HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE,

BEREKUM

A PATIENT AND FAMILY CARE STUDY ON

GASTROENTERITIS

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

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PREFACE

Nursing is a profession within the health care sector focused on the care of the individual, families and communities so they may attain, maintain or recover optimal health and quality of life. This involves the promotion of health, treatment, prevention of illness and the care of ill.

Patient /family care study is carried out by student nurses to enable them put into practice the knowledge and skills which they have acquired throughout their training and to render an individualized /family centered and comprehensive nursing care to patient from the day of admission till the patient recover.

This helps the student nurse to encounter with the patient and gather important information on a disease condition in order to provide a comprehensive nursing care to the patient and family.

This study serves as a requirement for the award of a professional license to practice by 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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Finally, my appreciation goes to all authors and publishers whose books I sampled for valuable information for writing this care study.

INTRODUCTION

Patient and family care study is a written report of the care rendered to the patient /family which is required by the Nursing and Midwifery Council of Ghana in partial fulfillment for the award of license to practice as a professional Registered General Nurse.

This study was carried out on Mrs. M.H, a 39-year-old woman who was admitted at the Female Medical ward at Tain district hospital in the Bono Region, with a diagnosis of gastroenteritis. Mrs. M.H. was admitted on 25TH of August 2023 and was discharged on the 29TH of August 2023. Mrs. M.H. spent five days in the hospital. I introduced myself to her as a final year student who would like to use her as my client for my patient/family care study. I told her instead of her full name, I will rather use her initials for the purpose of confidentiality which she agreed.

On admission, patient complained of vomiting, nausea, anorexia, headache, abdominal discomfort and dizziness. Patient temperature was taken and recorded as follows, Temperature 38.1^{o}c, Blood pressure 110/70mmHg, pulse 98bpm, respiratory 19cpm, spo2 98% RBS 5.4, patient was reassured of competent nursing care and interventions were made. Patient was discharged with no complications due to the effective medical and nursing care rendered to her. Home visit was made during admission and after discharge to ensure continuity of care, and to educate client and family on the disease condition. I chose Mrs. M.H for my care study in order to learn more about gastroenteritis.

This script is presented in six (6) chapters that is in line with the nursing process as follows;

Chapter 1: Assessment of patient and family

Chapter 2: Analysis of data

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment is the systematic collection of data to determine the patient's health status and any actual or potential health problems (Smeltzer &Bare, 2012). It is an interactive process of gathering information to identify strength of the patient, his potential and actual health problems, as well as to evaluate the effectiveness of the care rendered. It is the first step in the nursing process. It is considered critical because it is the only step that helps in obtaining subjective data and objective data that will lead to effective planning of care for the patient. It consists of patient biographic data, family socio-economic history, patient's developmental history, patient's lifestyle and hobbies, patient's past medical history and the present medical history of the patient, literature review and validation of data. Data was collected through interview and observation of both patient and family which helps to identify patient problems. Laboratory investigations were also done.

1.1 Patient's Particulars

Patient's particulars are defined as the details about the individual receiving treatment at the hospital, especially when officially recorded (McIntosh 2020). Mrs. M.H, a 36-year-old woman from Seikwa in the Bono Region and was born on June15th,1988 at Tain District Hospital in the Bono region. She was born to Mr. S.U and Mrs. R.U. She is the second born among eight children, of which two are females and six are males. She is fair in complexion with round face and a pointed nose. She weighs 60kg and has a height of 1.29m. Miss M.H has no physical impairment. She is a science tutor at Nsawkaw state Senior High School. She stays at the school bungalow with her first-

born Miss P.U. She uses Miss P.U as her next of king. She is a Christian who attends Jehovah Witness. She is Bono by tribe, speaks Twi and English. Mrs. M.H has no physical impairment.

1.2 Family's Medical History.

Medical history is a record of medical information about an individual and their biological family. Family history provides a ready view of problems and illness within the family and facilitates analysis of inheritance or familial patterns (Shiel,2019).

According to Mrs. M.H, there is no known chronic or hereditary disease such as diabetes, hypertension, asthma, mental illness or epilepsy in the family. She said her father died a natural death some years ago. She said sometimes her family members do suffer from minor conditions like common cold, fever, headache and they intervene by going to the hospital instead of over-the-counter drugs, due to the advice a friend gave her concerning those drugs. She has no known allergies to food and drugs.

1.3 Family socio-economical history

According to my client, she gets support from her husband who is also a teacher at Wenchi Methodist senior high school, her salary and senior brother financially. My patient source of funding her medical care is from the National Health Insurance (NHIS). She also said she has good interpersonal relationship with her neighbors same as her co - tutors and participates in almost all kind of school, community and religious activities.

1.4 Patient's Developmental History

Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Weller, 2014).

According to Mrs. M.H, she was delivered at term through spontaneous vaginal delivery at Wenchi Methodist Hospital on the 15th of June, 1988 with no complications of pregnancy and labour . She has no congenital malformation such as cleft lip or cleft palate. She was breastfed and was also introduced to supplementary foods as well but due to lack of knowledge she was introduced before her sixth month. She was breastfed for one year. According to her, she was told by her mother that she started sitting at six months and it did not take up to a month for her to crawl with her teeth erupting that same month and by the Eleventh month she started walking. However, she could not trace her immunization card. She saw her first menstrual period when she was 13years old (Menarche). According to Mrs. M.H, She stayed with her mother from birth until she completed tertiary and now staying at Nsawkaw where she teaches. She said every week her husband gives her money which she uses some to cater for herself and daughter. She started schooling when she was three years at Seikwa where her mother stays.

According to Erikson's theory of psychosocial development in 1954 describes the human life cycle as a series of eight egos developmental stages from birth to death. The theory focuses on psychological task that are accomplished throughout the life cycle. According to Erikson's theory of psychosocial development (1995), there are eight distinct stages with each possible result. These could be success or failure. These stages are

1. Trust versus Mistrust (birth to 18months)

2. Autonomy versus Shame and Doubt (18m to 3 years)

3. Initiative versus guilt (3 to 6 years)

4. Industry versus Inferiority (6 to12 years)

5. Identity versus Role confusion (12 to20)

6. Intimacy versus Isolation (20 to35)

7. Generativity versus Stagnation (35 to 65 years)

9.Integrity versus Despair (65 to death)

Mrs. M.H is considered to be under Generativity versus Despair which is (35 to 65) since she is 39 years of age, this stage is characterized by fulfilling life goals that involves family, career and society. Generativity is the concern of helping in guiding the future generation. Social –valued work and disciplines are expression of the stage. When a person makes a contribution during this stage by raising their own family and working towards the betterment of the society, sense of generativity, sense of productivity and accomplishment results. A person who is self- centered and unable to help society develops a feeling of stagnation ,dissatisfaction with relatives and lack of productivity. Therefore Mrs M.H falls under generativity because she has been able to raise her own family and working hard to achieve a better future for her family and also she contributes to society by attending any gathering and taking part in all activities that is taken to bring about development of the society .

1.5 Patients life style\Hobbies

Life style is the pattern of daily living that an individual develops (Weller, 2014). Hobbies are activities one does for pleasure when he or she is not working (Hornby, 2012).

According to Mrs M.H., she usually goes to bed around 10:00pm after studying and wakes up around 5:30am every day except on weekends. She brushes her teeth with tooth brush and Pepsodent, sweep, visits the toilet, takes her bath with warm water and prepare for school. She normally takes porridge as breakfast around 10:00am and takes launch at 12:30pm and after closing from school, she goes back home and prepare food for she and her child to eat. During weekends,

she wakes up around 8:00am, washes her clothes and cleans the house. On Saturday evening, she goes to the chapel with her friends to assist in sweeping there for Sunday services. On Sundays, she goes to church with her daughter and afterwards she comes home to rest. She eliminates her bowel and bladder when she feels the urge to do so. Even though, rice with stew is her favorite but she eats all kinds of food. She said she is not fun of making many friends so she spends most of her time with her daughter and husband on weekends during her leisure time. They usually go on outing at a particular restaurant to eat and have fun. According to her this helps them release stress, strengthen their bond and create loving memories.

1.6 Patient's Past Medical/Surgical History

Patient's past medical history provides information on client's state of health and illness before the present complaints (Bailliere's Nurses Dictionary, 2019). According to Mrs. M.H, she has never experienced any childhood illness. However, she usually suffers from minor illness such as headache, fever, common cold but purchase over the counter drugs. She has no known allergies to food or drugs.

1.7 Patient's Present Medical/Surgical History

According to Mrs. M.H, on 24th August, after super around 6:40pm, she started experiencing abdominal discomfort, vomiting and diarrhea. The following day she became weak and could not do anything for herself. She told her husband and was brought to Tain District hospital on the 25th of August 2023 and She was detained at the Emergency Unit and later was admitted to the Female Medical Ward.

1.8 Admission of patient

Admission of a patient means allowing and facilitating a patient to stay in the hospital unit or ward for observation, investigation and treatment of the disease he/she is suffering from (Potter &Perry, 2016). On the 25th of August 2023 patient was admitted into the Female Medical Ward around 2:30pm from the Emergency Unit accompanied by her relative and I to the female medical ward with a diagnose of Gastroenteritis by Doctor E.A. They were welcomed and received warmly. Patient was given a bed which was already prepared and she was made comfortable in bed. Her valuables were collected and kept in her locker beside her bed. On observation, she was alert and conscious but weak. Her vital signs were checked and recorded as follows:

1. Temperature: 38.1^0C
2. Blood pressure 110/70mmHg
3. Pulse 98 bpm
4. Respiratory 19 cpm
5. Oxygen saturation 98%
6. Random blood sugar 5.4 mmol/L
7. Weight 60kg

Patients name, sex, in-patient number were all written into the admission and discharge book and unto the daily ward state. Since patient was weak, his wife was oriented on the ward environment, lavatory, visiting hours, ward routines and time for ward rounds

The patient was placed on the following treatment plan:

1. Intravenous Ringers Lactate 1.0L over 24hours
2. Intravenous Normal Saline 1.0L over 24hours

3. Intravenous Ciprofloxacin 400mg bid for 24hours
4. Intravenous Metronidazole 500mg tid for 24hours
5. Intravenous Paracetamol lg tid for 24hours

Below are the laboratory investigations that were done at the accident and emergency unit

1. Full Blood Count
2. H- Pylori test
3. Malaria Parasite Test
4. Abdominopelvic ultrasonography
5. Pregnancy test

Patient and relatives were informed that the National Health Insurance Scheme covers some medicines but others may not be covered and so they will be prescribed for them to buy them from the pharmacy shop (Scab pharmacy) or they can be asked to pay for such drugs. She was admitted into the admission section on the ward computer. I reintroduced myself to patient as a final year student nurse of the Nursing and Midwifery Training College, Berekum, who would like to take her and her family for my care study. Mrs. M.H and her relatives were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of license to practice as a Registered General Nurse. I explained to the patient and her relatives about the concept of the patient/family care study and assured them of privacy and confidentiality. It was added that a report will be written after the entire event. Mrs. M.H and her relatives agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. to Mrs. M.H and relative.

