HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A PATIENT/FAMILY CENTERED NURSING CARE STUDY ON

GASTRITIS

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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

Nursing is a professional health service that is directed towards the promotion and maintenance of health, treatment and prevention of diseases and the restoration of optimal functioning of the individual, family and communities. To be able to meet the various needs of patients and family, and thus give quality care to them, nursing care has moved from task-oriented approach to giving of total or individualized care involving both patient and family.

Patient/Family care study is carried out by student nurses to enable them put into practice the knowledge and skills which they have acquired from the three-year training period in school. This is to ascertain how best the theoretical knowledge could be used practically to help patient get the effective nursing care.

It helps the student nurse to encounter the patient closely, understand his/her condition and identify problems of the patient. It is satisfactory to both the nurse and patient, that is, the patient becomes satisfied with the care rendered to him or her. The student nurse also feels happy upon being able to achieve his or her goal.

The study serves as a requirement for the award of a professional license to practice by the Nurses and Midwives council of Ghana.

Patient/Family initial have been used instead of their full names to ensure privacy and confidentiality as part of the ethics of the Nurses and Midwives Council.

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INTRODUCTION

A patient and family care study uses the nursing process which is defined as the sum total of interventions rendered to attain and maintain an optimal level of wellness for the patient as well as his or her family. The patient/family care study was conducted on Madam M.K. a 45-year-old woman who was diagnosed of Gastritis. She was admitted to the Females' ward of Presbyterian Hospital, Dormaa Ahenkro in the Bono Region on the 26th day of November 2022 at 1pm.

I chose Madam M.K for the care study because of the urgent needs for the implementation of the appropriate nursing care for her recovery and the need to educate her on the condition to allay her of any anxiety and promote her confidence of good prognosis for the condition. I humbly introduced myself as a student nurse to Madam M.K and her relatives and that I had interest in her condition to write a patient/family care study to which they all agreed and were very co-operative.

Madam M.K. spent four days on the ward before she was fully discharged on the 29/11/2022. All the necessary surgical, medical and nursing care were respectively rendered during the period of hospitalization. Client fully recovered and was free from all the signs and symptoms without any complication on the day of discharge.

In the subsequent chapters, the reader will be introduced to how the nursing process was applied in the nursing care of Madam M.K.

Chapter one gives information on the assessment made on client and her family. This involves client's particulars, developmental history, past and presents medical history, hobbies and lifestyle, family medical and socio – economic history. It also comprises the literature review of

the condition including the anatomy of the peritoneum, definition of the diabetes mellitus, causes, pathophysiology, diagnostic investigations and treatment modalities.

Chapter two gives the reader an insight into data of analysis, the pharmacology of drugs used to treat client such as antibiotics, analgesics and the comparison of Laboratory Investigations conducted on Madam M.K. with standard. Also, it gives a brief outline on the comparison made on the signs and symptoms presented by patient in relation to those in the literature review as well as the health strength and problems both preoperative and post-operative.

However, chapter three discusses the objectives and outcome criteria set, actual nursing care rendered to relieve client from her problems encountered during hospitalization and evaluation of such nursing care.

In Addition to this, chapter four gives a summary of nursing care implementation and the preparation of client for discharge to ensure continuity of care. Home visits were made to access client's living condition and education on how to adapt and adjust following discharge.

The chapter five involves evaluation of the care rendered together with any amendments on unmet goals during the care and how the client and family were prepared towards termination of nursing care.

Finally, the chapter six involves the summary and conclusion of the study.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment is the first phase of activities in the nursing process. It is the systematic gathering of information about the patient potential and actual health problems and needs through interviewing, observation, physical examination and laboratory studies. (Bates, 2012)Data collected is analyzed and this gives information about the patient, her family, their community characteristics and identification of their health problems. This helps to plan appropriate care for the patient and family.

Assessing the patient and family helps the nurse to identify the physical, emotional and intellectual needs of the patient and family to be able to give quality nursing care to the patient and family. Assessment includes the patient's particulars, patient/family medical history, patients past medical/surgical history, patient's lifestyle and hobbies, patient's developmental history. Data for this study were subjective and objective which were gathered from the patient, relatives and the health team through interviews, physical examinations, and observations.

1.1 Patient's Particulars

Particular or biography are the information collected from the patient at the first visit, which forms a picture of the patient as a unique individual. It includes the person name, date of birth ,age, gender, occupation, hometown , nationality, marital status and the sources of data (Wilson, Fickertt & Giddens, 2020)

Madam M.K, a 45-year-old woman was the patient for my care study, born on 16th November, 1977 at Sampa in the Bono region. Madam M.K comes from Kofibadukrom in the Dormaa

Central Municipal in the Bono Region of Ghana. She currently stays at Kofibadukrom in a house with a registration number of KKB10/2A with a GP address of BS-1537-1349. Madam M.K is the second born of five children (2 females and 3 males). She was born to the late Mr. D.K. and Madam H.H. Madam M.K is chocolate in complexion and 1.66 metres tall with a weight of 55 kilogram. Her next of kin is Madam A.K. her first born who lives with her at Kofibadukrom. Madam M.K is a widow with 7 children, four females and 3 males. Madam M.K is a Bono by tribe and communicates fluently in Bono and Asante Twi. she is a Muslim. Madam M.K is a farmer and that is how they earn a source of income for the family. she dropped out of school at primary level at Kofibadukrom D/A School. She has no physical impairment.

1.2 Patient/Family's Medical History

During the interaction with Madam M.K she said, there had been a history of Diabetes and Hypertension in the family suffered by her parents and also resulted to their death. She said there is no known incidence of communicable diseases like tuberculosis, Cerebrospinal Meningitis (CSM), leprosy and others. According to Madam M.K., there is no known history of mental illness as well in the family. She however described a family history of occasional abdominal upset, common cold, body pain, headaches and minor ailments, which are usually controlled with over-the-counter medication from the community drug store. There are no known allergies in the family. Occasionally, her family members seek medical treatment from St. Kyeadeɛ Clinic, a private clinic in the area and Presbyterian Hospital in Dormaa in the case of serious health issues and sometimes use herbal medicines appropriately as an alternative.

1.3 Family's Socio-Economic History

Madam M.K said that the family has been at peace since her marriage. According to her, she and the family do not receive any financial support from outside. She said, she earns income from the farming and her eldest child. Her husband is deceased.

The family members are beneficiaries of the National Health Insurance Scheme and also said there is a good relationship between her and the family. This was evidenced by the frequent visit, care and concern they showed to her during her admission period till discharge. She said, she attends all social gathering including wedding, out-dooring, parties and funerals. According to madam M.K, she makes sure that she settles all her dues as a member of the community. They use electricity and also drink bore-hole water. She said that the family does not show interest in any 'Juju'.

1.4 Patient's Developmental History

Growth is the progressive development of living thing, especially the process by which the body reaches it points of complete physical development. It is characterized by an increase in size of cells (Hypertrophy) and an increase in the number of cell (Hyperplasia) (Dennis ,2013).

Development is the progressive increase in skills and capacity of function. It explains the qualitative change in an individual when there is an increase in skills (Kalat, 2008).

Developmental Milestone is a specific skill, task or learned behaviour that can be used to assess development at a particular age of an individual (Dennis , 2013).

Maturation is the orderly sequence of changes in the physical and behavioral pattern of an individual (Weller, 2009).

According to Madam M.K, even though she cannot tell much about her childhood, she could remember what her mother had told her. She said she was born at term thus between the 38^{th} and

40th week of pregnancy (Spontaneous Vaginal Delivery), at Sampa Government Hospital. She said that, she was given immunization against the childhood preventable diseases such as polio, measles, tuberculosis etc. and even showed me a scar on her right upper arm. She also said that exclusive breastfeeding was practiced for 6 months before introducing a complementary feed. She started crawling at the sixth month and began to walk when she was eleven months old. Her language development started when she was ten months old.

Madam M.K. said she started schooling at the age of four (4). She was at primary one at the age of seven. She started growing pubic hairs at the age thirteen (13) and had her menarche at the age of thirteen (13). She said during her adolescent period she always spends time with her female friends and she also had an opportunity to be educated by her mother about her reproductive health. She wanted to be a professional teacher but she could not continue her education due to financial problem. She is a widow.

In Erik Erickson's psychosocial theory (1950), he suggested the eight stages that one goes through from birth to death and failure to go through one stage successfully can result in crises. My patient falls within the 8th stage thus generativity versus stagnation of Erik Erikson's psychosocial theory. When people reach their 40s, they enter the time known as middle adulthood, which extends to the mid-60s. The social task of middle adulthood is *generativity vs. stagnation.* Generativity involves finding your life's work and contributing to the development of others through activities such as volunteering, mentoring, and raising children. During this stage, middle-aged adults begin contributing to the next generation, often through childbirth and caring for others; they also engage in meaningful and productive work which contributes positively to society. Those who do not master this task may experience stagnation and feel as though they are not leaving a mark on the world in a meaningful way; they may have little

connection with others and little interest in productivity and self-improvement. In respect to patient's age and psychosocial behavior, she falls under the middle adulthood group where there is conflict between generativity and stagnation (35 to 65). In respect to patient's supportive effort, sharing and giving to people in her community and her family indicates that she is in her generativity dimension of Erickson's psychosocial development.

