance, they may experience despair. Where bitterness and resentments in relationship and life event can lead to despair at the end of life. According to Erikson (1982), successful completion of this stage leads to wisdom in life.

1.5 Obstetric History

According to Mrs. A.K., she had her menarche around the age of eighteen. She has had 5 pregnancies and 5 spontaneous deliveries, with five children and all her children are alive. Mrs.

A.K. said she has never committed an abortion before. She revealed that she does not use oral contraceptives to prevent herself from getting pregnant but has been practicing natural family planning. She also said that she has a regular menstrual cycle and that she usually gets her menses every 30 days.

1.6 Patient's Lifestyle And Hobbies.

Lifestyle and hobbies are the styles of living that reflects the attitudes and values of a person (Wang &Peura, 2015).

According to Mrs.A.K. Is a known to be extrovert. She performs her personal hygiene and other house chores before daybreak. Patient sleeps at 8pm and wakes-up at 5am and is always indoors. She has very few friends whom she visits but not always. Patient favourite meal is Fufu with palm nut soup and dried fish. She have her breakfast at 7am, lunch at 12 to 1pm and supper at 5pm after that she wash and gather her cooking utensils, bath and enters the room to sleep. On Saturday, according to patient, she goes to farm with her grandchildren and on Sunday she goes to church at 7:30am. Her hobby is story telling. She dislikes untruthfulness and telling lies.

1.7 Patient's Past Medical History.

Past medical history according to medical dictionary (2015) is a comprehensive statement of facts pertaining to past health gathered, ideally from the patient by directed questioning.

According to Mrs.A.K, She was diagnosis of hypertension at age 35 after experiencing episodes of high blood pressure. As a result of her condition, she was told not to take in pepper, salt and fatty foods as well as any drug that contain sodium. Also patient was admitted at Happy Hospital which she was diagnosed of severe anaemia and was transfused with 2unit of O positive Blood

that was July 2022. Beside this, she sometimes suffer from malaria and headaches which she visit the hospital for treatment on Outpatient basis.

1.8 Patient's Present Medical History.

Present medical history according to medical dictionary (2015) is a chronologic description of the development of the patient's present illness, from the first signs and symptoms from the previous encounter to the present which includes the location, quality, severity, duration, timing, content, modifying factor and associated signs and symptoms.

Mrs.A.K, a known hypertensive patient diagnosed at the age of 35 and on her medication which she was on her usual state of health until 2 weeks ago she started experiencing fatigue, weakness, headache, chest pain and dizziness. Patient reported to the OPD department where she was attended to by a doctor, She was looking pale and complained of polyuria, nocturia, dizziness, body pains, headache, chest pain and loss of appetite. With the above signs and symptoms the doctor diagnosed her to be suffering from severe anaemia. The doctor admitted her into the females ward for further investigations and treatment.

1.9 Admission of Patient.

Mrs.A.K was admitted on the 6th December, 2022 at about 12:40 pm into the female ward with the diagnosis of severe anaemia. Prior to the admission, the nurse in-charge at the females ward was pre-informed about the client's admission into the ward. Pre-admission preparations made included bed making, arrangement of infusion drip stand and setting of a tray for vital signs. The patient walked with a walking stick into the ward in the company of her daughter and the outpatient department (OPD) nurse. The nurse in-charge took over the patient's particulars from the OPD nurse. Patient particulars were taken and patient and daughter assured that they were in the care of

competent health team. A simple bed was offered to the client and her daughter was oriented at the ward. Visiting hours were explained to the daughter as well as the rules and regulations of the ward. Patient was reassured and made comfortable in bed.

Vital signs were checked and recorded as;

- Blood Pressure. 135/70mmhg
- Temperature 35.3^0C
- Pulse. 77bpm
- Respiration. 19cpm
- SPO2. 98%
- Random Blood Sugar 5.2mmol/L

Various investigations requested and done including the following;

1. Full Blood Count including; Haemoglobin level, white blood count and red blood count.

2. Grouping and cross matching

3. Blood film for malaria parasite

4. Sickling test

IV line was accessed and secured and her blood sample was taken for grouping and cross matching at the laboratory. The result revealed that she is O positive and her haemoglobin level was 6.8g/dl. The need for blood transfusion was explained to her and her daughter.

Patient was to be managed on the following;

1. IV N/S 500ml bid x 24hrs

2. Tablet Omeprazole 20mg bid x7

3. Suspension Nugel 15ml tid x7

4. Transfused 2 units of whole blood

5. IV Furosemide 10mg/ml OD x 2

6. Paracetamol 1mg tid x 7

Patient drugs were collected and served according to treatment modalities. Blood with group O with Rhesus positive and batch number FR09 was collected from the laboratory and IV furosemide 40mg was served as pre medication at 6:42pm. Vital signs checked and recorded as;

- Blood Pressure. 99/56mmhg
- Temperature 36.9^0C
- Pulse. 92bpm
- Respiration. 23cpm
- SPO2. 99%.

Patient was informed to report any signs she might see and she was under close monitoring. At 7:20pm, patient complains of dizziness whiles blood was in situ, vital signs were checked and recorded as;

- Temperature 37.1^0C
- Pulse 89bpm
- Respiration 21cpm
- Blood Pressure 100/50mmhg
- SPO2 100%
- Random Blood Sugar 7mmol/L.

On call doctor was called but was not reachable so blood was discontinued patient look well and fit. Blood was sent back to the lab for preservation. Patient was reassured and made comfortable in bed.

1.10 Patient's/Family Concept of Illness

According to Merriam-Webster's Learners Dictionary (2016) patient's concept of illness can be defined as an abstract idea generalized from one's illness.

Mrs.A.K. Had no knowledge about the condition however, she does believe that she will be well and there will be no reoccurrence of the disease. She hopes to get well with the care and treatment given to her by competent health workers.

1.11 Literature Review On Anaemia

Anaemia is a deficiency in either quantity or quantity of red corpuscle in the blood that reduces the oxygen carrying capacity of the blood giving rise to especially symptoms of anoxaemia. On other words anaemia can be defined as "It is a condition in which haemoglobin concentration is lower than normal; it reflects the presence of fewer than normal number of erythrocytes within the circulation" (Brunner and Saddath 12^{th} edition). Anaemia denotes a reduction in the oxygen carrying capacity of the blood. This occurs as a result of fewer circulation erythrocytes than is needed or is normally defined as a haemoglobin level in the blood of less than 13.5g/dl in men and 11.5g/dl in women by WATSON'S Clinical Nursing and related sciences. Seventh edition.

Incidence.

The incidence of anaemia is extremely high particularly in developing countries where nutrition is poor and of fewer requirements. It is also high in the tropical regions where hookworm and malaria is endemic. Women of the reproductive age especially pregnant women and children are the most vulnerable. Elderly people are not left out in this and it is the most common

haematological condition that affects the elderly.

Cause

There are many different kinds of anaemia but all can be classified into three broad cause categories.

They include the following;

1. Decreased production of red blood cells.

    a. Sickle cell anaemia.
    b. Vitamin deficiency such as vitamin B12.
    c. Iron deficiency such as folic acid.
    d. Bone marrow and stem cell problems.
    e. Other health conditions.

2. Excessive destruction of red blood cell

    a. Inherited condition such as sickle cell and thalassemia.
    b. Stressor such as infections, drugs, snake or spider venom.
    c. Toxins from advanced liver or kidney disease.
    d. Inappropriate attack by the immune system (called haemolytic disease).
    e. Vascular graft.

3. Excessive blood loss

    a. Trauma
    b. Condition causing internal bleeding like bleeding from the gastrointestinal tract, uterus and nose.
    c. Post-partum haemoglobin

Pathophysiology.

The function of red blood cell is to transport oxygen to all body tissues and organs. This is achieved by oxygen in the lungs combining with haemoglobin that is therefore transported via the circulation to every cells in the body where the oxygen is released for use. A reduction in haemoglobin level from a severe loss, excessive destruction and decreased production will result in a reduced supply of oxygen to the body tissues and organs. This leads to a variety of symptoms depending on the severity of the anaemia. Initially, compensatory mechanism sets in to reduced blood flow to the peripheral structures like the muscles and skin thereby the body conserves the supply for the central and vital organs. In acute blood loss, anaemia appears later if plasma substitute are not given. In severe loss, the hypovolemic shock becomes irreversible and the person's condition progresses into death. When there is acute blood loss associated with other disease state that impairs erythropoiesis, recovery of haemoglobin level to normal is very slow then anaemia becomes chronic. The deficiency in blood results in to headache, dizziness pale conjunctiva, tiredness and weakness among others as signs and symptoms

Classification /Types of Anaemia

Anaemia can be classified according to the factor that lead to the development. The physiological approach is to determine whether the deficiency in red blood cell is caused by a defect in their production, their destruction and by their loss. There are three main classifications of anaemia, which includes the following;

1. Haemolytic anaemia: this type starts from premature destruction of red blood cells which results in liberation of haemoglobin from the red blood cell into plasma. The increased red blood cell destruction results in tissue hypoxia, which in then stimulates erythropoietin production. This increased production is reflected in an increased reticulocyte count, as the bone marrow responds

to the loss of red blood cells. The released haemoglobin is converted in large part to bilirubin, where the bilirubin concentration level rises. Haemolysis therefore can result from the following;

A. Glucose-6-phosphate Dehydrogenase is a gene that produces the enzyme within the red blood cell that is essential for membrane stability. A defect in it can cause early haemolysis of the red blood cell resulting in G-6-PD anaemia. It may be precipitated by stress factors like fever and some antimalarial drugs.

