HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

PATIENT/FAMILY CENTERED NURSING CARE STUDY ON GASTROENTERITIS

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

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PREFACE

The Nursing profession today has gone through evolutions to reach where it is now today. Nursing was not taught in the past, until the 1800's where it became an organized practice. In 1854, Nightingale had the opportunity to test her beliefs during the Britain's Crimean War. The British Government asked Nightingale to take a small group of nurses to the military hospital at Scutari. Nightingale within days of arrival reorganized the hospital, scrubbing the walls for sanitation, windows opened for ventilation, nourishing food was prepared and served with medications and treatments administered efficiently. Death rates plummeted in weeks, with the graceful public knowing of the work done by the ''Lady with the Lamp', who made night rounds giving comfort to the sick and wounded. Nightingale pushed for reform of hospital sanitation methods and invented methods of graphing statistical data. Nightingale's work led to drastic changes in army medical care, the establishment of army Medical School and medical records, and ignited the growth of nursing as an organized profession. For these contributions, Nightingale is widely accepted as the founder of nursing.

The nursing profession gained a lot of recognition and support from civilians during this time, as they realized the essential asset to medical care that nurses truly are. In the early 1900's, nursing education was received primarily from hospitals rather than colleges or universities. The training of nurses in diploma program, licensing of nurses, specialization of hospitals, diagnosis, and advanced degree programs, scientific and technological development are been offered today. This therefore has effectively improved upon the quality of health care delivered by the use of the nursing process.

The nursing process is a series of organized steps designed by nurses to ensure a planned and quality of patient care.

This helps to assess patient needs and to also derive various means of intervening. It provides an organized framework for the practice of nursing and the knowledge, judgments, and actions that nurses bring to patient care. The process requires effective thinking, activity and affective skills and abilities of the nurse.

The patient and family care study is a comprehensive and extensive description of the entire nursing care rendered to a patient and the family during and after hospitalization period. This is to meet the physical, emotional, psychological, spiritual and social-economic needs of the patient and her family within a specific period of time. This care study, forms part of the assessment of the final year student in the awarding of License to practice as a professional Registered General Nurse.

The patient and family care study helps widen the scope of knowledge of the student nurse, helping the student nurse to put his theoretical knowledge and skills acquired through training together to give a comprehensive nursing care to patient and family.

The patient and family care study also enhances the interpersonal relationship of the student nurse as he constantly communicates with the patient, relatives, friends and other health care team in the various units of the hospital in order to provide a comprehensive care for the patient.

For the purpose of confidentiality and security reasons, my patient's identity will not be disclosed; A.H will be used to represent my patient's name throughout the script. I also admonish students and readers to always try to read prefaces which are a way of expanding our scope of knowledge and understanding.

ACKNOWLEDGEMENT

I use this opportunity to express my profound gratitude and appreciation to the Lord Almighty for his grace, strength and protection throughout the course of my study at Holy Family Nursing and Midwifery Training College, Berekum.

I am also grateful for the awesome cooperation and understanding expressed by my patient and family for willingly giving in and providing all the information I sort both at the ward and at home to the success of this study.

My unending appreciation goes to the entire tutorial staff of Holy Family Nursing and Midwifery Training College, Berekum, not forgetting the Principal of the Institution, Ms. Monica Nkrumah. I wish to express my heartfelt gratitude to the doctors, nurses and other paramedical staff of Sunyani Municipal Hospital, especially the in – charge and entire staff of Female Ward.

My Supervisor Mr. Edward Amponsah for his guidance, assistance during the study, advice, patience and for taking his time and pain to go through my work

Finally, I thank the various authors whose books I extracted information from to make the writing complete and successful.

INTRODUCTION

Patient and family care study basically involves interaction between the patient and the health team. It involves selecting of patient with a specific disease in the ward. The patient is nursed from day of admission to the day of discharge and follow ups are made to help provide a comprehensive healthcare to the patient.

The study was conducted on A.H a thirty four year old lady. She was admitted on 15th November, 2021 with a history of abdominal pains, loss of appetite and vomiting and diarrhea. Upon assessment, and laboratory investigation, she was diagnosed of Acute Gastroenteritis. Patient's condition improved and was discharged on 20th November, 2021

My interaction with A.H started on the 15th of November, 2021. When she was admitted to Females Ward of the Sunyani Municipal Hospital and was discharged on the 20th November, 2021. I decided to use this patient because I was interested in knowing the precipitating factors of Acute Gastroenteritis, its causes, management, complications as well as its treatment and able to put into practice actual and holistic nursing care, as it has been learnt theoretically of this condition.

The following treatment regimens were given to A.H to enhance his speedy recovery

1. IV cefuroxime 750mg tds × 24 hours
2. Tablet cotrimazole (400+80) BD × 24 hours
3. Tablet Amoksiclav 1g bd × 7 days
4. Tottema 1 vial BD × 7 days
5. Tablet Azithromycin 500mg daily × 7 days
6. Tablet cefuroxime 500mg bd × 7 days
7. 5%Dextrose in normal saline

8. IVF Ringers lactate 1L×24hours

9. IVF Normal Saline 1L × 24 hours

Full Blood count was the diagnostic investigation conducted for my patient. Three (3) home visits were made, during admission, after discharge and lastly after review. My first home visit was made on 17th November, 2021 with the purpose of finding out about the environment in which she lives to help identify possible health problems in the area and establish a link between the problems and my patient's condition and then remedy the situation through health education and it was done while patient was still on admission, my second on the 21st November, 2021 with the purpose of finding out how she was coping with the treatment regimen and remind her of the review date and last home visit was also made on 26th November, 2021 with the purpose of termination of care and how she is adhering to the treatment regimen.

The patient/family care study is organized under six broad headings and it includes;

1. Assessment of Patient/Family.
2. Analysis of data.
3. Planning of Patient/Family care.
4. Implementation of Patient/Family care plan.
5. Evaluation of care rendered to Patient/Family.
6. Summary and conclusion.

TABLE OF CONTENTS

PREFACE i

ACKNOWLEDGEMENT iii

INTRODUCTION iv

TABLE OF CONTENTS vi

LIST OF TABLES ix

CHAPTER ONE 1

ASSESSMENT OF PATIENT AND FAMILY 1

1.0 Introduction 1

1.1 Patient's Particulars 1

1.2 Patient's Family Medical History 2

1.3 Family's Socio-Economic History 2

1.4 Patient's Developmental History 2

1.5 Obstetric History 4

1.6 Patient's Lifestyles / Hobbies 4

1.7 Patient's Past Medical History 5

1.8 Patient's Present Medical History 5

1.9 Admission of Patient 6

1.10 Patient/Family Concept of Illness 7

1.11 Literature Review on Gastroenteritis 8

1.12 Validation of Data 17

CHAPTER TWO 18

ANALYSIS OF DATA 18

2.0 Introduction 18

2.1 Comparison of Data with Standard 18

2.1.1 Diagnostic Investigation/Test 18

2.1.2 Cause of the Patients Condition 21

2.1.3 Clinical features/Signs and symptoms 21

2.1.4 Treatment given to A.H 22

2.1.5 Complications 27

2.2 Patient/Family's Strengths 27

2.3 Patient /Family Health Problems 27

2.4 Nursing Diagnoses 28

CHAPTER THREE 29

PLANNING FOR PATIENT/FAMILY CARE 29

3.0 Introduction 29

3.1 Patient/Family Care Objectives/ Outcome Criteria. 29

CHAPTER FOUR 41

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN 41

4.0 Introduction 41

4.1.1 First Day of Admission (15th November, 2021) 41

4.1.2 Second day of admission (16th November, 2021) 44

4.1.3 Third day of admission (17th November, 2021) 45

4.1.4 Fourth day of Admission (18th November, 2021) 47

4.1.5 Fifth Day of Admission (19th November, 2021) 48

4.1.6 Sixth day of Admission/Day of Discharge (20th November, 2021) 49

4.2 Preparation of patient/Family for Discharge/Rehabilitation 50

4.3 Follow Up/Home Visit/Continuity of Care 50

CHAPTER FIVE 54

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY 54

5.0 Introduction 54

5.1. Statement of Evaluation 54

5.2 Amendment of Nursing Care Plan for Patient Partially Met or Unmet Outcome Criteria 58

5.3 Termination of Care 58

CHAPTER SIX 59

SUMMARY AND CONCLUSION 59

6.0 Introduction 59

6.1 Summary of Care 59

6.2 Conclusion 60

APPENDIX 61

BIBLIOGRAPHY 64

SIGNATORIES ..... **Error! Bookmark not defined.**

LIST OF TABLES

Table 1: Comparison of Diagnostic Tests done to Literature Review……19

Table 2: Results of Diagnostic investigations carried Out on A.H ……20

Table 3: Clinical Features Exhibited By A.H Compared with those in the Literature Review……..21

Table 4: Comparison of treatment in the Literature Review to those given to A.H……22

Table 5: Pharmacology of Drugs Given to A.H……...….24

Table 6: Nursing care plan for A.H and family…….31

Table 7: Vital signs for A.H……61

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 (Hinkle & Cheever, 2018). Nursing assessment is the first step in the nursing process.

The information was collected from patient as well as other family members through observation, interview, physical examination, laboratory investigations.

The data is then analyzed to arrive at the patient's problems so that the nurse can determine the possible ways of nursing the patient back to an independent life.