Discharge planning was initiated with the relatives; thus, they will continue the care at home once she is well. I decided to choose this patient for the study because I wanted to know more about gastroenteritis as the incidence of this condition is more prevalent in this locality and identify empirical ways of preventing it.

Her condition was explained to her and her relative. They were oriented to the ward by introducing them to other staffs, showing them the toilet and bath room and told them the visiting hours. I also told them the time the doctors do their rounds and the time she will be taking her drugs too. Patient details such as name, age, sex, occupation was entered into the admission and discharge book. I then informed the ward in-charge about my intention of using the patient for my care study and she approved it. I introduced myself to the patient and relative as a final year student of Holy Family Nursing and Midwifery Training College, Berekum conducting a care study and I would be glad if they would permit me to use Mrs. M.H. as my patient. I told them that it is a requirement of the Nursing and Midwifery Council of Ghana to all final year student nurses to take a patient each and nurse them from day of admission till discharge and then home visit. I told them I would be using her initials for the purpose of confidentiality. They agreed and assured me of their cooperation. I decided to choose the patient for the study because I wanted to put into practice the theoretical knowledge that I acquired and also get a detailed understanding into Gastroenteritis disease and its available management.

1.9 Patient's Concept about illness

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

During my interaction, Mrs. M.H made and family had no knowledge about her condition, thus gastroenteritis and they did not attribute the illness to any spiritual causes. They expressed confidence of getting well soon because according to them, they believed that with God's healing through good nursing and medical treatment, she would have a complete recovery and join family back home and return to daily duties.

1.10 Literature Review on Gastroenteritis

Anatomy and physiology of the stomach

The stomach is situated in the left upper portion of the abdomen under the left lobe of the liver and the diaphragm, overlaying most of the pancreas. A hollow muscular organ with a capacity of approximately 1500 mL, the stomach stores food during eating, secretes digestive fluids, and propels the partially digested food, or chyme, into the small intestine. The gastroesophageal junction is the inlet to the stomach. The stomach has four anatomic regions: the cardia (entrance), fundus, body, and pylorus (outlet). Circular smooth muscle in the wall of the pylorus forms the pyloric sphincter and controls the opening between the stomach and the small intestine. The stomach is lined with columnar epithelial tissues. The small intestine is the longest segment of the GI tract, accounting for about two thirds of the total length. It folds back and forth on itself, providing approximately 7000 cm (70 m) of surface area for secretion and absorption, the process by which nutrients enter the bloodstream through the intestinal walls. It has three sections: The most proximal section is the duodenum, the middle section is the jejunum, and the distal section is the ileum. The ileum terminates at the ileocecal valve. This valve, or sphincter, controls the flow of digested material from the ileum into the cecal portion of the large intestine and prevents reflux of bacteria into the small intestine. Attached to the cecum is the vermiform appendix, an appendage that has little or no physiologic function. Emptying into the duodenum at the ampulla of Vater is the

common bile duct, which allows for the passage of both bile and pancreatic secretions. The large intestine consists of an ascending segment on the right side of the abdomen, a transverse segment that extends from right to left in the upper abdomen, and a descending segment on the left side of the abdomen. The sigmoid colon, the rectum, and the anus complete the terminal portion of the large intestine. A network of striated muscle that forms both the internal and the external anal Sphincter (Hinkle & Cheever, 2018)

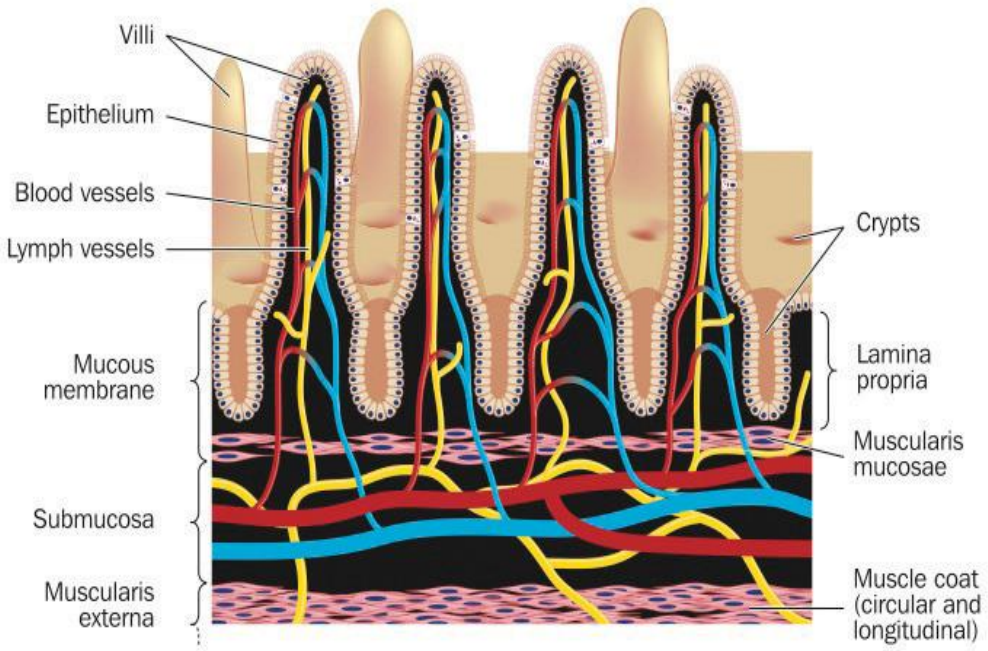

Figure 1. Microscopic structure of the intestine

The diagram below shows the anatomy of the stomach.

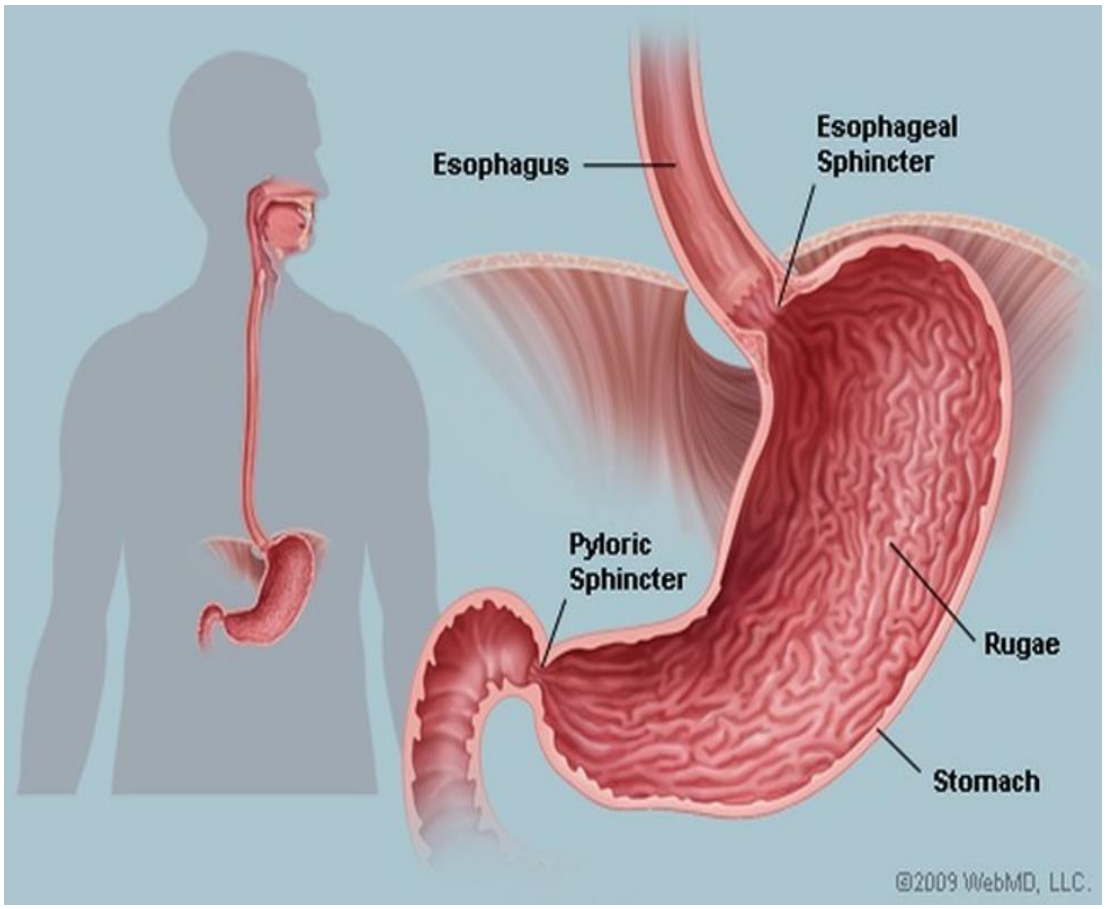

Figure 2. The anatomy of the stomach

Layers of The Stomach

The stomach has four (4) layers and they are (Hinkle & Cheever, 2018);

The inner mucosa (mucous membrane); This is the inner lining of the stomach made of epithelial cells (simple columnar) which is thrown into folds called rugae. These rugae expands to help increase the total surface area of the stomach. These epithelial cells dip downwards to form pit where these gastric glands secrete their content (gastric juice) into

Submucosa; This is the next layer that covers the mucosa and is made up of connective tissues such as blood and lymph vessels as well as network of nerves and fibres.

Muscularis externa; It is the next layer that covers the submucosa and muscle fibres.

Serosa. It is a fibrous membrane that covers the outside of the stomach and it is called visceral peritoneum. Structure That Connects the Mouth to The Stomach

Structure That Connects the Mouth to The Stomach

Oesophagus: It is a tube-like organ that connects the mouth and throat to the stomach at a junction called the gastroesophageal junction which forms a physiological sphincter that control and prevent back flow of food from the stomach to the oesophagus.

Definition of Gastroenteritis is a medical condition from inflammation (“-itis”) of the gastrointestinal tract that involves both the stomach (“gastro" -) and the small intestine (“entero" -). Gastroenteritis is inflammation of the mucosal lining of the stomach and intestines characterized by abdominal cramping, vomiting, nausea and diarrhea (Hinkle & Cheever, 2018). It is also referred to as stomach or intestinal flu or traveler’s diarrhea or intestinal flu.

