QUADRA INSTITUTE OF NURSING

ROORKEE

NURSING CARE PLAN ON-

HYPERTENSION

SUBMITTED TO

SUBMITTED BY

SUBMISSION ON

HISTORY COLLECTION

DEMOGRAPHIC PROFILE

Name	:	Mr. Akash Saini
Age	:	38 years
Gender	:	Male
Marital status	:	Married
Religion	:	Hindu
Occupation	:	Teacher
Address	:	Ramnagar, Roorkee
Ward Name	:	Male Ward
Bed No	:	06
Medical Diagnosis	:	Hypertension
Doctor in charge	:	Mr. Arun Sharma
Date of Admission	:	
Hospital Name	:	

CHIEF COMPLAINTS

Patien (Mr Akash saini) complaints that he is suffer from headache, fatigue, dizziness, vision problem, chest pain & irregular heart beat and also breathing problem

PRESENT MEDICAL HISTORY

Mr. Akash saini, 38 years came to hospital with complaints of headache, fatigue, dizziness, chest pain, breathing problem from last 4 days.

PAST MEDICAL HISTORY

Patient doesnot have any past medical history of any disease or any major health problem.

PRESENT SURGICAL HISTORY

No any significant surgery needed.

PAST SURGICAL HISTORY

There is no significant past surgical history.

FAMILY HISTORY

Types of family - Nuclear family

Total number of family members - 4

Head of the family - Patient (Mr. Akash saini)

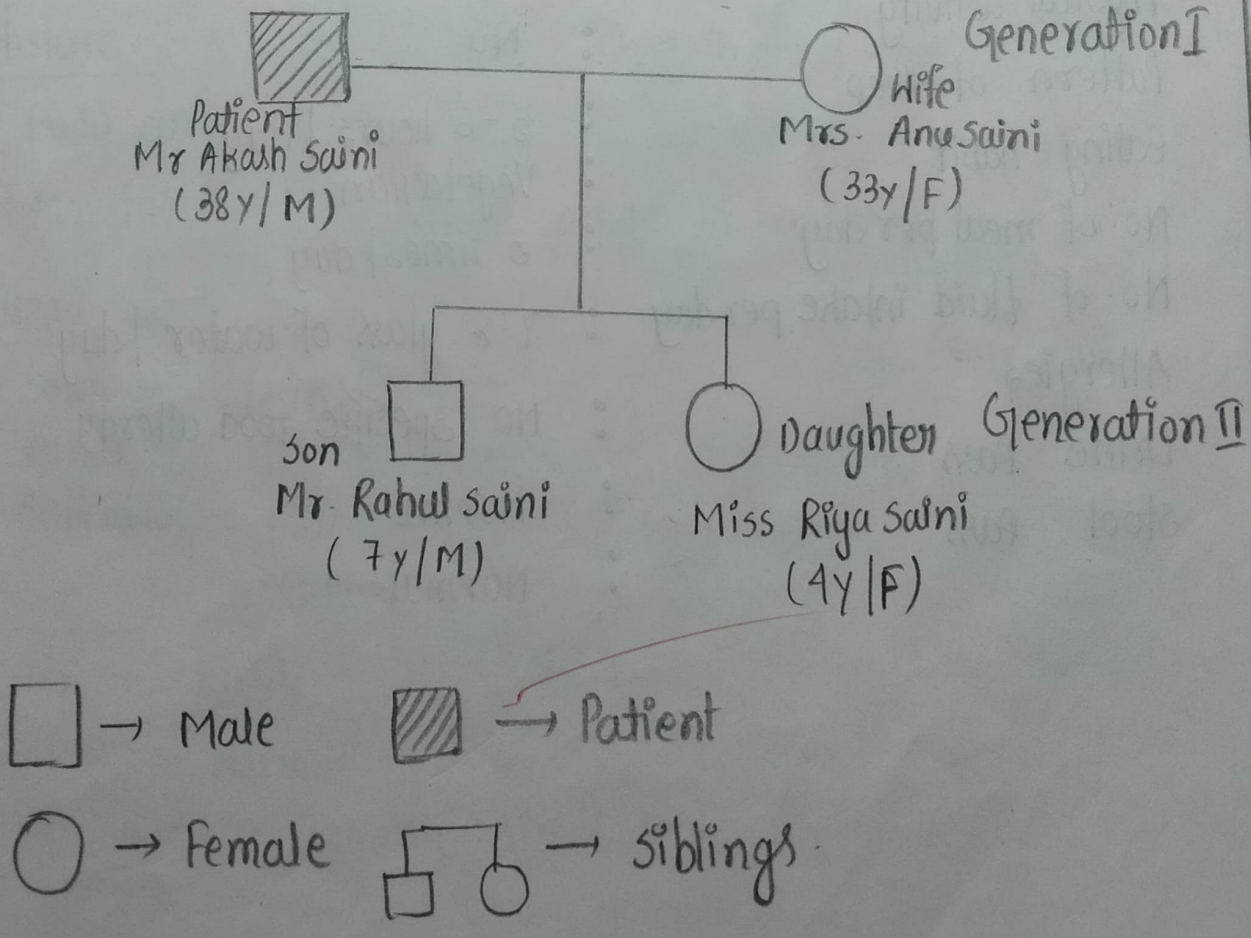
The patient name is Mr. Akash saini 38 years. There are four members in his family and they havenot any medical or surgical history. Only the patient is unhealthy in his family.