According to her relatives, Madam M.K is very friendly and likes hardworking people.

1.5 Patient's Obstetric History

Madam M.K said that she had never had an abortion in life and she has seven children all of them are alive. During labour, she had a spontaneous vagina delivery without any complications except her last child that she was finding it difficult to deliver at the labor ward and was taken to theatre for caesarean section. According to the patient, she had her menarche at the age of 13, menstrual cycle is 28 days, and menstrual flow is 4 days of which she has a heavy flow for the first 2 days with clot sometimes and normal flow for the remaining 2 days. She said, menstruation occurs at the end of each cycle. She also stated that, she has not used any contraceptive before in her life.

1.6 Patient's Lifestyle / Hobbies

Madam M.K said she usually wakes up at 4:00am. She brushes her teeth with pepsodent or at times chewing stick and takes her bath with warm water immediately and performs Fajr (Muslims religious morning prayer). Madam M.K bathes her grandchildren and then takes her breakfast at 8:00am and set off to the farm except on Friday which is reserved for worship as her belief demands.

According to Madam M.K., she takes three meals a day and empties her bowel once or twice daily and empties her bladder when she feels the urge. She said after a hard day's work from farming,

she usually converses with her friends. This depicts that she is not hostile. Her favourite food is Tuo Zaafi with okro soup. She does not take in alcohol, coffee, tobacco and does not encounter any difficulties in the performance of household activities. Through the interaction, I noticed that she had the ability to verbalize her emotions appropriately which was evidenced by her non-verbal communication cues, for example; her gestures, facial expressions and eye movements. As a young adult in the community, she attends all social gathering including wedding, outdooring, parties and funerals. She said she likes playing with friends but dislikes associating herself with bad friends. After her routine morning activities, she goes to her farm and comes at 3:30pm to prepare supper for the family and often attends any due social gathering.

By 7:00pm in the evening, she takes her bath with medicated soap and brushes her teeth with a tooth brush and paste. She sometimes watches television with her family in the evening. She does not sleep under insecticide treated net and normally buys porridge from a vendor.

1.7 Patient's Past Medical/Surgical History

According to Madam M.K., she had Chicken pox when she was young. She has no allergies to drugs or food and has not been involved in any accidents or injuries. She has been admitted at Presbyterian Hospital in Dormaa for a number of times with malaria, abdominal pain, and others of which she was given medications like Artemether Lumefantrine, ibuprofen acetaminophen, omeprazole etc.

She said, she had a surgery (caesarean section) during her last delivery at Presbyterian Hospital. She said she has been coming to the hospital for medical check-ups even when she is not sick.

According to her, there is a known history of hypertension and diabetes in the family that was suffered by her grandparents and her parents. She has not been referred to any specialist for treatment.

1.8 Patient's Present Medical/Surgical History

Upon various interactions with Madam M.K., she was faring well until 25th November, 2022, around 8pm that she became weak and felt severe abdominal pain. Madam M.K. was made to take in Paracetamol to alleviate the pain. They took care of her until the next morning since it was already late that day. On the next day, 26th November,2022, she was sent to the O.P.D by Miss A.K around 12:30 pm.

At the O.P.D, she complained of severe abdominal pain, nausea, dizziness, headache and vomiting.

The following investigations were carried out

1. Full Blood Count- WBC-5.21× 10^3/µl

   RBC- 4.32 × 10^3/µl

   HGB- 9.8 g/dl
2. Blood sample for Malaria Parasites (MPs) - no parasites seen.
3. Upper Endoscopy: Gastric ulcer 2nd H. Pylori infection R/O malignancy.

Madam M.K was diagnosed of Gastritis based on the signs and symptoms she presented and the laboratory investigations. Dr. A.S therefore admitted her to the females' ward.

1.9 Admission of Patient

Admission is the process of receiving a patient into the ward in order to ensure continuity of the nursing care to enhance smooth and faster recovery and to prevent any complications from arising.

On the 26th November, 2022 at 1pm, Madam M.K. with her daughter arrived at the Presbyterian Hospital Dormaa, Females' ward by her daughter through the O.P.D with the diagnosis of Chronic Gastritis upon complains of severe abdominal pain and body weakness. Patient was

weak but fully conscious. Patient and daughter were warmly received and given seats, patient's hospital card was collected, entered into the ward computer and quickly read through. She was admitted into a bed with side rails to protect her from injury since she was restless due to pain. She was reassured that she would be well in the shortest possible time.

The necessary documents were collected. Her particulars such as name, sex, age, residential address and religion were cross –checked and entered into the admission and discharge book and the daily ward state. Her vital signs that is temperature, pulse, respiration and blood pressure were checked and recorded as follows.

1. Temperature: 36.2 degrees Celsius
2. Pulse: 100 beats per minute
3. Respiration: 21 cycles per minute
4. Blood pressure: 129/70 millimeters of mercury

The following laboratory investigations were requested

1. Blood sample for Malaria Parasites (MPs)
2. Blood for Full Blood Count
3. Upper Gastro Intestinal Endoscopy

An IV cannula tray was set and the Nurse-In-Charge was assisted to secure IV line and take blood samples which were labelled and taken to laboratory.

Madam M. K's daughter was then reassured that measures were being put in place to bring the condition under control. Her daughter was asked to bring items like plate, cup, cutlery, bucket, soaps, sponge, towel and other items which patient would need during her hospitalization. She had registered on the national health insurance scheme. It was however explained to her that

some of the drugs and the laboratory tests may be non–insured for which she would pay for before discharged. She was being managed on

1. Intravenous Buscopan 40mg stat
2. Intravenous Omeprazole 80mg stat then 40mg bd x 48 hours
3. Intravenous Paracetamol 1g tds x 24 hours
4. Intravenous Dextrose Normal Saline 1L for 24 hours
5. Intravenous Normal Saline 1L for 24 hours

I oriented Madam M. K and relative to the ward and its annexes, Hospital protocol regarding visiting hours, time for checking vital signs were explained to patient. Her valuables were kept at the nurses' station. Physical examination was conducted and patient had abdominal pain Discharge planning was initiated with the relative; thus they will continue the care at home once she is well.

I went to her later and introduced myself to her as a final year student of Holy Family Nursing and Midwifery Training College, Berekum. I made her aware that as a final year, it is a requirement by the Nursing and Midwifery Council of Ghana to take a patient, render individualized nursing care to her through discharge and to follow up visit after discharge until she recovers fully and the care terminates. This serves as partial fulfilment of an award of a Registered General Nursing certificate in Ghana. Madam M.K and her relative permitted me after I explained to them and said they would cooperate with me and give all necessary information to complete the care I am rendering to them. I therefore expressed my gratitude to them.

1.10 Patient's Concept of Illness

According to Madam M.K., She had heard a lot about Gastritis but at her age, she never thought of having it. she believed Allah would heal her and her expectation was to attain an effective health care to facilitate early recovery and believed that she would be relieved of the symptoms and recover fully to continue working and perform other activities per her daily living.

1.11 Literature Review

Definition

Gastritis is an inflammation of the gastric or stomach mucosa. it is a most common gastrointestinal problem. Gastritis may be acute, lasting several hours to a few days, or chronic, resulting from a repeated exposure to irritating agents or recurring episodes of acute gastritis. (Cheever,2015).

Incidence

Epidemiologic studies reflect the widespread incidence of gastritis. In the United States, It accounts for approximately 1.8 -2.1 million visit to doctor's offices each year. It is especially common in people older than 60 years. (Hopper 2015).

Classification

a. Acute Gastritis

This is an inflammation of the stomach mucosa which may last several hours to a few days. Gastric biopsies often show gastritis, which is related to high prevalence of *Helicobacter pylori* infection

Causes

Acute gastritis is often caused by dietary indiscretion the person eats food that is contaminated with disease-causing microorganisms or that is irritating or too highly seasoned. Other causes of acute gastritis include;

1. Overuse of aspirin and other Non - Steroidal Anti-Inflammatory Drugs (NSAIDs),
2. Excessive alcohol intake,
3. Bile reflux,
4. Radiation therapy.
5. Ingestion of strong acid or alkali.

Clinical Manifestations

Acute gastritis may be asymptomatic. But some patients may have rapid onset of symptoms, such as;

1. Vomiting
2. Nausea
3. Burning abdominal pain
4. Anorexia
5. Abdominal bloating
6. Heart burns
7. Belching
8. Hiccough
9. Weight loss
10. Halitosis (foul breath)
11. Dehydration

12. Black, coffee or dark stool
13. Fever
14. Diarrhoea
15. Body pains (malaise) and headache

b. Chronic Gastritis

Chronic gastritis may result from repeated exposure to irritating agents or recurring episodes of acute gastritis and they are found in patient with pernicious anaemia, autoimmune disorders, chronic alcohol abuse, peptic ulceration and gastric cancer, and following gastric surgery. Chronic gastritis is characterized by progressive and irreversible changes in the gastric mucosa.

