HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT AND FAMILY CARE STUDY ON UNCOMPLICATED GASTRITIS

ASARE PEPERTUAL

(4120190048)

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

AUGUST 2022

PREFACE

Health care is undergoing drastic changes globally, posing challenges to all categories of health professionals. Health seekers increasingly demand high quality, accessible and affordable health care. In line with these challenges, Nursing has to be considered alongside the work of other health care professionals. Undoubtedly however, a range of nursing services is required to respond adequately to the health needs of all patients. Rather than treating the patient as a disease entity, the nursing process enable the nurse to give a holistic care to patient with reference to their physical, psychological, physiological, social and spiritual needs of the patient. Today’s Nurse Trainee should be equipped with requisite knowledge, skills and attitude for the new challenges of their role in society. The patient/family centered care study method is an opportunity for the Nurse Trainee to translate his theories of Nursing, especially the Nursing process concept into reality, in the clinical setting. The patient/family care study is a requirement by the Nursing and Midwifery Council of Ghana for every final year nursing student to undertake in. It is a script prepared by a final year student nurse on a patient. The study is to render a scientific based holistic care on the patient till his full recovery using the nursing process. The care study offers the best chance for a final year nursing student to show his/her competency in rendering care to a patient till his full recovery. It also gives the student nurse the chance to interact and co-ordinate with other members of the health team and for the promotion of optimal health to individuals and communities at large. It also helps to raise the standard of nursing education as it ensures a comprehensive and individualized care given to patient and community as a whole. I conducted this patient and family care study because as a final year student, it is a requirement by the nursing and midwifery council of Ghana to carry out such a study in partial fulfilment for the award leniency to parties as a registered general nurse in Ghana. For confidentiality to prevail, initials of the patient/family are used instead of their identity.

ACKNOWLEDGEMENT

My first thanks go to the Lord Almighty for granting me the ability and knowledge without which the writing of this script would not have been successful. My most felt gratitude goes to my patient, Mr. D.T and his family for accepting and co-operating with me throughout my nursing care. I also thank my supervisor Mr Samuel Osafo Asare fo making this work successful and standard. My next appreciation goes to all the staff nurses at Male Medical ward Techiman Holy Family Hospital for their encouragement and contributions, Furthermore, my thanks go to my family, especially to my parents, for their support both financially and in prayer throughout this educational journey of mine. And to my fellow colleagues who contributed in diverse ways in making my study a success. God richly bless you all. Finally, to the authors and publishers of all the books I used for referencing in this study, I say God bless you in abundance. And to all the entire tutorial board of Holy Family Nursing and Midwifery Training College especially the principal of the college, Monica Nkrumah God Bless you.

INTRODUCTION

Nursing is defined as the process of assisting the individual either sick or well in the performance of those activities which contribute to health or peaceful death that he will perform unaided if he had the necessary strength, will, or knowledge and to do this in such a way as to help him gain independence as rapidly as possible according to Virginia Henderson. The patient and family care study are part of the nursing care rendered to a patient and his family which involves the interaction between the patient and health team.

Nursing care is rendered through effective use of the nursing process. This involves, assessment of the patient's health profile, analysis and nursing diagnosis, planning or rendering of the nursing care, implementing nursing care and evaluation of the care given.

Mr. D.T 18-year-old boy came to the hospital very ill. He was admitted at the male medical ward, at Techiman Holy Family Hospital on the 20th May, 2022 after been detained for about eleven (11) hours at the accident and emergency unit. His condition at the time of admission was not encouraging but later as he underwent through medical treatment and nursing management during the 5 days of nursing patient condition improved daily. Interactions between the patient, his mother and nurse began on the day of admission and ended after the 3rd home visit. Patient presented the following nursing problems abdominal pain, vomiting, general body weakness, loss of appetite and inadequate knowledge on disease condition.

A care plan was drawn and appropriate nursing orders were implemented to ensure speedy recovery of the patient. With cooperation and support from the patient and his family members and the staffs of the male medical ward, patient's health was restored. The investigation done on the patient during admission include the following Full Blood Count, abdominal CT scan, Blood Film for Malaria Parasite, physical examination and History taking.

Treatment given to patient during admission, checking of patient vital signs, patient medication was administered, patient was educated on the condition(gastritis), IV fluids were administered to prevent dehydration, patient was relived of anxiety. Some of the medication given to him on admission were Metronidazole, IV Paracetamol, IV Omeprazole, Nugel suspension, Hyoscine butylbromide (Buscopam).

On admission patient presented with abdominal pain, vomiting, general body weakness, loss of appetite and inadequate knowledge on gastritis but on the day of discharge patient was relive of all the symptom mention before he was been discharge, my interest is to learn much about the condition attracted me to choose him for my study.

The study has been divided into five chapters.

Chapter one covers the assessment of patient/family, thus it entails patient particulars, family's medical/surgical history, patient's developmental history, patient's lifestyle/hobbies, past medical/surgical history, present medical/surgical history, admission of patient, patient's concept of illness, literature review and validation of data.

Chapter two covers the analysis of data which entails; comparison of data with standards, health problems, patient's/family strengths and nursing diagnoses.

Chapter three covers planning for patient and family care and it entails; the objective and outcome criteria.

Chapter four covers the implementation of the patient/family care and it entails; summary of the actual nursing care, preparation of patient/family for discharge and rehabilitation, follow-ups/home visits/continuity of care.

Chapter five covers the evaluation of care rendered to the patient/family and it entails; statement of evaluation, amendment of nursing care plan, termination of care and finally, summary and conclusion.

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CHAPTER ONE

ASSESSMENT OF PATIENT/ FAMILY

1.0 Introduction

This is a procedural approach used in finding out problems of the patient and family in order to meet their health needs. It also gives information about the patient, his family and community characteristics. During this study, information was gathered from the patient himself, the patient's folder, patient's family members and health workers. Therefore, both subjective and objective data were used in the study. It includes the following; patient's particulars, family's medical and socio-economic history, patient's life style/hobbies, past medical history, admission of patient, and patient's concept about illness, literature review and validation of data.

1.1 Patient's Particulars

Mr. DT, 18-year-old young man is the subject of this study. He was born on the 7th January, 2003 to Mr. T.K and Madam J.D. Mr. D.T is a farmer. He is the fourth born of seven children. All his siblings are alive. He is dark in complexion, stands about 1.38 meters tall and weighs 57 kilograms.

Mr. D.T is Daagati by tribe and a Ghanaian by nationality. He hails from Wa, capital town of Upper West Region, but currently lives in Techiman in the Bono Region of Ghana. Mr. D.T speaks Twi and Dagaati.

He is also a Christian and worships with the Roman Catholic Church Techiman. Mr. D.T had his education up to JHS Two (2) due to financial problem and academically he is not very good as told by his brother. Mr. D. T is single and his next of kin is his brother, Mr. D.E

1.2 Patient Family's Medical and Socio-Economic History

According to Mr. D.T, his family has no history of chronic diseases such as Diabetes, Hypertension and Epilepsy. However, they sometimes suffer from minor ailments like malaria,

headache, and abdominal pains for which they manage with over-the-counter medicines and sometimes with herbal preparations. They seek medical treatment at the Holy Family Hospital in Techiman when the symptoms persist. He revealed that one of his relative died from complains of severe abdominal pains when he was 15 years. According to my patient he has been admitted to Holy Family Hospital before when he came with complaint of abdominal pain, vomiting and general body weakness

The main source of income to Mr. D.T and his family is from their foodstuffs they sell from their farm thus, yam, cashew and maize. The family has no known allergy. Mr. D.T has a good interpersonal relationship with his family and his religious support system is good. Patient and his family members are registered with the National Health Insurance Scheme therefore sometimes do not have problems financing with their hospital bills.

1.3 Patient's Developmental History

According to Mr. D. T's mother, she had a normal pregnancy and delivered Mr. D.T at the hospital, without any abnormalities such as club foot, hydrocephalous, spinal Bifida. Patient's mother said Mr. D.T was immunized against all the Six (6) vaccine preventable diseases, although there were minor ailments along his growth, such as common cold. He had been hospitalized during childhood. He went through the normal milestones of development and was able to sit with support when he was four months old. And at five months old the first deciduous tooth had started erupting and he could smile to himself in the mirror whenever he looked into it.