B. When there is reduction in globin synthesis with resultant reduced haemoglobin production and increased friability of the cell membrane, it leads to early haemolysis which results in a type of anaemia called thalassaemia.

C. An abnormal haemoglobin molecule becomes misshapen when deoxygenated is making the erythrocyte sickle shape. Such cell life span is reduced by early haemolysis which causes this type of anaemia called sickle cell anaemia.

D. Exposure of the red blood cells to antibodies leads to early haemolysis causing a type of anaemia called immune haemolytic anaemia. Antibodies fighting against the host resulting from immunization or individuals with foreign antigens such as; immunization of Rhesus-negative person with Rhesus-positive blood. It turns to be large and cause immediate destruction of the sensitized red blood cells either within the blood vessels or within the liver which is the most common haemolytic transfusion reaction which occurs in adult.

2. Haemorrhagic anaemia: this form occurs as a result of an acute loss of large volume of blood over a short period or can be a chronic loss with small volumes of blood over a long period of time. This blood loss can be as a results of bleeding from the gastrointestinal tract, trauma, epistaxis and uterus. Blood loss removes erythrocytes from circulation, reducing the oxygen capacity of the

blood over a period. This intravascular volume is restored by the entrance of extracellular fluid into the vascular compartment. The red blood cell remaining at this time are those remained after the blood loss and are now disposed in greater volume of plasma. The count of red blood cell now gives a more accurate indication of the severity of the anaemia and also the bone marrow begins to produce red blood cells as a result of hypoxia

3. Hypoproliferative anaemia: this is where red blood cells survive normally but the bone marrow cannot produce adequate number of these cells, the decreased production is reflected in a low reticulocyte count. Inadequate production of red blood cell may result from bone marrow destruction due to medication or chemicals such as; chloramphenicol, benzene and also lack of iron, folic acid, vitamin B12 and erythropoietin. Types of anaemia under this classification are;

- **Iron deficiency anaemia**: Iron is inadequate for haemoglobin synthesis. The body stores an amount of its iron and it is not used until those stores are depleted that iron deficiency anaemia actually begins to develop. It is the most common type of anaemia in all age group and it is the most common anaemia in the world especially developing countries. This is as a result of inadequate intake of foods rich in iron and vital nutrient common in the formation of red blood cells. In this type of anaemia, erythrocytes are microcytic and hypochromic because, their haemoglobin level is low.
- **Megaloblastic or Macrocytic anaemia**: is the type of anaemia caused by deficiencies of vitamin B12 or folic acid which are essential for normal deoxyribonucleic acid (DNA) synthesis. IN other anaemia's the erythrocyte that are produced are abnormally large and are called megaloblastic red cells. Other cells derived from the myeloid stem cell (Non lymphoid leucocyte, platelet) are also abnormal .Bone marrow analysis reveals abnormal increase in the number of cells and the precursor elytroid and myeloid

of the abnormal erythroid and myeloid cells are destroyed within the bone marrow, so the mature cells that do leave the bone marrow are actually fewer in number.

- **Aplastic anaemia**: this is secondary to impaired production of erythrocytes characterized by bone marrow hyperplasia resulting in pancytopenia. It is also a decrease in precursor cells if the bone marrow fails to produce red blood cells. Aplastic anaemia may be as a result of exposure to certain drugs such as anti-inflammatory bacterial, anti-epileptic and miscellaneous drugs such as chloramphenicol. It can also be as a result of viral infections and chemical toxins like sulphamide insecticides. Patient with aplastic anaemia exhibits signs of pallor, weakness, palpitations and dyspnoea.

Clinical Manifestation

The signs and symptoms of anaemia associated with specific symptoms include;

1. **Integumentary System**
    a. There is pallor of the palm, conjunctiva, nail beds, and the circumoral areas that is around the mouth
    b. Delayed wound healing
    c. Sore mouth and tongue
    d. Sensitivity to cold
    e. Jaundice
2. **Respiratory**
    a. Shortness of breath
    b. Dyspnea on exertion
    c. Orthopnea

3. Cardiovascular

I. Palpitations

II. Angina

III. Tachycardia

IV. Cardiomegaly

V. Fatigue

VI. Tachypnea

VII. Dependent oedema

VIII. Weakness

4. Gastrointestinal

1. Nausea
2. Anorexia
3. Constipation
4. Diarrhoea
5. Abdominal pain
6. Loss of weight
7. Haematemesis

5. Genitourinary

1. Menstrual irregularities
2. Dark coloured urine (haematuria)
3. Renal failure

6. Neurologic

a. Headache

b. Dizziness

c. Tingling extremities

d. Irritability

7. Musculoskeletal

a. Night cramps

b. Bone and joint pains

c. General fatigue.

Complications

Based on the assessment data, potential complications that may develop includes the following;

1. Hepatomegaly
2. Splenomegaly
3. Congestive heart failure
4. Renal failure
5. Growth retardation in children
6. Angina pectoris
7. Shock
8. Infection
9. Priaspism
10. Brain death
11. Ischaemia
12. Pericarditis
13. Myocardial infarction

Diagnostic Investigation

There are more haematological test and other investigation that can be done to determine the type and causes of anaemia. Some of these are as follows;

1. Physical examination
2. Full blood count
3. Blood film for malaria parasite
4. Sickling test
5. Red bone marrow examination
6. Haemoglobin level estimation
7. Haematocrit
8. Computed tomography for cancers
9. Erythrocyte sedimentation rate
10. A test for vitamin B 12 absorption (schilling test)
11. Blood smear reveals variation in size , shape and number of cells
12. Glucose-6-phosphate dehydrogenate deficiency (G-6-PD) examination

Specific Medical Treatment Of Anaemia.

Medical treatment of anaemia can be directed as follows;

1. Treating the underlying cause of anaemia and restoration of haemoglobin level to normal i.e. 13-18g/dl in males and 11-16g/dl in females
2. Replenishing iron store after correction of anaemia in iron deficiency

In order to achieve the above objective, the following treatment regimen can be given;

a. Blood transfusion in severe cases
b. Iron preparations like ferrous sulphate orally

i. Adults: 200mg tid x 30 days

ii. Children: syrup 5mls/ 100mg

iii. Give anti malaria drug if anaemia is due to malaria

3. In the case of sickle cell anaemia, hydroxyuria which is effective in increasing haemoglobin level and decrease the formation of sickle cell can be given
4. Folic acid can be given and the dosage depends on the condition but it can be given prophylactically. The dosage is as follow adult 5mg daily x 30 days, children 2.5mg daily x 30 days
5. If anaemia is due to worm infestation, tabs albendazole can be given adult 400mg bid x 3 days, children 200mg daily x 3 days.
6. Tabs vitamin C 200mg tid x 7 days
7. Analgesics like tabs tramadol, paracetamol to relief pain
8. Antibiotics may be given to control and treat infections. Some of the antibiotics that can be given include; ciprofloxacin, amoxicillin, metronidazole etc.

Nursing Management.

Nursing management of a client with anaemia is focused on the replacement of the lost blood and if possible the correction of the cause of the condition. It is also in the objectives to the nurse to ensure prevention of possible complications whiles on admission. The management of patient with anaemia can be grouped under the following headings;

Diet

1. The nurse should explain to the patient and family that there is a direct relationship between a balanced diet and resolving the disease

2. The nurse must ensure that the client is served with a well-balanced diet as much as possible. The diet should be rich in iron, protein, vitamin etc. some of the food advisable for the patient includes egg, milk, vegetables, meat fruits like banana, orange and others
3. Give iron and folic acid supplements daily.
4. Diet must be served in bits to enhance appetite
5. Pass NG tube if necessary

Rest And Sleep

Rest and sleep should be observed since this can promote fast recovery. The follow points are noted to ensuring rest and sleep

1. Dress the bed to be free from creases and cramps
2. Restrict visitors
3. Minimize noise and improve ventilation by opening windows and funs
4. Plan activities in such a way that they don't interfere with the patient's time of rest and sleep
5. Give warm bath and serve beverages at bed time
6. Assess patient's sleeping pattern
7. Administer prescribed analgesics and sedatives

Exercise

The patient should be made to undergo exercise in a form of passive and active moderately has tolerated. Some of these exercises are deep breathing, walking around the ward to prevent boredom. If possible the service of physiotherapist should be employed.

Personal Hygiene

1. The relevance of personal hygiene must be explained to the client

2. The patient has to be educated on the need to bath at least twice daily and if the client is bed ridden, bed bathing should be given.
3. Assist the client to trim his/her nails and also care for hair of the patient
4. Ensure oral hygiene twice daily
5. Advice the patient on washing the hands after visiting toilet.

Observation

1. General physical appearance of the client should be observed and examined including the colour of the skin and mucus membrane, nature of hair and nails
2. Check and record vital signs four hourly or as directed
3. Observe for bed sore and treat if any
4. Observe and estimate the level of anxiety in client and family
5. Look for signs of shock including tremors, hypotension, dummy skin and others.
6. If the patient is on transfusion, monitor for reaction eg, sweating, restlessness, rashes, flushing and many more.
7. Check out for any reaction or side effects of drugs and report if any
8. Observe and record intake and output of the client.