Causes

1. Bacterial infection: Most case of gastritis is caused by infestation of helicobacter pylori that lives deep in the mucous layer of the stomach causing inflammatory responses.
2. Regurgitation of bile into the stomach. If the pyloric sphincter is weak and does not close properly, bile can flow back into the stomach leading to inflammation o the mucosal lining.
3. Regular use certain during: Drugs such as Non-steroidal Anti-inflammatory drugs (NSAIDs), aspirin and cortisone can cause stomach inflammation reducing the protective lining of the stomach.
4. Radiation and chemotherapy: large doses of radiation cause irreversible erosion on the stomach lining and destruction of acid producing glands.
5. Excessive intake of caffeine, alcohol and smoking: These irritate and erode the mucosal lining of the stomach making it vulnerable to caustic effects of normal stomach secretion.

6. Autoimmune disorder: The initial cause of abnormal autoimmunity is not known but there is familial predisposition that, cells are destroyed as a result of inflammatory response that gradually thins the mucosal lining.
7. Severe stress such as trauma or burns also causes the reflux of bile and pancreatic secretions causing erosion of the stomach mucosa.

Pathophysiology

Normally the stomach is protected from the digestive substances it secretes, namely hydrochloric acid and pepsin, produced by the mucosal barrier. When this barrier is disrupted by an acute or chronic irritant, or when the processes that maintain the barrier are altered by disease, the gastric mucosa becomes irritated and inflamed. The mucous membrane becomes oedematous and hyperaemic (congested with fluid and blood) and undergoes superficial erosion. Lipid soluble substances such as aspirin and alcohol penetrate the gastric mucosal barrier, leading to irritation and inflammation. Bile acids also break down the lipids in the mucosal barrier, increasing the potential for irritation.

In addition, aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs) inhibit prostaglandins. Prostaglandins stimulate the production of bicarbonate, which neutralizes hydrochloric acid and increases the thickness of the mucosal barrier (Wollner T, 2004).

Diagnostic Tests and Procedures

1. Endoscopy
2. Stool for routine examination
3. Full blood count

4. Clinical features
5. Blood test
6. Abdominal computed tomography
7. Gastric analysis
8. Culture and sensitivity test
9. Blood for haemoglobin level
10. Medical history of client

Medical Management

Medical management is aimed at:

1. Diluting and neutralizing the offending agent.
2. Reducing and controlling secretions.
3. To protect the mucosal barrier.
4. And to subside inflammation.

The various medications that can be used include;

1. H_2 receptor antagonist; they inhibit pepsin secretion and reduces the volume of gastric secretions Examples are; Ranitidine Hydrochloride (Zantac), Cimetidine (Tagamet) 400mg bd for 4 to 6 weeks.
2. Antacids: they decrease acidity thus neutralizing acid content in the stomach. Examples include; Magnesium Trisilicate 5-15mls tds for 3-6 weeks.
3. Antibiotics and Bismuth salts; to treat Helicobacter pylori. Examples include; Bismuth subsalicylate (Pepto-Bismol); tetracycline, Amoxicillin etc.
4. Proton (Gastric Acid) Pump Inhibitor; Suppresses Helicobacter pylori bacteria in the gastric mucosa and assists with healing of mucosal lesions. It also inhibits acid secretion

by blocking the action of histamine on the histamine receptors of the parietal cells in the stomach. Examples include Omeprazole (Prilosec), Lansoprazole (Prevacid), and Rabeprazole (Aciphex).

Supportive treatment includes:

1. Nasogastric (NG) intubation.
2. Analgesic agents and sedatives, and intravenous (IV) fluids.
3. If corrosion is extensive or severe, emetics and lavage are avoided because of the danger of perforation and damage to the esophagus.
4. Alcohol intake is avoided as well as irritating diet, promoting rest, reducing stress.

Nursing Management

Rest and Sedation: Both physical and mental rests are necessary for the healing of a gastritis. If there are domestic problems, then a change in environment may be indicated possibly hospitalization for a week or two. This may take the combined effort of a physician, nurse, family and the social workers to help the patient understand the need for complete rest and to secure his cooperation in achieving it.

Dietary Management: For acute gastritis, the nurse provides physical and emotional support and helps the patient manage the symptoms, which may include nausea, vomiting, heartburn, and fatigue. The patient should take no foods or fluids by mouth-possibly for a few days-until the acute symptoms subside, thus allowing the gastric mucosa to heal. If IV therapy is necessary, the nurse monitors it regularly, along with serum electrolyte values. After the symptoms subside, the nurse can offer the patient ice chips followed by clear liquids. Introducing solid food as soon as possible will provide oral nutrition, decrease the need for IV therapy, and minimize irritation to

the gastric mucosa. As food is introduced, the nurse evaluates and reports any symptoms that suggest a repeat episode of gastritis.

Stress reduction: Patient may need help in identifying situations that are stressful or exhausting. The patient may also benefit from suggestions about regular rest period during the day at least during the acute phase of the disease.

Patient must participate in recreational activities and hobbies that promote relaxations and must avoid factors found to increase symptoms if possible.

Smoking and Alcohol: Smoking and alcohol should be avoided as they stimulate acid secretions. Smoking decreases the secretion of bicarbonate from the pancreas into the duodenum. Therefore, the acidity in the duodenum is higher when one smokes, thus smoking having an anti-healing effect.

Relieving Pain: Measures to help relieve pain includes; instructing the patient to avoid foods and beverages that may be irritating to the gastric mucosa and instructing the patient about the correct use of medications to relieve chronic gastritis. The nurse must regularly assess the patient's level of pain and the extent of comfort achieved through the use of medications and avoidance of irritating substances.

Observation*:* Monitor patient's vital signs (temperature, pulse, respiration and blood pressure) to ascertain the progress of the condition. Deviations are noted and proper
actions taken to mitigate or overcome them. Monitor intake and output daily and balance the chart after 24 hours to obtain an index of fluid balance. Weigh patient daily especially in the morning to obtain improvement in weight. Monitor patient for therapeutic and adverse effects of medication.

Elimination*:* Measure amount of urine and vomitus and chart. Maintain correct input and output

chart by measuring all fluids given orally and parentally as well as the output. Monitor bowel sound before encouraging oral intake of food.

Psychological care: Reassure patient and family that the condition can be managed and that the competent staff will do their best to ensure recovery. Introduce other patients, who are recovering from the same condition to the client. Allow client to express his or her anxiety.

Pain: Assess the location and level of pain using the pain rating scale and help minimize pain by engaging patient in divisional therapy such as watching of TV. Administer prescribed analgesics such as paracetamol. Patient should be encouraged to avoid
irritating agents.

Hygiene: Patient is assisted to carry out personal hygiene such as bathing, mouth care, care of the hair and nails. Client's bed dressings and clothing should be kept clean and neat.

Promoting Home and Community-Based Care

Teaching Patients Self-Care

The nurse evaluates the patient's knowledge about gastritis and develops an individualized teaching plan that includes information about stress management, diet, and medications. Dietary instructions take into account the patient's daily caloric needs, food preferences, and pattern of eating. The nurse and patient review foods and other substances to be avoided (e.g., spicy, irritating, or highly seasoned foods; caffeine; nicotine; alcohol). Consultation with a dietician may be recommended.

Surgical Treatment

1. **Pyloroplasty:** is a drainage operation in which a longitudinal incision is made into the pylorus and transverse sutured closed to enlarge the outlet and relax the muscle.
2. **Gastrectomy:** it involves removal of a portion of the stomach, most commonly the distal half or two thirds of the stomach resected.
3. **Antrectomy:** (a type of Gastrostomy). It involves removal of that portion of the stomach containing gastrin secreting cells.

The remaining portion of the stomach is anastomosed either to the duodenum (Billroth I) or jejunum (Billroth II). Usually some combination of these procedures is performed.

Health Education/Preventive Measures

1. Educate patient on good food hygiene by covering food and protecting it from contamination.
2. Discourage prolong use of certain drugs like aspirin, NSAIDs etc which cause inflammation of the stomach lining.
3. Educate patient also on good eating habits. The type of food eaten is important as well as the manner in which it is eaten. Patient should eat moderate proportions at regular intervals.
4. Educate patient on the dangers associate with excessive intake of alcohol, food containing caffeine example, kola and tobacco products example, and cigarette.
5. Teach patient how to cope with stress since stress can precipitate the onset of the condition. Encourage patient to play indoor games at his or her leisure time.
6. Encourage enough body exercise as exercise makes healthy and fit.
7. Teach patient to avoid foods that do not digest easily such as fried foods. Also spicy food must be avoided but rather encourage balanced diet.