Causes of Gastroenteritis

As specified by (Walker & Whittlesea, 2015) Gastroenteritis has many causes which include the following;

1. Bacteria such as; Escherichia coli, staphylococcus aureus, salmonella, shigella, and clostridium perfringes.

2. Parasites such as; Ascaris, enterobius and trichivellaspiralis

3. Viruses such as; Echo viruses, adenoviruses, norovirus, and rotavirus

4. Amoeba like Entamoebahistolytica

5. Reaction to some drugs like antibiotics.

6. Enzymes deficiencies

7. Food allergies.

Pathophysiology Gastroenteritis

Bacteria in the gastrointestinal tract use the following mechanism to bring about the disease condition (Ethelwayann, 2019). They are;

Enterotoxin production; the organism gain entry into the GIT, multiply and release toxins that bind to the mucosa and cause a profuse secretion of water and electrolytes. Example; shigella and Vibrio cholerae.

Invasion of epithelial cells: The bacteria invade and destroy the cells of the intestinal epithelium. This therefore, leads to bloody mucoid stools. Example E- coli.

Penetration and systemic invasion: There are local inflammation in which the organisms try to penetrate the mucosa and gain access to the systemic circulation. This inflammatory process goes a long way to bring about stimulation and secretion of intestinal fluids. Because the mucosa lining of the GIT is inflamed, food cannot be retained and there is no alternative than to be vomited or passed out as watery stool. As a result of the excessive loss of water through vomiting and stool, dehydration becomes the order for the day and also the individual becomes very weak due to the inability to retain food. There is also scanty and concentrated urine because most of the fluid is passed out as stools and vomitus.

Also, inflammation reaction and the presence of toxin also stimulate a sympathetic nerve which stimulates salivation, nausea and vomiting. It further increases intestinal activities leading to

diarrhoea and abdominal pain. Persistent diarrhoea and vomiting subsequently lead to depletion of body fluid and electrolyte especially bicarbonate reserves. It predisposes to acidosis, fluid volume deficit and circulatory collapse. This further leads to fluid shift from intracellular compartment to extracellular compartment resulting in to systemic disturbances in cellular functions and changes in their shape which manifest as sunken eyes and dry mucous membrane.

Also, fluid volume deficit and subsequent electrolyte imbalance result in hypocalcemia which triggers the sympathetic nerve to stimulate the heart to increase pulse rate.

Incidence

Gastroenteritis occurs in persons of all ages and is a major cause of morbidity and mortality in most developing countries. It ranks second to common cold as a cause of loss of work time and fifth as the cause of death among children. It can be life threatening in the elderly. The very young, old and immune suppressed patients can become quite ill with this self-limiting condition (Hinkle & Cheever, 2018).

Mode of Transmission

Fecal-oral is the main mode of transmission. The human hand is the main medium for transmission aided by flies where these are prevalent or rampant. Infective materials spread to the hands and then to the mouth (Hinkle & Cheever, 2018).

Types of Gastroenteritis.

There are two (2) types of gastroenteritis according to Schloss-berg, (2015) based on the location.

Parenteral – This is where the condition occurs in other systems of the body other than the gastrointestinal tract. Example is whooping cough among others.

Enteral – This is the most common form and is result from the inflammation of the gastroenteritis tract.

Two Types of Gastroenteritis Based on Onset and Duration

Acute gastroenteritis: It is an irritation and inflammation of the gastrointestinal tract which have a sudden and do not last longer. It can also resolve on its own when given an immediate treatment, and do not last longer.

Chronic gastroenteritis: It occurs gradually and last longer. This result when the condition in its acute state is left untreated.

Clinical Manifestation of Gastroenteritis

The following are some clinical manifestations of gastroenteritis according to Hinkle and Cheever, (2018).

1. General body weakness and feeling of restless as a result of inadequate intake of food and malabsorption
2. Sudden loss of appetite
3. Frequent watery stool (diarrhoea)
4. Presence of blood or mucous in stool.
5. Mild to severe abdominal pain
6. Nausea with or without vomiting which may be forceful and may occur right after eating.
7. Fever
8. Hyperactive bowel sounds may be present (Borborygmi).
9. Weight loss

In severe form, there can be

10. Rapid pulse as a result of re-hydration
11. Severe headache from fluid insufficient
12. Poor skin turgor
13. Scanty and dark urine from dehydration.

Diagnostic Investigations

The following diagnostic investigations can be carried out to diagnose an individual of gastroenteritis (Lewis, Dirksen, Heitkemper, & Bucher, 2014).

1. The presentation of the clinical manifestation
2. History taking: this is to rule out any parenteral cause of illness
3. Stool examination to determine the parasite present in stool
4. Blood culture to identify the causative organism
5. Complete blood count (CBC). To know if there is rise in white blood cells
6. Abdominal X-ray
7. Serum electrolytes estimation to compare the normal electrolytes level such as sodium, potassium among others.

Treatments for Gastroenteritis Medical Management

Gastroenteritis when acute must be treated as medical emergency for the following reasons (Hinkle & Cheever, 2018);

To avoid the spread of disease to other people.

1. To avoid the complications of the disease.

2. Severe diarrhoea is treated with oral rehydration salt (ORS) therapy in which physiological salt solutions are given orally to correct dehydration and electrolyte imbalance.
3. Hospitalization may be needed as the patient requires as support treatment consisting of bed rest, nutritional support and increase fluid which needs monitoring
4. Histamine-receptor antagonist such as cimetidine may be prescribed as they block gastric secretion.
5. Antacids such as Aluminium Hydroxide may be used as buffers which can be administered hourly.
6. Analgesics such as Budesonide and Ibuprofen (NSAID) can also be given for abdominal pains.
7. Anti-emetics, for example Phenergan is given to reduce vomiting.
7. Intravenous fluids and electrolytes replacement can be given. The intravenous fluids which are normally given are normal saline, dextrose saline and ringers lactate.
8. Bismuth containing compounds such as prochlorperazine, or thiobenzamide can be given,
9. Antimicrobial agents are not usually used for gastroenteritis, although they are sometimes recommended if symptoms are particularly severe or if a susceptible bacterial cause is isolated or suspected. If antibiotics are to be employed, a macrolide (such as azithromycin) is preferred. Other antibiotics prescribed may include metronidazole, cefuroxime and ciprofloxacin
10. Antispasmodics example Buscopan

Nursing Management of Gastroenteritis (Lewis, Dirksen, Heitkemper, & Bucher, 2014)

Rest & Sleep

1. Encourage patient to rest to conserve energy and to reduce peristalsis
2. Encourage patient to do minimum activities and turns to prevent thromboembolitics complications.

Pain & Relieve Management

1. Reassure patient of the appropriate measures that are put in place to reduce the pain.
2. Encourage patient to describe the nature and characteristics of the pain
3. Encourage patient to assume a comfortable position
4. Local application of heat (as prescribe) to minimize pain
5. Encourage patient to engage in diversional activities.

Maintaining Food Intake

Keep accurate record of oral and intravenous fluids and records of outputs such as vomitus, urine and watery stool.

1. Monitor and record patient's daily weight for fluid gain or loss.
2. Assess patient's skin for dehydration
3. Encourage oral intake of fluid.
4. Monitor flow rate of any intravenous fluids to prevent overload of fluid.
5. Put measure in place to prevent diarrhoea agents.

Maintaining Optimal Nutrition

1. Plan diet with patient and relatives to meet his or her nutritional demands.
2. Encourage oral toileting twice daily to stimulate appetite and prevent nausea.
3. Encourage patient to eat adequate caloric, protein and vitamin rich foods to control infection and provide adequate energy
4. Encourage patient to food that are spicy free to prevent of the GI mucosa. 5. Encourage patient to eat in bit but frequent to prevent vomiting

5. If patient cannot tolerate oral foods, put patient on parenteral feeding and assess patient's weight daily to prevent hyperglycaemia and monitor blood glucose every four or six hourly.

Anxiety Reduction

1. Reassure patient and relative of competent nursing care.
2. Introduce patient to patient with the same condition who are recovering positively.
3. Encourage patient and relatives to ask questions to free their minds 4. Answer all asked questions tactfully to allay their fears and anxieties.
4. Educate patient and her relatives on her condition.

Personal Hygiene

1. Encourage patient to do oral toileting twice daily.
2. Encourage patient to bath at least twice daily to minimize and control cross infection.
3. Encourage patient to do oral care always to prevent infections and anal sore due to frequent diarrhoea.
4. Change patient's linen daily.
5. Encourage patient to the need to change clothing after bathing.

Education of Patient and Family

1. Educate patient and relatives on the need to cover foods to prevent exposure of foods to flies.
2. Educate patient and family to eat warm foods.
3. Educate patient on the need to avoid open defecation.
4. Educate patient and family on the need to thoroughly wash raw fruits and vegetables with salty clear water before eating.

5. Educate patient and family on the need to practice personal and environmental hygiene.
6. Educate patient and family on the need to do proper hand washing before eating.
7. Educate patient and family on the early signs of dehydration and diarrhoea.

Complications

As specified in Lewis et al. (2014), if early treatment is not sought for, the following complications may develop.

1. Acute renal failure is due to frequent vomiting and diarrhoea may lead to dehydration, which in turn may decrease blood volume and hence reduced circulatory volume. This therefore decreases renal perfusion and may lead to renal failure.
2. Fluid and electrolytes Imbalance as a result of diarrhoea and vomiting may lead to loss of hydrogen ions from the stomach. Bicarbonate ions may also be lost through diarrhoea which may cause imbalance in these electrolytes in the blood and may lead to acidosis or alkalosis.
3. Convulsions (in case of a child) due to inadequate blood supply to the brain and fever and also infections travelling to the brain causes problem to the brain which may lead to convulsion.
4. Malnutrition this occurs when the body doesn't get enough nutrients e.g., poor diet and digestive conditions.
5. Dehydration may occur as a result of diarrhoea. In diarrhoea, there is loss of bicarbonate ions from the intravascular component. The loss of these electrolytes goes along with plasma (water), causing the increase in osmotic/oncotic pressure. This causes fluid to shift from the extracellular and intracellular spaces, causing the cells to shrink causing dehydration.