Chemotherapy

1. Administer prescribed drugs and chart them
2. Observe for any side effects and report appropriately

3. Educate patient on side effects.

Psychological Care

1. Reassure patient and family of competent care
2. Introduce the patient to other patients especially those recovering from similar sickness

3. Encourage client to ask questions to express her feeling and take time to address those questions
4. Explain every procedure to carry on the patient and family
5. Establish an effective interpersonal relationship between yourself and the client and family

Health Education And Prevention

1. The nurse should educate the client and family on the causes, signs and symptoms, treatment and prevention of anaemia
2. The patient should be advised against self-medication
3. Encourage client and relatives to undertake regular exercise
4. Educate the patient to take a well-balanced diet
5. Inform the client to report any abnormality to the hospital after discharge

Surgical Treatment Option

1. Bone marrow transplantation can be done if anaemia is due to bone marrow depression
2. Splenectomy is done if anaemia is caused by hyperslenism
3. Stripping and ligation can be done if blood vessels are damaged due to trauma.

1.11 Validation of Data

It is the process by which data retrieved is confirmed. Data of Mrs.A.K were collected from herself and other members of her family, clinical features in the literature review obtained from textbooks and the results from laboratory investigation confirms that Mrs.A.K.

Had got severe anaemia as diagnosed by Doctor Collins. All data collected were free from errors and biases and they are valid.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis is a statistic that measures differences among group means and uses a statistical technique to equate the under study in relation to another given variable (Weller B. F., 2014). This forms the second step in the nursing process is whereby information collected during patients assessment is compared with standard. It is further broken down to identify the patient's actual and potential problem. The nurse formulates the nursing diagnoses and renders the care accordingly based on these process. This chapter includes the following:

1. Comparism of data with standards
2. Patient and family strengths
3. Patient and family health problems
4. Nursing diagnosis

2.1 Comparison of Data with Standards

Comparism is the process of considering how a group of information are similar from each other (Bailer's 25th.ed). Information which were analytically obtained from client are compared to what is standardized in literature in other to solicit for more understanding about client course of treatment and their effectiveness in patient's improvement.

This comprises;

1. Diagnostic investigations
2. Causes

3. Clinical features

4. Treatment

5. Complications

A. Diagnostic Investigations and test for Mrs. A.K

Diagnostic investigation refers to the process of identifying the nature and cause of a disease condition.

Diagnostic investigation carried out on her include,

1. Full blood count including; Haemoglobin level, white blood count and red blood count.

2. Grouping and cross matching

3. Blood film for Malaria parasite

4. Sickling test

The table below indicates the diagnostic investigation which were carried out on Mrs. A.K. during her period of hospitalization compared with literature.

Table 1: Comparison of diagnostic investigation of patient to that in Literature review.

Diagnostic investigations Outlined in Literature Review	**Diagnostic investigations done for patient**
1. Physical examination	1. Physical examination was done.
2. Full Blood Count	2. Full Blood Count were conducted For patient
3. Blood film for malaria	3. Blood film for malaria was done
4. Sickling test	4. Sickling test was conducted
5. Red bone marrow examination	5. Red bone marrow examination was not conducted
6. Haemoglobin level estimation	6. Haemoglobin level estimation was done
7. Haematocrit	7. Haematocrit was not done
8. Computed tomography for cancer	8. Computed tomography for cancer was not done
9. Erythrocyte sedimentation rate	9. Erythrocyte sedimentation rate were not conducted
10. A test for vitamin B12 absorption (schilling test)	10.A test for vitamin B12 absorption(schilling test)was not done
11. Blood smear reveals variation in size , shape and number of cells	11. Blood smear was not done
12.Glucose-6-phosphate dehydrogenate deficiency (G-6-PD) examination.	12.Glucose-6-phosphate dehydrogenate deficiency(G-6-PD) examination was not conducted

Pre literature comparison with what was conducted on patient, Full Blood Count, Grouping and cross matching, Blood film for malaria parasite and sickling test were exhibited by patient.

Table 2: Comparism of Diagnostic Investigation With Standards

DATE	SPECIMEN	INVESTIGATION	RESULT	NORMAL VALUES	INTERPRETATION OF FINDINGS	REMARKS
6-12-22	Blood	Haemoglobin level estimation	6.8g/dl	14-18g/dl in males 12-16g/dl in females	Below normal and indicates severe anaemia	Blood transfusion and haematimic given
6-12-22	Blood	For malaria parasite	No malaria parasite seen	No malaria parasite should be seen	Indicating that client is not suffering from malaria	Anaemia was not due to malaria
6-12-22	Blood	Grouping and cross matching	Blood group O Rhesus positive	Blood group A,B,O and AB Rhesus negative and positive factor	Blood group O Rhesus positive	Blood group O positive was transfused without reactions.
6-12-22	Blood	Sickling test	Negative	Negative	Patient does not have sickle trait	Anaemia is not due to sickle cell haemolysis

11-12-22	Blood	Haemoglobin level estimation	10.3g/dl	14-18g/dl in males 12-16g/dl in females	Below normal and indicates severe anaemia	Blood transfusion and haematimic was not given but blood supplement were given such as folic acid and ferrous fumarate.

B. Causes of Patient's Illness.

With reference to the general causes of anaemia in the literature reviewed and compared with the laboratory results, Mrs.A.K suffered hypochronic microcytic anaemia which may be due to low dietary intake of iron (iron deficiency anaemia). It was evidenced by low corpuscular volume Iron deficiency anaemia is most common in people with poor diet as prescribed in the case of Mrs.A.K. It is also common in old age, young growing children, and women of reproductive age especially pregnant women's.

C. Clinical Features

The table two (2) below indicates the signs and symptoms exhibited by patient with the literature review.

Table 3: Comparison of Clinical Features Of Patient To That In The Literature Review.

TEXTBOOK CLINICAL FEATURES	CLINICAL FEATURES OF Mrs.A.K
1. Loss of appetite	1. It was observed on patient
2. Dizziness	2. Patient complains of dizziness
3. Headache	3. Patient complains of headache
4. Tachycardia	4. Tachycardia was observed in patient
5. Vomiting	5. Patient did not vomit
6. Palpitation	6. Palpitation was observed in patient
7. Oedema of the ankle	7. Ankle oedema was not manifested
8. Increased sensitivity to cold	8. Patient sensitivity to cold was not increased
9. Hepatomegaly	9. Hepatomegaly was not manifested by patient

10. Impaired thought process	10. It was manifested by patient
11. Anorexia	11. Patient complains of anorexia
12. Weight loss	12. It was observed in patient
13. Low grade fever	13. It was observed in patient
14. Increased pulse rate	14. Patient did not experience increase pulse rate
15. Cough	15. It was not manifested by patient
16. Spleen enlargement	16. It was not observed in patient
17. Pallor of the skin	17. It was observed in patient
18. Pin and needle sensation in the extremities	18. It was not manifested by patient
19.Intermittent claudification	19. It was not manifested by patient
20. Polyuria	20. Patient did not manifest
21. Nocturia	21. Patient complains of nocturia
22. Abdominal pain	22. Patient complains of abdominal pain.

With reference to the literature review and the clinical manifestations exhibited by patient, it is confirmed that she had severe anaemia

D. Specific Medical Treatments Given To Mrs.A.K.

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

The following drugs were ordered and administered to Mrs. A.K.

1. IV Normal Saline 2L x 24hours
2. IV Omeprazole 40mg bid x 1
3. IV Furosemide 10mg/ml in 2ml OD x 2

4. Tablet Cetrizine 10mg daily at night x 5
5. Syrup Nugel 15mls tid x 7
6. Paracetamol 1mg tid x 7
7. Tablet Folic Acid 5mg daily x 30
8. Tablet Omeprazole 20mg bid x 7
9. Tablet Ferrous fumarate200g daily x 30
10. 2 units of blood for transfusion

Table 4: Comparison Of Drugs given to Patient and those in Literature Review

Drugs Outlined In The Literature Review	**Drugs given to patient**
1.Antibiotics	1. Antibiotics was not given
2.Analgesics	2. Analgesics (paracetamol) were given
3.Tablets Vitamins	3.Tablet vitamins was not given
4.Iv fluids	4.Iv fluids (normal saline) were given
5.Diuretics	5.Diuretics (iv furosemide) were given
6.Albendazole	6.Albendazole was not given
7.Blood transfusion	7.Blood transfusion was given
8.Anti-malaria	8.Anti-malaria was not given
9.Folic acid/iron	9.Folic acid/iron was given
10.Haematinics	10.Haematinics(Tablet folic acid and tablet ferrous fumarate) were given

11.Hydroxyuria	11.Hydroxyuria was not given
12.Anti-haemorrhoidal	12.Anti-harmorrhoidal was not given
13.Antihistamines	13.Antihistamines
14. Anti-secretion compound	14.Anti-secretion compound (Syrup Nugel) was given
15. Anti-acid	15.Anti-acid (Tablet Omeprazole) was given

Table 3: Pharmacology of Drugs Prescribed For Mrs. A.K.