8. On discharge, patient should be educated on the need for review and how to continue medication in the house. He/she should be told to report back earlier before review date in case of any of illness.
9. Educate patient on the causes, signs and symptoms as well as the complications of gastritis.

Complications

1. Peptic ulcers
2. Gastric cancer
3. Hemorrhage
4. Perforation
5. Malignancy

1.11 Validation of Data

Validation of data is defined as the process of establishing the truth or logical cogency of something. (American Association, 2020). The study covers detail information about Madam M.K., her family and the disease condition.

Madam M.K.'s subjective data was taken from her and her relatives. The objective data about Madam M.K. was obtained from observations, from the doctor's case histories about her disease conditions and from her. Various textbooks were used to compile the literature review about her disease condition. The home visit I embarked in and the the interaction I had with other family of the patient confirmed the information given to me by my patient.

With reference to the data collected from Madam M.K, literature review and all sources of information, the data is found to be accurate and relevant. For example, clinical features are similar to that of the literature review. This data is therefore considered valid.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis is the second stage of the nursing process and it deals with comparison of data with standard to identify patient/family strengths, actual and potential problems. The chapter includes;

1. Comparison of data with standard.
2. Health problems
3. Patient/family strength
4. Nursing diagnosis

2.1 Comparison of Data with Standard

This will cover:

1. Diagnostic investigations/tests
2. Causes of the disease
3. Clinical features
4. Treatment
5. Complication

2.2 Diagnostic Investigations/Tests

Investigation refers to procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatment. The following investigations were carried out:

1.Blood sample for Malaria Parasites (MPs)

2.Blood for Full Blood Count

3. Endoscopy of the stomach

Table 1: Comparison of diagnostic measures of Madam M.K to the literature review

Diagnostic Measures in the Literature Review	**Diagnostic Measures conducted on Madam M.K**
Endoscopy.	Endoscopy was conducted on the patient.
Stool analysis.	Stool analysis was not conducted on the patient.
Gastric analysis	Gastric analysis was not conducted on the patient.
Full blood count	Full blood count was conducted on the patient.
Computed tomography scan of the stomach	Computed tomography scan of the stomach was not conducted on the patient.
Physical examination	Physical examination was conducted on the patient.
Culture and sensitivity test	Culture and sensitivity test was not conducted on the patient.

Based on the diagnostic measures conducted on Madam M.K., as compared to the literature review, three diagnostic measures were conducted on her, which shows that, she has the condition gastritis.

TABLE 2.0: Diagnostic Investigations carried out on Madam M.K

Date	Specimen	Investigations	Results	Normal Values	Interpretations	Remarks
26/11/22	Blood	Hemoglobin level estimation.	9.8g/dl	Female 11-16g/dl Male 12-18g/dl	Patient was anemic.	Patient was encouraged to take more iron rich foods.
26/11/22	Blood	Red blood cells count.	4.32 units	2.5-5.5 units	Patient was not anemic.	No treatment was given.
26/11/22	Blood	White blood cell count.	5.21 g/dl	4.0-12g/dl	There was no infection.	No treatment given.
26/11/20	Blood	Malaria parasites (MPs)	No malaria parasites seen	No malaria parasites should be found in blood.	Patient does not have malaria.	No treatment given.
26/11/22	GIT	Endoscopy	Gastric ulcer 2^{nd} H. Pylori infection R/O malignancy.	Ulceration should not be present.	Gastric ulcer present.	IV omeprazole and IV Buscopan was given.

2.3 Cause of Patient's Condition

In considering the causes of gastritis stated in the literature review as well as laboratory and personal investigations carried out, Madam M.K's condition could be due to excessive gastric secretions in stress situation at home and long-term use of NSAIDS as she had stated earlier that she normally buys over the counter medications to relieve her of bodily pains, headaches etc.

Table 3: Clinical Manifestations of Client Compared to Literature Review:

CLINICAL FEATURES IN LITERATURE	CLINICAL FEATURES PRESENTED BY PATIENT
1.Abdominal bloating	Abdominal bloating was not exhibited by patient
2.Abdominal pain	Patient has severe abdominal pain
3. Nausea	Patient was feeling nauseated
4. Loss of weight	Patient did not lose weight
5. Anorexia	Patient did not experience anorexia
6.Vomiting	Patient had vomited
7. Dehydration	Patient was not dehydrated
8. Diarrhea	Patient had no diarrhoea
9. Hiccups	Patient did not experience any hiccups
10. Belching	Patient experienced episodes of belching
11. Fever	Patient had no fever
12.Weakness	Patient experienced body weakness
13. Heartburns	Patient experienced heart burns
14. Bloody, coffee, dark stool	Patient do not have bloody, coffee, dark stool

The above comparison indicates that patient was truly having gastritis since she exhibited some of the key signs and symptoms in the literature review.

2.4. Specific Medical Treatment

The following drugs were used in the treatment of the condition:

1. Intravenous Buscopan 40mg stat
2. Intravenous Omeprazole 80mg stat then 40mg bd x 48 hours
3. Intravenous Paracetamol 1g tds x 24 hours
4. Infusion Dextrose Normal Saline 1L for 24 hours
5. Infusion Normal Saline 1L for 24 hours

Table 1: Treatment Given to Patient as Compared with Literature Review

Treatment as in literature review	**Treatment given to patient**
Analgesics	IV Paracetamol 1g tds x 1 day
Antimuscarinic	I.M Buscopan 40mg stat
Intravenous infusions	The following intravenous infusions were given: i. IV Normal Saline 1L x 24 hours ii. IV DNS 1L x 24 hours
Antacids	IV Omeprazole was given
Antiemetics	None was given

From the above table, comparison of drugs in the literature review with drugs given to patient, the treatments given to patient were in line with the literature.

TABLE 5: PHARMACOLOGY OF DRUGS ADMINISTERED

DATE	DRUGS	DOSAGE / ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE / ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED ACTION	ACTUAL ACTION OBSERVED	SIDE EFFECTS / REMARKS
26/11/22	Buscopan	20mg, then 20mg after 30minutes, maximum 100mg per day. Route oral, intravenous and intramuscular.	40mg, stat Intravenously	Antimuscarinic	To reduce smooth muscle spasms of the stomach.	Patient said stomach muscle spasms had stopped	Dry mouth, dilation of pupils, flushing, constipation None was present in my client
26/11/22	Dextrose Normal Saline	Amount depends on hydration status of patient. Route, intravenous.	1 litre x 24hours Intravenously	Isotonic fluid and electrolyte solution	To restore fluid and electrolyte balance	Patient maintained fluid and electrolyte balance	Circulatory over load when given in large doses. Was not present in my client
26/11/22	Normal saline	Amount depends on patient fluids and electrolytes level. Route,	1 litre tid x 24 hours Intravenously	Isotonic fluid and electrolyte solution	To restore fluid and electrolyte balance	Patient maintained fluid and electrolyte	Circulatory overload when given in large doses. None

		intravenous				balance	was present in my client
26/11/22	Paracetamol	0.15-1g every 4-6hrs; maximum. 4g per day. Route, oral, rectal and intravenous.	1g tid x 24 hours Intravenously, orally	Analgesic /Antipyretic	To relieve pain and fever	Patient headache was relieved	Vomiting, nausea, and anorexia. None was observed in my client
26/11/22	Omeprazole	40mg every 12hrs; maximum.120mg daily. Route IV, oral.	40mg bd x 4 days Orally	Proton Pump Inhibitor	To inhibit the secretion of hydrochloric acid	Patient was relieved of abdominal discomfort	Vomiting, diarrhea, osteomalacia, muscle cramps. None was observed in my client.

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2.5 Complications

With reference to the complications listed in the literature review such as Peptic ulcers, Gastric cancer, Hemorrhage, Perforation, Malignancy, Madam M.K exhibited no complications throughout the period of hospitalization which resulted in her early recovery. Patient did not develop any complications because of the early seeking of medical help and prompt treatment given to her throughout her period of hospitalization.

2.6 Patient / Family Strengths

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

1. Patient could verbalize the exact location of pain.
2. Patient could verbalize the colour and frequency of vomiting.
3. Patient could perform daily activities if supported.
4. Patient could walk around her bed.
5. Patient could verbalize the level of anxiety.
6. Patient is willing to know more about the disease condition.

2.7 Patient's Health Problems

A health problem is when an individual does not meet a certain psychological, social and physiological standard and which can be detrimental and can cause negative reactions to health, hence, requires both nursing and medical attention.

To give effective nursing care, health problems must be identified through observation and interactions. From the data collected during assessment, the following health problems were noticed on patient:

1. (26/11/22) Patient complained of severe abdominal pains.
2. (26/11/22) Patient had episodes of nausea and vomiting.
3. (26/11/22) Patient complained of general body weakness.
4. (26/11/22) Patient complained of dizziness.
5. (26/11/22) Patient was anxious.
6. (26/11/22) Patient had little knowledge on disease condition.