6. Cardiac failure occurs as a result of decreased cardiac output. The heart is the first organ to receive oxygenated blood. In diarrhea, the patient losses fluid and subsequently lead to hypovolemia. This leads to decreased blood volume and hence decreased cardiac perfusion. This then leads to ischemia and may lead to cardiac failure.
7. Hypovolemic Shock occurs as a result of fluid lost along with electrolytes. As the fluids are lost from the intravascular spaces, the volume of the blood reduces, causing reduction in cardiac output, and hence, decreased perfusion to the vital organs, leading to shock

1.11 Validation of Data

Validation is the extent to which a measure, indicator or a method of data collection possesses the quality of being sound or true as far as can be judged (Weller, 2016). Data collected from Mrs. M.H were similar to those the relative told me, also during my home visit most of the information given to me by Mrs. M.H and her relative at the hospital were confirmed by other relative in the house. Data presented by Mrs. M.H and the diagnostic investigations carried out were similar to those in the literature review. When the patient's condition became stable and all the relatives had calm down, I again asked them the same questions which were asked previously and the same response was given. Upon this I therefore believe the information gathered was

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis of data is a systematic examination and evaluation of data or information, by breaking it into its component parts to uncover their interrelationship, thus providing basis for problem solving and decision making (Weller, 2016).

It forms the second phase of patient and family care study. This section of the client/family care study comprises of examination of data and grouping them into constituent parts. This then helps identify client's problems and also formulation of nursing diagnosis

Analysis also help to prioritize client's problems and carefully institute plans to aid solve the health problems of the client and the family.

It also comprises of critical examination and interpretation of the data collected during assessment of the patient and comparison of the results of investigations carried out with standards in literature. It also talks about the pharmacology of drugs prescribed by the Doctor and also interpretation and identification of the patient and family health needs; which comprises of physical, social, spiritual and psychological health needs of the Mrs. M.H and her family.

This chapter also reviews the causes, clinical manifestation, diagnostic investigations, medical pharmacological management, complications of gastroenteritis, patient and family strength related health problems identified and their respective nursing diagnosis.

2.1 Comparison of Data with Standard

This is where patient's data are studied and compared with the standards set in literature. They include the following;

1. Diagnostic investigation/ Tests
2. Causes
3. Clinical features
4. Treatment
5. Complications

Medical/ Surgical treatment

A. Diagnostic Investigation/Test

Investigations are procedures performed to establish a diagnosis, to monitor a previous health disease or the effectiveness of treatment (Weller, 2016). They can be classified as no invasive when there is no direct entry into the body. Example is recording a body weight on invasive, example is endoscopy or blood sampling.

The following diagnostic investigations were carried out on Mrs. M.H

1. Urine routine and examination
2. Full blood count (FBC)
3. Blood sample for malaria parasites (MP's)
4. Helicobacter pyloric test
5. Abdominopelvic USG
6. Pregnancy test

Table 2. 1: Comparison of Laboratory Investigations In Literature With Those That Were Carried Out On Mrs. M.H

Laboratory Investigation in Literature Review	**Laboratory Investigations Conducted in Patient**
1. Stool examination	1. Stool examination was not done
2. Blood culture	2. Blood culture was not done
3. Complete blood count	3. Blood count was done
4. Abdominal x-ray	4. Abdominopelvic x-ray was not done
5. Serum electrolyte estimation	5. Serum electrolyte was not done
6. Urine routine examination	6. Urine examination was done
7. Pregnancy test was not in literature review	7. Pregnancy test was done
8. Helicobacter pylori test was not in literature review	8. Helicobacter pylori test was done
9. Malaria parasite test was not in literature review	9. Malaria parasite test was done
10. Abdominopelvic ultrasonography was not in literature review	10. Abdominopelvic ultrasonography was done

With reference to table 2.1 the tests that were not in the literature but were conducted on Mrs. M.H to rule out other causes from her condition (gastroenteritis). Also, serum electrolytes estimation, stool examination and blood culture and abdominal x-ray were not conducted on Mrs. M.H because the diagnosis was confirmed using the result of the abdominopelvic ultrasonography.

Table 2: Diagnostic Investigation/Test Carried on Mrs. M.H Compared with Standard

Date	Specimen	Investigations	Results	Normal Value	Interpretations	Remarks
25\8\23	Blood sample	Blood film for malaria parasites (MP's)	No malaria parasites seen.	No malaria parasites should be seen	Absent of malaria parasite indicate that patient is not having malaria.	No treatment was given to patient.
25\8\23	Blood	Full Blood Count				
		White blood cell count.	11.1g/dl	4.0-10 × 10^3g/dl	Abnormal	Antibiotic were administered(ciprofloxacin and metronidazole)
		Red blood cell	4.7×10^{12}g/dl	4.5-5.5×10^{12}g/dl	Red blood cell is within normal values.	No treatmen.t were given
		Hemoglobin (HB) level	13.1g/dl	Females (12.0-16.0) Males (14.0-18.0)	It was within the normal ranges.	No treatment was given to patient.

Table 2: Diagnostic Investigation/Test Carried on Mrs. M.H Cont'd…

Date	Specimen	Investigations	Results	Normal Value	Interpretations	Remarks
25/08/23	Abdomen	Abdominopelvic ultrasonography Liver	0.1cm	Should not be enlarged	No hepatic problems	No treatment given.
		Gall bladder	16.6cm	Should not be enlarged and inflamed.	It indicate healthy bladder	No treatment were given.
		Bowel loop	Dilated with thickened wall with increased peristaltic movement	Should not be dilated and peristaltic movement should not increase.	Findings are in keeping with inflammatory bowel disease.	Prescribed antibiotic were administered(metronidazole, paracetamol)
25/08/23	Urine	Pregnancy test	Negative	Should be negative	No possible pregnancy	No treatment.

25/08/23	Urine	Urine R/E Color	Amber	Amber/straw	Normal	No treatment given
		Clarity	Clear	Clear	normal	No treatment was given
		Ph	6.4	4.6-8.0	Normal	No treatment was given
		Glucose	0.0	Glucose should not be in urine.	normal	No treatment was given

B. Cause of Patient's Illness

From the history taking from my patient, physical examinations performed on my patient and the laboratory investigation carried out on Mrs. M.H condition can be confirmed to be caused by infections as indicated in the elevation of white blood cell count. Also, it can be associated with any the predisposing factors such as eating and drinking contaminated foods and water as well as the poor environmental sanitation system.

C. Clinical Manifestation

Table 3: Comparison of Clinical Manifestation of Gastroenteritis in Literature and Those Exhibited by Mrs. M.H

Clinical manifestation in Literature Review	**Presentation by the patient**
1. General body weakness	1. General body weakness was present
2. Sudden loss of appetite	2. Loss of appetite was present
3. Frequent watery stool	3. Patient had frequent watery stool
4. Presence of blood or mucus in stool	4. Absence of blood and mucus in stool
5. Mild to severe abdominal pains	5. Patient had abdominal pain
6. Nausea with or without vomiting	6. Nausea without vomiting was present
7. Fever	7. Patient had fever
8. Hyperactive bowel sound (borborgim)	8. Hyperactive bowel was not present
9. Weight loss	9. Patient had weight loss
10. Rapid pulse	10. Rapid pulse was not present
11. Severe headache from fluid insufficiency	11. Severe headache was not present

12. Poor skin turgor	12. Poor skin turgor was not present
13. Scanty and dark urine	13. Scanty and dark urine was not present

The above comparisons indicate that Mrs. M.H had gastroenteritis and exhibited the signs and symptoms captured in the literature reviewed.

D. Specific Treatments Ordered

Treatment refers to the mode of dealing with a patient or disease in order to prevent, restore health or relieve distress (Weller, 2016)

Table 4: Comparison of Treatments Given to Mrs. M.H with Those in Literature review

Drugs Outlined in Literature Review	**Drug Given to Mrs. M.H**
1. Oral rehydrated salt	1. Oral rehydrated salt was not administered
2. Administration of antibiotic such as ciprofloxacin and metronidazole.	2. Intravenous ciprofloxacin 400mg bd x 3days and intravenous metronidazole 500mg tds x 3days. Tablet ciprofloxacin 500mg bd x 7days and tablet metronidazole 400mg x 7days.
3. Anti-emetics such as promethazine and metoclopramide.	3. Was not administered
4. Adequate hydration and electrolyte balance such as normal saline, dextrose, ringers' lactate, etc.	4. Intravenous normal saline 1liter x 3days and intravenous ringers' lactate 1liter x 3days.
5. Antacids such as Magnesium Trisilicate can also be administered.	5. Magnesium Trisilicate 15mls tds x 5days was served

The above drugs prescribed and administered to Mrs. M.H compared to that of literature reviewed clearly indicate that, Mrs. M.H was given the right drugs with right doses which aided in her speedy recovery

Table 2.5 Pharmacology of Drugs Given Mrs. M.H

Date	Drugs name	Dosage / route in literature review	Dosage / route of administration	Classification	Desired effect	Actual action observed	Side effects /remarks
25/08 /23	Normal saline	**Dosage:** Depends on the patient fluid and electrolyte imbalance levels **Route:** Intravenous	**Dosage:** 1litre over 24 hours. **Route:** Intravenously	Electrolytic and fluid balance (intravenous fluid	Provide sodium chloride in patient with reduced oral or fluid intake and replace lost electrolytes and fluid replacement.	Patient provided with needed energy, electrolytes and adequate hydration.	Fluid overload may result in pulmonary oedema and hyperventilation. Patient did not experience ant of these
25/08 /23	Ringer's lactate	**Dosage:** Amount to be given depend on patient fluid and electrolyte imbalance level as well as patient condition.	Patient was given 1litre with 24 hours intravenously.	Intravenous fluid	Replace fluid and electrolyte in those who have low blood volume and low blood pressure.	Patient's fluid and electrolyte replaced.	Febrile, venous thrombosis, hypervolemia and venous irritation. Patient did not experience any of the above.
25/08 /23	Paraceta mol	**Dosage:** 0.5- 1g every 4 – 6 hours; maximum daily dose is 4g. **Route:** oral, rectal, IV.	**Dosage:**1g tid for 5days. **Route:** Orally, intravenously.	Antipyretics/An algesic	To relieve pain by blocking generation of pain impulses, probably by inhibiting prostaglandin synthesis in the central nervous system.	Patient was relieved of fever.	Dizziness, urticarial liver damage and disorientation. Patient exhibited none of these side effects

Table 2.5 pharmacology of drugs for Mrs. M.H cond't….