DATE	DRUGS	DOSAGE/ROUTE OF ADMINISTRATION FOR PATIENT	DOSAGE/ROUTE OF ADMINISTRATION IN LITERATURE REVIEW	CLASSIFICATION	ACTION	ACTION OBSERVED	SIDE EFFECTS AND REMARKS
06-12-22	IV normal saline	Dosage:2Lx 8hours Route: Intravenous	Depends on the patient fluid and electrolyte requirement and age. Route: Intravenously	Isotonic intravenous infusion	Hydration and electrolyte replacement	Dehydration and electrolyte were replaced	Circulatory overload. This was not observed
06-12-22	Tablet Omeprazole	Dosage: 20 mg bid x 1 Route: Oral	Adults:20mg daily x 30days Route: Oral	Anti-acid	Suppress gastric secretion	The client was relieved of abdominal discomfort	Diarrhea, abdominal pain, constipation, nausea. These were not observed

06-12-22	Syrup Nugel	Dosage: 15mls tid x 7 Route: Oral	Adult:15mls Route: Oral	Anti-secretion compound	Inhibits gastric secretion	The client was relieved of abdominal discomfort	Abdominal pain, nausea, vomiting. These were not observed
06-12-22	IV Furosemide	Dosage: 10mg/ml in 2ml OD x 2 Route: Intravenous	Adults: 10mg/ml in 2mls Route: Intravenously	Loop diuretics	It act on the kidneys to increase the flow of urine.	Client was urinating frequently.	Headaches, dry mouth, nausea and vomiting, feeling confused. These were not observed.
06-12-22	Blood	Dosage: 1 unit Route: Intravenous	Depends on severity of condition and blood loss. Route: Intravenously	Blood	Increases blood volume and haemoglobin level	Haemoglobin level increased	Pyrexia, rigor, circulatory overload, haemolysis, rashes. These were not observed

06-12-22	Tab Paracetamol	Dosage: 1gm tid x 7 Route: Oral	Adult:1 gm to be taken every 4-6hours to a maximum of 4g daily. Children:500mg to be taken 3-4 times daily Route: oral	Antipyretic and analgesic drugs	Use in the treatment of pain, headache and to reduce fever.	Patient pain was relieved.	Rash, flushing, fast heartbeat, low blood pressure, liver and kidney damage. These were not observed.
08-12-22	Blood	Dosage: 1 unit Route: Intravenous	Depends on severity of condition and blood loss. Route: Intravenously	Blood	Increases blood volume and haemoglobin level	Haemoglobin level increased	Pyrexia, rigor, circulatory overload, haemolysis, rashes. These were not observed

09-12-22	Tablet Cetrizine	Dosage: 10mg daily at night x 5 Route: Oral	Adult: 10mg daily at night Route: Oral	Antihistamines	It works by blocking the action of histamine, a substance in the body that causes allergic symptoms.	Allergic reactions were prevented.	Headaches, dry mouth, dizziness and diarrhea. These were not observed.
10-12-22	Tab folic acid	Dosage: 5 mg daily x 30 day Route: Oral	Adults:5mg daily x 30days Children:2.5mg daily x30days Route: Oral	Haematimic	It stimulate the production of red blood cells, white blood cells and platelets. It is essential	Haemoglobin level of client improved	Flushing, bronchospasm. These were not observed

					for nucleoprotein and maintenance of normal erythropoisis.		
10-12-22	Tablet ferrous fumarate	Dosage: 200mg daily x3 Route: Oral	Adults:200mg tid x 30days Children:100mg Route: Oral	Haematimic	Increase red blood cell formation and preventions of anaemia. It correct erythropietic abnormalities and deficiency of iron.	Haemoglobin level of client improved	Flushing, bronchospasm. These were not observed

E. Complications

With regards to the complications stated under the literature review in chapter one, Mrs.A.K. did not experience any complication throughout her stay in the hospital.

2.2 Patient/Family Strengths

Strength according to Merriam (2015) is the quality that allows someone to deal with problems in a determined and effective way.

The following strength were exhibited by patient

1. She communicated effectively with the health team.
2. She was co-operative during her stay in the hospital
3. She was able to undertake some activities of daily living like bathing, walking and mouth care
4. Patient could sleep 3hours in the afternoon time.
5. Patient can eat three spoonfull of food served.
6. Patient is ready to learn about the condition.

2.3 Patient/Family Health Problems.

1. Patient was anxious(06/12/22)
2. Patient complaint of general body pains(06/12/22)
3. Patient complaint of dizziness(07/12/22)
4. Patient complaint of difficulty in sleeping(07/12/22)
5. Patient complaint of loss of appetite(08/12/22)
6. Lack of knowledge about condition(09/12/22)

2.4 Nursing Diagnosis

1. Anxiety related to unknown outcome of disease condition and its management.
2. Altered body discomfort (general body pains) related disease process(Severe anaemia)
3. High risk for injury related to dizziness
4. Altered sleep pattern related to a change of environment as manifested by patient verbalizing of insomnia
5. Imbalanced nutrition less done body requirement related to loss of appetite.
6. Knowledge deficits related to causes, signs and symptoms and management of anaemia.

CHAPTER THREE

PLANNING THE CARE FOR PATIENT AND FAMILY

3.0 Introduction

This is the third vital component of the nursing process and it entails setting up nursing objectives, nursing orders and instituting the appropriate nursing interventions to achieving the set goals and objectives within a time frame. Following these, an evaluation is done to see whether or not these objectives set have been achieved within the stipulated time. The objectives are formulated based on the nursing diagnosis made. The objective could either be a short term or long term ones but must have a specific time period within which they can be achieved.

3.1 Patient/Family Care Objectives/ Outcome Criteria

1. Patient and family will be relieved of anxiety within 24 hours as evidenced by;

a. Patient and family verbalizing that anxiety have being relieved.

b. Nurse observing patient is relaxed and cheerful in bed.

2. Patient will be relieved of general body pains within 24 hours as evidenced by;

a. Patient verbalizing that pain has subsided

b.Nurse observing that patient has a cheerful and relaxed facial expression.

3. Patient will not sustain any injury within the period of hospitalization as evidence by;

a. Patient verbalizing that there is cessation of dizziness.

b. Nurse observing there is absence of injury.

4. Patient sleeping pattern will be restored to normal within 24 hours as evidence;

a. Patient having uninterrupted sleep for 6-8 hours during the night and 2 hours during the day.

b. Nurse observing patient can sleep for 6-8 hours at night and 2 hours during day time.

5. Patient will be able to attain and maintain adequate nutrition within 48 hours as evidenced by;

a. Patient maintaining adequate amount of iron, vitamins and proteins from diet and supplement.

b. Nurse observing that patient takes in diet that contains iron, vitamins and proteins and supplement.

6. Patient and family will gain adequate knowledge on severe anaemia within 24hours as evidenced by;

a. Patient and family verbalising the causes, clinical features and management of severe anaemia.

Care plan for madam A.K.

DATE / TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGNATURE
06/12/2022 1:00 pm	Anxiety related to unknown outcome of disease condition and management	Client and family will be relieved of anxiety within 24 hours as evidenced by 1. Client and family verbalizing that anxiety have being relieved 2. Nurse observing client is relaxed and cheerful in bed	1.Reassure patient that she is in the care of competent staffs 2. Introduce the client to other patients who are recovering from anaemia 3. Allow patient to express her fears and ask questions bothering them. 4. Explain every procedure to patient 5. Educate patient relaxation	1.Patient was reassured that she was in the hands of competent staffs 2. She was introduced to patients recovering from anaemia 3. Patient was allowed to express her fears and they were addressed accordingly 4. Every procedure was explained 5. Patient was educated on relaxation techniques	07/12/22 1:00 pm	Goal was fully met as patient showed a relaxed facial expression Patient could be seen interacting cheerfully and freely with other patients on the ward	K.W.B

			techniques such as diversional therapy to divert her mind of the anxiety. 6. Explain to client the need of hospitalization and management of disease.	such as diversional therapy to divert her mind of the anxiety. 6. The need of hospitalization and management of disease were explained to client.			

Care plan for madam A.K. cont'd

DATE / TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGNATURE
06/12/2022 1:50pm	Alteration in comfort (general body pains) related to severe anaemia	Patient will be relieved of general body pains within 24hours as evidenced by, 1. Patient verbalizing that pain has subside. 2. Nurse observing patient has a relaxed and cheerful facial expression.	1. Reassure patient 2. Assess the pain level 3. Put patient in a comfortable bed and in comfortable position 4. Minimize noise level at the ward.	1. Patient was reassured that pain will be relieved where necessary measures will be done to relieve the pain. 2. Pain level was assessed considering the onset, duration and intensity of the pain. 3. Patient was put in a comfortable be free from creases and cramps. 4. A noise free environment was maintained by	07/12/2022 1:50pm	Goal fully met as patient verbalized that there is no pain and nurse observing patient has a cheerful and relaxed facial expression.	K.W.B

				restricting visitors and lowering of television set on the ward			
			5. Divert client mind of the pain using diversional therapy.	5. Client was engaged in diversional therapy such as conversation to help divert her mind of the pain.			
			6.Serve prescribed analgesic (paracetamol).	6.Prescribed analgesic was served (paracetamol).			