2.4 Nursing Diagnosis

According to NANDA International, nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group, or community.

1. Acute pain (abdominal) related to the inflammatory process in the gastric mucosa.
2. Risk for fluid volume deficit related to nausea and vomiting.
3. Activity intolerance related to general bodily weakness.
4. Risk for fall related to dizziness.
5. Anxiety related to unknown outcome of disease and its management.
6. Knowledge deficit (partial) related to causes, signs, symptoms, diagnosis, treatment and preventive measures on gastritis.

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is the third phase in the nursing process. Plans for implementation are based on assessing and diagnosis of the Patient health status, strength and concerns. After nursing diagnosis is validated, they provide direction for determining how to assist the restoration, maintenance and promotion of health. Planning involves systematically assessing and identifying a Patient problem setting objectives, establishing interventions and evaluating results. The nursing care plan facilitates achievement of the Patient goals. It communicates clearly the nature of the Patient problem and specifies the nursing and medical interventions necessary for the Patient's

3.1 **Objective/ Outcome Criteria**

This refers to expected outcome of the nursing diagnosis and should be specific, measurable, accurate, and realistic and time bound. The following were the objectives/outcome criteria set based on the nursing diagnosis formulated:

1. Patient would be relieved of abdominal pain within 24 hours as evidenced by:

a. Patient reporting relief of abdominal pains.

b. The nurse observing patient being calm in bed.

2. Patient would maintain a normal fluid volume within 48 hours as evidenced by;

a. Patient verbalizing that nausea and vomiting has stopped.

b. Nurse's assessment revealing that patient has a normal skin turgor, urine specific gravity within normal range, stable weight and moist mucous membrane.

3. Patient would regain strength for her daily activities within 48 hours as evidenced by

a. Patient participating in activity within tolerance.

b. Nurse observing patient walking around.

4. Patient would be free from falling within 24 hours as evidenced by;

a. Patient not experiencing any injury within 24hours of hospitalization.

b. Nurse observing patient walking with normal gait.

5. Patient and family will be relieved of anxiety within 12 hours as evidenced by;

a. Patient and family verbalizing that they are relieved of anxiety.

b. Nurse observing patient having a relaxed facial expression.

6. Patient/family will have basic understanding of gastritis within 12hours as evidenced by:

a. Patient testifying that she now has adequate knowledge on gastritis.

b. Nurse observing patient/family repeating some of the predisposing factors and signs and symptoms she has taught them.

Table 6: Patient/Family care plan

Date / Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
26/11/22 at 01:30pm	Acute pain (abdominal) related to inflammatory process in the gastric mucosa.	Patient would be relieved of abdominal pain within 24 hours as evidence by: 1. Patient reporting relief of abdominal pains. 2. The nurse observing patient being calm in bed.	1. Explain to patient/family the reasons for the pain and the available management. 2. Provide diversional therapy such as watching television and conversing with her. 3. Review factors that aggravate or alleviate pain. 4. Provide adequate rest. 5. Instruct patient to perform deep breathing exercise. 6. Administer prescribed analgesic and antispasmodic.	1. Patient / family were told the pain is as a result of inflammatory process in the stomach and the drugs given will relieve the pain. 2. Patient was allowed to watch television news and I conversed with her about her children. 3. Factors such as coughing which aggravates pain and change of position which alleviate pain were reviewed. 4. Patient was provided with a comfortable bed free of creases and crumbs to ensure adequate rest. 5. Patient was instructed to take in a deep breath (deep inspiration and expiration) if pain occur. 6. IM Buscopan 40mg stat and IV Paracetamol 1g tid were administered.	27/11/22 at 01:30pm	Goal was fully met as Patient reported relieved of abdominal pains and nurse observing patient to be calm in bed.	

Patient/Family care plan cont'd

Date & Time	Nursing Diagnosis	Objectives/Outcome Criteria	Nursing Orders	Nursing Interventions	Date &Time	Evaluation	Sign
26/11/22 at 01:35pm	Risk for fluid volume deficit related to nausea and vomiting.	Patient would maintain a normal fluid volume within 48hours as evidenced by; 1. Patient verbalizing that vomiting has stopped. 2. Nurse's assessment revealing that patient has a normal skin turgor, urine specific gravity within normal range, stable weight and moist mucous membrane.	1. Reassure patient of competent care and support. 2. Monitor and maintain intake and output chart. 3. Encourage patient to take liberal fluids which she can tolerate. 4. Assess for signs of dehydration such as decreased skin turgor, dry mucous membrane, thirst. 5.Monitor vital signs 6. Serve prescribed drugs and IV fluids e.g. Normal saline Ringers Lactate as ordered.	1. Patient was reassured of competent care and support. 2. Intake and output was monitored. 3. Patient was encouraged to take in liberal fluids. 4. Signs of dehydration were assessed. 5. Vital signs were monitored and recorded. 6. Infusion ringer's lactate and normal saline were administered.	28/11/22 at 01:35pm	Goal was met as evidence by the nurse's assessment revealing that patient has a normal skin turgor, urine specific gravity within normal range, stable weight and moist mucous membrane.	

Patient/Family care plan cont'd

Date and Time	Nursing Diagnosis	Objective/Out come Criteria	Nursing Orders	Nursing Interventions	Date and Time	Evaluation	Sign
26/11/22 at 01:42pm	Activity intolerance related to general bodily weakness	Patient would regain strength for her daily activities within 48 hours as evidenced by; a. Patient participating in activities within tolerance. b. Nurse observing patient walking around.	1. Reassure Patient that measures would be put in place to help regain strength. 2. Identify factors contributing to activity intolerance. 3. Arrange items of daily use within Patient reach. 4. Encourage Patient to participate in activities within limits and adequate sleep.	1. Patient was reassured that measures will be taken to help her regain strength for her normal activities. 2. Factors contributing to Patient's fatigue such as, low level of blood volume, lack of sleep, stress etc. 3. Items of daily use like comb, cup, brush and other were arranged within Patient reach. 4. Patient was encouraged to perform activity within tolerance like brushing of teeth, combing of hair and to rest whenever tired. 5. Patient was engaged in a 5meters walk with assistance.	28/11/22 at 01:42pm	Goal fully met as Patient participating in activities within tolerance and nurse observing patient walking around.	

			5. Engage patient in a passive exercise.				

Patient/Family care plan cont'd

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Interventions	Date /Time	Evaluation	Sign
26/11/22 at 02:10pm	Risk for fall related to dizziness.	Patient would be free from falling within 24 hours of hospitalization as evidenced by a. patient not experiencing any injury within 24 hours of hospitalization. **b.** nurse observing patient walking with normal gait.	1. Reassure patient of being in safe and competent hands. 2. Orientate patient to the ward frequently. 3. Encourage patient to rest. 4. Nurse patient on a bedside rail. 5. Ensure appropriate lightening system.	1. Patient was reassured of being in safe hands of doctors and nurses. 2. Patient was orientated. 3. A comfortable and wrinkle free bed was provided for my patient to ensure rest. 4. Bed side rails were provided to prevent patient from falling. 5. Adequate lights were provided in patient's room.	27/11/22 at 02:10pm	Goal was fully met, as patient did not experience any injury.	

			6.Clean all spillages on the floor.	6. All spillages on the floor were cleaned and dried.			

Patient/Family care plan cont'd

Date & Time	Nursing Diagnosis	Objectives / Outcome Criteria	Nursing Orders	Nursing Interventions	Date &Time	Evaluation	Sign
27/11/22 at 07:05am	Anxiety related to unknown outcome of disease condition (gastritis)	Patient and family would be relieved of anxiety within 12 hours as evidenced by: 1. Patient / family verbalizing that, she is no more anxious. 2. Nurse observing Patient relating cordially with care providers with cheerful facial expressing	1. Reassure patient and family that there is treatment for their daughter's condition. 2. Explain the importance of hospitalization to client and family. 3. Introduce client to other clients who have undergone similar treatment. 4. Engage patient's family in diversional therapy to allay anxiety.	1. Patient and relatives were reassured. 2. The importance of hospitalization was explained to them. 3. Patient was introduced to other clients who have gone through similar treatment. 4. Patient was engaged in diversional therapy like watching television to allay anxiety.	27/11/22 at 07:05pm	Goal fully met as evidenced by patient and family verbalizing they are relieved of anxiety and relating well with care providers.	

			5. Allow patient and family to ask questions bothering them and provide answers tactfully.	5. Patient and family were given the opportunity to ask questions bothering them.			