25/08 /23	Metronidazole	**Dosage**:400-800mg three times daily. **Route:** Intravenously, oral.	Dosage; 500mg intravenously and 400mg orally twice daily. Route: Intravenously and orally.	Antibacterial, antiprotozoal.	Disrupts DNA, inhibiting nucleic acid synthesis.	Patient did not show any sign of infection.	Anorexia, dry mouth, diarrhoea, constipation, dizziness. None of the above effect was observed
25/08 /23	Magnesium Trisilicate	**Dosage:** 10-15mls three time daily for 3-5days **Route:** Orally	**Dosage:** 15mls three times daily for 5days **Route:** Orally	Acid controlling drug (Antacid)	It neutralizes the acid content produced by the parietal cells in the gastric mucosa.	Patient abdominal pains were subsided.	Chalky taste, constipation, nausea, vomiting. No side effect was observed on patient
25/08 /23	Ciprofloxacin	**Dosage:**400mg-750mog every 12 hours for 7-14days. **Route:** Intravenously, oral	**Dosage**:400mg intravenously for 48 hours and 500mg × 5day bd orally **Route:** Intravenously Orally.	Antibiotic (Fluoroquinolone)	It inhibits DNA synthesis and inhibit DNA gyrase, an enzyme that replicate DNA.	Patient's infection resolved	Nausea and vomiting or constipation, flatulence, rashes, abdominal pains. No side effect was observed on patient.

The patient on admission exhibited most cardinal signs and symptoms of acute gastroenteritis outlined in the literature review. These signs and symptoms provided the clue and aided in his early diagnosis and treatment.

E. Complication of Patient Condition

Complication is an accident or second disease process arising during the course of or following the primary condition which may be fatal (Weller, 2016). Due to the holistic management of Mrs. M.H condition by the health team, she did not experience any of the complications indicated in the literature reviewed.

2.2 Patient/Family Strength

Definition Strength refers to the factors that contribute to patient wellbeing (Homby, 2019)

1. Patient could tolerate tepid sponging (25/08/23)
2. Patient and relatives could express their fear (25/08/23)
3. Patient could describe the nature, location and the intensity of the pain (25/08/23)
4. patient can describe the nature of the stool and number of times (5times) (26/08/23)
5. Patient could perform basic activities with assistance (26/08/23)
6. Patient could consume 500mls of her porridge served (27/08/23)

2.3 Patient/Family Problem

Definition Patient /family health problems are the health issues of patient and family that are difficult for them to solve or understand (Homby, 2019)

1. Patient had fever (38.20C) (25/08/23).
2. Patient and relatives were anxious (25/08/23)

3. Patient complained of abdominal pain (25/08/23)
4. Patient complained of diarrhoea (5x) (26/08/23)
5. Patient complained of general body weakness (27/08/23)
6. Patient cannot eat (27/08/23).

2.4 Nursing Diagnoses

Nursing diagnosis is the organization, analysis, synthesis and summarization of data collected and determines the patient's need for care (Hinkle & Cheever, 2018).

1. Hyperthermia (38.2oC) related to infectious and inflammatory processes in the gastrointestinal tract (GIT) (25/08/23).
2. Anxiety related to unknown outcome of the condition (25/08/23)
3. Acute abdominal pain related to inflammatory process and increased peristalsis in the gastrointestinal tract (intestine) (25/08/23)
4. Risk for fluid volume and electrolyte imbalance (less than body requirement) as evidenced by diarrhoea (5x) (26/08/23)
5. Activity intolerance related to general body weakness (26/08/23)
6. Risk for nutritional imbalance (less than body requirement) as evidenced by loss of appetite (27/08/23).

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is the development of measurable goals and outcomes as well as plan of care designed to assist the patient in solving the diagnose problems and achieving the identified goals and desired outcome (Hinkle & Cheever, 2018)

3.1 Objectives and Outcome Criteria

Patient/Family Care Nursing outcome refers to a measurable behavior or perception demonstrated by an individual, a family, group or a community that is responsible to nursing intervention (Herdsman and Kami Tsuru, 2018).

1. Patient's body temperature will reduce by at least 1 degree Celsius within 4hours as evidenced by;
    a. Patient verbalizing that she is no more feeling warm to touch.
    b. Nurse observing that patient's body temperature is within the normal range (36.2OC - 37.2OC).
2. Patient and her relatives will be relieved from anxiety within 24hours as evidenced by;
    a. Patient and relatives verbalizing that they are no more feeling anxious.
    b. Nurse observing that patient and relatives are having relaxed facial expression and are cooperating with the care.
3. Patient will be relieved from the abdominal pains within 48hours as evidenced by;
    a. Patient verbalizing relieved of the abdominal pain.
    b. Nurse observing that patient is having a calm and relaxed facial expression.

4. Patient will maintain normal fluid volume and electrolyte balance throughout period of hospitalization as evidenced by;
    a. Patient verbalizing, that she has regain her normal bowel pattern.
    b. Nurse observing that patient is having good skin turgor.
5. Patient will be able to perform her activities of daily living without assistance within 24hours as evidenced by;
    a. Patient verbalizing that she is relieved from the body weakness.
    a. Nurse observing performing self- care activities like bathing and grooming without assistance.
6. Patient appetite will improve throughout period of hospitalization as evidenced by;
    a. Patient verbalizing that she has regain her appetite.
    b. Nurse observing that patient has consumed 800mls of her porridge served.

3.2 Nursing Care Plan

This is the last step in the series of approaches used for presenting the patient's plan of nursing care. It enables the staff nurse to meet the needs of the patient and her family at a given time. The nursing care plan consists of date and time, nursing diagnosis, objectives/outcome criteria, nursing orders/interventions and evaluation.

Table 5: Nursing Care Plan for Mrs M.H

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
25\08\23 02:40pm	Hyperthermia (38.1 ^{0}C) related to infectious and inflammatory processes in the gastrointestinal tract.	Patient body temperature will be reduced by at least 1^{0}C within 4hours as evidence by: a. Patient verbalizing, that she is no more feeling warm to touch b. Nurse checking patient body temperature and is within the normal range (36.8 0C)	1. Reassure patient and relatives 2. Tepid sponge patient 3. Ensure adequate ventilation 4. Remove excess clothing 5. Monitor patient vital signs(temperature) 6. Administer prescribed antipyretic	1. Patient and relatives were reassured that the temperature will be normal. 2. Patient was tepid sponged 3. Windows near patient were opened to enhance adequate ventilation 4. Excess clothing were removed to cool down patient body temperature 5. Patient boy was monitored and recorded (36.8^{0}C) 6. Intravenous paracetamol was served	25\08\23 06:40pm	Goal was fully met as evidenced by; patient verbalizing that she is no more feeling warm to touch and nurse observing that patient body temperature is within the normal range (36.8^{0}C).	S.B

Table 5: Nursing Care Plan for Mrs. M.H Cont'd…

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
25/08/23 02;50pm	Anxiety related to unknown outcome of the condition as evidenced by patient verbalizing her fears.	patient and her family will be relieved of the anxiety within 24 hours as evidence by; a. Patient and relatives verbalizing that they are no more feeling anxious b. Nurse observing that patient and relatives are having relaxed facial expression and are coping with the care.	1. Reassure patient and relatives 2. Assess the anxiety status of patient and relative 3. Explain all procedures to the relatives 4. Encourage patient and relative to ask question. 5. Answer all question tactfully 6. Introduce patient to other patient who are recovering positively from gastroenteritis	1.Patient and relatives were reassured to allay anxiety 2. Patient and relative levels of anxiety were assessed 3. All procedures were explain to patient and relative. 4. Patient and relative were encouraged to ask questions. 5. All question were answered tactfully 6. Patient was introduced to other patient who are recovering.	26/08/23 02:50pm	Goal was fully met as patient and relatives verbalized, that they are no more feeling anxious and nurse observed that patient and relatives are having relaxed facial expression and are coping with the care.	S.B

Table 5: Nursing care plan for Mrs. M.H cond't….

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
25/08/23 3:40pm	Acute abdominal pain related to inflammatory processes and increase peristalsis in the gastrointestinal tract (intestine)	Patient abdominal pain will subside within 48hours as evidence by a. Patient verbalizing the pain has subsided b. Nurse observing that patient is having a calm and relax facial expression.	1. Reassured patient and relatives 2. Assess patient level pain(0-10) 3. Provide divisional therapy 4. Provide patient with warm comfortable bed. 5. Allow patient to assume comfortable position 6.Serve prescribe analgesics and antibiotic	1. Patient and relatives were reassured of competent nursing care 2. Patient level of pain was assessed on a scale of (0 - 10). 3. Ward television was switched on. 4. Patient was provided with warm comfortable bed 5. Patient was allowed to assumed comfortable position. 6.prescribed analgesic was served paracetamol 1g and metronidazole 500mg	27/08/23 3:40pm	Goal fully met as evidenced by patient verbalizing that the pain has subsided and nurse observing that patient is having a calm and relax facial expression	S.B

Table 3.1: Nursing care plan for Mrs. M.H cond't….

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
26/08/23 8:00am	Risk for fluid volume and electrolyte imbalanced (less than body requiremen t) as evidenced by diarrhoea (5)	Patient would be prevented from fluid and electrolyte volume imbalanced throughout the period of hospitalization as evidenced by, a. patient verbalizing, she has gain her normal bowel patten b. The nurse observing patient has a normal skin turgor.	1. Reassure patient and relatives 2. Assess for signs and symptoms of dehydration. 3. Monitor blood pressure 4. Encourage patient to take liberal fluids 5. Assess characteristics of diarrheal stools. 6. Administer isotonic intravenous fluids	Patient and relatives were reassured of competent nursing care 2. Patient's skin was assessed for dehydration. 3. Blood pressure was monitored and recorded to rule out hypovolemic shock. 4. Patient was encouraged to take liberal fluids to prevent dehydration 5. Patient stool was assessed to know the nature of the stool 6. Intravenous normal saline 1litre	29/08/23 08:00am	Goal fully met as evidenced by Patient verbalized she has gain her normal bowel pattern and nurse observed patient having a normal skin turgor .	S.B

Table 3.1: Nursing Care Plan for Mrs. M.H. cond't….