At six months, he could sit up unsupported and everything he picked went to his mouth. He enjoyed laughing so much and could recognize both parents even from a distance.

Madam J.D introduced supplementary feed to Mr. D.T after the sixth month exclusive breastfeeding. Mr. D.T was fed on porridge which was prepared from corn dough with sugar and milk.

He started crawling at the age of seven months. He started Schooling at the age of five at Goshen primary and he continue at the same school up to JHS level and he stopped schooling to join his parents in farming because he was not good academically. According Erik Erikson's Psychological theory of Development, describes the human life cycle as a series of eight egos developmental stage from birth to death. Each stage is characterized by distinct conflict, or crisis, relating to the person's physiologic maturation and to what society expects of a person at that age. Mr. D.T is in Intimacy versus Isolation stage of life. In respect to my patient age and psychological behaviour, Mr D.T falls under the intimacy versus isolation since he is Eighteen years of age. Under intimacy versus isolation stage (18 to 40 years), young adults are still eager to blend their identity with friends and explore personal relationships because they went to fit in. Those who are successful at this stage will have the ability to love and have a committed and secured relationship. Through an interaction with Mr D.T, it was made clear that he has attained intimacy because he is in an intimacy relationship with his family. He also said he will get married when the time is due.

1.4 Patient's Lifestyle and Hobbies

According to my patient, Mr. D. T, He wakes up at 5:30am and He brushes his teeth daily and takes breakfast around 6: 00 am and 7: 00am respectively. He normally does not bath before going to farm.

According to him, he takes his breakfast with his father at home whiles he takes his lunch in the farm. He takes his supper after bathing each evening around 6:00 pm. After supper each evening, he plays with the family and listens to news on radio. He empties his bowel whenever he has the urge to do so. According my patient, he smokes weed but with the advised I gave to him during his hospitalization he vowed to me he will stop smoking.

His hobbies are listening to radio especially on sports. He does walking exercises for about thirty minutes, usually after his supper each day whiles listening to news on radio. Also, during his leisure period, he plays ludo, draft and cards with his friends. He also involves himself in all communal labor within his community. He has no known allergies to any food and drugs.

1.5 Patient's Past Medical/Surgical History

According to Mr. D.T, he had been admitted to hospital before when he suffered from severe abdominal pains, vomiting and general body weakness. He further revealed that he had not undergone any surgery before neither has he received any blood transfusion. He had no injury and physical disabilities.

1.6 Patient's Present Medical/Surgical History

According to Mr. D.T he was well until Thursday 19th May 2022 around 7:00pm when he came from farm then he started having headache and chills. He ignored these symptoms until on the20th May,2022 midnight when he started having other symptoms like persistent vomiting, nausea, severe abdominal pains, fever, dizziness, and pains at the epigastric region so he had to come to hospital for treatment accompanied by his brother on 20th May, 2022.

During the assessment done by Dr. E.G at the Accident and Emergency unit and complains by my patient, he was supposed to carry out abdominal CT scan but financially, he and his family were not sound so they could not do it. With other laboratory test he was diagnosed of Gastritis.

1.7 Patient's Admission

Mr. D.T with his brother arrived at the Holy Family Hospital. Mr. D.T was transferred to the Male Medical ward after being detained for about eleven (11) hours at the Accident and emergency Unit by Dr. E.G with the history of persistent vomiting, nausea, severe abdominal pains, fever, dizziness, pain at the epigastric region and was observed that patient was anxious.

He was diagnosed of Gastritis. The medical ward was informed that a patient with Gastritis was to be transferred into the ward.

He was brought into the ward at 12:30pm in a wheel chair by a nurse and accompanied by a relative from the accident and emergency unit with complains mentioned above. They were warmly welcomed, the ward was introduced to them as male medical ward, and nurses on duty were also introduced to them. The patient's particulars were then taken and recorded in admission and discharge book. Vital signs, weight and height then checked and recorded as fellows;

Temperature - 38.5^0C

Pulse - 79 beats per minute

Respiration - 24 per minutes

Blood pressure - 116/74mmhg

Weight - 57 kilograms

Height - 1.38 metres

Due to patient's discomfort, he was quickly led to already made admission bed whereas his brother was oriented to the ward activities and patient himself was later oriented when his pain had subsided such as visiting hours; morning, 5:30-6:00am, evening, 5:30pm-6:30pm, Medications which are administered at 6:00am in the morning, 10:00am in the morning, 2:00pm in the afternoon, 6:00pm in the evening and 10:00pm. Also, the time for checking of vital signs was explained to his brother, Mr. D.T and his brother were shown to places such as the nurses' room, toilet facilities, bathroom, laboratory and the dispensary. I explained to them that the National Health Insurance Scheme will cater for their bills except the exempted drugs.

Patient's condition was ill as observed from physical assessment since even his facial expression told his discomfort. He was conscious and alert. Palpation done on him revealed a clear chest but abdomen felt full and soft. There was also a tenderness felt at the epigastric region which indicated Gastritis as diagnosed by Dr. E.G. He looked dehydrated. Since medications were already given to him at the emergency unit early morning, he was not given any medication on arrival but intravenous Normal saline 1litre was set up. Patient was made comfortable in Bed and the following medications were ordered;

1. Dextrose 5% in sodium chloride 0.9%(500mls) stat x1
2. Hyoscine Bytylbromide Ing 20mg,40 stat x 1
3. IV Omeprazole 40mg bd x 7
4. Suspension Nugel 10 ml x 5
5. Paracetamol 1g tid x 5

The following were the laboratory investigations ordered:

1. Blood specimen for Full Blood Count
2. Blood film (BF) for malaria parasite (MPs)
3. Random blood sugar (RBS)

He was assured of being in competent staff and was told to expect the best service with encouragement of speedy recovery. His relative was very participative and cooperative in the care of the patient. Patient was encouraged to take in fluid due to his condition.

Patient was then excused to have some time with his relatives. I then sought permission from the nurse in charge to take Mr. D.T for my care study after the admission process. I approached

him and his relative at this point and introduced myself as Asare Pepertual, a student nurse of Holy Family Nursing and Midwifery Berekum. I then explained to them that as part of my final exams, it is required of me to choose a patient with any medical or surgical condition, render professional nursing care from the time of admission till discharge and continually keep in touch to ensure patient health is stable and help patient with any health challenges. I further explained that, I will pay them visit after they have been discharged and then hand him over to community nurse of the area for continuity of care. I made them understand that I am going to write report on the care I rendered to them so the particulars will be taken including their names which their name will not be fully stated for confidentially sake. Permission was granted to use him. I chose my patient mainly because they were very cooperative and also gain more knowledge on the condition Gastritis.

1.8 Patient/Family's Concept of Illness

From the interaction I had with him and family revealed that he had no knowledge and understanding of the condition and he never attributed the cause of the condition to supernatural forces. He hopes to recover as soon as possible with the help of the competent staff taking care of him and prescribed medications ordered and help of God.

1.9 Literature Review on Gastritis

Definition of condition

Gastritis is inflammation of the stomach lining. The stomach lining resist irritation and can usually withstand very strong acid. Nevertheless, in gastritis the stomach lining becomes irritated and inflamed. (William D. Chey)

Incidence

The incidence of gastritis is the highest in the fifth and sixth decade of life; men are more frequently affected than women. The incidence is greater in patient who are heavy drinkers and smokers.

Types of Gastritis

Gastritis can basically be classified into two types, thus,

- Acute gastritis
- Chronic gastritis

Acute gastritis

Acute gastritis is sudden inflammation of the mucosa lining of stomach. It 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.

Causes Of Acute Gastritis

1. Alcohol abuse
2. Cigarette smoking
3. Use of NSAIDs, steroid or digitalis medication
4. Ingestion of corrosive agents
5. Chemotherapy/radiation therapy to the upper abdomen

6. Excessive gastric secretions (in stress cases)
7. **Staphylococcus food poisoning**

Chronic gastritis

It is an inflammation of the mucosa of the stomach that exists for prolonged period. It can be caused by either benign or malignant ulcer of the stomach, cirrhosis of the liver, or by the bacteria helicobacter pylori. It may be sometimes associated with autoimmune diseases such as pernicious anaemia.