Patient/Family care plan cont'd

Date/Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Interventions	Date and Time	Evaluation	Sign
27/11/22 at 07:30am	Knowledge deficit (partial) related to causes, signs, symptoms, diagnosis, treatment and preventive measures.	Patient and family will gain adequate knowledge on the causes, signs and symptoms, of the disease condition within 12 hours as evidenced by; 1. Patient not attributing the cause of the disease condition to any spiritual force. 2. Nurse observing patient/family repeating some of the	1. Reassure patient and family that the health team will help them to know much about disease condition. 2.Create a conducive environment to enhance learning. 3.Educate patient and family on the disease condition. 4. Allow them to ask questions and clarify	1. Patient and family were reassured of support of the health team. 2.. Patient and family were warmly welcomed, offered with seat, made comfortable. 3.Thorough education was done on the disease condition. 4. Patient and family were given the opportunity to	27/11/22 at 07:30pm	Goal was fully met as patient and family could mention the causes, signs and symptoms, management and preventive measures of the disease condition.	

		predisposing factors and signs and symptoms she has taught them.	their doubt and misconception	ask questions to clear their minds			

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction.

This chapter deals with the detailed nursing care rendered to the patient and his family from the day of admission until discharge based on the health problems identified. It also entails the home visits and follow ups to ensure continuity of care.

4.1 Summary of the actual nursing care

It involves the summary of the nursing care rendered to the patient from day of admission which was 26th November,2022 to day of discharge on (29th November,2022.) The management aimed at alleviating patient's abdominal pain and presenting symptoms. For the purpose of organization, the actual nursing care rendered to madam M.K and family has been discussed on daily basis.

First Day of Admission (26/11/2022)

On the 26th November, 2022 at 1pm, Madam M.K. with her daughter arrived at the Presbyterian Hospital, Dormaa, Females' ward accompanied by her daughter through the O.P.D with the diagnosis of Chronic Gastritis. She complained of severe abdominal pain, nausea and body weakness. Patient was weak but fully conscious. Patient and daughter were warmly received and given seats, patient's hospital card was collected, entered into the ward computer and quickly read through her notes. She was admitted into a bed with side rails to protect her from injury since she was restless due to pain. She was reassured that she would be fine in the shortest possible time.

The necessary documents were collected from the accompanying nurse. Her particulars such as name, sex, age, residential address and religion were cross –checked and entered into the

admission and discharge book and the daily ward state. Her vital signs that is temperature, pulse, respiration and blood pressure were checked and recorded as shown in the appendix.

An IV cannula tray was set and the Nurse-In-Charge was assisted to secure IV line and take blood samples which were labelled and taken to laboratory.

Madam M.K's daughter was then reassured that measures were being put in place to bring the condition under control. Her daughter was asked to bring items like plate, cup, cutlery, bucket, soaps, sponge, towel and other items which patient would need during her hospitalization. She was registered on the national health insurance scheme. It was however explained to her that some of the drugs and the laboratory tests may be non–insured which she would pay for before discharged.

At 1:30pm, assessment revealed that patient was in pain. A nursing diagnosis of Acute pain (abdominal) related to the inflammatory process in the gastric mucosa was made. An objective was set to help relieve patient from abdominal pain within 24 hours. The following interventions were implemented; Patient and family were told the pain was as a result of inflammatory process in the stomach and the drugs given would help relieve the pain. Patient was allowed to watch television news and I conversed with her about her children to divert her attention from the pain. Factors such as coughing which aggravates pain and change of position which alleviate pain were reviewed. Patient was provided with a comfortable bed free of creases and cramps to ensure adequate rest. Patient was instructed to take in a deep breath (deep inspiration and expiration) if pain occurs to relieve her of the pain. Prescribed injection buscopan and Paracetamol were administered to help relieve the abdominal pain.

At 01:35pm patient complained of vomiting hence a nursing diagnosis of Risk for fluid volume deficit related to nausea and vomiting was formulated. An objective was set to help patient maintain a normal fluid volume within 48 hours. The following nursing interventions were then implemented; Patient was reassured of competent care and support of the medical team. Intake and output of fluid was monitored to assess rate of hydration and renal function. Patient was encouraged to take liberal fluids. Signs of dehydration were assessed. Vital signs were monitored and recorded as shown in the appendix. Prescribed drugs and IV fluids were administered and charted.

At 1:42pm assessment revealed that patient was weak. a nursing diagnosis of activity intolerance related to general bodily weakness was formulated. An objective was set to help patient regain strength for her daily activities within 48 hours. The following interventions were implemented to improve on patient's strength. Factors contributing to patient fatigue in patient's activity intolerance like low level of blood volume were identified. Items of daily use like comb, cup, brush and others were arranged within patient's reach. Patient was encouraged to perform activity within tolerance like brushing of teeth, combing of hair and to rest whenever tired. Patient was engaged in a 5 meters walk with assistance.

At 2:10pm, madam M.K complained of dizziness, therefore a nursing diagnosis of risk for fall related to dizziness was formulated. The following interventions were implemented to help prevent from falling; patient was reassured of being in safe hands of doctors and nurses. Patient was oriented, a comfortable and wrinkled free bed was provided for patient to rest, the bed side rails were raised, adequate lighting was provided for patient and all spillages were cleaned and dried.

Second Day of Admission (27/11/2022)

At 6:25am when I arrived at the ward, my patient was already awake and well. Routine nursing care such as assisting in bath in the bathroom, care of mouth by observing her while doing it, bed making and serving of breakfast were done and documented in the nurses note. Prescribed drugs were administered and documented in the nurse's note for continuity of care. Patient's vital signs were checked and recorded as indicated in the appendix.

Her breakfast which was porridge made with millet and a slice of bread was served but she could not eat it because she was anxious.

Patient showed signs of apprehension on admission, my interaction revealed that she was anxious hence a nursing diagnosis of Anxiety related to unknown outcome of disease condition (Gastritis) was formulated at 07:05am. An objective was set to help relieve patient from anxiety within 12hours. The following interventions were implemented; Patient and relatives were reassured that there is treatment for patient's condition. The importance of hospitalization was explained to them. Patient was introduced to other clients who have gone through similar treatment. Patient was engaged in diversional therapy like watching television to allay anxiety. Patient and family were given the opportunity to ask questions bothering them for tactful answers.

During the doctor's review, it was realized that patient has knowledge deficit (partial) related to causes, signs, symptoms, diagnosis, treatment and preventive measures of gastritis. An objective was set that patient and family will have adequate knowledge about the causes, signs and symptoms of the disease condition (gastritis) within 12hours. The following interventions were carried out to enable them gain adequate knowledge: patient and family were reassured of

support of the health care team, patient and family were warmly welcomed, offered seats and made comfortable. Thorough education was done on the disease condition. Patient and her family were given the opportunity to ask questions to clear their minds.
On 27/11/22 at 01:30pm, an evaluation of the set objective on 26/11/22 at 01:30pm to relieve patient of abdominal pain within 24 hours was done and goal was fully met as Patient reported relieve of abdominal pains and nurse observing patient to be calm in bed.

At 2:00pm patient's medications were administered and vital signs were checked and recorded as well as observing the therapeutic effect of the drugs. At 6:00pm and 10pm, the routine vital signs were checked as recorded in the appendix and due medications were administered.
At 01:42pm, the objective set on 26/11/2022 to enable patient regain her strength for her daily activities within 48 hours were fully met as patient participated in activities within tolerance and nurse observed patient walk around.

On 27/11/22 at 02:10pm, an evaluation of the set objective on 26/11/22 at 02:10pm to relieve patient of dizziness within 24 hours was done and goal was fully met as patient did not experience any injury.
On 27/11/22 at 07:05pm, another evaluation of an objective set on 27/11/22 at 07:05am to relieve patient of anxiety within 12 hours was done and goal was fully met as patient and family verbalizing they are relieved of anxiety and relating with care providers.
On 27/11/22 at 07:30pm, an evaluation of the objective set on 27/11/22 at 07:30am to help patient gain adequate knowledge on disease condition was done and goal was fully met as patient and family could mention the causes, signs and symptoms, management and preventive measures of gastritis.

All procedures and findings were documented in the nurses' notes. Patient slept around 10:30pm.

Third Day of Admission (28/11/22)

Patient woke up at 5: 30am, she emptied her bowel and maintained her personal hygiene that is brushing her teeth and taking her bath before the vital signs were checked and due medications were administered at 6:00am. Her vital signs were as indicated in the appendix.

Her bed linen and clothes were changed to make her comfortable. She was served with porridge and bread in the morning as her breakfast after which her medications were administered and documented in the nurse's note. Her 10am and 2pm vitals were checked as recorded in the appendix and her due medications were administered and recorded in the nurses' notes. I gave patient and her relatives a prior notice that I would want to go and see their place of residence and permission was granted after which they gave me directions to their house.

At 6:00pm, the routine vital signs were checked and due medications administered.

All procedures and findings were recorded in the nurses' continuation sheet. Patient slept around 10:30pm after her vitals had been checked as indicated in the appendix. Her 10pm medications were administered and documented in the nurses' note.

Fourth Day of Admission (Day of Discharge) (29/11/22)

Patient woke up at 5:30am and observed her personal hygiene. At 6am, her vital signs were checked and recorded as indicated in the appendix and her prescribed medications were administered.