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
26/08/23 8:15am	Activity intolerance related to general body weakness	Patient will be able to perform her activities of daily living without assistant within 24hours as evidenced by: a. Patient verbalizing that she is relieved from the body weakness b. Nurse observing that patient is performing self-care activities like bathing and grooming without assistance.	1.Reassure patient and relatives 2. assist patient to perform self-care activities 3. Encourage patient to do minimal turns in bed 4. Encourage patient to do active exercise 5. Encourage patient to take enough bed rest. 6. Administer prescribed analgesics and antipyretics	1.Patient and relatives were reassured of competent nursing care. 2. Patient was assisted to perform self – care activities. 3. Patient was encouraged to do minimal things in bed to enhance adequate circulation 4. Patient was encouraged to do exercise that she can tolerate. 5. Patient was encouraged to take enough bed rest. 6. Tablet Paracetamol 1g and Tablet ciprofloxacin 50mg was served.	27/08/23 8:15am	Goal was fully met as evidenced by patient verbalizing that she is relieved from the body weakness and nurse observed patient performing self-care activities like bathing and grooming without assistance.	S.B

Table 3.1: Nursing Care Plan for Mrs. M.H. cond't……

Date/ Time	Nursing Diagnosis	Objectives/ Outcome criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
27/08/23 8:00am	Risk for nutritional imbalance (less than body requirement) as evidenced by loss of appetite	Patient appetite will improve within 48hours as evidence by: a. Patient verbalizing she has regain her appetite b. Nurse observing that patient has consume 800mls of her porridge served.	1.Reassure patient and relatives 2. Plan diet with patient and relatives 3. Encourage patient to perform oral hygiene 4. Remove all nauseating items 5. Serve patient meal attractive 6. serve food in bit but at regular interval	Reassure patient and relatives 2. Plan diet with patient and relatives 3.Patient was encouraged to perform oral hygiene 4. All nauseating items were removed. 5. Patient meal was served attractive. 6. food was served in bit but at regular at regular interval	28/08/23 8:00am	Goal was fully met as evidenced by patient verbalized, she has regain her appetite and nurse observed that patient has consumed 800mls of her porridge served.	S.B

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

Implementation refers to the actualization or carrying out of the plan of care through nursing interventions (Hinkle & Cheever, 2018)

Nursing intervention is any act carried out to prevent harm to patient or to improve, promote or enhance their physical, natural or spiritual well-being (Weller, 2016).

The patient and relatives were therefore encouraged to play their role in the care to aid in the speedy recovery of the patient and the Nurse bearing in mind the individuality of patient and relatives.

4.1 Summary of the Actual Nursing Care

Summary of actual Nursing care rendered to Mrs. M.H and family. This comprises of the nursing orders and interventions that were rendered to Mrs. M.H and her family against the identified health problems.

The actual nursing care rendered to patient and his family commenced on the day of admission, 25TH August 2023, to the time care was terminated. The management of patient and his family was planned to meet their physiological, psychological, emotional and spiritual needs.

First Day of Admission (25th August 2023)

Mrs. M.H was diagnosed of Acute Gastroenteritis and was admitted to the Female Medical Ward through the accident and emergency unit of the Tian District Hospital on 25th August 2023 at 2:31 pm with temperature of 38.1^{0}C (fever), patient and relatives were anxious on observation and with complains of severe abdominal pain.

Patient was brought to the ward in a wheel chair accompanied by a relative and a staff Nurse in an alert and conscious state. They were warmly welcomed to the ward and offered a seat. Confirmation of patient was done by mentioning the name and other particulars like diagnosis and treatments on the transfer section on the ward computer.

Patient and relatives were introduced to the Nurses on duty, other close patients and were oriented to the ward and it annexes. They were reassured of competent nursing care and patient was made comfortable in bed. Her baseline vital signs were checked and recorded as followed after procedures have been explained to her.

1. Temperature 38.1^{0}C
2. Pulse 92bpm
3. Blood Pressure 110/ 72mmHg
4. Respiration 19cpm
5. Weight 60kg

On 25th August, 2023, at 2:40pm, it was found out that, patient had high body temperature (fever)

nursing diagnosis of hyperthermia (38.1^0C) related to infectious and inflammatory processes in the gastrointestinal tract. an objective was set to enable patient maintain his normal body temperature that is (36.8^0C-37.2^0C) within 4hours.The following nursing interventions were carried out; patient and relatives were reassured of that her body temperature will be normal, adequate room ventilation was ensured by opening nearby windows, she was tepid sponged to help cool down her body temperature, cold drinks and liberal fluids were to be served, Tablet Paracetamol 1gram was administered as prescribed, temperature was checked every 4 hours as appropriate and recorded.

At 2:50pm, patient and relatives were observed to be anxious due to unknown outcome of the

condition. An objective was set to relieve patient and relative from the anxiety within 24hours.

The following interventions were set; patient and relatives were reassured of competent health team to allay their fears and anxiety, their level of anxiety was assessed using their facial expressions, all procedures were explained to patient and relatives to reduce the fears and anxiety, they were also encouraged to ask any questions bordering their minds and they were introduced to patients in the ward with same conditions who are recovering positively.

At 03:40pm, patient gave a verbal complaint of abdominal pains and a nursing diagnosis of acute abdominal pains related to inflammatory process and increased peristalsis in gastrointestinal tract (intestine) was formulated and a goal was made to relieve patient of the abdominal pains within 48 hours. The following interventions were carried out to meet the objective set; patient and relatives were reassured that the pain will subside in the course of treatment, the level of pain was assessed pain rating scale of 0 – 10, ward television was turned on to divert patient's mind from the pain, patient was allowed to assume a comfortable position to alleviate the pain, she was encouraged to

verbalize her feelings about the pain and prescribed tablet paracetamol 1gram, intravenous metronidazole 500mg and intravenous ciprofloxacin 400mg were served.

At 12:30pm, jollof with chicken was served as lunch. 02:00pm vital signs were checked and recorded as in the appendix. Due medication was served.

on 25th August 2023 at 6:40pm, goal was evaluated to enable patient maintain his normal body temperature that is (36.8^0C-37.2^0C) within 4hours.was fully met as evidenced by;

patient verbalizing that she is no more feeling warm to touch and nurse observing that patient

body temperature is within the normal range (36.8^0C).

at 06:00pm vital signs were checked and recorded as in the appendix. Due medication were served. Banku with grandnut soup was served as supper.

At 10:00pm, patients' vital signs were checked and recorded as indicated in the appendix. Patient slept around 10:10pm

Second Day of Admission 26th August, 2023

On the second day of admission, Mrs. M.H woke up at 5:30am slightly better than the previous day she took her bath with warm water, urine sample bottle was given to her to take urine sample to the lab for investigation such as urine R/E and pregnancy test as ordered during ward rounds after she was reviewed by the doctor on duty. At 6:00am, routine activities such as making of patient's bed and changing linen when dirty, monitoring of vital signs, administration of all due medicines as prescribed were commenced and Mrs. M.H took in millet porridge and "koose".

At 08:00am, patient complained of having diarrhoea (5 times) and a nursing diagnosis of risk for fluid volume and electrolyte imbalanced (less than body requirement) as evidenced by diarrhoea (5

times). An objective was set to prevent patient from fluid and electrolyte imbalance throughout her period of hospitalization and the following nursing intervention were done for her; Patient and relatives were reassured of competent health care, she was encouraged to take in adequate liberal fluids to prevent dehydration, she was assessed for possible dehydration and intravenous Normal Saline 1Litre over 24 hours, tablet ciprofloxacin 500mg and tablet metronidazole 400mg and suspension magnesium trisilicate 15mls were served.

At 8:15am, patient complained of general weakness and a nursing diagnosis of Activity intolerance related to general body weakness was formulated. An objective was set to perform activities of her daily living within 24hours and the following intervention were carried out for her; Mrs. M.H and her relatives were reassured of competent nursing intervention, patient was encouraged to do minimal turns in bed to enhance adequate circulation, she was encouraged to do active exercises that she could tolerate and patient was educated on the need to take adequate bed rest to conserve much energy and all prescribed medications were served. She was reviewed by doctor on duty at 9:45am, which her plan was to continue treatment.

At 12:50pm patient was served with her lunch which was boiled yam with vegetable stew and a cup of orange juice.

At 2:00pm, her vitals were checked and recorded as indicated in the appendix. Due medication was administered Patient was made comfortable.

At 2:50pm, evaluation of set objective on 25th August,2023 to relieve patients and relatives from the anxiety within 24hours was done and goal was fully met as patient and relatives were observed to have calm facial expression and were cooperating with care and patient and relatives verbalizing absence of the anxiety and they confirmed by verbalizing that they are no more feeling anxious

She was reviewed by doctor on duty at 9:45am, which her plan was to continue treatment. At 12:50pm patient was served with her lunch which was boiled yam with vegetable stew and a cup of orange juice.

At 2:00pm, her vitals were checked and recorded as indicated in the appendix. Patient was made comfortable. The first home visit was conducted at 3:00pm. Permission was granted by the ward in-charge and with the help of the information I gathered during the admission process, I was able to locate her house. The purpose was to know patient residence and the environment in which her lives to verify the information given to me and also to identify the risk factors such as poor sanitation that can lead to her condition.

At 5:30pm, patient ate Banku and groundnut soup with fish and banana as supper. At 6:00pm, patients' vital signs were checked and recorded as indicated in the appendix. A 6:40pm, she maintained her evening routines that promotes sleep such as toileting, bathing, oral hygiene. At 10:00pm, patients' vital signs were checked and recorded as indicated in the appendix, due medications were administered. Patient was put to sleep at 10:30pm.

Third Day of Admission, (27th August, 2023)

Patient woke up early in the morning at 5:35am on the third day, brush her teeth, took her bath and groomed herself and took in hot milo tea with bread as breakfast of which she was not able to consume on observation and organized herself for ward rounds.

At 6:00am, routine vital signs were checked and recorded as indicated in the appendix. At 8:40am, patient complained of loss of appetite and a nursing diagnosis risk for nutritional imbalance (less than body requirement) as evidenced by loss of appetite was formulated. An objective was set to improve patient appetite throughout period of hospitalization and the following nursing

interventions were put in place; patient and relatives were reassured of competent nursing care, diets were planned with patient and relatives to know patient's likes and dislikes, all nauseating items were removed from patient's bed side, her meals were served attractively, food was served in bit but regular and she was encouraged to do maintain oral hygiene to enhance her appetite.

At 8:00am, she was reviewed by the doctor on duty with plan of care to continue the due medications.

At 08:15am, evaluation of set objective on 26th August, 2023 to enable patient to perform activities of daily living was fully met as nurse observed patient to participating willingly in necessary and desired activities and patient also verbalized that she does not feel weak anymore.

At 12:55pm, patient was served with fufu with smoked fish with slice of water melon. At 2:00pm, patient's vital signs were monitored and recorded as stated in the appendix.

At 03:40pm, evaluation of set objective on 25th August,2023, goal was made to relieve patient of the abdominal pains within 48hours was fully met as it was evidenced by patient verbalizing relief of the abdominal pain and nurse observing that patient is having a calm and relaxed facial expression.

At 5:20pm patient was served with banku with vegetable soup as supper. At 6:00pm, her vitals were checked and recorded as indicated in the appendix. Due medications were administered. Patient watched the ward television after taking care of her personal hygiene needs. At 10:00pm, patients' vital signs were checked and recorded as indicated in the appendix, due medications were administered. Patient was put to sleep at 10:20pm.

Fourth, Day of Admission (28th August, 2023)

Mrs. M.H. woke up at 5:50am in the morning. She was assisted to perform proper personal hygiene when she woke up. She ate oat and bread as breakfast and verbalize that she could now eat well.