1.1 Patient's Particulars

Patient particulars is defined as details or information about a person, especially when officially recorded (McIntosh, 2019). They include patient's name, address, age, sex, marital status, occupation, religious preferences, healthcare financing and usual source of medical care.

Mrs. A. H., a 34 year old woman is the subject of the study. She is the second born among three siblings of Mr A.I. She was born on the 2nd May, 1987. Mrs. A.H lives at New Dormaa house number A250/E Sunyani in the Bono Region of the Republic of Ghana. She is married to Mr. S.D. She is unemployed. She is a Muslim. Her husband, Mr. SD.is her next of kin. Mrs. A. H. never had any education while growing up. She speaks only Twi language. She is blessed with three children, two males and a female. She is also dark in complexion, 1.98 meters tall and weighs 58kg with no physical impairment.

1.2 Patient's Family Medical History

Health history is a series of questions used to provide an overview of the patient's current health status. Information is obtained on both paternal and maternal sides of the family (Hinkle & Cheever, 2018). Patient stated that there is no known hereditary disease such as Diabetes Mellitus, Mental illness or Hypertension in the family and there are no chronic and infectious conditions like epilepsy, tuberculosis and leprosy in the family. However, she said that occasionally, the family members do experience minor ailments like common cold, headache and diarrhea which are treated by self-medication (using both over-the-counter drugs and traditional medicines) but if symptoms persist, they report to the hospital.

Mrs. A.H parents are not alive and they all died at old age. Madam A.H obliged that this is the first time she is being hospitalized. The sources of medical treatment for Mrs. A.H and family are both orthodox and herbal medicine. There are no known allergies in the family.

1.3 Family's Socio-Economic History

Mrs. A. H. has a family size of five, of which two are females and three males. She has all children alive. She is registered with the National Health Insurance Scheme (NHIS).
According to her, the entire families are Muslims. The family is very sociable and relate very well with their neighbors. The income used to support the family is solely derived from the husband.

1.4 Patient's Developmental History

Growth refers to an increase in the size of an organism or any of its parts, as measured in increments of weight, volume, or linear dimensions, which occur as a result of hyperplasia or hypertrophy (Weller, 2014). Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Weller, 2014).

Weller (2014) defined maturation as the process or condition of attaining complete development. In humans, the unfolding of full physical, emotional and intellectual capacities that enables a person to function at a higher level of competency and adaptability within the environment.

According to Mrs. A. H., her aunty told her that she had no problems after birth was immunized against the childhood vaccine-preventable diseases as evidenced by Bacilli Calmet Guerin (BCG) scar on her right deltoid muscle. She did not experience any serious diseases that could have impeded her development while growing up. She was also told by her aunty who took care of her that she started sitting as early as six months and walking quite early as well. She did not have the chance of attending school while growing up. She grew up with her aunty with her three other siblings and was not schooled as a result of the financial burden. Mrs. A. H. developed her secondary sexual characteristics such as enlargement of breasts, growing of pubic hairs at 12 years. She experienced her menarche at the age of 15 and had a regular menstrual flow and a normal 28 day cycle.

According to Erik Erikson's theory of psychosocial development (1959), there are eight distinct stages with each possible results, thus either success or failure and its includes the following

- Trust verses Mistrust (Birth to 12 months).
- Autonomy verses Shame and Doubt (1 to 3 years).
- Initiative verses Guilt (3 to 6 years).
- Industry verses Role Inferiority (6 to 12 years).
- Identity verses Role Confusion (12 to 20 years).
- Intimacy verses Isolation (20 to 40years).
- Generatively verses Stagnation (40 to 65 years).

- Integrity verses Despair (65 to death)

Mrs. A. H. is within the sixth stage; Intimacy versus Isolation (20 to 35 years) during young adulthood, during which there is a conflict centered on forming intimate and loving relationships with other people and failure to establish them results in loneliness and isolation. Through various interactions with the patient, I realized patient had fulfilled intimacy through her close relationship with her family. I also observed this from how she interacted with her eldest daughter and also with the number of people who visited her while on the ward.

1.5 Obstetric History

Obstetric history involves asking questions relevant to a patient's current and previous pregnancies (Potter, 2020). According to patient she had her menarche around the age of fifteen. Patient indicated that she has never had an abortion before. Patient has had three pregnancies with three deliveries. She gave birth to all her children through spontaneous vaginal delivery with no complications. All deliveries were assisted by a skilled midwife. She revealed that she used to take oral contraceptives to prevent herself from getting pregnant. She also revealed that she has a regular menstrual cycle and that she usually gets her menses every twenty-eight days.

1.6 Patient's Lifestyles / Hobbies

Mrs. A. H. said she wakes up at 5:00am every day. She says a prayer, performs her first oral hygiene; empty's her bowel and her bladder, takes her first bath and prepares breakfast for the family. She also takes time to prepare her younger children for school. Mrs. A. H empties her bowel twice daily and performs oral hygiene twice as well, thus morning and evening and she eats three times daily and sleeps at 10:00pm. The above mentioned routines are done usually from Monday to Friday. Nevertheless, when Mrs. A. H is alone at home, she

performs her chores at home, prepares food for the family on their return and watches television when she gets bored or takes a short nap when she gets tired. She also observes the five daily prayers as laid down by Prophet Mohammed. Mrs. A.H normally attends funerals and weddings at weekends most especially on Sundays as most of the Islamic weddings and funerals are held on Sundays. She however sometimes attends non-Islamic wedding and funerals on Saturdays as well as in the week days. She also said she has no favorite meals and that has always eaten what she had. Mrs. A. H. said she does not take alcohol nor smoke. She likes to watch television programs such as telenovelas and among others. Mrs. A. H is an introvert, kind, caring and teaches her children to behave as such. She also loves to express her emotions through talking and has good communication skills as well.

1.7 Patient's Past Medical History

Mrs. A. H has not been hospitalized before but occasionally experiences minor ailments such as fever or cold which she treats using drugs bought from a pharmaceutical shop. But when symptoms persist or become worse, she reports to the Hospital for the necessary treatments to be given her. She was also encouraged to regularly visit the hospital facility for checkups.

1.8 Patient's Present Medical History

Mrs. A. H said that on the 14th of November, 2021, she was about going to bed when she begun to feel some pains in her abdomen. In about 15 minutes from then, she began to have diarrhea. She visited the wash room about three times throughout the night. The following morning, she felt very weak, and also lost appetite. She decided to seek medical treatment the next day on the 15th of November, 2021 at the Sunyani Municipal Hospital where she was admitted at the Females ward and was managed as a case of Gastroenteritis upon various assessments and investigations.

1.9 Admission of Patient

A.H came into the ward in a conscious and ambulatory state through the Out Patient Department of the Municipal hospital on the 15th of November, 2021. Patient was weak upon assessment; she also complained of abdominal pains, she was also having diarrhoea and loss of appetite as well. Blood sample was taken for full blood count and she was diagnosed of Gastroenteritis.

Patient's vital signs were checked and recorded accurately as follows;

Temperature	35.9°C
Pulse	104 beats per minute
Respiration	26 cycles per minute
Blood pressure	100/60mmHg

Patient was managed on the following drugs:

Intravenous Cefuroxime 750mg tds × 24 hours

Tablet cotrimazole (400+80) bd × 24 hours

Tablet Amoksiclav 1g bd × 7 days

Tottema 1 vial BD × 7 days

Tablet Azithromycin 500mg daily × 7 days

Tablet cefuroxime 500mg bd × 7 days

Intravenous 5%Dextrose in normal saline

Intravenous Ringers lactate 1L×24 hours

Intravenous Normal Saline 1L × 24 hours

Patient and relative were reassured and oriented to the ward. Her particulars such as name, sex, age, and residential address were recorded in the admission and discharge book and on the daily ward state. Hospital policies regarding visiting periods, payment of bills and National Insurance policy, medications, rounds, the time vital signs will be checked were explained to the patient as well as the relative. Patient's relative was told the rules and regulations including visiting hours and meal time. Patient relative were asked to get A.H's own bowl, spoon, drinking cup, bathing sponge, bucket, towel, and other toiletries. Patient and relative were then introduced to the other patients who have come to seek medical care in the facility more particularly at the Female Ward of the Sunyani Municipal Hospital.

Physical examination on the patient was performed from head to toe and no abnormalities were seen. I reintroduced myself to the patient's mother as a final year student nurse of the Nursing and Midwifery Training College, Berekum, with the desire to engage them for my care study. Madam A.H was informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of Diploma in Registered General Nursing. I explained to patient and relative 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. Madam A.H agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. Discharge planning was initiated with the relatives, thus they will continue the care at home once A.H is well. I decided to choose this patient so as to put into practice actual and holistic nursing care on Gastroenteritis, as it has been learnt theoretically.

1.10 Patient/Family Concept of Illness

Madam A.H did not attribute her illness to any spiritual cause. She however verbalized that some conditions like epilepsy and mental disorders can have spiritual implications and she

strongly believes that the treatment planned for her in the hospital will help cure the illness and prevent any further complications associated with it.

1.11 Literature Review on Gastroenteritis

Review Anatomy and Physiology of the Digestive System

The digestive system contributes to homeostasis by breaking down food into forms that can be absorbed and used by body cells. It also absorbs water, vitamins, and minerals, and eliminates wastes from the body (Hinkle & Cheever, 2018). The digestive system is composed of two groups of organs namely the gastrointestinal tract or alimentary canal which is a continuous tube that extends from the mouth to the anus through the thoracic and abdominopelvic cavities.