During doctor's rounds at exactly 09:45am, patient did not make any complaints and upon observation and assessment, she was discharged by the Dr. S at 10:00am. Patient was informed

to continue her treatment regimen at home with the following prescribed medications; Nugel O 15mls tds x 7, Capsule Omeprazole bd x7 and Capsule Clindamycin tds x 7. Patient and relatives were educated on her disease condition, its causes, signs and symptoms, and management. I also educated them to seek immediate medical treatment in case of any abnormality and she was encouraged to continue and complete her prescribed medications. All her bills which were not covered by NHIA were fully settled. I also educated her to avoid over-the- counter drugs, take a nutritious and well-balanced diet, avoid spicy diet, and renew her National Health Insurance card before it expires and the importance of review and follow-ups. I informed patient and relatives on the review date which was on the 06/12/22. Her date of discharge was documented in the admission and discharge book and the ward state. I also explained to the patient and the relatives on the medications, its side effects and its administration. I also gave them the opportunity to ask questions to clarify any doubt. I assisted in packing her belongings, disinfected patient's bed and locker to enhance infection prevention. Patient thanked the staff present and other patients at the ward. I escorted them to the hospital entrance where they boarded a taxi and set off.

Preparation of Patient/ Family for Discharged and Rehabilitation

Preparation of a patient and family for discharge and rehabilitation is necessary and important in comprehensive nursing care to ensure an adequate self-care at home. This was started from the day of admission and was intensified on the third day when she looked strong and cheerful as most of her symptoms were no longer felt and she was reassured. The patient was informed that staying in the hospital was for a temporal period of time.

Madam M.K and her family were educated on her condition, with regards to the predisposing factors, sign and symptoms, drug used for management, lifestyle modifications and

complications. Patient and family were encouraged to take in foods rich in the essential food nutrients like protein and avoid saturated fats.

Patient and family were educated to avoid or reduce the intake of alcohol since it interferes with the utilization of essential nutrients like vitamin B12. They were also advised to eat adequate balanced diet, not to eat very late in the night to prevent indigestion and to avoid sleeping right after eating. Emphasis was also made on the need to eat more fruits, avoid smoking and avoid irritating diets such as spicy foods, pepper etc.

Patient and family were also educated on the need to maintain personal and environmental hygiene. They were then advised to use insecticide treated nets to prevent malaria. The patient was advised to continue the medication or treatment regimen at home as prescribed to prevent relapse of the disease condition. The side effects of the drugs were explained to her. She was informed to come for review on the 6th December, 2022.

Finally, in order to ensure continuity of care and to establish rehabilitation, she was informed of subsequent home visits, and encouraged her to visit the hospital any time aside the review date, when she is not feeling well. She was discharged on the 29th November, 2022 and left the ward on the same day. Her name was entered into the admission and discharge book.

Patient was assisted in carrying her luggage. They were accompanied to the entrance of the hospital where they boarded a taxi. I bade them farewell when the car set off. They left the entrance around 10:30am on the day of discharge.

Follow Up/Home Visit/ Continuity of Care

Follow up or home visit is a friendly but purposeful visit to the patient with the aim of preventing disease, promoting and maintaining health and prolonging life through health education,

counselling, nursing etc. The visit is also to assess the use of available resources at home as well as in the community that can be used to solve actual and potential health problems. It also helps to monitor patient's progress after discharge.

First Home Visit (28/11/22)

I made my first home visit on the 28th of November 2022 while my patient was still on admission. The purpose of this visit was to know my patient's residence at kofibadukrom and the environment in which she lives, verify the information given to me as well as to see if there is any problem in the house that could serve as a precipitating factor for patient's condition and also enable me to know the nearest health facility for possible referral and validation of patient data. I left the hospital at 2pm and reached kofibadukrom where patient lives around 3pm. The relative warmly welcomed me and I introduced myself once again and told them of my mission. I noticed that, she was staying in a family house with her children and grandchildren. Their environment was neatly swept. The house was a five single bedrooms and a hall which was built with burnt bricks and painted in yellow and black and roofed with aluminum sheet. It was fenced with aluminium sheets with a wooden gate serving as a passage. Ventilation was very good since each room in the house had windows. There was a bathroom which was neatly scrubbed. The toilet was a pit latrine and had a well -covered waste bin for disposing their used wipes. Their household refuse was kept in a plastic waste bin and was being informed that their waste is being disposed in a big container provided by the Zoomlion company which was not too far from their house. The compound was neatly swept and there was a tree planted in the middle of the compound which provided them with fresh air. I found out on the first home visit that patient's house was close to kofibadukrom health centre. I took the opportunity to introduce myself to a

community nurse at the facility and told her about handing my patient over to her. He agreed to my request. I also encouraged her children to continue assisting her in all her activities after discharge. I made it clear to them that I would visit them frequently even when patient is being discharged home. I therefore sought permission to leave after sitting for a while.

Second Home Visit (04/12/22)

The second visit was made on the 4th December, 2022. I made this visit to find out how patient was doing and to see if she was following her treatment regimen and also to remind the patient the review date which was 6th December, 2022. I was warmly welcomed by patient and her children. Madam M.K was well and was enjoying her leisure by watching television with her children. Patient explained that there was marked improvement in her condition since she was adhering to the drug regimen, diet and lifestyle modification. Patient and family were able to give positive feedback on all education given during the period of admission. Patient and family were further educated on enough rest and sleep and the need for good dietary habit. I informed and explained to the patient and relatives that she would be handed over to the Community Health Nurse of their community on my next visit which would be my last visit or if the need arose for continuity of care. After staying for a while, I later asked for permission to leave which was granted to me. I left patient's residence around 4pm.

Review Day (6th December, 2022)

Madam M.K came to the Hospital with her daughter for review on the 6th December 2022. On their arrival, I went with them to go and verify her hospital identification number on her card from the medical records department. Upon my interaction with patient, her vital signs were

checked and recorded as follows: Temperature: 36.3ºC, Respiration: 20cpm and the Pulse: 82bpm and BP 110/80mmHg. I observed that her condition had really improved. Patient and her daughter were escorted to consulting room four of the out-patient department and upon assessment by the doctor, he confirmed the condition had improved. Patient had no complains. Patient was educated to adhere strictly to her medication and educated on her diet. They thanked me for my care and concern. I assured them of a third home visit and bade them goodbye.

Third Home Visit (14th December,2022)

The purpose for this visit was to hand over the care of my patient to a community Health nurse to ensure continuity of care and also terminate care. The Community Health nurse from Kofibadukrom Health Centre, Dormaa was contacted and sent to the patient's house at 10am. Madam M.K, and some other family members were introduced to the community health nurse. Explanation was made to them on the need for continuity of care and stressed on the fact that they need to cooperate with the community health nurse for effective health care. The community health nurse also assured them of her readiness to help them achieve the best health status.

Madam M.K and her relatives were reminded of the dietary restrictions and the fact that she needs to have adequate rest and avoid stress. She was also encouraged to visit the hospital frequently for check-up. The entire family commended me for the good work done and accepted to continue the care of mad. M.K at home. However, I reinforced that they should always report to the nearest health facility whenever they fall sick and should not practice self-medication. After interacting with patient and family for a while, I reemphasized on health education that had been given to them already. Since it was my last day of therapeutic relationship with client and

family, I terminated my care and thanked them for their cooperation which has made my study a success. I finally sought permission and bade them the final farewell. I boarded a taxi and came to my house around 2pm.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction.

Evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process, (Smeltzer, 2020).

This is the last phase of the nursing process. The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to my patient and family.

5.1 Statement of Evaluation.

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

1: Madam M.K was relieved of abdominal pain.

On the 26th November,2022 at 01:30pm, patient complained of abdominal pain hence a nursing diagnosis of Acute pain (abdomen) related to inflammation of the gastric mucosa was formulated for the patient. As such, an objective was set to help relieve patient from pain within 24hours. The following interventions were carried out: patient and family were told that the pain was as a result of inflammatory process in the stomach and the drugs given would relieve the pain, patient was allowed to watch television news and I conversed with her about her children. Factors such as coughing which aggravate pain and change of position which alleviate pain were reviewed, patient was provided with a comfortable bed free of creases and cramps to ensure adequate rest, patient was instructed to take in a deep breath (deep inspiration and expiration) if pain occurs. IM Buscopan 40mg stat and IV paracetamol 1g tid were administered. On 27th November, 2022 at 1 :30pm, evaluation was done and the goal was fully met as patient reported relieve of abdominal pains

2: Madam M.K was relieved of vomiting.

On the 26th November,2022 at 01:35pm Madam M.K was seen vomiting and complained of feeling nauseated. A nursing diagnosis of risk for fluid volume deficit related nausea and vomiting was formulated. An objective was set to help relieve patient from vomiting within 48 hours. The following interventions were carried out : Patient was reassured of competent care and support. Intake and output were monitored. Patient was encouraged to take liberal fluids. Signs of dehydration were assessed. Vital signs were monitored and recorded. Prescribed drugs and IV fluids were administered and documented in the nurses' note.