At 6:00am, due medications were administered and vital signs were checked and recorded as indicated in the appendix. At 6:50am, she took her breakfast which was porridge with koose
On 27th August 2023, at 08:00am, An objective was set to improve patient appetite throughout period of hospitalization.

On 28th August, at 08: 00am, an evaluation was made on the objectives set and goals was fully met as evidenced by patient verbalizing that she has regain her appetite and nurse observing that patient was able to consume 800mls of her porridge served.

At 9:45am, she was reviewed by doctor on duty, which her plan was to continue treatment and a possible discharge the next day if her condition remains stable. She ate rice and stew at 1:40pm with sliced water melon.

At 2:00pm vital signs were checked and recorded as in the appendix. Due medications were served. Patient had an early bath at 5:40pm. She ate kenkey with stew and a glass of water as served. At 6:00pm, her vitals were checked and recorded as in the appendix. Due medications were administered.

At 10:00pm, patients' vital signs were checked and recorded as indicated in the appendix, due medications were administered. Patient was put to sleep at 10:35pm.

Day of Discharge, (29th August, 2023)

Patient woke up at 5:00am and on this very day she was much better than previous days. She took her bath as usual, brushed her teeth, took in millet porridge with bread and dinner. At 6:00am vital

signs monitored and recorded as in the appendix. At 8:00am, patient was reviewed by the doctor on duty and her plan of care was to continue with old medications.

At 8:00am, evaluation of set objective on 29th August, 2023to prevented from fluid and electrolyte volume imbalanced throughout the period of hospitalization was fully met as evidenced by, patient verbalizing, that she has regain her normal bowel pattern and nurse observing that patient is having good skin turgor.

At 1:30apm she was then reviewed again by the doctor on duty and was ordered to be discharged which was around 1:50pm after the doctor was satisfied with Mrs. M.H health progress. This was documented into the admission and discharge (specifically) section on the ward computer. I took her ordered medication such as Tab Metronidazole 400mg tds x 3days, Tab Ciprofloxacin 500mg bd x 5days from the ward pharmacy as ordered by the Drugs taken from the ward pharmacy together with the old drugs, Magnesium trisilicate 15mls bd and Tab Paracetamol 1g tds x5 days were handed over to the patient's relatives and were educated on the drugs prior to discharge. Mrs. M.H and relatives were informed on the review date and were informed to always report to the hospital early at any time when feeling unwell and the need to not self-medicate. Mrs. M.H was advised on the need to maintain personal hygiene and to avoid eating outside foods. They were then assisted to pack their belongings, were asked to go to the revenue department to settle all pending bills after which receipt was shown to confirm the payment. Her cannula was removed they thanked the Nurses and the Doctor on duty. I accompanied them to the hospital gate where they left the hospital with a taxi.

4.2 Preparation of Patient/Family for Discharge and Rehabilitation

Preparation of patient and relatives towards discharge begun on the day of admission to the day of admission. Mrs. M.H and her relatives were informed that the ward was a temporal place for her and so she would be discharged home as soon as she recovers. This was done to prevent over dependence on the health team after discharge. In this, Mrs. M.H health status was assessed daily and compared with baseline data to ascertain the level of recovery. Patient and relatives were educated on the cause, mode of transmission, clinical manifestation, treatments, complication and prevention of the gastroenteritis. They were then educated on the need to seek immediate medical attention when feeling unwell and when symptoms still persist, for treatment at the hospital, and were also educated on the need to maintain personal and environmental hygiene and avoid the intake of unhygienic food in order to break the chain of the transmission. Mrs. M.H was also encouraged on the need to take in well balanced meals and have adequate rest in order to build up her immunity to help fight against infections to help improve her health. On 29th August,2023, at 01:50pm being the day of discharge, the Doctor on duty prepared and signed for Mrs. M.H to be officially discharged home, and they were assisted to pack their belongings and Mrs. M.H, all hospital bills were cared for. They were informed on the date scheduled for the review which is on 5th September,2023. and were educated to report on time. They were educated on how, when and route of the drugs to be taken home and patient was discharged from the ward and in the discharge section on the ward computer, state ward diary and discharge note done. Her linens were removed and decontaminated and together with the bed and locker. They then Thanked the Nurses and the Doctor on duty who accompanied them to the hospital gate where they took taxi to the house. The first home visit was done when patient was on admission (2nd day on hospitalization) on 26th August,2023 at where patient resides. The purpose of this visit was to survey for any predisposing

factors that might have contributed to her condition and to look for available resource in the house as well as in the community that can help in the speedy recovery of the patient.

4.3 Follow-Up/Home Visit and Continuity of Care

It is an essential element of the patient/family care study. The purpose of home visit in nursing is to give care to the sick with the view to teach a responsible family member to give the subsequent care, also to assess the living condition of the patient and his family and their health practices in order to provide the appropriate health teaching.

First Home Visit (26th August,2023)

The aim of this home visit was basically to find out about the environment in which the family live, and also to help identify the possible health problems in the home environment and to establish a link between the problems of my patient's condition and then to help remedy the situation through health education and also prepare the family for patient's discharge. The first home visit came off when Mrs. M.H was at the ward on the 2nd day on 26th august,2023 and I arrived in the house around 3:20pm. On arrival, the building was inspected and was painted with yellow paint with aluminium roofing. The husband gave me a seat to make myself comfortable and a water was also served to me. Inquiries regarding the state of Mrs. M.H's health in the house was made clear her illness. It was observed that, sanitary conditions in the house were good but there was an opened dumping refuse. Mrs. F.M led me to their room which was single room self-contained in which the room was kept tidy and things well organized with windows well opened enhancing adequate ventilation. Patient's relative (husband) personal hygiene was also assessed and was on point as evidenced by how he was neatly dressed. Education was given to Mrs. M.H, husband on the need to possibly use well covered dustbin or to keep the dump well by constantly burning the rubbish to

prevent flies from cross contaminating their foods and drinking water. He was encouraged to continue the good habit with regards to the proper sanitary keeping in the environment. He was also reassured of competent health team and nursing care that is being given to Mrs. M.H at the hospital which will aid in her speed recovery. At 4:00pm, I thanked him for his cooperation and the visitation for the day came to an end.

Second Home Visit (3rd September, 2023)

The purpose of this visit was to assess the health of Mrs. M.H and her family and to see whether the education given during admission and first home visit were being followed. The purpose of this second home visit was to find out how Mrs. M.H was doing and how she was going about her daily activities and it was done on the 3rd August 2023, after Mrs. M.H had been discharged home. On arrival at 3:00pm, Mrs. M.H was seen sitting under a tree in front of her building with one of her child and she was looking very cheerful and much healthy. On observation and interaction with her after I was offered a seat, it was observed that Mrs. M.H condition has improved speedily and it was as a result of patient's family compliance to the health education given and drug regimen including good personal and environmental hygiene, adequate rest, adherence to drug regimen and good family support. Additional health education was given to Mrs. M.H on the need to seek immediate health care. to Mrs. M.H was reminded of the date for review which was to be on 5th September, 2023 was very happy and thankful, and she was informed that I will be there to accompanied her to the hospital for the review, likewise they were appreciated for their patience with thanks.

Date of Review (5th September,2023)

At 8:15am on 5th August 2023, I met Mrs. M.H at the hospital gate and was warmly welcomed. Her hospital card was taken to the record department and details were sent through digital means after

which vital signs were checked at the Nurses station at the outpatient department and were recorded as;

1. Temperature 36.4^0C
2. Pulse 78bpm
3. Respiration 16cpm
4. blood pressure 115/72mmHg
5. oxygen saturation 98%
6. random blood sugar 5.2mmol/L

Mrs. M.H was then directed to Nurses room number two to meet the doctor on duty. On her turn, she was accompanied to see the doctor on duty. During consultation with the doctor, patient did not mention any new complaint, and an education was given to her again on the need to maintain good personal and environmental hygiene, avoidance of buying an outside food, the need to take in well balanced meals and healthy drinking water and also prompt and immediate report to the facility when not feeling well. After seeing the doctor, Mrs. M.H was informed on the date for the 3rd home visit which was on 10th September,2023 and were also pre-informed that, the visit would be carried with a purpose of handing her to a community Nurse for continuity of care in her area. They were accompanied to the hospital gate and were bid goodbye.

Third Home Visit (10th September,2023)

The main reason for conducting the third home visit was to assess the general condition of patient and family, reinforce the need to comply with treatment regimen and finally terminate care. On visitation, patient and family were well doing and the visitation was made with the company of Registered General Nurse (RGN) who is a staff at Tian District Hospital. We were welcomed at the

house and seats were also offered to make us comfortable and patient's health was greatly improved on observation. Patient was asked if she had encountered any complication and said no, and observations (assessment) was conducted on her and there was no sign of complication and was also looking very strong, healthy and good. The nurse in Tian district hospital was introduced to Mrs. M.H and the family and they were informed that, she will be taking charge of the rest of the care and may make home visit anytime the need arises to make sure the good health status of her and the family is well maintained and they were also encouraged to give the Nurse their maximum cooperation. They were encouraged to see immediate health care when feeling unwell and to practice good personal and environmental hygiene. Mrs. M.H and her family showed their gratitude for the selfless concern for their health through the home visit to me. They were also thanked for their constant cooperation throughout the whole process and for allowing to build good therapeutic Nurse-Patient relationship.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation is the final step of the nursing process which allows the nurse to determine the patient's response to the nursing interventions and the extent to which the objectives have been achieved (Hinkle & Cheever, 2018).

5.1 Statement of Evaluation

Evaluation is the final step of the nursing process which allows the nurse to determine the patient's response to the nursing interventions and the extent to which the objectives have been achieved (Hinkle & Cheever, 2018).

Mrs. M.H was admitted to the Females Medical Ward with the diagnosis of Gastroenteritis (acute) and all goals and objectives set were fully met. Below is the summary;

1. Patient's body temperature was reduced to normal (25th August,2023)

On 25th August, 2023at 02:40pm, that patient had high body temperature (fever), a nursing diagnosis of hyperthermia (38.1^0C) related to inflammatory processes and released of bacteria toxins the stomach and intestinal mucosa. An objective was set to enable patient maintain his normal body temperature that is (36.8^0C-37.2^0C) within 4hours.The following nursing interventions were carried out; patient and relatives were reassured of that her body temperature will be normal, adequate room ventilation was ensured by opening nearby windows, she was tepid sponged to help cool down her body temperature Tablet Paracetamol

1gram was administered as prescribed and temperature was checked, cold drinks and liberal fluids were served, temperature was checked every 4 hourly or as appropriate and recorded.