Organs of the gastrointestinal tract include the mouth, most of the pharynx, esophagus, stomach, small intestine and large intestine. The length of the GI tract is about 5-7 metres in a living person.

Gastroenteritis

Gastroenteritis is also called intestinal flu, traveller's diarrhoea, viral enteritis and food poisoning. It is a self – limiting disorder characterized by diarrhoea, nausea, vomiting and abdominal cramping.

Gastroenteritis is an inflammation of the stomach and intestinal tract that primarily affects the small bowel. There is an increase in passage of loose stools which increases in frequency.

Incidence

This condition occurs in persons of all ages and is a major cause of morbidity and mortality in under developed nations. In the United Nations, gastroenteritis ranks second to common

cold as a cause of lost work time and fifth as the cause of death among young children. It also can be life threatening in the elderly and the debilitating people. It is common in an area of poor sanitary conditions. In 1980 gastroenteritis from all causes caused 4.6 million deaths in children with most of these occurring in the third world. Current death rates have come down significantly to approximately 1.5 million deaths annually in the year 2000, largely due to the global introduction of oral rehydration therapy. Internationally, the mortality rate is 5-10 million deaths each year.

Predisposing Factors

1. Low socio-economic status, malnutrition feeding habits.
2. Infants are more susceptible.
3. Contamination of food.
4. Poor sanitation

Causes

Gastroenteritis has many causes including;

1. Bacteria (which are responsible for acute food poisoning). Examples are staphylococcus aureus, Salmonella, Shigella, and Clostridium Perfringes
2. Amoebae especially Entamoebae histolytica
3. Parasites examples Ascaris, Enterobius and Trinchinella spiralis
4. Viruses (they may be responsible for traveller's diarrhoea, examples are (asteno-viruses, echoviruses or coxsackieviruses.)
5. Ingestion of toxins: plants or toadstools
6. Drugs reactions: antibiotics
7. Enzymes deficiencies

8. Food allergens

Incubation Period: The incubation period for gastroenteritis is between twelve hours to ten days

Pathophysiology

When microorganisms capable of causing gastroenteritis enter the gastrointestinal tract (GIT) through ingestion of contaminated food or when any possible causes of gastroenteritis is present, they irritate and penetrate the mucous of the small intestine producing injury to the gastroenterocytes resulting in inflammation and subsequently causing pain and fever. The body reacts to these irritations by invading the area with leucocytes and other inflammation process occur (Prescilla, 2018). The mucous membrane become edematous and undergoes superficial erosion. Inflammation of the mucous membrane of the small intestines increases cyclic adenosine none-phosphate which results in the net flow of fluid into the intestinal lumen. There is also an increase in chloride with the inhibition of normal intestine mucosa sodium and water absorption. Also inflammation reaction and the presence of toxin also stimulates sympathetic nerves which stimulates salivation and vomiting Centre increasing salivation, nausea, hiccough, and vomiting. It further increases intestinal activities leading to diarrhea and abdominal pains (Prescilla, 2018). Persistent diarrhea and vomiting subsequently lead to depletion of body fluid and electrolyte especially bicarbonate reserves. It predisposes to acidosis, fluid volume deficit and circulation collapse. This further leads to fluid from intracellular compartment to extracellular compartment resulting in systemic disturbance in cellular function and changes in their shape which manifest sunken eyes and dry mucous membrane. Also, fluid volume depletion and subsequent electrolyte imbalance results in hypokalemia, which triggers the sympathetic nerves to stimulate the heart to increase pulse

rate. Both viruses and bacteria are found in contaminated food and drinking water (Hinkle & Cheever, 2018).

Clinical Manifestations

1. The adult or child passes loose or liquid stools frequently (Diarrhoea)
2. There is pain in the abdomen
3. The child/adult becomes weak and restless
4. Tenesmus (straining and defecation) may be present or not
5. There is sudden loss of appetite (anorexia)
6. The abdomen is often distended
7. Vomiting may be present
8. There may be fever and chills
9. General malaise
10. Irritability
11. Headache
12. In view of the dehydration;
    - The fontanels (infants only) are depressed and the skin is dry and inelastic and the eyes are sunken
    - Rapid pulses
    - Less urine production
    - Poor food intake
    - Low blood pressure
    - Poor skin turgor and dry mucus membrane
13. Nausea may be present
14. Borborygmi (hyperactive bowel sounds) may be present

Diagnostic Investigations

The following diagnostic investigations can be carried out to diagnose an individual of gastroenteritis.

1. Through the history taken to exclude any parenteral causes of illness.
2. By the signs and symptoms.
3. Serum electrolytes estimation. Example potassium and sodium calcium.
4. Blood culture identifies causative bacteria or parasites.
5. Full blood count.
6. Stool testing for bacteria.
7. Blood, urea and nitrogen levels.

Types of Gastroenteritis

Gastroenteritis can be basically divided into three main groups which are;

1. Acute gastroenteritis
2. Chronic gastroenteritis
3. Toxic gastroenteritis

Acute Gastroenteritis

This may develop in acute illness especially when the patient has had a major traumatic injury like burns and severe infections. The ingestion of irritating foods such as hot pepper can cause acute gastroenteritis. Excessive intake of alcohol and hypersensitivity to food such as gluten and cow milk can lead to this condition. It may also be secondary to infection like malaria, pernicious anemia among others. Acute gastroenteritis is characterized by severe abdominal cramps, nausea, vomiting, fever, general malaise and diarrhea.

Chronic Gastroenteritis

This is caused by intestinal infections caused by recurring exposure to irritating substances which includes surgical alterations such as short bowel syndrome which reduces the size of the colon leading to decrease anal status like anxiety or depression over a period of time can lead to chronic gastroenteritis. Chronic gastroenteritis is characterized by nausea, vomiting, anorexia, diarrhea, dyspepsia, non-specific fever, hiccup and dehydration.

Toxic Gastroenteritis

It occurs as a result of ingestion of irritants or corrosive poisons and substances that counteract the protective function of mucosal lining of the gastrointestinal tract. Ingestion of poison like mercury, ammonia, and carbon dioxide can lead to the condition. Drugs like aspirin and other non-steroidal anti-inflammatory drugs, cytotoxic agents, caffeine, corticosteroids and indomethacin when taken in large doses can lead to toxic gastroenteritis. Endotoxins released from infecting bacteria such as Escherichia coli, staphylococcus aureus or salmonella can lead to this condition. Toxic gastroenteritis is characterized by nausea, vomiting, anorexia, diarrhea, fever, malaise and dyspepsia.

Medical Treatment

1. Plenty of liquids orally: water, lime juice, rice water, coffee with or without lime should be given with the aim to rehydrate the patient.
2. Solid foods especially hot or spicy foods are avoided.
3. Severe diarrhoea is treated with ORS (oral rehydration salt) therapy in which physiological salt solutions are given orally to correct dehydration and electrolyte imbalance.
4. The appropriate antibiotic after culture and sensitivity of the stool is given.

5. Anti-emetics are also given to control vomiting. Example; Metoclopramide and ondansetron may be helpful for vomiting in children.
6. Intravenous fluids are given to maintain electrolytes balance.
7. Sedatives may be prescribed for patients with severe restlessness to control the pain.
8. Absorbents such as Kaolin and pectin may decrease the frequency of evacuation.
9. Anti-motility/Antidiarrheal agents (loperamide) may be used. They are thus discouraged in people with bloody diarrhea or diarrhea complicated by a fever.

Nursing Management

Nursing management for a patient with gastroenteritis is focused on preventing/managing dehydration, controlling signs and symptoms and offering the needed help and nursing care to bring about recovery and help prevent complications. Nursing care given to a patient with gastroenteritis can be grouped as follows:

Rest and Sleep

This helps to improve circulation and conservation of energy.

1. In view of this, a well-ventilated and lightened room in a serene environment is recommended.
2. Visitors should be restricted from disturbing the patient.
3. Bed should be free from creases and crumps to ensure patient's comfort and sleep.

Observation

1. Vital signs such as temperature, pulse, and respiration of the patient should be monitored. This is done four hourly until patient's condition is resolved.

2. Fluid and electrolyte levels should also be observed by monitoring the input and output chart.
3. Also patient should be weighed frequently to check if there is any weight loss.
4. Patient should also be monitored for the desired and adverse effects of the drugs.

Nutrition

1. Diet should be planned with patient to ensure compliance.
2. Patient should be encouraged to eat as normally as possible.
3. Educate patient about proper storage, preparation and cooking of food, and good hygiene to help prevent gastroenteritis.
4. Educate patient to drink more water and also avoid intake of caffeinated drinks such as coffee.
5. Dietician should educate on how to plan diet in relation to her condition and make sure the local foods known to the patient are used in the plan**.**

Exercise

1. Patient should be encouraged to have moderate exercises since this help to improve circulation. Patient's exercise can be in the form of walking around the ward, frequent turning in bed and extension of limbs.

Elimination

1. Bowel elimination should be encouraged by serving bed pan on request. Encourage patient to take in fruits and more fluids to facilitate bowel elimination.
2. Patient should be encouraged to have regular bladder elimination. Urinals should be served when necessary.