The objective was met fully on 28th November,2022 at 01:35pm as evidenced by; the nurse's assessment revealing that patient has a normal skin turgor, urine specific gravity within normal range, stable weight and moist mucous membrane.

3: Patient regained her normal strength for her daily activities.

26th November,2022 at 01:42pm, patient complained of been weak hence a nursing diagnosis of activity intolerance related to general bodily weakness was formulated. An objective was set to enable patient regain her strength for her daily activities within 48 hours. The following interventions were carried out : Reassuring Patient that measures are taken to help her regain strength for her normal activities. Factors contributing to Patient fatigue like low level of blood volume, stress and lack of sleep were identified. Items of daily use like comb, cup, brush and others were arranged within Patient reach. Patient was encouraged to perform activity within tolerance like brushing of teeth, combing of hair and to rest whenever tired. Patient was engaged in a five meters walk with assistance.

At 01:42pm 28/11/2022 it was indicated through evaluation that the objective set on 26/11/2022 to enable patient regain her strength for her daily activities within 48 hours was fully met.

4: Patient did not experience any injury.

Madam M.K complained of dizziness on the 26th November,202 at 2 :10pm for which a nursing diagnosis on Risk for falls related to dizziness was formulated for her. An objective was set to prevent patient from falling within 24 hours of hospitalization. Some of the interventions carried out were: She was reassured of being in safe hands of doctors and nurses, Patient was oriented, Bed side rails were provided to prevent her from falling, adequate lightening was provided in patient's room and all spillages on the floor were cleaned and dried.

On the 27th November,2022 at 02:10pm goal was fully met as patient did not experience any form of injury.

5: Madam M.K and family were relieved of anxiety.

On 27th November,2022 (second day of admission), at 07:05am Madam M.K and family were anxious related to unknown outcome of the disease. A nursing diagnosis of anxiety related to unknown outcome of disease condition(gastritis) was formulated. An objective was set to allay their anxiety within 12 hours. The following nursing interventions carried out were; Patient and relatives were reassured. The importance of hospitalization was explained to them. Patient was introduced to other clients who had gone through similar treatment. Patient was engaged in diversional therapy like watching television to allay anxiety. Patient and family were given the opportunity to ask questions bothering them.

On the 27th November,2022 at 07:05pm the goal set was fully met as Madam M.K and family verbalized that they were relieved of anxiety and related well with others.

6: Patient and family had adequate information about her condition.

On 27/11/22 at 07:30am, I realized patient has little knowledge on disease condition (gastritis) hence a nursing diagnosis of knowledge deficit (partial) related causes, signs, symptoms, diagnosis, treatment and preventive measures on gastritis was formulated and an objective was set to help patient and family gain adequate knowledge on the causes, signs, symptoms, diagnosis, treatment and preventive measures on gastritis within 12 hours. The following interventions were carried out to help patient gain adequate knowledge on gastritis: patient and family were reassured of the support of the health team. Patient and family were warmly welcomed. They were offered seats and made comfortable. Thorough education was done on the

disease condition. Patient and family were given the opportunity to ask questions to clear their minds.

This goal was fully met on 27th November, 2022 at 07:30pm as patient and family could mention the causes, signs and symptoms, management and preventive measures of gastritis.

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5.2 Amendment of Nursing/Family Care Plan for Partially Met or Unmet Outcome Criteria

With the competent nursing and medical care as well as support from other members of the health team and family. All the objectives set for Madam M.K and family were fully achieved. Therefore, there was no need for amendment of the nursing care plan.

5.3 Termination of Care

Termination of care is the official ending of care and the relationship between the patient, relatives and the nurse. Since separation can sometimes bring about anxiety and depression due to its accompanied psychological pain, the patient's family members were given a gradual psychological preparation from the day of admission to the day of discharge. They were told that hospitalization was just a temporal measure to improve patient 's condition and that she would be discharged home to continue care. When Mad. M.K was reviewed by the doctor, she was declared fit and looked healthy with no complains. During my visit to her home especially the third time, I observed that her general condition was encouraging and therefore terminated my care with her on 14th December, 2022 by finally advising her om eating balanced meals and having and having enough rest and officially handed over to a community health nurse at Kofibadukrom health center.

An expression of gratitude was shown to the entire family for their cooperation in the course of the interaction with them and promised to call and visit anytime there was a chance of which they were grateful and enthused.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation, or compendium of previously stated facts or statements. Conclusion is something that you decide when you have thought about all the information connected with the situation.

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

6.1 Summary

This is the last step of the patient and family care study, which entails the student's personal appreciation of the therapeutic relationship with the patient as well as the use of the nursing process. This is a compiled documentation of the comprehensive nursing care rendered to Madam M.K and family.

On the 26th November, 2022 at 1pm, patient was received into the females' ward from the OPD of Presbyterian Hospital, Dormaa with complains of severe abdominal pain, nausea and body weakness. Patient was diagnosed of gastritis with following laboratory investigations being carried out: full blood count, Upper Gastro intestinal Endoscopy and blood sample for Malaria test. She was being managed on intravenous Buscopan 40mg stat, intravenous Omeprazole 80mg stat then 40mg bd x 48 hours, intravenous paracetamol 1g tds x 24 hours, intravenous Dextrose Normal saline and intravenous normal saline 1 liter each for 24 hours. With the use of nursing process, the problems identified were implemented to help solve these problems and promote recovery. Mad. M.K spent four days at the ward and was discharged on 29th November,2022 Discharged when her condition had improved and was declared fit to go home with no complains. Goals were fully met during evaluation of care. Three home visits were paid to her to assess progress of her condition at home. The first home visit was on 28th November, 2022 , second home visit was on 4th December, 2022 and the third home visit was on 14th December, 2022 . she reported to the hospital for review on the 6th December, 2022. The termination of care was on 14th December,2022.

6.2 Conclusion

Generally, my study on Madam M.K has been a successful one because she recovered and regained strength in the end and resumed her normal daily activities. This write up has enabled me to put into practice the nursing process learned during my training. It has broadened my

knowledge on gastritis, especially the causes, clinical manifestation, complications and the management of Patient with this condition. The study has helped to boost my confidence and improved my communication skills. It has also helped me to understand comprehensive nursing care rendered to the Patient and family as well as developing a cordial relationship with this Patient and family to provide effective care. This study has also helped me to provide a holistic nursing care to Patient and be a useful member of the health team. The study has benefitted Patient and family to meet their health needs. I therefore recommend that patient and family case study should be maintained as a façade of the nurse trainee and fully established in the country health care delivery system to aid in the improvement of health for the country.

BIBLIOGRAPHY

1. Bare, B.G, Smeltzer, S.C [et al.]. (2016). *Brunner and Saddarth's Medical-Surgical Nursing*. (12th ed.). Philadelphia: J.B Lippincott Company.
2. Elaine, N., and Katja, H. (2019). *Human Anatomy and Physiology* (7thed.) New York:
    a. Benjamin Cummings Ltd.
3. G. Kendall, K.Y. Shiu and S.L. Johnston (2018). *Medicine and surgery textbook.* (1sted.) Blackwell Ltd.
4. Johnson –young, J. (2017). *Textbook of medical-surgical nursing*. (1sted.) Lippincott Williams and Wilkins, Philadelphia, Pa.
5. Mensah, A.E. (2019). *Pharmacology and Therapeutics*. (3rded.). Sunyani: Excel Print
6. Parry, E., and Gill, B. (2019). *Principles of Medicine in Africa. Singapore:*TeinsWa (Pte) Ltd.
7. Weller, F.B. (2018).*Bailliere's Nurses' Dictionary for Nurses and Health Workers.* (25thed.) New York: Bailliere Tindal Elsever.
8. (Bates, 2012). (Wilson.,Fickertt & Giddens,2020). (Dennis, 2013). (Cheever,2015). (Hopper,2015). (Wollner T, 2004). (American Association,2020)

APPENDIX

Date	Time	Temperature (ºC)	Pulse (Bpm)	Respiration (Cpm)	Blood pressure mmHg
26/11/22	1:00pm	36.2	100	21	129/70
	1:35pm	36.0	96	22	115/70
	6:00pm	36.1	85	20	110/80
	10:00pm	36.4	90	20	122/70
27/11/22	06:00am	36.2	66	22	119/70
	10:00am	35.8	80	20	115/76
	02:00pm	36.1	89	22	120/75
	06:00pm	36.0	92	20	105/71
	10:00pm	36.0	86	22	100/70
28/11/22	06:00am	36.4	78	20	100/80
	10:00am	36.0	96	22	120/70
	02:00pm	36.3	82	22	120/75
	06:00pm	36.2	80	22	125/70
	10:00pm	36.0	90	22	120/80
29/11/22	06:00am	36.1	85	20	115/70
	10:00am	36.2	90	22	110/80

SIGNATORIES

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Name: Fatima Aziz

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Date: 10/07/2023

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The Principal, Holy Family Nursing And Midwifery Training College, Berekum.

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