Causes

1. Bacteria (usually Helicobacter pylori) infestation. Most common causes
2. gastritis (usually due to lack of vitamin B12)
3. Genetic predisposition
4. Bile reflux

Clinical Features of both acute and chronic gastritis

The clinical manifestation of gastritis includes;

1. Abdominal pain usually at the epigastria region
2. Nauseas and vomiting
3. Weight loss
4. Anorexia and loss of appetite
5. Diarrhea
6. Dehydration
7. Hiccups and belching
8. Abdominal bloating
9. Fever

10. Heartburns

11. Bloody, coffee ground or dark stool

12. Body weakness and restlessness.

Pathophysiology

Prostaglandin provide a protective mucosal barrier that prevent the stomach from digesting itself by a process called acid auto digestion. If there is a break in the protective barrier mucosal injury occurs. The result of injury is compounded by histamine release and vagal nerve stimulation. Hydrochloric acid can them diffuse back into the mucosa and injury small vessel. This back diffusion result in edema, hemorrhage and erosion of the stomach lining. The pathological changes of gastritis include vascular congestion, edema, acute inflammatory cell infiltration and degenerative changes in the superficial epithelium of the stomach lining. The early pathological manifestation of gastritis is a thickened, reddened mucous membrane with prominent rugae or fold. As the disease progress, the wall and lining of the stomach thin and atrophy.

With progressive gastric atrophy from chronic mucosal injury, the function of the parietal (acid –secretion) cells decrease and the source of intrinsic factor is lost. The intrinsic factor is critical for absorption of vitamin B12. When body store of vitamin B12 are eventually depleted, pernicious anemia results. The amount and concentration of acid in the stomach secretion gradually decrease until the secretion consist of only critical mucus and water. (Medical – Surgical nursing critical thinking. *IGNATAVICIUS AND WALKMAN 4TH Edition)*

Diagnostic investigation

1. Endoscopy of stomach to verify whether there is inflammation and also to check for erosion on the stomach linings
2. Gastric biopsy is performed to rule out other pathogenic changes such as cellular dysplasia.

3. Gastric secretion study may be performed to established hyperchlorhydria or achlorhydria
4. Stool examination to check for the presence of H. pylori
5. Blood for hemoglobin estimation and full blood count (FBC)
6. Abdominal computed tomography (CT) scan and x-ray
7. Urinalysis.
8. Physical examination
9. History taking

Medical Treatment

The aim of medical treatment is to eliminate the causative factor and to restore normal function of the stomach. Common medications that are used include the following;

1. Antibiotics if there is bacterial infection e.g., ceftriaxone
2. Intravenous fluid to correct dehydration
3. Antacids such as aluminum hydroxide, calcium carbonate to neutralize the gastric acid.
4. Hydrogen (H2) receptor antagonist such as cimetidine, ranitidine, nigatidine or famotidine is prescribed to help reduce the amount of acid the stomach produces.
5. Protein pump inhibitors such as omeprazole, lansoprazole, rabeprazole and esomeprazole are prescribed to shut down the acid pumps within acid secreting stomach cells and also to inhibit it H. Pylori activity.
6. Cytoprotective drugs such as sucralfate to protect the stomach lining.
7. Antichlolinergics such as pro-panthine to decrease gastric emptying.
8. Analgesics and antipyretics to combat pain and fever respectively e.g., paracetamol

Nursing Management

Psychological management

1. Reassure patient and family that patient condition will be managed since he is in the hands of competent health term.

2. Explain to patient and relatives about the need for hospitalization and treatment

3. Encourage patient and his relatives to ask questions about the condition (gastritis).

4. Allow patient to verbalize his fears and anxiety as well as his concerns.

5. Explain the cause, signs and symptoms and treatment about gastritis to patient and relatives

Rest and sleep

1. Patient is encouraged to rest to avoid over exertion and possible aggravation of symptoms
2. Patient is put in comfortable position in bed to promote rest
3. Rest the gastric intestinal tract until symptom subsides.
4. Visitors are restricted into the ward to enable the patient to rest adequately.
5. Siren environment should be ensured to enhance sound sleep.

Nutrition

1. Ensure nil per os until nausea and vomiting subsides
2. Start with sips of water
3. Serve semi-solid diet then to normal diet
4. Serve bland diet that takes into account his food preferences

5. In case of anorexia, serve food in bit and at regular interval and also reduce the amount of irritating food that produces gastric secretion.
6. Help the patient identify specific food that cause gastric upset, them eliminate them from his diet.
7. If pain and nausea interfere with the patient's appetite, administer pain medication or anti-emetic about 1 hour before meals
8. Food should be rich in calorie and protein to restore energy.
9. Encourage lots of fruit and vegetables intake to aid in elimination of bowel
10. Encourage patient to take in 3-4 liters of water per day.
11. Administer intravenous fluid as prescribed.

Observation

1. Assess the level of pain and serve prescribed analgesic
2. Monitor the rate of frequency of vomiting and diarrhea
3. Examine stool and vomitus for blood
4. Monitor pulse, respiration, temperature, blood pressure and record 4 hourly.
5. Assess the degree of dehydration by inspecting skin and checking skin turgor
6. Monitor fluid intake and output chart.

Patient teaching

1. Educate patient and relatives on gastritis, sign and symptoms, treatment and its complication
2. Advice patient to refrain from risk behavior that are likely to worsen the disease.

3. Educate on the need to return for review after discharge and the need to report on the given date.
4. Encourage patient on the need to continue medication after discharge if even condition get better.
5. Educate on the need to maintain personal hygiene.
6. Teach family members the importance of supporting the patient as he makes the necessary dietary and lifestyle changes.
7. Advice patient to avoid contaminated food and water.

Medication

1. Serve patient all ordered medication with care considering the 10 rights of medication.
2. Observe patient for side effect of drugs.
3. Explain rationale for giving drug to get patient to comply.
4. Advice patient against adding other unprescribed medications to the already prescribe once.

Complication

1. **Heamorrhage:** When the inflammation extending or affecting the whole thickness of the lining get ton affect a major artery, there is continual bleeding that can lead to serious and possibly life-threatening haemorrhage.
2. **Anemia:** if haemorrhage is not recognised early and managed, chronic persistent low level of iron can lead to anemia. And also, if the gastric glands are eroded, secretion of

intrinsic factor that is secreted by the parietal cells in the stomach is reduced which can lead to the occurrence of pernicious anemia.

3. **Peptic ulcers:** this involves the full thickness of the gastrointestinal mucosa. It results from the disruption of the normal balance between the corrosive effect of gastric juice and the protective effect of mucus on the gastric epithelial cells. When this balance is altered in acute gastritis, the chances of an occurrence of peptic ulcer increases.
4. **Growth in the stomach lining:** The risk of both benign and malignant growth in people with gastritis. If Helicobacter pylori (H pylori) bacterial causes gastritis, they also increase the risk of specific form of cancer known as gastric mucosa-associated lymphoid tissue (MALT) lymphoma.
5. **Dehydration**

Prevention

In order to prevent gastritis:

1. Eat regularly and moderately
2. Avoid long use drug that can irritates stomach lining such as NSAIDS for example aspirin.
3. Avoid smoking
4. Take bland diet such as fish, fruit, whole grain and beans
5. Avoid all foods that serve as irritants e.g., Caffeine product such as coffee.
6. Maintain personal hygiene.
7. Avoid stressful lifestyle since it increases stomach acid production and slows digestion.

1.10 Validation of Data

This is the art of confirming or verifying data. With reference to the literature review, diagnostic investigations, signs and symptoms exhibited by the patient, it is clear that Mr. D.T diagnosis of gastritis was standard. Relatives also confirmed the information given by the patient. All these were put in place to ensure that the data gathered on the patient was accurate.