Health Education

1. Patient should be educated on the causes and predisposing factors of the condition. He should also be taught about the signs and symptoms of the condition, side effects of drug, treatment and to take his medications seriously and report any undesired signs and symptoms of it.
2. Always wash your hands after playing with your child or changing diapers. Family should be educated on careful and effective hand washing after visiting the washroom, before preparing, serving or eating food and to also dry hands properly afterwards.
3. Educate patient about proper storage, preparation and cooking of food under very hygienic conditions.
4. Immunization - Rotavirus is the most common cause of gastroenteritis in children. There is an effective vaccine against rotavirus. Mothers should therefore vaccinate their children against this virus.

Complications

The following complications can occur if early medical treatment is not sought for;

1. Malnutrition
2. Convulsions
3. Hypovolemic shock
4. Anaemia
5. Acute renal failure
6. Peripheral circulatory failure
7. Dehydration
8. Electrolyte imbalance.

Prevention

1. The patient is isolated from others to prevent cross contamination.
2. Patients vomitus and stools should be well disposed after being disinfected.
3. Proper barrier nursing should be practiced by using mask, gloves and gown.
4. Hand washing should be well practiced and encouraged.
5. Personal hygiene should be practiced by cutting fingernails short, shaving of hairs and others.

1.12 Validation of Data

Validation refers to the extent to which a measure, indicator or a method of data collection possesses the quality of being sound or untrue (Weller, 2014). Since I want to be certain about the information given to me by my patient, I continuously assessed the information by asking those questions in different ways and all the time had the same answers. The visit to their home and the interactions I had with other family members of the patient confirmed the information given to me by my patient. Again, the same information gathered from the doctor's notes, nurses' records, the investigations carried out and the results and literature review of the condition strongly confirms the validity of the information gathered.

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, 2014). It is the second phase of the nursing process. The chapter presents information on the comparison of data gathered with standards. Patient/family strength and health problems as well as associated nursing diagnosis.

2.1 Comparison of Data with Standard

The following data would be compared with standards;

2. Diagnostic investigation/ Tests
3. Causes/ Risk factors
4. Clinical features
5. Medical management
6. Complications

2.1.1 Diagnostic Investigation/Test

The following diagnostic investigations were carried out to assist in the treatment of A.H.

1. Full blood count
2. Blood film for malaria parasite

Table 1: Diagnostic Investigations/Tests In Literature Review Compared With Those Carried Out On A.H

Diagnostic Test Outlined In Literature Review	Diagnostic Test Carried Out On A.H
1. History Taking	1. History was taking from patient in diagnosing her
2. Serum electrolytes estimation	2. No serum electrolytes estimation was done
3. Blood culture	3. Blood culture was not done on Mrs. A.H
4. Full blood count	4. Blood sample was taking for FBC
5. Stool testing for bacteria	5. Stool culture was not done for Mrs. A.H
6. Blood, urea and nitrogen levels	6. Blood, urea and nitrogen levels was not estimated
7. Malaria parasite count was not included in the literature review	7. Blood sample was taken to exclude the presence of malaria in Mrs. A.H's blood

Few of the diagnostic tests in the literature review were done on A.H with the exception of the Malaria parasite count which was not in the literature review but waned to exclude the presence of the plasmodium parasite in the blood.

Table 2: Results of Diagnostic investigations carried Out on A.H

Date	Specimen	Investigations	Results	Normal values	Interpretation	Remarks
15/11/2021	Blood	Blood film for malaria parasite count	No parasites were seen	No malaria parasite was to be seen	Patient has no malaria parasite in his blood	No treatment given
15/11/2021	Blood	Red blood cell count	4.63 $x10^{12}$/L	**Males:** 5.0 $x10^{12}$/L -6.0 $x10^{12}$/L **Females:** 4.3 $x10^{12}$/L-5.3 $x10^{12}$/L	Red blood cell count was within normal range	No treatment was given
15/11/2021	Blood	Hematocrit	37.6%	**Males:** 42.7% - 51.5% **Females:** 38.4% - 43.5%	Hematocrit level was below normal	Tottema 1 vial BD × 7 was given
15/11/2021	Blood	White blood cell count	5.3×10^{9}/L	**Males:** 5.0 $x10^{9}$/L - 10.5 $x10^{9}$/L **Females:** 4.45 $x10^{9}$/L - 9.5 $x10^{9}$/L	White blood cell count was within normal range	IV Cefuroxime 750mg tds × 7 was given

2.1.2 Cause of the Patients Condition

With reference to the causes of Gastroenteritis in the literature review, there was every indication that patient had the disease through the ingestion of microorganism but not associated with any spiritual cause.

2.1.3 Clinical features/Signs and symptoms

Table 3: Clinical Features Exhibited By A.H Compared with those in the Literature Review.

Clinical Features Stated in Literature Review	Clinical Features Exhibited By A.H
1. Diarrhoea	1. Patient had diarrhea
2. Abdominal pain	2. Patient had abdominal pains
3. General body weakness	3. Patient had general body weakness
4. Tenesmus (straining and defecation)	4. Patient did not experience tenesmus
5. Loss of appetite	5. Patient experienced loss of appetite
6. Distended abdomen	6. Patient did not have distended abdomen
7. Vomiting	7. Patient did not vomit
8. Fever and chills	8. No fever and chills was experience by Mrs. A.H
9. Irritability	9. Patient did not experience irritability
10. Headache	10. Patient had no headache
11. Dehydration	11. Patient was dehydrated

With reference to the table above, patient presented most of the clinical manifestations as stated in the literature.

2.1.4 Treatment given to A.H

The following treatment were given to A.H

1. Intravenous Cefuroxime 750mg tds × 24 hours
2. Tablet Cotrimazole (400+80) bd × 24 hours
3. Tablet Amoksiclav 1g bd × 7 days
4. Tottema 1 vial BD × 7 days
5. Tablet Azithromycin 500mg daily × 7 days
6. Tablet cefuroxime 500mg bd × 7 days
7. Intravenous 5%Dextrose in normal saline
8. Intravenous Ringers lactate 1L×24 hours
9. Intravenous Normal Saline 1L × 24 hours

Table 4: Comparison of treatment outlined in the Literature Review with those given to A.H

Treatment outline in Literature Review	**Treatment given to A.H**
Anti-Biotics	
Cefuroxime	Cefuroxime was given to AH
Amoxiclav	Amoxiclav was given to A.H
Cotrimazole	Cotrimazole was given to A.H
Anti-emetics	
Metoclopramide	Metoclopramide was not given to my patient
IV Fluids	
Dextrose	5%Dextrose in normal saline was given
Ringers lactate	Ringers lactate was given to A.H
Normal Saline	Normal Saline was given to A.H
Oral Rehydration Salt	Oral Rehydration Salt was not given to A.H

Sedatives	
Diazepam	No sedative was given to AH
Anti-motility/Antidiarrheal agents	
Loperamide	No Anti-motility/Antidiarrheal agents was given to AH

Table 5: Pharmacology of Drugs Given to AH

Date	Drug	Dosage/Route	Classification	Desired Effect	Actual Action Observed	Side Effects/ Remedies
15/11/21	Cotrimoxazole Tablet	**Dosage:** (400+80) mg BD x 24 hours **Route**: Oral	Sulfonamide Antibiotic	Prevents synthesis of folic acid in bacteria and destroys its development.	Patient's infection was resolved.	Nausea, vomiting, Stephen Johnson's syndrome, diarrhea, tinnitus. No side effect observed.
15/11/21	Dextrose 5% in Sodium Chloride	0.9 solution one (1) liter over 24 hours **Route**: IV	Electrolytic and fluid balance	To restore fluids and electrolytes balance, supplement lost glucose and expand plasma volume.	Patient was well hydrated. The patient's skin turgor improved	Fluid overload, example pulmonary edema. No side effect was observed
15/11/21	Intravenous Ringers Lactate	**Dosage:** 1 liter×24 hours **Route: IV**	Isotonic solution	To correct fluid and electrolyte imbalance	Patient's body fluids and electrolytes were raised	Fluid overload, example pulmonary edema. No side effect was observed
16/11/21	IV Cefuroxime	**Dosage:** 750mg tid x 24 hours **Route**: IV	Semi Synthetic Cephalosporin antibiotic	Attacks penicillin binding proteins to inhibit bacterial cell wall synthesis.	Patient's infection was resolved**.**	Nausea, anorexia, vomiting, headache. No side effect was observed.

16/11/21	Tablet Azithromycin	**Dosage:** 500mg daily × 7 days **Route**: Oral	Macrolide	Prevents bacteria from growing by interfering with their protein synthesis	Patient's infection was resolved**.**	Nausea, headaches, dizziness, vomiting. No side effect was observed.

Table 5: Pharmacology of Drugs Given to Mrs. A. H Continues.

Date	**Drug**	**Dosage/Route of Administration**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effects/ Remedies**
17/11/2021	Tablet Amoxiclav	**Dosage:** 1g bd x 7 days **Route:** orally	Penicillin Antibiotic	Inhibits cell wall of bacteria by blocking trans peptidase and prevents its synthesis.	Patient did not show any signs of infection	Hypersensitivity, stomach upset, fever, nausea, vomiting. No side effect was observed.
17/11/2021	Tablet Azithromycin	**Dosage:** 500mg daily × 7 days **Route:** Orally	Antibiotic	Inhibits cell wall of bacteria by blocking trans peptidase and prevents its synthesis.	Patient did not show any signs of infection	Stomach upset, fever, nausea, vomiting.