S.No	Fam
1.	M
2.	Mrs
3.	Mr
4.	Mi

FAMILY CHART

S.No	Family Members	Relationship with patient	Age/sex	Occupation	Health status
1.	Mr. Akash saini	Patient	38/M	Teacher	Unhealthy
2.	Mrs. Anu saini	Wife	33/F	House wife	Healthy
3.	Mr. Rahul saini	Son	7/M	Student	Healthy
4.	Miss. Riya saini	Daughter	4/F	Student	Healthy.

FAMILY TREE



PERSONAL HISTORY

Living place	: Ramnagar, Roorkee
Occupation	: Teacher
Finalcial status	: 20000 /month
Presence of Hazards	: No
Religion	: Hindu
Believes in God	: Yes
Language	: Hindi
Housing	: Pakka
Smoking /Alcohol	: No
Substance Abuse	: No
Physical activity	: No
Pattern of sleep	: 5-6 hours / day
Eating habit	: Vegetarian
No. of meal per day	: 3 times/ day
No. of fluid intake per day	: 7-8 glass of water / day.
Allergies	: No specific food allergy
Urine Pass	: Normal
Stool Pass	: Normal

PHYSICAL EXAMINATION

General Appearance

- Nourishment – Over weight
- Body build – Obese
- Health status – Unhealthy
- Activity – Not active

Mental Health Status

- Consciousness – Semiconscious
- Looks – Weak and anxious
- Concentration – Decrease
- Orientation – Not well oriented

Posture

- Body curve – Normal
- Movement – Impaired range of motion

Head

- Scalp – Clean
- Dandruff – Not present
- Pediculosis – Not present

Hair

Color – Black
Texture – Normal
Distributory – Equally distribute

Eyes :→

- Eyelids - Normal
- Pupils - Equals & reacted to bright light
- Vision - Blured vision due to high blood pressure.
- Eyebrows - Evenly distributed
- Cornea & iris - Normal

Ears :→

- External ear - No discharge present
- Hearing capacity - Normal hearing
- Pain - Not present
- Presence of cerumen - Cerumen present

Nose :→

- Secretions - Not present
- symmetry - Symmetrical
- Smell - Normal
- Color of nasal mucosa - Pinkish

Mouth :→

- Lips - Dry
- Colour of lips - Brownish
- Presence of smell - No
- Presence of ulcer - No
- Gums - Gangivitis not present
- Teeth - White in color
- Tongue - Dry

Neck :→

- Lymph nodes – No enlargment
- Thyroid glands – Normal in size

Chest :→

- Size – Enlarge
- Shape – Straight
- Chest circumference – 46 cm

Abdomen :→

- Observation – Rashes , Scar absent
- Palpation – Alter bowel sound
- Percussion – No fluid accumulation
- Auscultation – Alter bowel sound

Extremities :→

- Movement – Abduction , flexion present
- Position – Semi fowler's position
- Deformity – Absent

INITIAL ASSESSMENT

Biographical Data

Name	:	Mr. Akash Saini
Age	:	38 years
Gender	:	Male
Height	:	5 feet 5 inches
Weight	:	70 kg
Ward Name	:	Male ward
Bed No	:	06
Medical Diagnosis	:	Hypertension

BMI (Body Mass Index)

$$BMI = \frac{\text{Weight in kg}}{\text{Height in m}^2}$$

Weight = 70 kg
Height = 165 cm
= 1.65 m

$$= \frac{70}{(1.65)^2}$$

$$= 25.7 \text{ (Over weight)}$$

Vital Sign :→

S.N	Date	Temperature	Pulse	Respiration	Blood Pressure	SPO2
1.		98°F	102 beats/min	22 ~~24~~ breath/min	150/90 mmHg	90%.
2.		99°F	106 beats/min	20 breath/min	140/90 mmHg	92%.
3.		98°F	89 beats/min	18 breath/min	130/80 mmHg	96%
4.		97°F	88 beats/min	18 breath/min	130/80 mmHg	97%.