CHAPTER TWO

DATA ANALYSIS

2.0 Introduction

Analysis of data is the second stage of the nursing process, where information gathered is interpreted, strength and weakness are identified and possible interventions employed.

Conclusions are drawn concerning the patient and family's problems, needs and concerns. Nursing diagnoses are formulated to serve as the pivot around which the rest of the phase will revolve (Barbara K., et al., 2008).

Chapter two consists of data analysis which involves comparison of investigation done with data collected and the comparison of the causes, clinical features, treatment and complication as in literature review and as manifested by the patient. It also involves patient and family health problems, strengths and nursing diagnosis.

2.1 Comparison of data with standards

This involves the comparison of data collected and gathered from Mr. D.T with standards. Both the objective and subjective data collected has been compared with accepted standards and norms. The areas concerned are the diagnostic investigations, etiology of gastritis, clinical features, treatment and complications

Table 1: Comparison of diagnostic tests carried out on my patient and with those outlined in the literature review.

Diagnostic test in literature	Diagnostic test carried out on my patient
Complete physical examination	Done
Endoscopy	Not done
Urinalysis	Not done
Blood specimen for Full Blood Count	Done
Blood Film for Malaria Parasite	Done
Chest x-ray and CT scan	Not done
Sputum Culture and sensitivity	Not done
History taking	Done

Table 2: Diagnostic Investigations carried out on the patient

Date	Specimen	Investigation	Results	Normal value	Interpretation	Remarks
20/05/22	Blood	Malaria Parasite (MPs)	No malaria parasite present	No malaria parasite should be present	Indicate there is no malaria parasite	No treatment was given
20/05/22	Blood	White blood cells (WBCs)	5.1x10.9/l	3.7-11.0 x 10.9/L	Within normal ranges. no possibility of infection	No treatment was given
20/05/22	Blood	Hemoglobin level estimate	11.3g/dl	13.0-18.0g/dl (males) 12.2-15.2g/dl (females)	Low hemoglobin level indicating anemia	Patient was educated on food supplement.
20/05/22	Blood	Random blood sugar	5.5mml/L	6.0-11.0mmol/L	Patient has no hyperglycaemia	No treatment given

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, Mr. D. T’s condition could be due to helicobacter pylori.

Table 3: Comparison of Clinical Features exhibited by my patient with literature

Clinical Features in Literature	Clinical Features Exhibited by Patient
Abdominal pain	Present
Nausea	Present
Vomiting	Present
Weight loss	Present
Anorexia	Present
Loss of appetite	Present
Diarrhea	Present
Fever	Present
Heartburns	Present
Body weakness	Present
Dehydration	Present
Bloody, coffee ground or dark stool	Absent

Table 4: Comparison 0f specific Treatment Given to compared to Literature

Treatment in literature	**Drugs Given to the Patient**
Antibiotics	Metronidazole
Antipyretics and analgesics	IV Paracetamol
Parenteral fluid	Intravenous Normal Saline, Dextrose
Antispasmodic	Hyoscine butylbromide (Buscopam)
Antiemetics	Promethazine hydrochloride,
Receptor antagonist	Metoclopramide
Proton Pump Inhibitor	IV Omeprazole
Antacid	Nugel suspension

Table 5: Pharmacology of Drugs Administered

Date	Drug	Dosage and Route of administration	Classification	Desired Effect	Actual Action observed	Side Effect	Remarks
20/05/22	5% Dextrose saline	500mls of dextrose saline stat x1.	Crystalloid glucose solution	Provide hydration and energy	Patient was rehydrated Patient's energy was restored and normalized	Circulatory overload.	Not observed
20/05/22	Omeprazole	80mg stat IV.	Proton-pump inhibitor	Reduce the amount of acid in the stomach	It prevents, heartburns exhibited by patient.	Headache, nausea, vomiting	None was observed
20/05/22	Paracetamol IV	1G, 1000mg stat x1	Analgesic and anti-pyretic	Relieved pain and reduce body temperature	Pain was relieved and body temperature was reduced (38.0-36.8).	Blurred vision and liver damage	None was observed
20/05/22	Suspension nugel	10mls tid x 7 Orally	Antacid	Reduce the amount of acid in the stomach	The amount of acid in the patient's stomach was reduced.	Chalky taste, diarrhea and constipation.	None was observed

Table 1: Pharmacology of Drugs Administered continued

Date	Drug	Dosage and Route of administration	Classification	Desired Effect	Actual Action observed	Side Effect	Remarks
20/05/22	Promethazine hydrochloride	25mg/ml in stat x1	Antiemetic	To treat nausea and vomiting	Patient vomiting stopped.	Weak or shallow breathing, uncontrolled muscle movement in the face.	None was observed
20/05/22	Normal saline(N/S)	500mls bd x1 Intravenously	Intravenous fluid and electrolyte	To correct dehydration.	Patient level of dehydration was restored	Circulatory overload, localized edema.	None was observed
20/05/22	Hyoscine Btylbromide (Buscopan)	Inj 20mg stat x 1 Intramuscular	Antispasmodic	To treat abdominal pain	Patient was relieved from abdominal cramps.	Constipation, dry mouth, and swelling of the hand or feet.	None was observed

Complications

With reference to the complications of gastritis stated in the literature review, Mr. D.T did not develop any complication. This could be due to the patient centered care rendered by the health care team.

2.2 Patient's Health Problems

1. Patient complained of abdominal pain. (20/05/22)
2. Patient had nausea and vomiting (20/05/22)
3. Patient had general body weakness (20/05/22)
4. Patient had loss of appetite (21/05/22).
5. Patient was anxious (22/05/22)
6. Patient lacked knowledge on the causes and treatment of Gastritis. (22/05/22)

2.3 Patient/family strengths

1. Patient was able to verbalize the severity of the pain (20/05/22)
2. Patient could take in oral fluid (20/05/22)
3. Patient could perform activities of daily living with assistance (brushing and bathing) (20/05/22)
4. Patient was able to eat 1/3 of food severed in 500mls of blow (21/05/22)
5. Patient was able to cooperate with health personnel and treatment without struggle (22/05/22)
6. Patient was willing, to receive health education on his gastritis (22/05/22)

2.4 Nursing diagnosis

1. Acute pain (abdominal pain) related to irritation of gastric mucosa.
2. Deficient fluid volume related to vomiting
3. Activity intolerance (brushing and bathing) related to general body weakness
4. Imbalance nutrition less than body requirement related to loss of appetite
5. Anxiety related to unknown outcome of gastritis and its treatment.
6. Deficient knowledge related inadequate information about disease condition (gastritis).

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Chapter three consists of planning of patient family care and it involves the use of care plan which consists of nursing diagnosis, objectives and outcome criteria, nursing orders, nursing interventions and evaluation.

Planning is a deliberative, individual, systematic phase of nursing process that involves decision making and problem solving. In planning, the nurse refers to the patient’s assessment data and diagnostic statements for direction in formulating care goals and designing the nursing intervention required to prevent, reduce or eliminate the patient’s health problems. (Michael, S 2004).

3.1 Objectives and outcome criteria

1. Patient will be relieved of pain within 8 hours as evidenced by;
    a. Patient verbalizing absence of pain
    b. Nurse observes patient having a cheerful facial expression
2. Patient will maintain adequate body fluid balance within 48 hours as evidenced by;
    a. Patient verbalizes absence of vomiting
    b. Nurse recording balanced intake and output.
3. Patient will be able to do all his activity of daily living without assistance within 72 hours as evidenced by;
    a. Patient verbalizes that he is able to perform activities of daily living without support.
    b. Nurse observes patient perform activities of daily living such as bathing and brushing without assistant.
4. Patient will regain his normal nutrition status within 24 hours as evidenced by;

a. Patient verbalizing gain in appetite.

b. Nurse observing patient consume more than half of food served.

5. Patient will express decreased anxiety within 24hours as evidenced by;

    a. Patient verbalizing absence of fear

    b. Nurse observing patient having cheerful facial expression in bed.