Care plan for madam A.K. cont'd

DATE / TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGNATURE
07/12/2022 8:00am	High risk for injury related to dizziness	Patient will not sustain any injury within the period of hospitalization as evidenced by; 1. Patient verbalizing that there is cessation of dizziness. 2. Nurse observing there is absence of injury.	1.Reassure patient of support in all activities 2. Remove injurious objects from patient's environment 3. Provide adequate light 4. Advice the client to rise slowly from bed and to sit down whenever she is feeling dizzy 5. Monitor vital signs and record 6. Ensure good rest	1.Client was reassure of support in all activities 2. Injurious objects were removed from patient's environment 3. Adequate lighting was provided 4.Patient was advised to rise slowly from bed and to sit down whenever she was feeling dizzy 5. Vital signs were monitored and recorded 6. Good rest was ensured	11/12/2022 9:30am	Goal was fully met as patient was discharged from the ward without sustaining any injury	K.W.B

Care plan for madam A.K. cont'd

DATE / TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGNATURE
07/12/22 1:30pm	Altered sleep pattern (insomnia) related to change of environment as manifested by the patient verbalizing of interrupted night sleep	Patient sleeping pattern will be restored to normal within 24 hours as evidence by; 1. Patient having uninterrupted sleep for 6-8 hours during the night and 2 hours during the day.	1. Reassure client that appropriate measures will be put in place to enable her sleep well. 2. Provide quite environment. 3. Restrict visitors	1. Client was reassured that appropriate measures will be put in place to enable her sleep well. 2. Noise was reduced on the ward by regulating volumes of television set and radio. 3. Visitors were restricted to prevent undue disturbances to help client sleep.	08/12/22 1:30pm	Goal fully met as client slept for 2 hours during the day and 7 hours during the night.	K.W.B

		2. Nurse observing patient can sleep for 6-8 hours at night and 2 hours during day time.	4. Ensure enough ventilation. 5. Encourage warm bath and take in soft drinks. 6. Nursing procedures on her should be done in bulk.	4. Adequate ventilation was provided by opening nearby windows to ensure sleep. 5. Warm bath and soft drinks were provided before bed time to stimulate sleep. 6. All nursing procedures were done at a goal to reduce the rate of disturbing client sleep.			

Care plan for madam A.K. cont'd

DATE / TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGNATURE
08/12/2022 9:00am	Imbalanced nutrition less then body requirement related to loss of appetite.	Client will be able to attain and maintain adequate nutrition within 48hours as evidenced by; 1. Client maintaining adequate amount of iron, vitamins and proteins from diet and supplements	1. Plan meals with the patient 2. Serve patient with her favorite meals 3. Serve food in bits but frequently to enhance appetite 4. Serve patient with fruits and a fruit juices 5. Serve food in a hygienic environment free from nauseating substances	1. Meals were planned with the patient 2. Patient was served with her favorite food 3. Foods were served in bits but frequently 4. Patient was served with fruits and fruit juices 5. Food was served in hygienic environment that was free from nauseating substances	10/12/2022 9:00am	Goal fully met as evidenced by patient eating all food served and requesting for more food to be added.	K.W.B

		2. Nurse observing that patient takes in diet that contains iron, vitamins and proteins and supplements.	6.Serve prescribed drugs e.g. multivites	6. Prescribed drugs were served E.g. multivites.			

Care plan for madam A.K. cont'd

DATE / TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGNATURE
09/12/2022 8:30am	Knowledge deficits related to causes, signs and symptoms and management of anaemia.	Client and family will gain adequate knowledge on severe anaemia within 24hours as evidenced by; 1. Client and family verbalizing the cause, signs and symptoms and management of severe anaemia.	1. Choose an appropriate time for discussion with patient 2. Explain in simple terms the causes, signs and symptoms, prevention and treatment of anemia 3. Allow patient to ask questions and answer them frankly	1. An appropriate time for discussion was chosen with patient 2. The causes, signs and symptom, prevention and treatment of anaemia were explained in simple terms 3. Patient was allowed to ask questions and frankly answers given	09/12/2022 8:30am	Goal fully met as patient was able to state three causes, signs and symptoms, preventive measures and food treatment of	K.W.B

			4. Involve family in the education 5. Ask her questions on the condition to assess the level of understanding 6. Provide patient with some good food source of protein, vitamins, minerals etc.	4. Patient and family were involved in the implementation of care 5. Questions were asked to assess the level of understanding 6. Patient was provided with some good food source of protein, vitamins, minerals etc.		severe anaemia.	

CHAPTER FOUR

IMPLEMENTATION OF THE PATIENT FAMILY CARE STRATEGIES.

4.0 Introduction

Implementation is the process of putting the nursing care plan into action. It is the actual nursing rendered to the patient and family throughout the period of hospitalization. This may be categorize into summary of actual nursing care rendered, preparations towards patient and family discharge, rehabilitation and follow up visits or continuity of care.

4.1 Summary Of The Actual Care Rendered To Patient.

This is the actual care rendered to patient and family commenced on the day of admission, 6th December, 2022 to the time care was terminated thus, 11th December, 2022.The management of patient and family was planned to meet their physiological, psychological, emotional and spiritual needs.

First Day Of Admission (06/12/2022)

On the 6th of December, 2022, Mrs.A.K was admitted into the females ward with severe anaemia at 12:40pm. She looked weak and pale and complained of polyuria, palpitation, body pains, dizziness, headache as well as loss of appetite. Patient said she ate rice and stew during lunch time at 12:15pm before she was brought to the hospital. Her vital signs were checked and recorded as;

Temperature - 35.3^{o}C

Pulse - 77bpm

Respiration - 19cpm

SPO2 - 98%

Blood pressure - 135/70mmHg

Random blood sugar - 5.2mmol/L

During my encounter with patient at 1:00pm patient was anxious. Nursing diagnosis was formulated as anxiety related to unknown outcome of disease condition and management and an objective was set as; patient and family will be relieved of anxiety within 24hours as evidenced by, patient and family verbalizing that anxiety have being relieved and nurse observing patient is relaxed and cheerful in bed. Nursing intervention given were; she was reassured that she was in hands of competent staffs, she was also introduced to other patient recovering from anaemia, patient was allowed to express her fears and they were addressed accordingly, every procedure that was to be carried out was explained to her, she was also educated on relaxation techniques such as diversional therapy to divert her mind of anxiety and the need of hospitalization and management of disease were explained to patient. Patient drugs were served according to treatment modalities. At 1:50pm; she also complained of general body pains. Nursing diagnosis was formulated as alteration in comfort related to severe anaemia and an objective was set as; patient will be relieved of general body pains within 24hours as evidenced by, patient verbalizing that pain has subside and nurse observing patient has a relaxed and cheerful facial expression. Nursing intervention given were; patient was reassured that pain will be relieved where necessary measures will be done to relive the pain, pain level was assessed considering the onset, duration and intensity of the pain, patient was put in a comfortable bed free from creases and cramps, a noise free environment was maintained by restricting visitors and lowering of television set on the ward, client was engaged in diversional therapy such as conversation to help divert her mind of the pain and also prescribed analgesic was served (paracetamol). Blood with group O with rhesus positive and batch number FR09 was collected from the lab and IV furosemide 40mg was served as pre medication at 6:42pm.

Vital signs were checked and recorded as;

Blood Pressure - 99/56mmhg,

Temperature - 36.93ºC,

Pulse. 92bpm,

Respiration. 23cpm

SPO2. 99%.

Patient was informed to report any signs she might see and she was under close monitoring. At 7:20pm, she complains of dizziness whiles blood was in situ. Vital signs were checked and recorded as;

Temperature. 37.13ºC

Pulse. 89bpm

Respiration. 21cpm

Blood Pressure. 100/50mmhg

SPO2. 100%,

Random Blood Sugar 7mmol/L.

On call doctor was called but was not reachable so blood was discontinued and after that patient looked well and fit. Blood was sent back to the lab for preservation. Patient was reassured and made comfortable in bed. Foods rich in calories and protein were served (ampasi with kontomire stew).Patient slept at 8pm.

Second Day of Admission (07/12/2022)

On the 7th of December, 2022, Mrs.A.K waked up at 5:30am and she expressed cheerfulness and started relating with the health personnel. Her vital signs were taken and recorded as indicated in the appendix at 6:00am. She cleaned her teeth, bath and took her breakfast at 7:30am before her drugs were administered and these drugs are syrup Nugel 15mls, paracetamol 1gm,

IV normal saline 1L. At 8:00am she told me that she was feeling dizzy and nursing diagnosis was formulated as high risk for injury related dizziness. Objective was set as; patient will not sustain any injury within the period of hospitalization as evidenced by; patient verbalizing that there is cessation of dizziness and nurse observing there is absence of injury. Nursing intervention implemented were, patient was reassured of support in all activities, injurious objects were removed from patient's environment, adequate lighting was provided, patient was advised to rise slowly from bed and to sit down whenever she was feeling dizzy, vital signs were monitored and recorded and good bed rest was ensured. At 10am patient vital signs were checked and recorded as indicated in the appendix. Patient slept at 10:35am and waked up at 11:15am. Patient was served with banku with Okro soup as lunch at 12:10pm. At 12:15pm blood with group O with rhesus positive and batch number FR09 was collected from the lab and IV furosemide 40mg was served as pre medication at12:20pm.

Vital signs were checked and recorded as;

Temperature	36.6^{o}C
Blood Pressure	100/60mmhg
Pulse	93bpm
Respiration	24cpm
SPO2	98%

Blood was set up at 12:30pm and patient was informed to report any signs she might see and was under close monitoring.