17/11/2021	Cefuroxime Tablet	**Dosage:** 500mg bd x 7 days **Route**: orally	Semi Synthetic Cephalosporin antibiotic	Attacks penicillin binding proteins to inhibit bacterial cell wall synthesis.	Patient's infection was resolved.	Nausea, anorexia, vomiting, headache. No side effect was observed.
18/11/2021	Tothema	**Dosage:** 1 vial BD x 7 days **Route:** orally	Hematinic	To correct anemia by helping in formation of red blood cells and boosting up immunity	Patient's anemia was corrected.	Nausea, vomiting, constipation, anorexia, diarrhea. No side effect was observed.

2.1.5 Complications

With regards to the complications outlined under the literature review, Mrs. A. H did not develop any of the complications. This can be attributed to the fact that, she was brought early to the hospital and hence early treatment was initiated and led to her early recovery.

2.2 Patient/Family's Strengths

Strength refers to the ability to do things that need lot of physical or mental effort (McIntosh, Cambridge advanced learner's dictionary, 2019). These involves the activities that contribute to the well-being of patient and her family as well as speedy recovery.

1. Patient was relieved of abdominal pains when put in the lateral position.
2. Patient was able to tolerate oral fluids.
3. Patient was able to perform self-care activities with assistance.
4. Patient was able to sleep for about two (2) to three (3) hours in the day.
5. Patient was able to eat one third of her food served.

2.3 Patient /Family Health Problems

Patient health problem refers to any medical ailment or an environmental condition that poses the risk of diseases or medical ailment to an individual (Weller, 2014).

The following health problems were identified during hospitalization

1. Patient had abdominal pains (15/11/2021)
2. Patient and had diarrhea (15/11/2021)
3. Patient had general body weakness (15/11/2021)
4. Patient had interrupted sleep (17/11/2021)

5. Patient could not eat well (17/11/2021)

2.4 Nursing Diagnoses

Nursing diagnosis is defined as a clear and a definite statement of a health problem or of a potential health problem in the patient's health status that a nurse is professionally competent to treatment (Weller, 2014). These nursing diagnoses were formulated based on the health problems that were identified.

1. Acute abdominal pains related to inflammation of the gastric mucosa.
2. Risk for fluid and electrolyte imbalance (less than body requirement) related to diarrhea.
3. Self-care deficit related to general body weakness.
4. Altered sleep pattern (insomnia) related to change of environment
5. Risk for imbalanced nutrition(less than body requirement) related to loss of appetit

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is consciously setting forth a scheme to achieve a desired end or goal. The planning phase of the nursing process provides a blueprint for nursing interventions to achieve specified goals. It is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan (Weller, 2014). This is the third phase in the nursing process which deals with setting of goals and objective/outcome criteria to meet the health needs of the patient. These objectives/outcome criteria are set in order of priority which can be long or short term. This is made possible based on the actual and potential problems identified.

3.1 Patient/Family Care Objectives/ Outcome Criteria.

1. Patient will be relieved of abdominal pains within 24 hours as evidenced by
    a. Nurse observed patient having a relax facial expression
    b. Patient verbalized relieved of abdominal pains
2. Patient will maintain his normal fluid and electrolyte volume within 48hours as evidenced by,
    a. Nurse observed that patient diarrhoea has stopped.
    b. Patient showing no signs of dehydration, such as sunken eyes, and rapid pulse.
3. Patient will be able to perform self-care activities unassisted within 48 hours as evidenced by.
    a. Nurse observed patient being able to perform self-care activities unassisted.
    b. Patient verbalized she is able to perform self-care activities unassisted.

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4. Patient’s normal sleeping pattern will be restored within 24hours as evidenced by

a. Nurse observed patient having uninterrupted sleep for 6-8hours during the night

b. Patient verbalized she had uninterrupted sleep during the night.

5. Patient’s nutritional status will be improved and maintained throughout hospitalization as evidenced by;

a. Nurse observed patient consumes at least more than half of the food served.

b. Patient verbalized that she has regain her appetite.

Table 6: Nursing care plan for A.H and family

Date/ Time	Nursing Diagnosis	Objectives/ outcome criteria	Nursing orders	Nursing intervention	Date Time	Evaluation	Sign
15/11/21 11:00am	Acute abdominal pains related to inflammation of the gastric mucosa	Patient will be relieved of abdominal pains within 24 hours as evidenced by a. Nurse observed patient having a relax facial expression b. Patient verbalized relieved of	1.Reassure patient and family 2.Assess the level and intensity of the pain 3.Reduce noise to encourage rest 4.Assist patient to assume a position he feels comfortable	1. Patient and family were reassured that with the treatment given, the pains will subsides 2. Pain was assessed using the pain rating scale and A.H chose 6 3. All forms of noise were reduced by restricting visitors, reducing volume of radio and television set. 4. Patient was assisted into semi-prone position	16/11/21 11:00am	Goals fully met as the Nurse observed patient having a relaxed facial expression and the patient verbalized	C.A

		abdominal pains	5. Provide diversional therapy 6. Serve prescribed medication	5. Patient was engaged in telenovela discussion to divert her mind of the pain 6. IV Cefuroxime 750mg served		that the pains have subsided	

Table 6: Nursing care plan for A.H and family continues

Date/ Time	Nursing Diagnosis	Objectives/ outcome criteria	Nursing orders	Nursing intervention	Date Time	Evaluation	Sign
15/11/21 11:30am	Risk for fluid and electrolyte imbalance (less than body requirement) related to diarrhea	Patient will maintain his normal fluid and electrolyte volume within 48hours as evidenced by, a. Nurse observed that patient diarrhoea has stopped. b. Patient showing no signs of	1. Reassure patient that all measures to maintain her fluid and electrolyte levels will be carried out. 2. Assess patient's skin turgor frequently for signs of dehydration. 3. Assess nature and severity of vomiting and diarrhea.	1. Patient was reassured all measures to maintain her fluid and electrolyte level will be carried out. 2. Patient's skin turgor was assessed frequently for dehydration signs. 3. Nature and severity of vomiting and diarrhea was assessed. 4. Prescribed 5%Dextrose	17/11/21 11:30am	Goals fully met as evidenced by Nurse observed that patient diarrhoea has stopped and patient showing no signs of dehydration,	C.A

		dehydration, such as sunken eyes, and rapid pulse.	4. Serve prescribed fluids. 5. Encourage frequent fluid intake. 6. Monitor fluid intake and output.	in was served for patient. 5. Frequent fluid intake was encouraged. 6. Fluid intake and output of patient was monitored.		such as sunken eyes, and rapid pulse.	

Table 6: Nursing care plan for A.H and family continues

Date/ Time	Nursing Diagnosis	Objectives/ outcome criteria	Nursing orders	Nursing intervention	Date Time	Evaluation	Sign
15/11/21 12:00pm	Self-care deficit related to general body weakness.	Patient will be able to perform self-care activities unassisted within 48 hours as evidenced by. a. Nurse observed patient being able to perform self-care activities unassisted. b. Patient verbalized she is	1. Reassure patient and mother. 2. Arrange items of daily use within the reach of patient. 3. Encourage patient to carry out activities he can tolerate. 4. Assist patient with the	1. Patient and mother re-assured that A.H will regain strength for his daily activities with commencement of nursing measures. 2. Patient spoon, cup, brush were arranged in his reach for easy access. 3. Patient was encourage to walk around his bed with rest period when tired 4. Patient was assisted in bathing and	17/11/21 12:00pm	Goals was fully met as Nurse observed patient being able to perform self-care activities unassisted and patient	C.A

		able to perform self-care activities unassisted.	performance of certain activities 5.Serve prescribed medications	brushing of teeth. 5. Tothema 1 vial was served		verbalized she is able to perform self-care activities unassisted.	

Table 6: Nursing care plan for A.H and family continues

Date/ Time	**Nursing Diagnosis**	**Objectives/ outcome criteria**	**Nursing orders**	**Nursing intervention**	**Date Time**	**Evaluation**	**Sign**
17/11/21 9am	Altered sleep pattern (insomnia) related to change of environment	Patient's normal sleeping pattern will be restored within 24hours as evidenced by a. Nurse observed patient having uninterrupted	1. Reassure patient and mother 2.Reduce noise making at the ward 3. Provide dim light in the evening to enhance sleep 4. Give warm bath and serve	1. Patient and mother were reassured that with the treatment given patient will be able to sleep 2. Volume of TV and radio was reduced at the ward. 3. Light at the ward was dimmed at the evening to enhance sleep. 4. Warm bath was given and warm drink	18/11/21 9am	Goals fully met as evidenced by Nurse observed patient having uninterrupted sleep for	C.A

		sleep for 6-8hours during the night b. Patient verbalized she had uninterrupted sleep during the night	warm drinks 5. Provide a comfortable bed free from creases 6. Carry nursing activities together to prevent distraction.	(milo) was served to induce sleep 5. Admission bed free from creases was provided and bed linen was changed when soiled. 6. All nursing activities were carried together to ensure patient have enough time to sleep		6-8hours during the night and Patient verbalized she had uninterrupted sleep during the night	

Table 6: Nursing care plan for A.H and family continues

Date/ Time	**Nursing Diagnosis**	**Objectives/ outcome criteria**	**Nursing orders**	**Nursing intervention**	**Date Time**	**Evaluation**	**Sign**
17/11/21 10am	Risk for imbalanced nutrition (less than body requirement) related to	Patient's nutritional status will be improved and maintained throughout hospitalization as evident by;	1. Reassure patient with the good nursing care, she will regain normal eating pattern. 2. Ensure oral hygiene twice daily to stimulate appetite. 3. Explain importance of food in her recovery and encourage eating.	1. Patient was reassured of good nursing care that she will regain normal eating pattern. 2. Oral hygiene was ensured to stimulate appetite. 3. Importance of food in recovering	20/11/21 10am	Goals was fully met as evidenced by Nurse observed patient	C.A

	loss of appetite.	a. Nurse observed patient consumes at least more than half of the food served. b. Patient verbalized that she has regain her appetite.	4. Remove nauseating items away from patient. 5. Plan diet with patient and dietician. 6. Serve food in small quantities attractively	was encouraged. 4. All nauseating items such as bed pans were removed from patient. 5. Diet was planned with patient and dietician. 6. Food was attractively served in small quantities.		consumes at least more than half of the food served and patient verbalized that she has regain her appetite.	