6. Patient and family will gain adequate knowledge regarding the causes, signs and symptoms, treatment and prevention of gastritis within 24hours as evidenced by;

    a. Patient ability to answer simple question on nursing procedure and activity

    b. Nurse observed patient and family cooperating during nursing procedure and care

Table 6: Nursing Care Plan

Date/ Time	Nursing diagnosis	Nursing objectives/ outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
20/05/22 at 1:00pm	Acute pain (abdominal pain) related to irritation of gastric mucosa.	Patient will be relieved of pain within 8hours as evidence by; 1. Patient verbalizing absence of pain 2. Nurse observes patient having a cheerful facial expression	1. Assess level of pain using the scale of 0-10 and location of pain. 2. Reassure patient of pain relief 3. Educate patient on the need to avoid stress 4. Ensure complete bed rest. 5. Engage patient in diversional activities. 6. Administer prescribe medication and observe for side effect.	1. Patient pain was rated 8 on a scale of 0-10 and pain was in epigastric region. 2. Patient/Family was reassured that everything would be done to relief his abdominal pain. 3. Patient was educated on good relaxation techniques to relieve pan. 4. Complete bed rest was also ensured. 5. Patient was engaged in diversional activities –watching of television 6. Prescribe medication was administered and side effect observed.	20/05/22 At 9:00pm	Goal fully met as evidenced by; 1. Patient verbalizing, he did not feel pain any more. 2. Nurse observed patient having a cheerful facial expression.	A.P

Table 6: Nursing care plan continued

Date/ Time	Nursing diagnosis	Nursing objectives/ outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
20/05/22 At 1:00pm	Deficient fluid volume related to vomiting	Patient will maintain adequate body fluid and electrolyte balance within 48 hours as evidenced by; 1. Patient verbalizes absence of vomiting 2. Nurse recording balanced intake and output.	1. Monitor and record intake and output on a chart and balance every 24hours 2. Encourage fluid intake 3. Daily weigh patient in the morning 4. Assess skin turgor 5. Administer prescribed IV fluid.	1. Fluid intake and output were recorded. 2. Patient was encouraged to take in a lot of water regularly 3. Patient was weighed Daily for possible weight loss 4. Patient's skin was assessed and the skin elasticity was intact as skin return fast to normal when release. 5. Prescribed IV fluids was given.	21/05/22 At 2:00pm	Goal fully met as evidenced by; a. Patient verbalizes absence of vomiting b. Nurse recorded balanced intake and output.	A.P

Table 6: Nursing care plan continued

Date/ Time	Nursing diagnosis	Nursing objectives/ outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
20/05/22 At 2:00pm	Activity intolerance related to general body weakness	Patient will be able to do all his activity of daily living without assistant within 72 hours as evidence by; 1. Patient verbalizes that he is able to perform activities of daily living without support. 2. Nurse observe patient perform activities of daily living such as bathing and brushing without assistant.	1. Reassure patient. 2. Assist patient to perform self-care activities. 3. Monitor and assist in passive exercise patient can tolerate 4. Put patient need within his reach 5. Provide a well-balanced diet rich in calorie to provide energy. 6. Ensure adequate bed rest	1. Patient was reassured of speedy recovery. 2. Patient was assisted to do mouth care in bed, assisted bath and grooming was observed. 3. Patient was massaged. 4. Drinking water and mobile phone were put within the reach of patient. 5. Patient was served with rice and stew. 6. Noise and visitors were minimized to ensure adequate bed rest	23/05/22 At 1:30pm	Goal fully met as evidence by; a. Patient verbalizing, he is able to perform activities on his own. b. Nurse observed patient perform activities on his own.	A.P

Table 6: Nursing care plan continued

Date/ Time	Nursing diagnosis	Nursing objectives/ outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
21/05/22 at 2:00pm	Nutrition imbalances less than body requirement related to loss of appetite	Patient will regain his normal nutrition status within 48 hours as evidenced by; 1. Patient verbalizing gain in appetite. 2. Nurse observing patient consume more than half of food served.	1. Plan diet with patient and his family. 2. Assist patient clean his mouth. 3. Serve food attractively in bit and based on his preference 4. Remove nauseated item from sight of patient	1. Patient's diet was planned with him and his family which included the intake of high protein and carbohydrate but low-fat intake to boost his immunity and strength 2. Patient was assisted to clean his mouth. 3. Patient food was served attractively. 4. Nauseated item was removed from patient bed	22/05/22 At 2:00pm	Goal fully met as evidenced by; 1. Patient verbalized he had appetite for food and requested for food to eat. 2. Nurse observed patient ate half of the food served to him	A.P

Table 6: Nursing care plan continued

Date/ Time	Nursing diagnosis	Nursing objectives/ outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
22/05/ 22 At 2:00pm	Anxiety related to unknown outcome of disease condition.	Patient will express decrease anxiety within 24hours as evidenced by; 1. Patient verbalizing of absence of fear 2. Nurse observed patient of cheerful facial expression in bed.	1. Assess anxiety status of the patient and relatives. 2. Allow patient to express his feelings about his condition and the environment 3. Reassure patient that he is in the good hands of competent health team 4. Introduce other patient who have recovering from similar condition.	1. Anxiety status of the patient and relatives was assessed. 2. Patient was made to express his feelings about his disease condition and the environment in which he found himself. 3. Patient was reassured that he is in the hands of competent health team. 4. Patient was introduced to other patient who was successfully recovering from similar condition.	23/05/22 At 2:20pm	Goal fully met as evidence by; a. Patient and relatives verbalize absence of fear b. Nurse observed cheerful facial expression of the patient and relatives	A.P

Table 6: Nursing care plan continued

Date/ Time	Nursing diagnosis	Nursing objectives/ outcome criteria	Nursing orders	Nursing intervention	Date/ Time	Evaluation	Sign
22/05/22 At 2:00pm	Deficient knowledge related inadequate information about disease condition (gastritis).	Patient and family will gain adequate knowledge regarding the causes sign and symptoms, treatment and prevention of gastritis within 24hours as evidenced by; 1. Patient ability to answer simple question on nursing procedure and activity to answer 2. Nurse observes patient cooperating during nursing procedure and care	1. Assess patient's knowledge on his condition. 2. Educate patient on the nature of the disease condition. 3. Encourage patient to ask questions. 4. Provide answers to questions using simple terminologies	1. Patient knowledge about condition was assessed 2. Education was made include, causes, sign and symptoms treatment precipitating factors, medication regimen, Prevention of the disease condition. 3. Patient was encouraged to ask questions concerning his condition and the treatment regimen 4. Questions were answered in simple terms to relief him of any misconception	23/05/22 At 12:30pm	Goal fully met as evidenced by; a. patient and family were able to answer simple question on nursing procedure and activities b. Nurse observed patient and family cooperated during procedure.	

CHAPTER FOUR

IMPLEMENTATING PATIENT/FAMILY CARE PLAN

4.0 Introduction

This chapter entails the summary of the actual nursing care rendered to the patient/family from the day of admission till discharge.

Implementation is the process of putting the nursing care plan which includes medical and nursing determined intervention into action. It is also the fourth step in the nursing care process. It is the action taken based on the findings in the care plan. The components of this chapter include; summary of actual care rendered to the patient, preparation of patient/ family for discharge and rehabilitation, follow-up/ home visit/ continuity of care.

4.1 Summary of Actual Nursing Care Rendered to Patient/Family

The nursing care rendered to Mr. D.T and his family started on the day of his admission which was 20th May, 2022 at 12:30pm and continued until he was discharged on the 24th May, 2022 at 10:15am. The nursing care given throughout this period at Male Medical Ward was aimed at meeting his psychological, physical and spiritual needs.