Nursing diagnosis that was formulated as anxiety related to unknown outcome of disease condition and management and its interventions were fully met on 07/12/2022 at 1:00pm as patient verbalizing that anxiety have being relieved. Her vital signs were checked and recorded and medications served were; Syrup Nugel 15ml and paracetamol 1gm at 2pm. She also told me that she was having problem with sleeping due to change in environment at 1:30pm. Nursing

diagnosis was formulated as; altered sleep pattern (insomnia) related to a change in environment as manifested by patient verbalizing of interrupted night sleep and an objective that was set was patient sleeping pattern will be restored to normal within 24hours as evidenced by; patient having uninterrupted sleep for 6-8hours during the night and 2hours during the day and nurse observing patient can sleep for 6-8hours at night and 2 hours during day time. Nursing interventions set for patient were; patient was reassured that appropriate measures will be put in place to enable her sleep well, noise was reduced on the ward by regulating volumes of television set and radio, visitors were restricted to prevent undue disturbances to help patient sleep, adequate ventilation was provided by opening nearby windows to ensure sleep, warm bath and soft drinks were provided before bed time to stimulate sleep and all nursing procedures were done at a goal to reduce the rate of disturbing patient sleep. The nursing intervention that was given for the diagnosis alteration in comfort related to severe anaemia was fully met as evidenced by patient verbalizing that the pain has subside 07/12/2022 at 1:50pm. Her vital signs were checked and recorded as indicated in the appendix at 2pm and medications were also served they are Syrup Nugel 15ml and Paracetamol 1mg. Blood completed successfully without any reactions at 3:40pm and was made comfortable in bed and was still under close monitoring. She was served with rice and stew during super at 5:00pm. Patient vital signs was checked and recorded as shown in the appendix. During her sleep time at 8:30pm in the night, she was served with warm milo.

Third Day of Admission (08/12/2022)

Mrs.A.K woke up at 5am, looking hopeful and said she was happy and glad about the way she was responding to treatment. It was obvious and convincing when the patient said she was generally better. Her vital signs were taken and recorded at 6am as shown in the appendix. Porridge and bread was served as her breakfast after which she took her due medications thus Syrup Nugel 15ml and Paracetamol 1mg. During ward rounds at 8am the doctor told her that she was to do an endoscopy thus upper and lower, so they can see the cause of her condition but

unfortunately, because it is costly patient told the doctor she cannot afford and so she was told to stop, he also ordered 1 unit of Blood for the patient. Of course, she said she had a sound sleep. During my interactions at 9am, she told me that she cannot eat and which a nursing diagnosis was formulated as Imbalance nutrition less than body requirement related to loss of appetite. Objective was client will be able to attain and maintain adequate nutrition within 48hours as evidenced by; patient maintaining adequate amount of iron, vitamins and proteins from diet and supplements and nurse observing that patient takes in diet that contains iron, vitamins and supplements which the nursing intervention set for patient were; meals were planned with the patient, patient was served with her favorite food, foods were served in bits but frequently, patient was served with fruits and fruit juices, food was served in hygienic environment that was free from nauseating substances and prescribed drugs were served (multivites). At 9:30am I informed patient that I will be going for home visit at her house and explained to her that it will help in her treatment. She accepted and showed me the location to her house I left the hospital around 11am.vital signs were checked and recorded as indicated in the appendix at 10am. I came back to the hospital at 12:35pm and she was served with ampasi with vegetable stew. She was served with rice and vegetable stew as lunch. Nursing interventions that was set on for altered sleep pattern related to change of environment as manifested by the patient verbalizing of interrupted night was fully met at 1:30pm. Her second unit of blood with batch number FR09 was ordered and collected from the laboratory, IV Furosemide 40mg was served as pre medication and set up at 12:15pm.

Vital signs were checked and recorded as;

Temperature	36.6^{o}C
Blood Pressure	100/60mmhg
Pulse	93bpm
Respiration	24cpm

SPO2 98%

which completed successfully without any reactions at 4:50pm and was made comfortable in bed and still under close monitoring. She was served with banku and Okro stew as super and her due medications were served and she went to bed at 8:40pm.

Fourth Day of Admission (09/12/2022)

At about 5:30am patient waked up, Mrs.A.K was assisted to care for her self-care needs. She confessed that, there have being a great improvement in her health status. She ate wheat and bread as breakfast and was served with her due medications. During my interactions with her at 8:30am, patient expressed to me their ignorance about anaemia in which a nursing diagnosis was formulated as Knowledge deficits related to causes, signs and symptoms and management of anaemia. Objective that was set were patient and family will gain adequate knowledge on severe anaemia within 24 hours as evidenced by; patient and family verbalizing the cause, signs and symptoms and management of severe anaemia and nursing intervention were set as; an appropriate time for discussion was chosen with patient, the causes, signs and symptoms, prevention and treatment of anaemia were explained in simple terms, patients was allowed to ask questions and frankly answers given, patient and family were involved in the implementation of care, questions were asked to assess the level of understanding and patient was provided with some good food source of proteins, vitamins, minerals and others. Time was scheduled with the patient and family and educated them on the causes, signs and symptoms, treatment and prevention of anaemia and was encouraged to report to the nearest health facility anytime they experience unusual symptoms. Her church members came around to visit, this made her very happy and raised her spirit high. Mrs.A.K. was taken through some exercise in the form of walking around the ward in the afternoon. All other routine nursing activities carried out and were documented appropriately. At 5:30pm rice balls with palm nut soup and

fish was served as supper. She watched television and went to bed after the 10:00pm medication. Her vital signs for the day checked and recorded as indicated in the appendix.

Fifth Day of Admission (10/12/2022)

Patient slept well throughout the night, she woke up at 6:40am and was assisted to perform her personal hygiene needs and other daily activities. She confessed this morning that, there have been a great improvement in her health status. At 7:00am, she ate tea and bread as breakfast. She lodged no complains this morning. The nursing intervention that was set for the diagnosis for Knowledge deficits related to causes, signs and symptoms and management of anaemia were Goal fully met on (10/12/2022) at 8:30am as patient and family were able to state three causes, signs and symptoms, preventive measures and food treatment of severe anaemia. Her family members and friends came around to visit. This made her very happy. The Physician assistant on duty came to review patient, he was satisfied with the progress and requested for haemoglobin level to be done again and if it is normal patient will be discharge possibly tomorrow. He prescribed Tablet ferrous fumarate200mg OD x 30 and Tablet folic acid 5mg OD x 30 for patient. At 9am nursing intervention that was set for imbalanced nutrition less than body requirement related to loss of appetite was fully met as evidence by patient eating all food served and requesting for more food to be added. Patient and relatives were informed of her discharge possible tomorrow. Patient became more excited on hearing of discharge tomorrow. All other routine nursing activities carried out and were documented appropriately. At 6:00pm rice with kontomire stew and fish was served as supper. She watched television and went to bed after the 10:00pm medication. Her vital signs for the day checked and recorded.

Sixth Day of Admission / Day of Discharge (11/12/2022)

On the 11th of December, 2022, Mrs.A.K waked up at 5:30am and expressed cheerfulness and started relating with the health personnel. Her vital signs were taken and recorded as indicated in the appendix. She cleaned her teeth, bath and took her breakfast at 7:30am before her drugs

were administered. The physician assistant which patient belongs to came around and inform the patient that, her haemoglobin level was normal 10.3g/dl and so she has being discharged and was to continue the care at home. The nursing intervention that was set for the diagnosis high risk for injury related to dizziness was fully met as patient was discharged from the ward without sustaining any injury. Review date was given to her which was 29th December, 2022. She was asked to continue with the remaining drugs; thus, Tablet omeprazole 20mg bid x 7, Nugel Suppension 15ml tid x 7, Tablet Cetirizine 10mg at night x 5, Tablet Ferrous Fumarate200mg daily x 30, Tablet Folic acid 5mg daily x 30. Patient was told how to take the drugs and its side effects were explained to her. She called her daughter and informed her about the discharge as we prepared and waited for her arrival. Bills and other payments were settled by her daughter and were given a chit that will be shown to the security before leaving the facility. Decontamination of bed and accessories were properly done by me.

4.2 Preparation of Patient and Family towards Discharge and Rehabilitation.

The preparation of Mrs.A.K and her family towards discharged started on the first day of her admission into the ward. Patient and family were made aware that her admission was temporal and she would recover soon and will be discharged. The patient and family were educated on the causes, signs and symptoms, prevention and treatment of anaemia. The early signs and symptoms were explained to the patient and were encouraged to report to the nearest health facility as soon as she feels unusual. She was advised to continue the treatment at home but discouraged her from over-the-counter drugs. The side effects of the drugs were explained to the patient and family. They were educated also on personal and environmental hygiene which includes bathing twice daily, mouth care twice daily, trimming of nails when grown, sweeping the compound and disposing of refuse properly and drinking clean water to prevent infection into the system. The need to eat a balance diet was emphasized by taking foods rich in calories, proteins and vitamins e.g. of calories include yam, cassava, rice etc. meat, fish, eggs, beans and snails are good

examples of proteins. Green leafy vegetable and fruits are sources of vitamins and minerals. She was told to take adequate rest and sleep and also to engage in regular exercise. During ward rounds on the 11th of December, 2022, the Physician assistant was satisfied with her condition and therefore discharged her home for continuity of care with the following treatment; tablet omeprazole 20mg bid x 7, Nugel Suppension 15ml tid x 7, tablet cetirizine 10mg at night x 5, tablet ferrous fumarate200mg daily x 30, tablet folic acid 5mg daily x 30.Assessment were carried out as client relatives were called to come over. Since client was insured her bills were not costly. The time and date of discharge was entered in the admission and discharge book as well as in the daily ward state. Patient and relatives were educated on the medications with its collect time it should be taken, they were told that, she is to come for review on 29th December, 2022.I stressed on the date for review and the importance of it. All their questions were answered and were assisted to pack their belongings and also accompanied them to the hospital gate to board Okada and bid them goodbye.