Goal was evaluated on 25th August 2023, at 06:40pm and was fully met as evidenced by Nurse recording body temperature of 36.4^0 C and patient verbalized she is no more feeling warm to touch.

2. Patient and relatives were relieved from anxiety (26th August,2023)

On 25th August 2023, at 02:50pm, patient and relatives were observed to be anxious due to unknown outcome of the condition. An objective was set to relieve patient and relative from the anxiety within 24hours. The following interventions were set; patient and relatives were reassured of competent health team to allay their fears and anxiety, their level of anxiety was assessed using their facial expressions, all procedures were explained to patient and relatives to reduce the fears and anxiety, they were also encouraged to ask any questions bordering their minds and they were introduced to patients in the ward with same conditions who are recovering positively.

Goals were evaluated on 26th August 2023 at 02:50pm and were fully met as patient and relatives were observed to have calm facial expression and were cooperating with care and patient and relatives verbalizing absence of the anxiety and they confirmed by verbalizing that they are no more feeling anxious.

3. Patient was relieved of abdominal pains (27th August 2023)

On 25th August,2023 at 03:40pm, patient gave a verbal complaint of abdominal pains and a nursing diagnosis of acute abdominal pains related to inflammatory process and increased peristalsis in gastrointestinal tract (intestine) was formulated and a goal was made to relieve patient of the abdominal pains within 48hours. The following interventions were carried out to meet the objective set; patient and relatives were reassured that the pain will subside in the

course of treatment, the level of pain was assessed pain rating scale of 0 – 10, ward television was turned on to divert patient's mind from the pain, patient was allowed to assume a comfortable position to alleviate the pain, she was encouraged to verbalize her feelings about the pain and prescribed tablet paracetamol 1gram, intravenous metronidazole 500mg and intravenous ciprofloxacin 400mg were served.

On 27th August 2023 at 03:40pm, the objective that was set was evaluated and goal was fully met as it was evidenced by patient verbalizing relief of the abdominal pain and nurse observing that patient is having a calm and relaxed facial expression.

4. Patient prevented from fluid volume and electrolyte imbalance (29th August 2023)

Assessment on the 26th august,2023, patient complained of having diarrhoea (5 times) and So, a nursing diagnosis of Risk for fluid volume and electrolyte imbalance (less than body requirement) related to diarrhea as evidenced by passage of loose unformed stools 5 times a day was formulated and a goal to help patient to be relieved of diarrhoea and to maintain normal fluid and electrolytes within period of hospitalization was set. The following nursing interventions were carried out; patient and relatives were reassured of competent health team, patient was encouraged to take in adequate liberal fluids, patient was assessed for signs and symptoms of dehydration; patient was educated on fluid needs. Copious intake of fluid was encouraged, assessed, isotonic intravenous fluids were administered, and prescribed antibiotics were administered.

On 29th August 2023, at 8:00am, the objective set to help patient maintain normal fluid volume and electrolyte balance throughout period of hospitalization was evaluated and was fully met as evidenced by, patient verbalizing, that she has regain her normal bowel pattern and nurse observing that patient is having good skin turgor.

5. Patient regained strength for her daily activities without assistance (27th August 2023)

On 26th August 2023 at 08:15am, patient gave a verbal complaint of generalized body weakness so a nursing diagnosis of Activity intolerance related to weakness as evidenced by inability to perform activities of daily living such grooming self was formulated and a goal was made to help patient regain strength for his daily activities without assistance within 24hours. The following interventions were carried out to meet the objective set; patient and relatives were reassured that she will regain her strength to carry her daily activities, patient was assisted to perform self-care activities like grooming and getting out from bed, she was encouraged to do minimal turns in bed to enhance adequate circulation, she was encouraged to do active exercises that she can tolerate like stretching so that patient does not injure or over stress herself, patient was encouraged to take adequate rest to conserve enough energy to carry on activities and tablet paracetamol 1gram, tablet metronidazole 400mg and tablet ciprofloxacin 500mg were served.

On 27th August 2023 at 08:15am, the objective was evaluated and goal was fully met as it was evidenced by patient verbalizing that she no longer has any feeling of bodily weakness and nurse observing that patient is performing self-care activities like bathing, grooming and getting dressed unassisted.

6. Patient's appetite improved (29th August 2023)

On 27th August 2023 at 08:00am, patient complained of loss of appetite and a nursing diagnosis of risk for nutritional imbalance (less than body requirement) related to loss of appetite was formulated for patient and a goal was set to help patient's appetite improve throughout period of hospitalization.

The following nursing interventions were made; patient was reassured that her appetite will

improve, diets were planned with patient and relatives to know her likes and dislikes, she was encouraged to maintain oral hygiene to stimulate her appetite, all nauseating items were removed from her bedside, her favourite meals were served attractively to stimulate her appetite and she was encouraged to eat in bit but at a regular interval to enhance her urge to eat. On 28th August 2023, at 08:00am an evaluation was made on the objectives set and goals was fully met as evidenced by patient verbalizing that she has regain her appetite and nurse observing that patient was able to consume 800mls of her porridge served.

5.2 Amendment of Nursing Care Plan

All the health care problems which were exhibited by Mrs. M.H were intensively managed and due to the quality nursing care, effective medical treatment and good cooperation from Mrs. M.H and her family, all the set goals were fully met. The care rendered were very successful as Mrs. M.H fully recovered from the health problems she presented without any complications since there were no unmet goals, amendment was also not needed

5.3 Termination of Care

Termination of care begun from the very day of admission to Mrs. M.H of till day of last home visit and the process was conducted gradually in order to prevent separation anxiety and to enhance adequate trust and cooperation. From the day of admission, Mrs. M.H and her relatives were informed that, their stay in the hospital was temporal and after her recovery from the illness, they would be discharged home to continue with their normal activities. Mrs. M.H was discharged on 29th August,2023 at 01:50pm and client and family did not show any anxiety as they were to be discharged home. Three (3) home visits were done and on the last home visit which took place on the 10th September 2023, the Student Nurse handed client and family over to a staff Nurse at Tian

District hospital for continuity of care, they were thanked by the Student Nurse for their constant cooperation.

They were also encountered to practice the acquired knowledge through the education given to break the chain of the mode of transmission of the condition (Gastroenteritis) in order to prevent occurrence. Mrs. M.H and the family expressed their gratitude for the care rendered to them.

CHAPTER SIX

SUMMARY AND CONCLUSION OF THE CARE RENDERED

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 (Weller, 2016). 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

Mrs. M.H was admitted into Females medical ward of the Tian District Hospital on the 25th August,2023 at 02:31pm through the accident and emergency unit with the diagnosis of acute gastroenteritis. Mrs. M.H presented signs and symptoms such as; loss of appetite, diarrhoea, general body pains, abdominal pains. All appropriate and necessary information were obtained from client and her mother, Mrs. F.M Her health problems were identified, there was formulation of appreciate nursing diagnosis, objectives were set, an individualized care plan drawn and expected outcome of these intervention resulted to meeting of all the objectives set, aiding in the massive improvement of client's health and therefore leading to her discharge on the 29th August,2023 at 01:50pm Specific and individual nursing care were rendered as proper measures were taken to manage the health problem using the nursing process. A nursing care problem was drawn and put into action for the effective and efficient individualized client and family care and these cares were rendered based on problems Mrs. M.H presented, specific and respective nursing diagnosis were formulated based on

the identified problems with appropriate nursing interventions being put into action based on the objectives. All set goals achieved their purposes after evaluation.

There were three home visits carried out on the 26th, 3rd and 10th August, 2023 to find out more about client's environment and to give the necessary health education when necessary. All the hospitalization periods through to the climax of the home visits, Mrs. M.H and her family were given intensive health education on gastroenteritis, including causes, mode of transmission, signs and symptoms, prevention and its complications when not treated or properly treated. They were more enlightened on the need to maintain a healthy lifestyle, good personal and environmental hygiene and the need to eat healthy and proper care of their refuse dump. Mrs. M.H and her family were thanked for their maximum cooperation and the kind reception they show throughout the care and termination of the care was done on the 29th August 2023.

6.2 Conclusion

The benefit of the client/family care study to the Student Nurse is very beneficial and essential. This study has helped me to apply the theoretical knowledge of nursing and related courses acquired in the classroom into the clinical and community setting as a whole. During the study, it helped me to improve my knowledge in nursing research and report writing and also, it has enlightened me more on gastroenteritis and its management. This aspect of nursing is somehow challenging but is a worthy professional and a good academic exercise. Client/family care study is an effective and holistic approach to the nursing of the client and so nurses must be encouraged to practice it in the management and care of their client in the clinical setting.

6.3 Recommendation

Due to the countless knowledge, I have gain throughout the period of the patient/family care study, I recommend that; there should be holistic and individualized care for every patient since each one

of them is unique in his or her own way and also adoption of intensive nursing care should be used in the clinical field in caring for the patient to prevent occurrence of diseases and to decrease mortality rate. Also, I therefore recommend that, all nursing students should be given the chance to participate in the patient/family care study in order to equip them adequately and to help them render good nursing at the field of work.

APPENDIX

Table 6: Vital Signs of Mrs. M.H

Date	Time	Temperature (^{0}C)	Pulse (cpm)	Respiration (bpm)	Blood pressure (mmHg)
25/08/23	2:30pm	38.1	98	19	110/70
	6:00pm	37.8	95	24	110/70
	10:00pm	37.5	91	22	120/80
26/08/23	6:00am	36.7	72	21	128/70
	10:00am	36.9	88	22	120/60
	2:00pm	37.1	92	22	116/76
	6:00pm	36.2	89	24	118/74
	10:00pm	36.1	85	22	110/80
27/08/23	6:00am	36.8	76	22	120/70
	10:00pm	36.3	74	21	120/78
	2:00pm	37.2	90	22	116/70
	6:00pm	36.8	86	24	110/80
	10:00pm	36.4	89	24	120/70
28/08/23	6:00am	36.1	84	22	120/75
	10:00am	36.9	79	20	110/68
	2:00pm	36.3	74	21	120/78
	6:00pm	37.0	70	21	120/70
	10:00pm	36.8	78	19	118/76
29/08/23	6am	36.4	78	20	110/68
	10am	36.6	76	21	116/72
	2pm	36.8	75	19	120/74

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SIGNATORIES

THE STUDENT NURSE

NAME: SAEED BARIKISU

SIGNATURE: .....

DATE: 03-06-2024

THE NURSE-IN-CHARGE, TAIN DISTRICT HOSPITAL

NAME: MR. DANIEL KOOSONO

SIGNATURE: .....

DATE: 18/06/2024

ACADEMIC CO-ORDINATOR NURSING
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