This subsection is discussed under the following headings:

Day of admission (20/05/2022)

On the 20th of May 2022 at 1:30am, Mr. D.T with his brother arrived at the Holy Family Hospital, Techiman. Mr. D.T was transferred to the Male Medical ward after being detained for about eleven (11) hours at the Accident and emergency Unit. The medical ward was informed that a patient with Gastritis was to be transferred into the ward. An admission bed was made in readiness to receive the patient. A few minutes later around 12:30pm, Mr. D. T was brought into the Male Medical ward with his brother accompanied by a staff nurse at the Accident and Emergency Unit. Mr. D.T. and his brother were welcomed, and they were offered

seats at the Nurses' station and necessary information taken and documented as needed. On admission his vital signs, weight and height were checked and recorded as follows:

Temperature	38.5^0C
Pulse	79 beats per minute
Respiration	24 per minutes
Blood pressure	116/74mmhg
Mass	57kg
Height	1.38m

All these were recorded on the vital signs monitoring sheets. After checking and recording of the vital signs the patient and brother were oriented to the ward and its annexes. During the orientation the following activities were carried out: they were introduced to the other nurses and the other patients on the ward, Mr. D. T and his brother were shown to places such as the nurses' room, toilet facilities, bathroom, laboratory and the dispensary. They were also informed of the visiting hours; morning, 5:30-6:00am, evening, 5:30pm-6:30pm.

I explained to them that the National Health Insurance Scheme will take part of their bills. The daily routines were explained to them; medications which are administered at 6:00am, 10:00am, 2:00pm, 6:00pm and 10:00pm. Also, the time for checking of vital signs was explained to the patient and his brother. After that, they were allowed to ask anything bothering their mind.

The following were the drugs ordered:

1. Dextrose 5% in sodium chloride 0.9%(500mls) stat x1
2. Hyoscine Bytylbromide Ing 20mg,40 stat x 1

3. IV Omeprazole 40mg

4. Suspension Nugel 10 ml x 5

5. IV Paracetamol 1g

The following were the laboratory investigations ordered:

1. Blood specimen for Full Blood Count

2. Blood film (BF) for malaria parasite (MPs)

Blood sample was collected and sent to the laboratory for investigations. Drugs ordered were collected from the ward pharmacy and started immediately. Patient was examined from head to toe and it was realized that, there were no abnormalities.

I later interacted with patient and his relative to identify his health problems. With the information from the patient, relatives and my own assessment, Patient's problems were identified and a nursing care plan with the aim of putting in nursing strategies to solve them instituted. Patient complained of severe abdominal pain. In order to relieve him of the pain, the following interventions were put in place: Patient's level and location of abdominal pain was assessed and the location of pain was in epigastric region, He was reassured that everything will be done to relief him of pain. He was put in bed to ensure complete bed rest, prescribed antacid (suspension Nugel) was served.

On the same day, patient was vomiting, the following nursing interventions were implemented to help maintain his fluid volume. Patient intake and output were recorded and balanced every 24hours, he was encouraged to take in more fluid, his skin turgor was assessed, he was weighed for possible decrease in weight, finally prescribed IV fluid was administered.

Again, patient complained of general body weakness. The following interventions were put in place to help him perform activities of daily living. Patient was assisted to do mouth care in bed, assisted bath and grooming was observed. He was massaged, his items such as mobile phone and drinking water were put within his reach. He was served with rice and stew to provide him with energy.

Relatives were engaged in a conversation about the condition of their son and also reassuring them of the competency of the health team. Around 5:30 pm patient was assisted to have his bath. He was served with oat and bread which he ate quarter of meal served in 500ml of bowl. His evening vital signs were checked and recorded and due medications served.

At 7:30pm, he was made comfortable in bed and handed over to the night nurse for continuity of care. At 9:00pm verbalized relieve of pain as he expressed cheerful facial expression. He retired to bed around 9:45pm.

Second day of admission (21/05/2022)

According to the Night nurse, Mr D.T woke up around 6:00am when they were checking vital signs. He complained of abdominal pain at 3:30 am. He was assisted to maintain his personal hygiene such as mouth care and bathing. He was served with porridge and bread as breakfast. Vital signs at 6:00am were checked and recorded as follow.

Temperature	37.5 degree Celsius
Pulse	76 beats per minute.
Respiration	21 cycles per minute.
Blood pressure	116/73millimeters of mercury.

At 10: 00am, the daily ward round was done and Doctor E.G made no alterations in treatment regimen and ordered treatment to be continued. His due medications were served and vital sign checked and recorded and was observed that his fluid volume has improved as vomiting reduced.

Later in the day, Mr. D.T had increase in body temperature (38.5 degree Celsius). Based on this, the following nursing interventions were implemented reduce the elevated body temperature; vital signs were checked especially temperature every 15mins. He was served with chilled drink, windows and fans around patient were open to facilitate ventilation, and patient was tepid sponged for 15minute to reduce high body temperature. He was covered with light clothing and IV Paracetamol 1g was also served to reduce increased in body temperature. At 2:00pm, due medications were served. Patient was served with banku and okro soup. Patient vital signs were rechecked and temperature was within normal range (36.4℃)

On the same day of carrying out the routine nursing care, it was realized that Mr. D.T could not also eat his food served due to loss of appetite and as a result the following measures were put in place which increased his appetite for food. Patient's menu was planned with him which includes the intake of high protein and carbohydrate but low-fat intake to boost his immunity and strength. He was assisted to clean his mouth, he was served with attractive food to boost his appetite (rice with stew, egg, and meat were served) and nauseating item (bed pan) was removed from the sight of patient.

Around 6:00pm patient was assisted to take his bath. He was served with TZ which he ate half of the food served in 500ml bowl. His due medications were served and vital signs checked and recorded. He was made comfortable in bed and handed over to the night nurse for continuity of care. Patient retired to bed around 9:00pm

Third day of admission (22/05/2022)

Mr. D.T was already awake before I got to the ward around 5:30am. He was assisted to bath with warm water and assisted him to care for his mouth. According to the night nurse's patient complained of eye pain which ciprofloxacin eye drop was given to him to relieve him from the eye pain. His bed linen was changed. Vital signs checked and recorded as follows;

Temperature	36.5 degree Celsius
Pulse	61 beat per minute.
Respiration	20 cycles per minute.
Blood pressure	110/63millimeters of mercury.

His morning medications were served. Doctors came for morning ward rounds and changes were made. IV Metoclopramide 10mg stat was prescribed. He was asked by Dr. E.G to do abdominal CT scan but due to financial problem they could not do it.

Mr. D.T took rice and stew for lunch, his afternoon vital signs checked and recorded and due medications served accordingly. Mr. D.T and his brother looked anxious due to the unknown outcome of the condition. The following were nursing intervention implemented to allay the anxiety of Mr. D.T and his relatives; Anxiety status of the patient and relatives was assessed, they were reassured that, he is in the hands of competent health team, He was introduced to other patients who had successfully recovered from similar condition who came for review and patient was made to express his feelings about his disease condition and the environment in which he finds himself.

I got to know that Mr. D.T and his relative had no knowledge about his condition during my interaction with them**.** Education was made to include, causes, signs and symptoms, treatment, precipitating factors, medication regimen and prevention of the disease condition. He was encouraged to ask questions concerning his condition and the treatment regimen and questions were answered in simple terms to relief him of any misconception. At 1:00pm patient verbalized absence of vomiting and patient demonstrate good skin turgor

In the evening his vital signs were checked and were within normal range. He was assisted to take his bath, he took in Ampesi and kontomire stew for supper. Evening medications were served. He did not vomit this time. I handed him over to the night nurses and patient went to bed around 8:30pm.

Fourth day of admission (23/05/2022)

Mr. D.T was awake as early as usual and has taken his bath and oral hygiene without assistance when I got the ward. He was cheerful looking because he thought he was going to be discharged. Information from the night nurses was that, he had undisturbed sleep. He took porridge and bread for his breakfast. His medications were given and vital signs were checked and recorded as follows;

Temperature	36.5 degree Celsius
Pulse	78 beats per minute.
Respiration	20 cycles per minute.
Blood pressure	125/80millimeters of mercury.

He told me there has been much improvement and he would like to be discharged. His bed linen was changed and he was made comfortable in bed.

A doctor came on rounds and declared Mr. D.T fit and was to be observed throughout the day for any problem before discharge the following day. No problem was identified. His vital signs including temperature, pulse, respiration and blood pressure were monitored. They were within normal ranges. Mr. D.T was informed to relax because he would soon go home. He took in banku and soup for lunch and due medication served and vital sign checked and recorded. He also verbalized released of anxiety as expresses cheerful facial expression. It was assessed that patient had gained adequate knowledge about his condition as he was able to answer questions asked.