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

Implementation is the phase of the nursing process signifying the giving of care in relation to the defined nursing intervention and goals. During this phase, the nursing care plan is tested for effectiveness and accuracy (Weller, 2014). It gives vivid account of the actual care that was given to the patient/family from the day of admission until discharge based on the health problems identified. The follow up visits/home visits made to ensure continuity of care is also discussed

4.1 Summary of actual Nursing Care rendered to Patient and Family

My interaction with A.H started on the 15th of November, 2021. When she was admitted to Females Ward of the Sunyani Municipal Hospital and was discharged on the 20th November, 2021. I decided to use this patient because I was interested in knowing the precipitating factors of Acute Gastroenteritis, its causes, management, complications as well as its treatment and able to put into practice actual and holistic nursing care, as it has been learnt theoretically of this condition.

4.1.1 First Day of Admission (15th November, 2021)

Patient came into the ward in a conscious and ambulatory state through the Out Patient Department of the Municipal hospital on the 15th of November, 2021. Patient was weak upon assessment; she also complained of abdominal pains, she was also having diarrhoea and loss of appetite as well. Blood sample was taken for full blood count and she was diagnosed of Gastroenteritis.

Patient's vital signs were checked and recorded as indicated in the appendix.

Patient was managed on the following drugs:

Intravenous Cefuroxime 750mg tds × 24 hours

Tablet cotrimazole (400+80) bd × 24 hours

Tablet Amoksiclav 1g bd × 7 days

Tottema 1 vial BD × 7 days

Tablet Azithromycin 500mg daily × 7 days

Tablet cefuroxime 500mg bd × 7 days

Intravenous 5%Dextrose in normal saline

Intravenous Ringers lactate 1L×24 hours

Intravenous Normal Saline 1L × 24 hours

Patient and relative were reassured and oriented to the ward. Her particulars such as name, sex, age, and residential address were recorded in the admission and discharge book and on the daily ward state. Hospital policies regarding visiting periods, payment of bills and National Insurance policy, medications, rounds, the time vital signs will be checked were explained to the patient as well as the relative. Patient's relative was told the rules and regulations including visiting hours and meal time. Patient relative were asked to get Patient own bowl, spoon, drinking cup, bathing sponge, bucket, towel, and other toiletries. Patient and relative were then introduced to the other patients who have come to seek medical care in the facility more particularly at the Female Ward of the Sunyani Municipal Hospital. Physical examination on the patient was performed from head to toe and no abnormalities were seen.

At 11:00am, patient complained of abdominal pains and a nursing diagnose of acute abdominal pains related to inflammation of the gastric mucosa. A 24 hour objective was set to help relieve patient from the abdominal pains. The following measures were initiated to help relieve patient from the pains; Patient and family were reassured that with the treatment given, the pains will subsides, the level and intensity of pain was assessed using the pain rating scale and A.H chose 6, All forms of noise were reduced by

restricting visitors, reducing volume of radio and television set, patient was assisted into semi-prone position, patient was engaged in telenovela discussion to divert her mind of the pain, IV Cefuroxime 750mg served

At 11:30am, patient was observed to be having diarrhoea and hence a nursing diagnose of Risk for fluid and electrolyte imbalance (less than body requirement) related to diarrhea was formulated and a 48 hour objectives was set to help restore A.H fluid status to normal. The following measures were implemented to help meet the targeted set goals; Patient was reassured all measures to maintain her fluid and electrolyte level will be carried out, patient's skin turgor was assessed frequently for dehydration signs, Nature and severity of vomiting and diarrhea was assessed, Prescribed 5%Dextrose in was administered for patient, Frequent fluid intake was encouraged, Fluid intake and output of patient was monitored.

At 12:00pm, I observed that patient was assisted in performing most of the activities of daily living hence a nursing diagnosis of Self-care deficit related to general body weakness was formulated and a 48 hour objective was set to help restore patient strength. The following interventions were initiated to help restore patient strength to normal; Patient and mother re-assured that patient will regain strength for his daily activities with commencement of nursing measures, Patient spoon, cup, brush were arranged in his reach for easy access, Patient was encourage to walk around his bed with rest period when tired, Patient was assisted in bathing and brushing of teeth.

At 1:00pm, patient took her lunch which was Ampesi and vegetable stew.

At 2:00pm, patient vital signs were checked and recorded as indicated in the appendix.

She had carried out her personal hygiene needs after having her supper at 5:00pm. Patient took fufu and light soup with meat as supper.

At 6:00pm, her vital signs were checked and recorded as indicated in the appendix. Due medications of Tablet cotrimazole 750mg, Tablet Amoksiclav 1g and Tottema 1 vial were administered.

At 10:00pm, her vital signs were checked and recorded as indicated in the appendix. Due medication of Intravenous Cefuroxime 750mg was administered. Patient slept around 10:30pm

4.1.2 Second day of admission (16th November, 2021)

On the second day of admission, patient woke up at 5:30am. Patient was assisted in performing her personal hygiene such as bathing, brushing of teeth. At 6:00am, her vital signs were checked and recorded as indicated in the appendix. Due medications of Tablet cotrimazole 750mg, Tablet Amoksiclav 1g, Intravenous Cefuroxime 750mg and Tottema 1 vial were administered.

At 7:00am, she was served with milo and bread as breakfast.

At 9:00am, the medical care came for ward rounds and the plan was to continue treatment.

On 16th November, 2021 at 11: 00am the 24 hour objective set to help relieve patient from the abdominal pains was evaluated and goals was fully met as evidenced by nurse observed patient having a relax facial expression and patient verbalized relieved of abdominal pains

At 2:00pm, patient's vital signs was checked and recorded as stated in the appendix.

At 6:00pm, her vital signs were checked and recorded as indicated in the appendix. Due medications of Tablet cotrimazole 750mg, Tablet Amoksiclav 1g and Tottema 1 vial were administered.

At 6:30pm, rice and stew were served as patient supper. Patient had her bath at 7:30pm.

At 10:00pm, her vital signs were checked and recorded as indicated in the appendix. Due medication of Intravenous Cefuroxime 750mg was administered. Patient slept around 10:30pm

4.1.3 Third day of admission (17th November, 2021)

Patient woke up around 5:30am clean the teeth and had her bath. At 6:00am, her vital signs were checked and recorded as in the appendix. At 6:00am, her vital signs were checked and recorded as indicated in the appendix. Due medications of Tablet Amoksiclav 1g and Tottema 1 vial were administered.

At 7:30am, patient took rice porridge and bread as breakfast.

At 8:50am, the medical care came for ward rounds and the plan was to continue treatment.

At 9:00am during the ward rounds, patient complained inability to sleep and a nursing diagnosis of Altered sleep pattern (insomnia) related to change of environment. A 24 hour objective was set to help restore patient's sleeping pattern to normal. To help achieve the set goals, the following interventions were initiated; patient and mother were reassured that with the treatment given patient will be able to sleep, the volume of TV and radio was reduced at the ward, light at the ward was dimmed at the evening to enhance sleep, warm bath was given and warm drink (milo) was served to induce sleep, admission bed free from creases was provided and bed linen was changed when soiled, all nursing activities were carried together to ensure patient have enough time to sleep.

Patient was informed that the first home visit will be made today, she gave me directions to her area of residence. It was about 10 -15 minutes' drive from the hospital. When we got to the house, thorough assessment, observation and adjustment were made in the house and environment to help accommodate patient after discharge and the family also. The visit took about 40 minutes and they were goodbye for another time.

At 10:00am, my interaction with patient revealed that she had loss of appetite and a nursing diagnoses of risk for imbalanced nutrition (less than body requirement) related to loss of appetite. To help restore patient's nutritional status, an objective was set to help bring her nutritional status to normal. The following nursing interventions were initiated to meet the targeted goals set; patient was reassured of good nursing care that she will regain normal eating pattern, oral hygiene was ensured to stimulate appetite, importance of food in recovering was encouraged, all nauseating items such as bed pans were removed from patient, diet was planned with patient and dietician, food was attractively served in small quantities.

At 11:30am the 48 hours objectives set to restore patient's fluid status was evaluated and goals was fully met as nurse observed that patient diarrhoea has stopped and patient showing no signs of dehydration, such as sunken eyes, and rapid pulse.

At 12:00pm, the 48 hours objective set to help restores patients activities of daily living was evaluated and goals was fully met as evidence nurse observed patient being able to perform self-care activities unassisted and patient verbalized she is able to perform self-care activities unassisted.

At 1:00pm, patient ate rice and tomato stew as lunch meal. Patient's vital signs was checked and recorded as recorded in the appendix at 2:00pm.

At 5:00pm, patient had Banku and Okro stew with fish as supper. She maintained her personal hygiene afterwards.