Investigation Chart :→

S.No	Date	Name of Investigation	Result	Normal value	Remarks
1.		**Blood**			
		Hb	14 g/dl	14-16 g/dl	Normal
		HBC	11100	5000-11000	Increase
		Glucose (random)	150 mg/dl	125 mg/dl	Normal
		Urine Test			
		pH	7.2	4.6-8	Normal
		Color	Pale yellow	Yellow	Normal
		HBC	Absent	Absent	Normal

Medication Chart :→

S.N	Drug Name	Dose/Route	Frequency	Action	Nursing Responsibility
1.	Diclofenac	5ml/IM	BD	To reduce the chest pain.	→Assess the patie general condition → check forany allergic reaction
2.	Lasix (Frusamide)	0.5mg/IV	OD	Diuretics drug.	→ Provide comfor to the patient
	Benazepril Hydrochloride	1mg/IM	OD	Antihyper-tensive drug	→ check blood pressure. → check the expire date of medicine →check proper drug administration route.

NURSING DIAGNOSIS

- Acute chest pain related to the disease condition as evidenced by patient verbalization and patien facial expression.
- Dyspnea related to increase blood pressure as evidenced by physical examination.
- Risk of decreased cardiac output related to high blood pressure as evidenced by self observation.
- Altered sleeping pattern related to anxiety and hospitalization as evidenced by patient verbalization and self observation.
- Deficient knowledge related to the relationship between the treatment regimen and control of the disease process

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Evaluation
Subjective Data Patient complaint that he is suffer from chest pain Objective Data I observed that patient suffering from chest pain by as evidenced by his facial expression	Acute chest pain related to the disease condition as evidenced by patient verbalization and patient facial expression	To relieve pain.	⇒ Check vital sign ⇒ Check the severity and characteristics of pain ⇒ Provide comfortable position to the patient ⇒ Provide diversional therapy to the patient ⇒ Provide analgesic to the patient as per doctor's order	⇒ Vital sign has been checked Temperature - 98°F BP - 150/90 mmHg Pulse - 82 beats/min Respiration - 22 breath/min ⇒ Severity and characteristics of the pain has been checked through pain scale. ⇒ Comfortable position has been provided to the patient ⇒ Diversional therapy has been provided to the patient ⇒ Analgesic has been provided to the patient as per doctor's order.	Patient get relief from chest pain by providing analgesic as per doctor's order at some extent.

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Evaluation
Subjective Data Patient complaint that he is suffer from breathing difficulty. Objective Data I observed that patient is suffer from dyspnea related to high B.P. as evidenced by physical examination.	Dyspnea related to increase blood pressure as evidenced by physical examination	To relief the patient from dyspnea and maintain blood pressure	⇒ Assess the breathing pattern and blood pressure of the patient. ⇒ Assess oxygen saturation level. ⇒ Provide oxygen to the patient. ⇒ Check oxygen level regularly. ⇒ Provide antihypertensive drug as per doctor's order. ⇒ Check blood pressure in every 1 hour.	⇒ Breathing pattern and blood pressure has been assessed ⇒ Oxygen saturation level has been assessed. SPO_2 - 90%. ⇒ Oxygen has been provided to the patient ⇒ Oxygen level has been checked regularly. ⇒ Antihypertensive drug has been provided as per doctor's order ⇒ Blood pressure has been checked	Patient get relief from dyspnea and high B.P after providing Oxygen and antihypertensive drug as per doctor's order at some extent

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Evaluation
Subjective Data Patient complaint that he is suffer from sleeping disturbance. Objective Data I observed that patient suffer from sleeping disturbance due to anxiety, hospitalization as evidenced by self observation	Altered sleeping pattern related to anxiety and hospitalization as evidenced by patient verbalization and self observation	Maintain sleeping patterns and give relief the patient from anxiety	⇒ Assess the sleeping pattern of the patient ⇒ Provide comfortable position to the patient. ⇒ Provide psychological support to the patient. ⇒ Provide comfortable environment to the patient	⇒ Sleeping pattern has been assessed of the patient ⇒ Comfortable position has been provided to the patient. ⇒ Psychological support has been provided to the patient. ⇒ Comfortable environment has been provided to the patient.	Patient get relief from anxiety and sleeping pattern has been changed at some extent.

←:: HEALTH EDUCATION ::→

Health Education on the basis of lifestyle :→

⇒ Advice patient to maintain healthy life style.

⇒ Advice patient to avoid smoking and consuming alcohol

⇒ Advice patient for getting regular physical activity.

⇒ Advice for maintaining a healthy weight or losing weight.

⇒ Getting 7 to 9 hours of sleep daily.

Health Education on the basis of diet :→

⇒ Advice for eating a heart healthy diet with less salt.

⇒ Advice for avoid fast food and salted food.

Health Education on the basis of medication and follow up :→

⇒ Advice patient to take medicine at proper time.

⇒ Advice for Followup check up

⇒ Advice for checking B.P. at home.