He had his evening bath, meals and medications were served. I handed him over to the night nurses and finally slept at 9:00pm after watching TV with the patients around.

Fifth day of admission (24/05/2022)

On this day, patient woke up at 6:00am, he had his bath and oral care done by himself. He was served with porridge and bread which he ate all food served indicating regain of appetite. His vital signs were checked and recorded as;

Temperature 36.5degree Celsius.

Pulse 79 beats per minutes.

Respiration 20cycles per minutes.

Blood pressure 122/80 millimeters of mercury.

Around 10:15am, Mr. D.T was discharged after he had been assessed by Dr. E.G. He expressed his sincere gratitude to the doctors and the nursing staff for their hard work and competency. A short health education on proper hygiene and preparation of food was delivered to the patient and family. They were also educated on the essence of completing treatment regimen and to report any side effect of the drugs immediately. They were also educated on the need to prevent malnutrition and to eat energy giving foods. The patient's name was entered into admission and discharge book and daily ward state.

They were briefed on the date of review which was on 29th May, 2022. The date for follow up visit was on the 27th May, 2022. Patient was on health insurance so most of his medical bill was footed by the National Health Insurance Scheme. They were helped to pack their belongings and see them off.

4.2 Preparation of patient and family towards discharge and rehabilitation

Preparation of Mr. D.T and his family towards discharge and rehabilitation started on the day of admission, 20th May, 2022, after there had been the establishment of good interpersonal relationship between the healthcare team and the patient and family. On admission they were welcomed and reassured that patient would surely be discharged within the shortest possible time since his condition was noticed and brought early and due to competency of the healthcare

team. The main aim of this preparation is to maintain health, prevent reoccurrence and onset of complications.

The patient and family were educated on the condition, its causes, clinical manifestation, complication and prevention of gastritis such as avoid prolong use of drug that can irritate stomach lining e.g., aspirin, avoid smoking, avoid stressful lifestyle and eat regularly and moderately etc. They were further educated on treatment regimen and the need to continue treatment even after discharge. They were told about the review after discharge and why it was necessary to show themselves to the doctor after discharge. They were encouraged to report any issues, side effect of medication to hospital as soon as it arises.

The discharge of Mr. D.T occurred on Thursday 24th May, 2022 at 10:15 am. He was made aware of his discharge after it was ordered by Dr. E.G during ward rounds in the morning. All entries were done, discharge papers signed, documentations completed and then Hospital bills obtained from the accounts office after prescribed medication were retrieved. Payment of bill was then made and then they expressed their gratitude to the healthcare team as they were leaving. I then made them aware of my next visit which was to happen on the 27th May, 2022.

4.3 Follow Ups/ Home Visits/ Continuity of Care

Home visiting is the visit made to patients in their homes to prevent illness and disability, to promote and maintain health, encourage individuals and family to live a healthy life and improve their health status.

First home visit (23/05/2022)

This visit was scheduled and made in the company of patient's brother on 23th MAY while patient was on admission. The purpose of this visit was to familiarize myself with the home and environment of my patient in order to know some of the health problem of the area. The brother and I set off at 10:30am. We reached Sansanma where he stays at around 11:25am.

When we got to the house, I greeted everyone in the house. Mr. D.E, who is patient's brother introduced me to the other relatives in the house. After they have welcomed me, I asked of their welfare including their health status.

Patient and family live in a 2-bed room mud house with thatch roofing. They have access to electricity and pipe borne water. The kitchen and bathroom built with bamboo were detached from the main building.

Their environment was bushy which was not impressive. They were advised to weed frequently around the house. They were also advised to cover their containers which they use to store their water. In conversation with them one of the relatives, she said that last night, mosquitos disturbed her sleep. I took that opportunity to ask them if they sleep under mosquito net which the answer was no, so they were encouraged to sleep under mosquito net to prevent mosquito bite which cause malaria. They were again advised on the use of over-the-counter drugs, herbal preparations and the need to report to qualified health personnel for proper treatment when sick.

They were told to avoid late night eating, sweets and alcohol. They were also told about my next visit, thus, after Mr. D.T comes home on discharge from the hospital. They were allowed to ask questions that might have been bothering their minds and were answered accordingly in simple understandable language.

After a fruitful and healthy interaction with them, I asked for their permission to leave and finally left the house and town at 12:20 back to my house.

Second home visit (27/05/2022)

The second home visit was paid on the 27th of May, 2022. It was a planned visit so as to know if patient and family maintained hygienic environment and how patient was responding to

treatment and to confirm the promise, he made to me that he will not smoke weed again. which was confirmed by his brother that since they came from the hospital, he has not seen him smoke. Mr. D.T was still taking his drugs as prescribed. He looked healthy. Patient and family were reminded of his review date which was 29th May, 2022. He was advised to have enough rest and take good care of himself. They expressed their gratitude for the knowledge acquired and care given. I asked for permission to leave. I was accompanied to the roadside to pick okada to my house.

Review (29/05/2022)

Mr. D.T was scheduled to come for review on 29th May, 2022. He arrived at the Out-Patients Department of Techiman Holy Family Hospital around 8:30am with his brother, where he retrieved his folder. I met him and he looked stronger and healthier. His vital signs were checked and recorded as follows:

Temperature - 36.4 Degree Celsius

Pulse - 76 beats per minute

Respiration - 20 Cycler per minute

Blood Pressure – 110/70Milimetres of Mercury

Weight - 60Kilograms

Dr. E.G after physical examination, declared his health status satisfactory. No laboratory investigations were requested and no medications were also prescribed for him. He was advised to eat well and should not stress himself. I discussed with him that I will pay him another visit in his home on the 31st May, 2022 to terminate the nursing care. I saw them off after everything.

Third home visit (31/05/2022)

My third home visit was on 31st May, 2022. I met Mr. D.T and his family. They were all happy to see me and welcomed the Community Health Nurse and me with great cheers. I was very impressed on their environment and Mr. D. T's personal hygiene and congratulated them. I also added the need to take a well-balanced diet to maintain the fitness.

I asked them, whether they had any complaints but they gave me none. They were then thanked for their full cooperation and support throughout our interaction after informing them that our interaction had officially ended. They were also told that I would occasionally visit and will make sure I talk to them on phone. I also added that they should not hesitate to call me anytime they need my help in clarifying any issues regarding their health. They were finally handed over to the Community Health Nurse. I thanked them and asked permission to leave.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation is the fifth and the last step of the nursing process. It is directed at determining the patient's response to the nursing interventions and measuring the extent to which the goals have been achieved. The patient's response to the treatment is determined by the nurse through evaluations to enable her accept responsibilities for her actions and also help the nurse to discard ineffective actions and continue with the effective ones. The evaluation steps include the following: Statement of evaluation**,** amendment of nursing care plan and terminating of care.

Patient was relieved from abdominal pain within 8 hours. 20th May 2022

On the 20th of May, 2022 at 1:00pm Mr. D.T complained of severe abdominal pain. An objective was set for patient to be relieved from pain within 8hours and the following interventions were put in place; Patient's level of pain was assessed. Patient was reassured that everything will be done to relieve the pain, He was put in bed to ensure complete bed rest, prescribed antacid (suspension Nugel) was served and effect of drug was monitored. On the same day at 9:00pm, Goal was fully met as patient verbalized that he did not feel pain anymore and patient look cheerful in bed.

Patient maintained adequate fluid and electrolyte balance level within 48hours. 20th May 2022

On the same day, at 1:00pm patient was vomiting. An objective was also set to maintain adequate body fluid and electrolyte level within 24hours. The following interventions were carried out; patient's intake and output were recorded and balanced every 24hours, he was encouraged to take in more fluid, his skin turgor was assessed, he was weighed for possible decrease in weight, finally prescribed IV fluid was administered. On the 21th of May 2022 at 2:00pm this objective was fully achieved as Patient verbalized absence of vomiting and nurse recording balanced intake and output.