At 6:00pm, her vital signs were checked and recorded as indicated in the appendix. Due medications of Tablet Amoksiclav 1g, Tablet cefuroxime 500mg and Tottema 1 vial were administered.

At 10:00pm, her vital signs were checked and recorded as indicated in the appendix. Due medication of Tablet Azithromycin 500mg was administered. Patient slept around 10:30pm.

4.1.4 Fourth day of Admission (18th November, 2021)

The care rendered to A.H continued at the fourth day of admission. Patient woke up feeling strong and better. Her personal hygiene was maintained. The vital signs at 6:00am was checked and recorded as indicated in appendix.

Due medications of Tablet Amoksiclav 1g, Tablet cefuroxime 500mg and Tottema 1 vial were administered.

At 7:00am, patient took porridge with 'koose' for breakfast.
At 9:00am, the 24 hour objective set to help restore patient's normal sleeping pattern was evaluated and goals was fully met as evidenced by nurse observed patient having uninterrupted sleep for 6-8hours during the night and Patient verbalized she had uninterrupted sleep during the night.

There was a general ward rounds at 10:00am and patient had no new complain.

Patient's vital signs was checked and recorded at 2:00pm as indicated in appendix.

At 5:00pm, patient had rice and vegetable stew as supper and patient took half of the food served. She maintained her personal hygiene afterwards.

At 6:00pm, her vital signs were checked and recorded as indicated in the appendix. Due medications of Tablet Amoksiclav 1g, Tablet cefuroxime 500mg and Tottema 1 vial were administered.

At 10:00pm, her vital signs were checked and recorded as indicated in the appendix. Due medication, Tablet Azithromycin 500mg was administered. Patient slept at 10:20pm.

4.1.5 Fifth Day of Admission (19th November, 2021)

Mrs. A.H woke up around 5:30am, had her bath, brushed her teeth and did all her activities of daily living herself. Patient looked fit and have cheerful facial expression.

At 7:20am, she took milo and bread as breakfast.

Patient had no new complained during the routine ward rounds at 9:20am.

At 10:00am, patient's vital signs was checked and recorded in appendix.

At 1:20pm, patient had her lunch which was rice ball and groundnut soup.

At 2:00pm, patient vital signs were checked and recorded as in the appendix. Patient was made comfortable in bed. She had a nap afterwards and woke up around 4:30pm.

At 5:00pm, patient had Ampesi and vegetable stew as supper. She carried out her personal hygiene needs. She laid comfortably in bed afterwards.

At 6:00pm, her vital signs were checked and recorded as indicated in the appendix. Due medications of Tablet Amoksiclav 1g, Tablet cefuroxime 500mg and Tottema 1 vial were administered.

At 10:00pm, her vital signs were checked and recorded as indicated in the appendix. Due medication of Tablet Azithromycin 500mg was administered. Patient slept at 10:30pm.

4.1.6 Sixth day of Admission/Day of Discharge (20th November, 2021)

The care rendered to Mrs. A.H continued at the sixth day of admission/Day of discharge. Patient woke up feeling strong and better. Her personal hygiene was maintained. The vital signs at 6:00am was checked and recorded in the appendix.

Patient took porridge with 'koose' for breakfast and his medications were served as ordered.

At 10:00am, the objective set to restore A.H nutritional status was evaluated and goals was fully met as evidenced by nurse observed patient consumes at least more than half of the food served and patient verbalized that she has regain her appetite

At 10:10am, during routine ward rounds, patient was discharged since her condition was stable and she had no new complained.

She was informed and the bills were assessed. Patient was educated on the need to keep their environment clean, maintaining good personal hygiene as well as the need for follow ups and regular check-ups. Patient was educated on the following drugs prior to discharge: Tablet Amoksiclav 1g bd × 7 days, Tottema 1 vial BD × 7 days, Tablet Azithromycin 500mg daily × 7 days and Tablet cefuroxime 500mg bd × 7 days. Patient was informed about review on the 24th November, 2021. The need to continue with medications and review date were emphasized. Cannula was removed. The discharge procedure was documented in the admission and discharge book and in the daily ward state as well as in the nurse's notes. They were helped to pack their belongings. Bed linens were sent to the laundry, the mattress and pillow were as well disinfected. Patient and the family bade the ward inmates and staff goodbye.

4.2 Preparation of patient/Family for Discharge/Rehabilitation

Preparation of patient/family for discharge started on the day of admission when they were told that the hospital is a temporal place for them and that they will be discharged if A.H health is restored. The aim was to make them comfortable and understand that the hospital was a temporary place for health care and patient would be discharged home to continue treatment when his condition improves. Patient and mother were once again educated on the risk factors, signs and symptoms, treatment, possible complications and prevention of gastroenteritis. They were also reminded of the review and to keep to the said date that's 24th November, 2021 and also to report promptly to the hospital for proper management if any change occurs in patient's condition before the review date. Patient was discharged on 20th November, 2021.

4.3 Follow Up/Home Visit/Continuity of Care

Home visit is the visit made to the patient in their home to prevent illness or disability to promote and maintain health, encourage individuals and families to live a healthy life and improve their health standards (Weller, 2014)

Follow up and home visits are really important after discharge of patient from the ward. It provides the personnel the chance to assess patient's condition and improvement after discharge. It also provides the patient a second chance to ask questions and get education too. It also helps the health personnel to monitor the recovery of patient and also identify setbacks quickly to prevent any kind of complication. It also provides the nurse the chance to provide new information about the condition if there is any.

First Home Visit (17th November, 2021)

My first home visit was a planned visit to New Dormaa, Sunyani in the Bono Region of the republic of Ghana where Mrs. A.H resides. The purpose of this visit was to know my patient's residence and the

environment in which she lives, verify the information given to me as well as to identify the risk factors such as familial tendency and stresses that can lead to her condition as well as identifying people who are susceptible or who stand the chance of getting some particular conditions such as cholera and among others. It will also enable me to know patient's nearest health facility for possible referral and validation of patient data. Patient was informed about my intention to visit their home whiles she was still on admission on 17th November, 2021.

I was given the direction to Mrs. A.H house and was given her husband's contact. I board a Taxi to New Dormaa. I left the hospital at 10:00am and I reach Mrs. AH, s junction at 10:15am. I called the husband so he met me at the junction and took me to their house.

The road leading from the facility to their junction is tarred but from the junction to where their house is located is not tarred with about 15 minutes from the main road.

The house is built with cement blocks and its single room self-contained. I had the opportunity to enter Mrs. A.H's room for observation and I realized things were in orderly arranged. They have a well-kept water closet which is shared by members of the household.

They have pipe born water as their source of drinking water. They have a waste bin in which they keep their rubbish and it's disposed -off to the central waste disposal site which is also disposed of by the Zoom lion Ghana limited when its full.

I expressed gratitude to the husband for their co-operation and assured them of paying them another visit to ensure the successful recovery of Mrs. A.H. He accompanied me to the junction where I board a taxi and came back to the hospital.

Second Home Visit (21st November, 2021)

I embarked on my second home visit on 21st November, 2021 a day after A.H was discharged to find out the health status of patient and to remind them of the review date. I left around 9:45am to the station to board a taxi to New Dormaa. It was around 11:00am and A.H was still in bed because of the weather was not favourable. I was welcomed by the husband. The husband went and woke Mrs. A.H up and I found out from her how she's doing she said she's doing well as I observe her cheerful facial expression. I also ask of how she is coping with the medication regimen. I reminded them of the review date as I proceed to pick a taxi back home. I took this opportunity to visit the nearby health facility to inform them about my intention to hand over patient to them for them to ensure the continuity of care since I will be terminating the care soon in my third home visit. I met madam A.S as the in-charge in the facility.

Date of Review (24th November, 2021)

Patient reported to the OPD department early in the morning on the 24th November, 2021. Patient's folder was retrieved from the records department. Patient vital signs checked and recorded as follows;

Temperature	36.7°C
Pulse	102bpm
Respiration	19cpm
Blood pressure	130/80mmHg

Patient was escorted to the consulting room and upon assessment and diagnostic findings; the prescriber confirmed an improved condition.

Third Home Visit (26th November, 2021)

On the 26th of November, 2021, at around 2:00 pm I made my last visit to patient's house for assessment, evaluation and termination of care.

The aim of the third visit was to hand over A.H to community health nurses for continuity of care. I arranged and went with the community health nurse at the New Dormaa Health Centre. After exchange of greetings and a little interaction, patient's family confirmed they were doing well. I thanked them for their co-operation and officially introduced madam A.S to them as the community health of the New Dormaa Health Centre who is taking over the care. I encouraged them to give her the same co-operation they gave me. I informed them that now that A.H's health has been restored, the care has officially ended. I told them I would visit them unofficially whenever I had the chance. They looked very happy. A.H's and family said they would give Madam A.S the maximum support she needed to care for AH. Again patient and his family expressed their gratitude by showing how grateful they were to me for the support and care given to them.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

It is the assessment of the patient's position on health and effectiveness of patient care activities in bringing about a change in the patient's position (Weller, 2014). It is also defined as the determination of the patient's responses to the nursing interventions and extent to which the outcomes have been achieved. This is the last phase of the nursing process. This chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to my patient and family.

5.1. Statement of Evaluation

Effective nursing care and medical treatment that was given in order to achieve full recovery and goals set were met within the said time. During the hospitalization of patient five problems were identified and objectives set for them. Below is the summary of the interventions carried out and to what extent the goals were met.