4.3 Follow Ups/Home Visits/Continuity of Care

Friendly but purposeful visit to the home of client with the aim of maintaining health, preventing disease, promoting life through health education, counselling and rehabilitation were carried out before and after client discharge from the hospital.

4.3.1 First Home Visit (08/12/2022)

I went for the first home visit on the 8th of December, 2022, in the morning whiles patient was still on admission. At 9:30am I informed patient that I will be going for home visit at her house and explained to her that it will help in her treatment. She accepted and showed me the location to her house I left the hospital around 11am.vital signs were checked and recorded as indicated in the appendix at 10am. I left the hospital around 11am and took an Okada to Senase, where my patient lives. My aim was to assess client home so that, health education would be centered on

the findings. On arrival, I met her daughter who has undergone surgery and so does not go anywhere and she offered me a seat and offered me water. I was asked the reason for coming and I explained that, I am a student nurse who is caring for Mrs. AK her mother and also studying her condition. As part of the study, I am to come and see her house and environment to help give health education on how prevent the reoccurrence of her condition. She was very glad to hear that and gave me the go ahead to do whatever was needed to be done. She asked of her mother's condition and I told her she was responding to treatment. An observation made on the environment which was found to be clean and quite. The house was built with cement block which is occupied by her daughter and client alone. Lightening system was good and a source of water behind their house. There is a mongo tree and a coconut tree behind the house. Her house is closer to a sport called Kabobo spot, Senase main refuse dump and Methodist Church. There is a toilet facility behind the house, which is clean and refuse are collected in a dustbin which is disposed to the refuse dump every day. I educated her daughter to always cover food and always serve food hot. They were not using treated mosquito night so, I educated her daughter on the importance of sleeping under treated mosquito night and so they should get some to use. I educated them to keep their surrounding clean by burning filth or waste to prevent disease like cholera, malaria etc, the need to eat well balanced diet was explained to the family and were discouraged from smoking, cola chewing and alcohol consumption. I also educated them to cook their food well and to cover them. There is a bathroom which is neatly scrubbed. The house was painted light pink. According to patient daughter, her mother does not eat food containing nutrient and irons, she also wakes up very early and sleep late and anyone who talks about it she will curse you. I told her daughter I will do anything possible to talk to her. She was commended for keeping the environment relatively clean and were tasked to improve on it before my subsequent visits. I thanked her for the co-operation and promised her of my next visit when client is being discharged.

4.3.2 Second Home Visit (20/12/2022)

My second home visit was on the 20th December, 2022. I was warmly welcomed by the patient and the family and was offered a cup of water after which we exchanged greetings and pleasantries. From my observation, I noticed a positive response to treatment from the patient's cheerful mood. I interacted with them and asked about their general health condition which they said there was no problem. There was a general improvement in the environmental hygiene. Patient was very healthy and active which her daughter commended that she was adhering to education and advice given to her. She now eat and also sleeps early and does not wakeup early anymore. I encouraged her daughter to continue supporting her. An assessment was done by looking at her conjunctiva which is, the mucus membrane covering the front of the eyeball and lining the eyelids to see if it is pink and it was good. The medications were cross checked to make sure that, they were effectively been taken as prescribed. I was told by the patient that she did not have any problem with taking the drugs and their side effects but rather asked whether she could buy those drugs after completing her dosage. She was advised not to since the course given was enough to heal her. I was told they are now using the treated mosquito night which I inspected it. They were allowed to ask questions and all the questions raised were answered appropriately. Patient and the family were advised against over-the-counter medications again and were told to report any abnormal development to a nearby health facility. I reminded her of the review date on 29th December, 2022. I asked permission to leave their company with a promise to visit again.

4.3.3 Review (29/12/2022)

On the 29th December, 2022, I met patient and daughter at the Out Patient's Department. After exchanging greetings, I helped patient to activate her folder. We went to the consulting room to see the Doctor, she was taken through observations and was asked if there was any problem. The

doctor ordered for a full blood count to check for her haemoglobin level and the results was 12.1g/dl. The doctor gave her a remark that she was really gaining her strength back and she should keep on taking in a well-balanced diet and also take in her drugs too. He prescribed drugs for her thus; Tablet Ferrous Fumarate200mg daily x 30 and Tablet Folic Acid 5mg daily x 30 which I went to collect them. She was told to report any complications and discomfort immediately. She thanked the doctor and went out. I escorted them to the hospital gate and bid them goodbye and promised to visit them again.

4.3.4 Third Home Visit (06/01/2023)

I visited my patient for the last time on the 6th January, 2023 in the morning at 10:40am. I met Mrs. A.K, and her two daughters and grandchildren at home. I greeted them and I was welcome and was offered a seat. For this day patient looks very healthy and strong. She had no complains. I told them this maybe my last home visit since we were reopening school. She expressed her gratitude to me and the health team for helping her gain a fast recovery. I recommended them to continue with every education I gave to them which will really help to prevent the reoccurrence of the condition. The medications were cross checked to make sure that, they were effectively been taken as prescribed and also told her to eat a well balanced meals to help her become healthy and stronger. The purpose of the visit was to terminate care, educate her on her health and also to encourage her to attend the nearest health facility whenever she feels sick or needs any health education. The patient and family showed their appreciation to me for the immense care given, they were much appreciative and I showed similar appreciation and commended them for the cooperation. I finally terminated my care with the patient and family and handed patient to the community health care nurse in-charge of the community at Senase. I encouraged her to report any aliment for health advice at the CHPS compound that served the town. I thanked patient and family and asked for my leave.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation is the final component of nursing process and is directed towards determining the patient's response to the nursing intervention and to which the set goals were achieved. The evaluation process of the patient's care deals with reviewing set objectives in accordance with the stipulated time frame.

5.1 Statement of Evaluation

Mrs.A.K. Was admitted to the female's ward at Holy Family Hospital on the 6th December, 2022 with the diagnosis of severe anaemia. The following were the objectives set for her health problems during hospitalization, and goals were set and interventions were put in place to solve these problem.

1. Patient was relieved of anxiety on 7th December, 2022

On the 6th of December, 2022 at 1:00pm, patient was anxious. Nursing diagnosis was formulated as anxiety related to unknown outcome of disease condition and management and an objective was set as; patient and family will be relieved of anxiety within 24hours as evidenced by, patient and family verbalizing that anxiety have being relieved and nurse observing patient is relaxed and cheerful in bed. Nursing intervention given were; she was reassured that she was in hands of competent staffs, she was also introduced to other patient recovering from anaemia, patient was allowed to express her fears and they were addressed accordingly, every procedure that was to be carried out was explained to her, she was also educated on relaxation techniques such as diversional therapy to divert her mind of anxiety and the need of hospitalization and management of disease were explained to patient. Goal was fully met on (07/12/2022) at 1:00pm as patient verbalize that anxiety have being relieved.

2. Patient was relieved from general body pains on 7th December, 2022

On this same day at 1:50pm, she also complained of general body pains. Nursing diagnosis was formulated as alteration in comfort related to severe anaemia and an objective was set as; patient will be relieved of general body pains within 24hours as evidenced by, patient verbalizing that pain has subside and nurse observing patient has a relaxed and cheerful facial expression. Nursing intervention given were; patient was reassured that pain will be relieved where necessary measures will be done to relive the pain, pain level was assessed considering the onset, duration and intensity of the pain, patient was put in a comfortable bed free from creases and cramps, a noise free environment was maintained by restricting visitors and lowering of television set on the ward, client was engaged in diversional therapy such as conversation to help divert her mind of the pain and also prescribed analgesic was served (paracetamol). Goal was fully met on (07/12/2022) at 1:50pm as nurse observing patient has a relaxed and cheerful facial expression.

3. Patient was free from injury throughout the stay at the hospital on 11/12/2022

On the 7th December, 2022 at 8am, patient told me that, she was feeling dizzy and nursing diagnosis was formulated as high risk for injury related dizziness. Objective was set as; patient will not sustain any injury within the period of hospitalization as evidenced by; patient verbalizing that there is cessation of dizziness and nurse observing there is absence of injury. Nursing intervention give were, patient was reassured of support in all activities, injurious objects were removed from patient's environment, adequate lighting was provided, patient was advised to rise slowly from bed and to sit down whenever she was feeling dizzy, vital signs were monitored and recorded and good bed rest was ensured. Goal was fully met on (11/12/2022) at 9:30am as Patient verbalize that there is cessation of dizziness and nurse observed that there is absence of injury.