Patient was able to perform activities of daily living within 72hours. 20th May 2022

On this same day, patient complained of general body weakness. An objective was set for him to be able to do all his activities of daily living without assistance within 72 hours. And the following interventions were put in place: Patient was assisted to do mouth care in bed, assisted bath and grooming were done. He was massaged. His items such as mobile phone and drinking water were put within his reach. He was served with rice and stew to provide him energy.

Goal was fully met on the 23th May, 2022 at 1:30 as patient verbalized that he was able to perform activities of daily living without support and nurse observed patient perform activities of daily living such as bathing and brushing.

Patient's normal nutritional status was regained within 24hours. 21th May 2022

On the same day, at 2:00pm patient complained loss of appetite and an objective was set to help patient regain his normal nutrition status within 24 hours as and the following interventions were put in place. Patient's Manu was planned with him which included the intake of high protein and carbohydrate but low-fat intake to boost his immunity and strength. He was assisted to clean his mouth, he was served with attractive food to boost his appetite (rice with stew, egg, and meat were served) and nauseating item (bed pan) was removed from the sight of patient.

On 22th May 2022, at 2:00pm objective was fully achieved as patient verbalized gain in appetite and nurse observed patient consume more than half of food served into a 500ml bowl.

Patients was relieved from anxiety within 24hours. 22th May 2022.

On this day, the patient and his relative were seen to be anxious about his condition (gastritis). An objective was therefore set to help the patient and his relatives to be relieved of anxiety within 24 hours. The following were nursing interventions implemented to allay the anxiety of Mr. D.T and his relatives; Anxiety status of the patient and relatives was assessed, they were

reassured that, he was in the hands of competent health team. He was introduced to other patient who had successfully recovered from similar condition who came for review and patient was made to express his feelings about his disease condition and the environment in which he found himself.

On Saturday 23 May 2022, goal was fully met as patient verbalized absence of fear and nurse observed patient having cheerful facial expression in bed.

Patient acquired adequate knowledge about the condition within 24hours. 22th May 2022

On the same day, it was realized that Mr. D.T and his relative had no knowledge about his condition. An objective was set to give adequate knowledge regarding the causes, signs and symptoms, treatment and prevention of Gastritis within 24hours**.**Education was made on, causes, signs and symptoms, treatment, precipitating factors, medication regimen and prevention of the disease condition, He was encouraged to ask questions concerning his condition and the treatment regimen and questions were answered in simple terms to relieve him of any misconception.

On 23th May 2022 an objective was fully met as patient and family was able to answer simple question on nursing procedure and activities and nurse observed patient and family cooperated during procedure.

5.2 Amendment of Nursing Care Plan

All objectives set during the planning phase were achieved with effective nursing care, implementation, and cooperation of patient and family, and the coordinated activities of other health staff. There was no amendment of any of the set objectives.

5.3 Termination of care

Termination of care is a therapeutic process that helps patient and the nurse to end their relationship. It is a gradual process which starts from the day of admission. [Kerry, H. C, 2014).

They were told that hospitalization was a temporal procedure to help treat him and that we will part company. Mr D.T and family did their best by co-operating and adhering to advice and education given during admission, discharge and home visits. He was told about the termination of care during his review day, 29th May, 2022 that it will take place during my last home visit 31st May, 2022. During my last home visit, care was indeed terminated where he was handed over to a Community Health Nurse to ensure continuity of care. In the end I thanked them for giving me the opportunity to render my nursing care to them.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

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

6.1 Summary

This case study was about the care given to Mr. D.T, eighteen (18) year old boy who was admitted to the male medical ward of the Holy Family Hospital Techiman through the Accident and Emergency department on the 20th May, 2022.

On admission, Mr. D.T presented persistent vomiting, nausea, severe abdominal pains, dizziness, pain at the epigastric region. After physical examination and laboratory investigations he was diagnosed of Gastritis. Through the use of the nursing process, his health problems were identified and all necessary actions including medical and nursing interventions were carried out to aid effective management and speedy recovery. six health problems were identified. Nursing diagnoses made included; acute pain (abdominal pain) related to irritation of stomach mucosa, Risk for fluid imbalanced as evidence by nausea and vomiting, Activity intolerance related to general body weakness, Imbalance nutrition less than body requirement related to loss of appetite, Anxiety related to unknown outcome of disease gastritis and Deficient knowledge related inadequate information about disease(gastritis).

Objectives were set and orders carried out to ensure achievement of goals. Routine nursing care and procedures such as assisted bathing, mouth care, drug and intravenous fluid administration, and monitoring of vital signs were carried out to ensure quick recovery of the patient.

After meticulous planning and intervention, in the holistic nursing care, Mr. D.T recovered and was discharged on the 24th of May, 2022 with no complications identified. The interaction between my patient and family lasted Five (5) days and came for review on the 29th May2022. Three follow – ups in the form of home visiting were made to determine the health status of the patient following discharge, identify other problems and help find solutions to the identified problems. Care was finally terminated on the 31st May, 2022 during my third home visit

6.2 Conclusion

In conclusion, I have become more conversant with the disease Gastritis as a result of the care study. The literature review from different books has helped me a lot in understanding this disease gastritis.

I strongly recommend that the writing of care study should be continued since it improves our communication and health education skills. Generally, the care of the patient was a successful one, because of the early recovery and regaining of his health. Through interaction with my patient and family, a lot have been learnt about the nursing process. It has broadened my knowledge on the condition both theoretically and practically. The patient and family have also benefited as they came to realize their health needs and were prepared to take the necessary measures to meet them. I therefore accept the concept of patient and family care study to be used in order to equip the student nurse for better performance in the line of duty.

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APPPENDIX

Table 7: Observation of vital signs

Date	Time	Temperature(^{0}C)	Pulse (bpm)	Respiration(cpm)	Blood pressure (mmHg)
20/05/22	12:30pm	38.5	79	24	116/74
	2:00pm	37.9	78	21	120/65
	6:00pm	37.8	79	20	120/60
	10:00pm	36.9	77	22	118/63
21/05/22	6:00am	37.5	76	21	116/73
	10:00am	38.6	78	20	120/60
	2:00pm	37.5	77	21	118/63
	6:00pm	36.5	80	21	120/60
	10:00pm	36.0	68	20	116/74
22/05/22	6:00am	36.5	61	20	110/63
	10:00am	36.5	76	20	120/60
	2:00pm	36.7	63	21	120/60
	6:00pm	37.0	76	21	120/80
	10:00pm	36.5	69	20	125/70

Table 7: Observation of vital signs continued

23/05/22	6:00am	36.5	78	20	125/80
	10:00am	36.7	69	20	120/80
	2:00pm	36.5	88	20	110/75
	6:00pm	36.5	78	21	110/65
	10:00pm	36.0	76	21	125/60
24/05/22	6:00am	36.5	79	20	122/80
	10:00am	36.0	75	19	120/60

SIGNATORIES

NAME OF CANDIDATE: ASARE PEPERTUAL

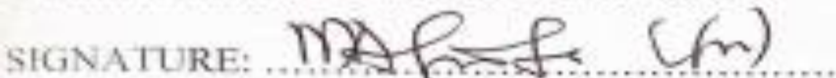
SIGNATURE: ....

DATE: ...06/10/2022...

NAME OF WARD IN- CHARGE (MALE'S WARD)

NAME: HENKIEL OPPONG KYEKYEKU

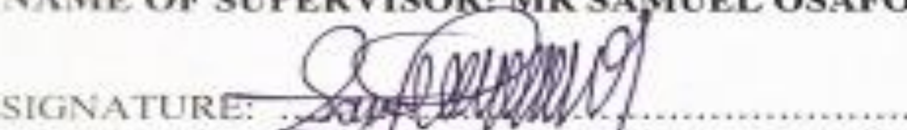
SIGNATURE: ....



DATE: ...06/10/2022...

NAME OF SUPERVISOR: MR SAMUEL OSAFO ASARE

SIGNATURE: ....



DATE: ...06-10-2022...

NAME OF COLLEGE PRINCIPAL: MONICA NKRUMAH

SIGNATURE..................................

DATE...07/10/2022.........

ACADEMIC CO-ORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BEREKUM