1. Patient's abdominal pain was relieved

On 15th November, 2021, at 11:00am, patient complained of abdominal pains and a nursing diagnose of acute abdominal pains related to inflammation of the gastric mucosa. A 24hour objective was set to help relieve patient from the abdominal pains. The following measures were initiated to help relieve patient from the pains; Patient and family were reassured that with the treatment given, the pains will subsides, the level and intensity of pain was assessed using the pain rating scale and patient chose 6, All forms of noise were reduced by restricting visitors, reducing volume of radio and television set, patient was assisted into semi-prone position, patient was engaged in telenovela discussion to divert her mind of the pain, IV Cefuroxime 750mg served.

On 16th November, 2021 at 11: 00am the 24 hour objective set on 15th November, 2021 to help relieve patient from the abdominal pains was evaluated and goals was fully met as evidenced by nurse observed patient having a relax facial expression and patient verbalized relieved of abdominal pains.

2. Patient's fluid and electrolyte balance was restored

On 15th November, 2021, at 11:30am, patient was observed to be having diarrhoea and hence a nursing diagnose of Risk for fluid and electrolyte imbalance (less than body requirement) related to diarrhea was formulated and a 48 hour objectives was set to help restore A.H fluid status to normal. The following measures were implemented to help meet the targeted set goals; Patient was reassured all measures to maintain her fluid and electrolyte level will be carried out, patient's skin turgor was assessed frequently for dehydration signs, Nature and severity of vomiting and diarrhea was assessed, Prescribed 5%Dextrose in was administered for patient, Frequent fluid intake was encouraged, Fluid intake and output of patient was monitored.

On 17th November, 2021 at 11:30am the objective set on 15th November, 2021 to restore patients fluid status was evaluated and goals was fully met as nurse observed that patient diarrhoea has stopped and patient showing no signs of dehydration, such as sunken eyes, and rapid pulse.

3. Patient's strength was restored to resume to her activities of daily living

On 15th November, 2021, at 12:00pm, I observed that patient was assisted in performing most of the activities of daily living hence a nursing diagnosis of Self-care deficit related to general body weakness was formulated and a 48 hour objective was set to help restore A.H strength. The following interventions were initiated to help restore A.H strength to normal; Patient and mother re-assured that A.H will regain strength for his daily activities with commencement of nursing measures, Patient spoon, cup, brush were arranged in his reach for easy access, Patient was encourage to walk around his bed with rest period when tired, Patient was assisted in bathing and brushing of teeth.

On 17th November, 2021 at 12:00pm the objective set on 15th November, 2021 to help restores patients activities of daily living was evaluated and goals was fully met as evidence nurse observed patient being able to perform self-care activities unassisted and patient verbalized she is able to perform self-care activities unassisted.

4. Patient had uninterrupted sleep within 24 hours

On 16th November, 2021, at 9:00am during the ward rounds, patient complained inability to sleep and a nursing diagnosis of Altered sleep pattern (insomnia) related to change of environment. A 24 hour objective was set to help restore A.H's sleeping pattern to normal. To help achieve the set goals, the following interventions were initiated; patient and mother were reassured that with the treatment given patient will be able to sleep, the volume of TV and radio was reduced at the ward, light at the ward was

dimmed at the evening to enhance sleep, warm bath was given and warm drink (milo) was served to induce sleep, admission bed free from creases was provided and bed linen was changed when soiled, all nursing activities were carried together to ensure patient have enough time to sleep.

On 18th November, 2021 at 9:00am the objective set on 16th November, 2021 to help restore patient's normal sleeping pattern was evaluated and goals was fully met as evidenced by nurse observed patient having uninterrupted sleep for 6-8hours during the night and Patient verbalized she had uninterrupted sleep during the night.

5. Patient's nutritional status was restored to normal

On 16th November, 2021, at 10:00am, my interaction with patient revealed that she had loss of appetite and a nursing diagnoses of risk for imbalanced nutrition (less than body requirement) related to loss of appetite. To help restore patient's nutritional status, an objective was set to help bring her nutritional status to normal. The following nursing interventions were initiated to meet the targeted goals set; patient was reassured of good nursing care that she will regain normal eating pattern, oral hygiene was ensured to stimulate appetite, importance of food in recovering was encouraged, all nauseating items such as bed pans were removed from patient, diet was planned with patient and dietician, food was attractively served in small quantities.

On 20th November, 2021 at 10:00am the objective set on 16th November, 2021 to restore A.H nutritional status was evaluated and goals was fully met as evidenced by nurse observed patient consumes at least more than half of the food served and patient verbalized that she has regain her appetite.

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

Despite the numerous problems identified, with the individualized comprehensive nursing care and support from other members of the health team and co-operation of patient and family, all of the goals set were fully met. The care plan was therefore not amended.

5.3 Termination of Care

Care of patient and family ended on the 15th November, 2021 which was my last home visit. This ended the interaction between the health team and Mrs. A.H. and her family. The preparation for termination started on day of admission through discharge, review to the third home visit. During these periods, patient and family were educated on various topics. I congratulated the family for the care they had rendered to Mrs. A.H. They were thanked for their co-operation and patient was handed over to community health nurse. They were told that now that Mrs. A.H. health had been restored, the care for her has officially ended. I informed them of my desire to visit them unofficially whenever I had the opportunity. They were happy and noted that they would miss my care and would strictly adhere to all instructions given to them. It was a moment to remember when I told them of my intention to leave. There was no separation anxiety as patient and the relatives had enough psychological preparations from the day of admission till discharge but it was still difficulty bidding them farewell.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

This is the last chapter and it is the last stage in the nursing process of the patient/ family care study and consists of the summary of the care rendered to A.H and her relatives on the day of admission up to the day her care was terminated as well as the conclusion drawn from the study.

6.1 Summary of Care

A.H came into the ward in a conscious and ambulatory state through the Out Patient Department of the Municipal hospital on the 15th of November, 2021. Patient was weak upon assessment; she also complained of abdominal pains, she was also having diarrhoea and loss of appetite as well. Blood sample was taken for full blood count and she was diagnosed of Gastroenteritis and was managed on IV cefuroxime 750mg tds × 24 hours, Tablet Cotrimazole (400+80) BD × 24 hours, Tablet Amoksiclav 1g bd × 7 days, Tottema 1 vial BD × 7 days, Tablet Azithromycin 500mg daily × 7 days, Tablet cefuroxime 500mg bd × 7 days, 5%Dextrose in normal saline, IVF Ringers lactate 1L×24 hours, IVF Normal Saline 1L × 24 hours. Patient and relative were reassured and oriented to the ward.

On the 24th of November, 2021 patient reported for review as scheduled. It was to find out if patient was adhering to the advice and all the education given to improve his health and standard of living. Three home visits were embarked on. The first home visit was done while patient was still on admission on 17th November, 2021, second home visit was on the 21st November, 2021 and third home visit was on the 26th November, 2021. The care of Mrs. A.H. and his family care were terminated on the 26th November , 2021, during the third home visit when patient had fully recovered.

6.2 Conclusion

The study has equipped me with knowledge on how to care for a patient as an individual. Through this study, I have been able to put into practice actual and holistic nursing care theoretically.

The study provided a therapeutic environment for nursing patient as an individual and has promoted a good nurse-patient (family) relationship as well as broadened my knowledge on gastroenteritis. It is recommended that, the idea and principle behind the adoption of the nursing process which is the core approach to the writing of patient and family care study should be embrace by all nurses to ensure total patient care.

APPENDIX

Table 7: Vital signs for AH

DATE	**TIME**	**TEMPERATURE (ºC)**	**PULSE (Bpm)**	**RESPIRATION (c/m)**	**BP (mmHg)**
15th November, 2021	10:00am	35.9	104	26	100/60
	2:00pm	36.6	90	19	120/70
	6:00pm	37.2	98	23	110/60
	10:00pm	36.2	97	21	100/70
16th November, 2021	6:00am	36.0	100	23	120/80
	10am	37.5	96	22	110/60
	2:00pm	36.4	92	22	100/70
	6:00pm	37.8	94	21	120/80
	10:00pm	36.1	90	20	100/60

17th November, 2021	6:00am	36.4	90	21	120/70
	10:00am	36.3	95	24	110/60
	2:00pm	37.0	99	24	100/70
	6:00pm	36.2	96	24	120/80
	10:00pm	36.0	100	20	110/60
18th November, 2021	6:00am	36.5	96	24	100/70
	10:00am	36.0	100	21	130/70
	2:00pm	36.4	94	23	120/80
	6:00pm	36.4	90	21	110/80
	10:00pm	36.2	96	20	120/80
19th November, 2021	6:00am	36.2	99	24	100/60
	10:00am	36.0	96	24	120/70
	2:00pm	36.5	100	20	120/80
	6:00pm	37.8	96	24	110/60

	10:00pm	36.1	100	21	100/70
20th November, 2021	6:00am	35.9	104	26	100/60
	10:00am	36.0	100	20	110/60

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Patient folder number: 22240/21, Municipal hospital sunyani

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HE STUDENT NURSE

AME: CYNTHIA AGYAPOMAA

GNATURE: .....

ATE: 7th October, 2022.

URSE IN-CHARGE OF FEMALE'S WARD, SUNYANI MUNICIPAL HOSPITAL

AME: NYAMEKE MUEZAH

GNATURE: .....

ATE: 07/10/2022

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