4. Patient gained her normal sleeping pattern on 08/12/2022

On that same day (07/12/2022) at 1:30pm, patient told me that she was having problem with sleeping due to change in environment. Nursing diagnosis was formulated as; altered sleep pattern (insomnia) related to a change in environment as manifested by patient verbalizing of interrupted night sleep and an objective that was set was patient sleeping pattern will be restored to normal within 24hours as evidenced by; patient having uninterrupted sleep for 6-8hours during the night and 2hours during the day and nurse observing patient can sleep for 6-8hours at night and 2 hours during day time. Nursing interventions set for patient were; patient was reassured that appropriate measures will be put in place to enable her sleep well, noise was reduced on the ward by regulating volumes of television set and radio, visitors were restricted to prevent undue disturbances to help patient sleep, adequate ventilation was provided by opening nearby windows to ensure sleep, warm bath and soft drinks were provided before bed time to stimulate sleep and all nursing procedures were done at a goal to reduce the rate of disturbing patient sleep Goal was fully met on (08/12/2022) at 1:30pm as patient verbalize that she has uninterrupted sleep for 6-8 hours during night and 2 hours during the day.

5. Patient gained her normal nutritional balance on 10/12/2022

On the 8th December, 2022 at 9am, patient told me that she cannot eat and which a nursing diagnosis was formulated as Imbalance nutrition less than body requirement related to loss of appetite. Objective was client will be able to attain and maintain adequate nutrition within 48hours as evidenced by; patient maintaining adequate amount of iron, vitamins and proteins from diet and supplements and nurse observing that patient takes in diet that contains iron, vitamins and supplements which the nursing intervention set for patient were; meals were planned with the patient, patient was served with her favorite food, foods were served in bits but frequently, patient was served with fruits and fruit juices, food was served in hygienic

environment that was free from nauseating substances and prescribed drugs were served (multivites). Goal fully met (10/12/2022) at 9am as patient eating all food served and requesting for more food to be added.

6. Patient and family gained enough knowledge about the condition anaemia on 09/12/2022

On 9th December, 2022 at 8:30am, patient and family expressed to me their ignorance about anaemia in which a nursing diagnosis was formulated as Knowledge deficits related to causes, signs and symptoms and management of anaemia. Objective that was set were patient and family will gain adequate knowledge on severe anaemia within 24 hours as evidenced by; patient and family verbalizing the cause, signs and symptoms and management of severe anaemia and nursing intervention were set as; an appropriate time for discussion was chosen with patient, the causes, signs and symptoms, prevention and treatment of anaemia were explained in simple terms, patients was allowed to ask questions and frankly answers given, patient and family were involved in the implementation of care, questions were asked to assess the level of understanding and patient was provided with some good food source of proteins, vitamins, minerals and others Goal fully met on (10/12/2022) at 8:30am as patient and family were able to state three causes, signs and symptoms, preventive measures and food treatment of severe anaemia. All objectives were met before she was discharged from the hospital.

5.2 Amendment of Nursing Care Plan for Partially Met or Unmet Outcome.

With the support from other members of the health team and competent nursing care rendered to Mrs.A.K. All goals and objectives set were fully met due to good medical and nursing care rendered and client and her family also co-operated to enhance speedy recovery, hence no amendment of nursing care was done.

5.3 Termination of Care.

This was the last aspect of the interaction between patient and I. It is another important section of the process of care for the patient. Separation can sometimes bring about anxiety and depression. This is the period in which a therapeutic interaction came to an end. Termination of care started when Mrs.A.K. Began to show signs of improvement of her condition which included relieve of anxiety, general body pains, dizziness and altered sleep pattern, loss of appetite and knowledge deficit about condition. Termination of care with patient and family was a very difficult task. My interaction with Mrs.A.K started on the 6th December, 2022 at the female's ward of Holy Family Hospital, Berekum. She was diagnosed of severe anaemia and the needed care was rendered to promote early recovery until she was discharged on the 11th December, 2022.

During my last home visit, patient's condition was very encouraging. I explained to patient that I had to terminate the care since she was fit and strong and had to continue with my academic works since we were about to re-open school. I reminded her to practice every education that was given to her. Finally, the care was terminated on the 6th January, 2023, during the third home visit when patient was handed over to a community health care nurse in-charge at Senase and encouraged her to report to the nearest health facility for treatment when the need arise. I bid them goodbye and they escorted me to pick tricycle (Okada).

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction.

This is the final aspect of the patient and family care study. It deals with the summation of all medical and nursing care rendered to the patient and her family as well as the conclusion.

6.1 Summary

Mrs.A.K a 74years old woman was admitted on 6th December, 2022 to female ward of Holy Family Hospital at Berekum with diagnosis of severe anaemia and was discharge on 11th December, 2022. Roles such as serving of medications and other nursing management such as checking of vital signs and education were done, medical treatment included Anti-acid, Anti-secretion compound, Loop diuretics, Antipyretic and analgesic, Antihistamines and Haematimics were administered to prevent the body pains dizziness and loss of appetite Mrs.A.K. problems that was identified during hospitalization were; anxiety, general body weakness, dizziness, difficulty in sleeping, loss of appetite and knowledge deficit of the condition and comprehensive care plan was drawn for her care. All procedures carried out on the patient were explained to her to obtain her co-operation. Laboratory investigations were requested and checked and the appropriate interventions made. Mrs.A.K and the family members were educated on the causes, risk factors, signs and symptoms, treatment and prevention of anaemia. They were also educated on the need to practice personal and environmental hygiene, eat proper foods and it should be served hot and to develop medical check-up habit. There were series of visits made to patient's home and I subsequently terminated care on 6th January, 2023 and handed over the nursing care to the community health care nurse in-charge when the patient's condition improved.

6.2 Conclusion and Recommendation.

By understanding the patient and family care study, the student nurse is able to render a holistic nursing care to the patient and family by applying the classroom knowledge acquired into clinical situation. The patient's care study although is challenging but, it is a very educative and a rewarding academic exercise. Also the nursing process makes the student to establish good interpersonal relationship with the patient and family through therapeutic communication skills. The patient and family care study gives the student nurse an insight into the disease condition and improves upon his or her knowledge and professional skills. The home visits enable the student to identify the resources available for him to solve a problem within his or her capacity. Therefore I recommend that, this remains part of the academic program as designed to assist final year nursing students, to develop a better understanding of their training and family centered care.

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APPENDIX

Table 6.0: Vital signs of Mrs.A.K throughout her hospitalization

Time/Date	Temperature	SPO2	Pulse	Respiration	Blood pressure
6/12/2022 12:40pm	35.3^{0}C	99 %	**77**bpm	19cpm	135/70mmhg
6/12/2022 2:12pm	36.2^{0}C	100%	79bpm	22cpm	97/57mm
6/12/2022 6:42pm	36.9^{0}C	99 %	92bpm	23cpm	99/56mmhg
6/12/2022 7:20pm	37.1^{0}C	100 %,	89bpm	21cpm	100/50mmhg
6/12/2022 10:30pm	36.8^{0}C	99 %	74bpm	22cpm	101/59mmhg
7/12/2022 6:00am	37.1^{0}C	99 %	85bpm	21cpm	120/70mmhg
7/12/2022 2:00pm	36.2^{0}C	99%	79bpm	21cpm	123/66mmhg
7/12/2022 6:00pm	36.7^{0}C	98%	80bpm	16cpm	93/57mmhg
7/12/2022 10:00pm	37.2^{0}C	98%	81bpm	20cpm	99/60mmhg
8/12/2022 6:00am	35.9^{0}C	99%	70bpm	18cpm	97/64mmhg
8/12/2022	36.4^{0}C	99%	74bpm	22cpm	99/60mmhg

10:00am					
8/12/2022 2:20pm	36.6^{0}C	98%	72bpm	22cpm	100/62mmhg
8/12/2022 6:00pm	35.6^{0}C	97%	75bpm	22cpm	119/65mmhg
8/12/2022 10:00pm	36.2^{0}C	99%	65bpm	19cpm	110/70mmhg
9/12/2022 6:05am	36.0^{0}C	98%	63bpm	20cpm	110/70mmhg
9/12/2022 10:12am	36.4^{0}C	99%	65bpm	21cpm	114/64mmhg
9/12/2022 2:00pm	36.9^{0}C	98%	63bpm	18cpm	125/69mmhg
9/12/2022 6:00pm	36.6^{0}C	99%	64bpm	16cpm	120/70mmhg
9/12/2022 10:12pm	36.9^{0}C	100%	68bpm	22cpm	116/62mmhg
10/12/2022 6:25am	36.2^{0}C	98%	65bpm	21cpm	133/75mmhg
10/12/2022 10:10am	36.5^{0}C	98%	65bpm	16cpm	99/58mmhg
10/12/2022 2:09pm	36.0^{0}C	100%	67bpm	17cpm	120/71mmhg
10/12/2022 6:12pm	37.0^{0}C	98%	64bpm	18cpm	121/73mmhg

10/12/2022 10:00pm	36.8^0C	100%	59bpm	18cpm	116/63mmHg
11/12/2022 6:10am	36.6^0C	100%	66bpm	22cpm	120/60mmHg

SIGNATORIES

1. THE STUDENT NURSE

Name: KONADU WENDY BLESSING

Signature.....

Date.....30th June, 2023.....

2. THE NURSE-IN-CHARGE OF THE FEMALES WARD (HOLY FAMILY HOSPITAL- BEREKUM).

Name: MRS. DEDE GRACE

Signature.....

Date.....11TH July, 2023.....

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

Name: OSEI OWUSU SHADRACK

Signature.....

Date.....07/07/2023.....

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

Name: MONICA NKRUMAH

Signature.....

Date.....17th July, 2023.....

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM