HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT /FAMILY CARE STUDY ON ENTERITIS

ADUSI POKU

4120190015

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

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PREFACE

Nursing for the past years was considered a vocation. Nursing care included bathing, wound dressing, feeding which were the physical needs of the patient. Towards the 19th century it became a profession when Florence Nightingale provided and set a pattern which became the basis of the nursing education and profession today.

Now in the state of comprehensive nursing, a systematic process of data collection, problem diagnosis, analysis, development of care plan and evaluation is practiced. This helps to give individualized care as to patients and their families as a whole. Nursing of late provides a holistic care taking into consideration the physical, psychological, spiritual, social, economic and intellectual needs of the patient. It also works on the three aspects of life: the body, soul, and the spirit.

Most diseases reported lately does not only result from poor sanitation and personal hygiene but as a result of bad eating habits and harmful lifestyle. As such, much education is shifted towards ensuring healthful practices like proper eating habits, regular exercise and avoidance of harmful lifestyles like smoking, alcoholism.

To achieve this, a comprehensive, individualized and holistic care must be highly utilized. Families and the communities should not be left out in giving health care.

Patient/family care study is a detailed account of nursing care rendered to the patient. This forms part of the final assessment of the student nurse at the end of the three-year training programme before the award of license to practice as a registered general nurse by the Nursing and Midwifery Council of Ghana.

The study is carried out to enable the student nurse put into practice the knowledge and skills acquired from the three-year training period in school and to determine how best the theoretical knowledge could be used to nurse patient who he/she would encounter.

The study enables the student nurse to utilize the knowledge and skills acquired from the various course in medical, surgical, public health, and pediatric nursing to give effective nursing care to patient, with reference to his condition. It also helps the student nurse to acquire more knowledge and insight about a specific disease condition. This study also provides an opportunity for the student nurse to apply the nursing Process.

Finally, it enables the student nurse to apply the knowledge acquired during training to real life situation. For confidentiality's sake, initials will be used rather than full names.

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I wish to express my sincere gratitude to the Almighty God for the successful conduction of this study.

My special thanks go to Mrs. M.F and her family for the smooth interaction and co-operation given to me in conducting the study.

I express my profound gratitude to my supervisor and the entire tutorial staff of Holy Family Nursing and Midwifery Training College- Berekum, for their guidance, support and contribution towards the success of my study.

My profound gratitude also goes to the nursing staff of the Females' Ward of Wenchi Methodist Hospital for their assistance and guidance during the care and management of the patient.

I would like to thank my entire family for all their support, motivation and prayers throughout my education.

Finally, I want to thank all the authors and publishers whose previous work contributed to the success of this Care study.

INTRODUCTION

The patient/family care study is the study and a report of the nursing care rendered to a patient and his family. It includes the interaction between the patient and the health team.

Mrs. M.F a 23-year-old woman was the subject in the study. She was admitted on the 9th day of November, 2021, with the diagnosis of enteritis. On admission, she presented problems such as; potential fluid and electrolyte volume deficit related to excess loss of fluid through frequent diarrhea and vomiting, altered body comfort (restlessness) related to abdominal pain, activity intolerance related to general body weakness, altered nutritional status (less than body requirements) related to loss of appetite, knowledge deficit related to inadequate information about the causes, management and prevention of the condition. After appropriate nursing interventions, patient's condition had improved and problems identified were solved at the time of discharge on, 13th November, 2021.

Follow up visits after discharge maintained the relationship between patient, family, and me until patient was eventually handed over to a public health nurse in the patient's home for continuity of care.

The study was written in five chapters and organized as follows:

Chapter one dealt with assessment of patient and family comprising; patient's particulars, family's medical history, socio-economic history, his lifestyle and hobbies, past and present medical history, admission of patient, his concept of the illness, literature review and validation of data.

Chapter two dealt with analysis of data involving comparison of data gathered, with standard for literature, patient and family strength, health problems and nursing diagnosis.

Planning of care for patient/family can be found in the third chapter of the care study. It involved setting of objectives and the nursing care plans for objectives set.

In chapter four, nursing interventions of the nursing care plans were implemented, thus, giving a summary of the actual nursing care plan, preparation of patient and family towards discharge and rehabilitation and also follow-up, home visit and continuity of care.

Chapter five comprises of evaluation of care and consist of statement of evaluation, amendment of nursing care for partially met or unmet outcome criteria, termination of care, summary and conclusion followed by, bibliography and appendix

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 INTRODUCTION.

Assessment involves the systematic collection of data about the health status of the patient, of which can be obtained from patient's relatives, friends and patient`s folder. The data gathered is used to make nursing diagnoses and plan care to solve patient problems. The data was collected through interviews, observations, investigations such as laboratory information, X-ray findings and results as well as literature from books.

This initial and one of the vital phases of the nursing process entails patient's particulars, patient/ family medical and socio-economic history, patient's developmental history, patient's lifestyle and hobbies, patient's past medical history, patient's present medical history, patient's admission, patient/ family concept of illness, relevant literature review on patient's condition and validation of data. This information gathered from the patient will help to identify patient's/family's problems and the appropriate recommended nursing intervention rendered to patient.

1.1 PATIENT PARTICULARS

Patient Particulars give details or information about the patient which comprise of patient's name, age, marital status, home town, nationality, date of birth, occupation, etc. Mrs. M.F is twenty-three years old and a Ghanaian by nationality. She was born on 25th August, 1998 to Mr. M.A and Mrs. F.M at Wenchi in the Bono region. She stays at Wenchi in a house with the number B094/3, Dagomba lane, together with her husband, Mr. A.S. She is fair in complexion and weighs 53kg with a height of 1.71m. She is the eldest of two siblings. Mrs. M.F is a Muslim

and speaks English, Twi and Hausa. Her next of kin is her husband. She is a level three hundred student at the local teacher training college. She has no physical impairment.

1.2 FAMILY MEDICAL/SURGICAL HISTORY.

It is a record of health information about a person and his or her relatives. This history provides insight into the conditions that are common in the family. According to the patient, there is no known family or chronic diseases like epilepsy, mental illness, hypertension, tuberculosis or any other form of abnormality in their family. Mrs. M.F said, her family sometimes suffer some minor illness such as headache, stomach pains and malaria and treat them with over-the-counter drugs. The family does not have any known allergies to any food or drug. Patient has no surgical history.

1.3 THE FAMILY SOCIO-ECONOMIC HISTORY.

This describes the patient's financial status and how she relates with others in the community. My interaction with Mrs. M.F reviewed that there is great harmony among the members of the family and they all relate very well with the community members. By observation, Mrs. M.F is sociable and friendly and enjoys attending weddings. She also attends mosque every Friday as well.

Mrs. M.F and her family have registered with the National Health Insurance Scheme (NHIS) which serves as a source of medical care. She is supported by husband who is a teacher and a trader. He deals in buying and selling of cattle. Her mother runs a provision shop and she helps her run the shop on vacation. Upon discussion with the patient, she disclosed that her husband makes an annual income of about One hundred and eight Ghana cedis (GHC 108,000) from teaching and trading. Mrs. M.F stays with her husband in his family's house. Analyzing the family socioeconomic status, she falls into middle socioeconomic status.

1.4 THE PATIENT'S DEVELOPMENTAL HISTORY

Developmental history of patient provides significant information of how the patient aged. This describes the events that transpired at the various stages of aging. Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Weller, 2014). Maturation is the process of becoming completely developed mentally or emotionally (Walter, 2014). Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development (Weller, 2014).

Mrs. M.F was born on 25th August, 1998 at Wenchi. Her birth was through spontaneous vaginal delivery. She started sitting and crawling when she was Seven (7) months old but could not tell the exact time she started developing her milk teeth. Mrs. M.F was immunized against six childhood killer diseases and there was an evidence of BCG scar on her right upper arm indicating immunization. She was not exclusively breastfed. She developed her secondary sex characteristics at the age of 13 years with hairs in the armpit and the pubic part. She had her menarche when she was 14 years. Mrs. M.F started kindergarten at the age of 4 years and completed elementary school at 15 years at Calvary Methodist Preparatory School, Wenchi. She gained admission at St. Louis Senior High School and studied General Arts. She completed secondary education and furthering education at AL- Faruk Teacher Training School, Wenchi.

Mrs. M.F is twenty-three (23) years old and according to Erik Erickson's psychosocial theory, she falls under Intimacy vs. Isolation. According to Erikson, people in the early adulthood between age 20 and 40 are concerned with intimacy and isolation, where they are ready to explore relationship with others in order to fit in. Mrs. M.F has succeeded in this stage with the ability to love and attaining a secured relationship.

1.5 OBSTETRICAL HISTORY

Obstetrical history provides information concerning pregnancy, childbirth, and the postpartum period and care given during pregnancy and childbirth. She had menarche at the age of 14. My patient started dating when she was 20 years old and married the year after. Mrs. M.F is in her menopausal age. She has never given birth nor had an abortion. She revealed she had a mutual agreement with her husband start having children after she graduate tertiary education. They agreed on IUD as a family planning method and have used it for 2 years without any complication.

1.6 PATIENT LIFESTYLE AND HOBBIES

Lifestyle is a pattern of living that reflects a person's attitude and values. Hobbies are activities one enjoys doing in one's leisure time. According to patient, she revises her notes and sleeps around 10:00pm. She wakes up around 5:00am to prepare for school. Before anything else, she observes the first prayer, visits the toilet, brushes her teeth and takes her bath with cold or warm water depending on the weather condition. She said she likes porridge made of millet in the morning. Her favorite meal is rice with beans stew. She empties her bowel whenever she has the urge and normally does it twice daily. Patient enjoys reading and chatting with relatives. She stated that attending mosques every Friday and observing Salat, the five daily prayer, is sacred. She also enjoys attending wedding ceremonies.

1.7 PATIENT'S PAST MEDICAL/SURGICAL HISTORY

In the course of the interactions with the patient, it came to light that, she has been admitted 6 months ago for 4 days with simple malaria and was successfully treated with anti-malarial drugs which she recovered fully and got better afterwards. Also, she has no known allergies to drugs and no history of herbal medicine intake. She has never suffered from any surgical condition.

1.8 PATIENT PRESENT MEDICAL HISTORY

Patient present medical history is an account obtained during the interview with the patient on the onset, duration, and character of the present illness, as well as any acts or factors that aggravate or ameliorate the symptoms. (Mosby's Medical Dictionary, 2009).

According to patient, she was well until the 8th day of November, 2021 in the morning when she started feeling abdominal pains. She sought for first aid treatment from a chemist shop. On the 9th day of August, the situation got worse as she started passing watery stools accompanied by vomiting. She was then brought to the Emergency Response Unit (E/R) at Wenchi Methodist Hospital. On arrival, patient was examined and diagnosed of Enteritis and was admitted to the ward.

1.9 ADMISSION OF PATIENT

Admission of a patient is when an illness or injury requires an immediate health care (Hornby, 2006). It is also the systematic process of allowing and facilitating a patient to stay in a hospital unit or ward for observation, investigation and treatment of the disease (Porter and Perry, 2013). Mrs. M.F had emergency admission because her admission was unplanned, unpredictable and at short notice because of clinical need. At 8:00am on the 9th day of November, 2021, Mrs. M.F was admitted at the Emergency Response Unit at Wenchi Methodist Hospital per ambulatory. On arrival to the unit, she was accompanied by her husband. Patient and family were welcomed. Patient was given an already prepared simple unoccupied bed and was placed in a supine position. I introduced myself and the other staffs to the relative. Since the patient was very weak, I assisted them in arranging her personal items after permission granted. Head to toe examination was performed. On observation, patient was slightly weak. She also complained of passing

watery stool for four times since 3:00am, vomiting, abdominal pains, general malaise, dizziness, nausea and loss of appetite. Patient's vital sign checked and recorded as below:

- Temperature: 37.5^0C
- Pulse: 76bpm
- Respiration: 19cpm
- Blood pressure: 101/57mmHg

Height and weight were also checked and recorded as follows;

- Weight: 53kg
- Height: 1.71m

Patient was diagnosed of Enteritis. Her particulars were therefore taken into the Admission and Discharge Book and Daily Ward State. Patient was introduced to the other roommates and I further introduced procedure to the patient and relatives. Patient and family were reassured of being in safe hands of competent health team. The relative except the patient who was weak and dizzy were oriented to the ward. The patient was managed on the following medications;

- IV Ringers Lactate (R/L) 1.5L x24 hours.
- IV Normal Saline (NS) 1L x24 hours.
- Intravenous Ciprofloxacin 400mg bd x 48 hours.
- Intravenous Metronidazole 500mg tds x48 hours.
- Tablet Paracetamol 1g tds x 7.
- Injectable Hyoscine 40mg stat.
- Intravenous Tramadol 100mg stat

These medications were collected from the dispensary and administered.

The following laboratory investigations were ordered by the doctor;

- Blood for malaria parasite.
- Blood for full blood count.
- Urine for routine examination.
- Urine for pregnancy test

Patient and relatives were told about the use of National Health Insurance Scheme that not all drugs are being covered by National Health Insurance Scheme. Patient's relative was also told about visiting hours and the things the patient may need during her stay at the ward in the next visit. After patient regaining enough strength, I introduced myself to her as a student nurse and informed patient that am a student at the Holy Family Nursing and Midwifery Training College, Berekum and conducting a case study at the hospital which is part of the requirement for getting license to become a professional nurse and that her maximum cooperation and concern will be required. Patient and relative accepted and assured me of their co-operation and I thanked them. Permission was also sort from the Nurse In-Charge which was given.

1.10 PATIENT CONCEPT OF ILLNESS

It is the perception of the patient about the condition, it causes, management and prevention. Upon interaction with Mrs. M.F, she had no idea of how she got this illness and had not even heard about it before. She however, did not relate the condition to anything spiritual. With the help of the health team, her condition would improve and with compliance to her drugs she will eventually get well. Patient said though she is weak she prefers doing things on her own to

people doing it for her. With regards to this, she was educated about the causes and prevention of the disease.

1.11 LITERATURE REVIEW ON ENTERITIS

Literature review is an account of what has been published on a topic by an accredited scholar who helps in identification of the experts on a particular topic and assess current state of research on a topic.

Definition of Enteritis

Enteritis is inflammation and irritation of the small intestine. An inflamed small intestine can't function the way it should. The inflammation may also affect the stomach (causing gastritis) or large intestine (causing colitis), further impairing digestive functions. Enteritis symptoms are the result of the inflammation and disruption of normal digestion. Common symptoms include abdominal pain, diarrhea, and nausea and vomiting

Enteritis is the inflammation of the intestines. It occurs in conjunction with some infectious diseases such as typhoid fever, dysentery and food poisoning. The cause might also be viral or unknown.

Basic Anatomy and Physiology of the Intestines.

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 700 cm (7m) of surface area for secretion and absorption, the process by which nutrients enter the bloodstream through the intestinal walls. It has three sections: duodenum, jejunum and ileum. 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. (Smeltzer S.C., 2010)

Causes

Enteritis is usually caused by eating or drinking substances that are contaminated by bacteria or viruses. Enteritis may also be caused by:

- Crohn's disease.
- Certain drugs; including ibuprofen, cocaine.
- Damage from radiation therapy

Causative Organisms

- Staphylococci aureus.
- Vibrio Cholera
- Salmonella typhi.

Classifications Of Enteritis

- Acute enteritis
- Chronic enteritis

Acute Enteritis

This is the inflammation of the jejunum but the duodenum and ileum may be occasionally affected.

Chronic Enteritis (Ileitis)

This is the inflammation of the ileum just as it joins the large intestine and may persist for years that need medical and surgical treatment.

Pathophysiology

The organism enters the small intestine by ingestion of contaminated food and water. The organism inflames the intestine and produces toxin which is seropurulent and covers the outer coat of the intestine. This reacts with the mucosa of the intestine and causes its sign and symptom.

If not treated earlier, the underlying wall being green and necrotic due to inflammation extends throughout the whole thickness of the bowel. The wall may become thin and perforate. Microscopically, the bowel shows edema hemorrhage. The mesenteric lymph gland enlarges and later these may be evidence of healing and fibrosis.

Signs And Symptoms

The symptoms may begin hour to days after infection.

- Weakness
- Prolong diarrhea
- Vomiting
- Abdominal pain
- Shock
- Loss of appetite
- Fever

- Nausea
- Low blood pressure
- Headache
- Diarrhea
- Occasional bloody stools.

Diagnoses

- By signs and symptoms
- Barium meal
- Stool for occult blood
- Full blood count for white blood count

Medical Management

- IV fluids and electrolyte replacement are given.
- Anti-emetics e.g. oral, IM or rectal suppository like prochlorperazine.
- O.R.S
- Anti-diarrhea e.g. loperamide
- Anti-biotic e.g. penicillin.

Surgical Management.

This is needed when perforation set in.

Nursing Management

1. **Comfort and rest**

In order to promote rest and comfort for patient there is the need to perform the following activities for the patient.

- Promote period of rest during symptomatic stages according to the level of fatigue. Maintain a well straighten bed, free of creases and cramps to promote comfort.
- Emotional support and divisional activities are necessary especially when recovery and convalesces are prolonged.
- Encourage gradual resumption of activities and mild exercise during convalescence period. They should however be planned not to interfere with rest period.
- Administer prescribed analgesics to relieve pain.

2. Personal hygiene

- Ensure adequate hand washing before and after attending to patient.
- Educate patient on personal hygiene.
- Educate patient to wash fruits and vegetables before eating.
- Educate patient to avoid contaminated water and food.

3. Rehydration

The primary treatment for enteritis in both children and adults is rehydration. This is achieved by Oral Rehydration Therapy and Intravenous Therapy. Intravenous therapy is required if there is a decreased level of consciousness or if dehydration is severe.

4. Maintain adequate nutrition

- It is always difficult for the patient to take in sufficient food and fluids due to the nausea and vomiting.
- If patient cannot tolerate fluids orally, then intravenous fluids should be instituted.
- Hot or spicy food should be avoided when planning a diet for patients.
- The appropriate soft diet may include rice water, porridge, and light soups.
- If patient cannot eat, replace the lost fluids and electrolytes with light soup as tolerated by the patient.
- Patient should be allowed to eat the food of her choice but is advisable to avoid milk and milk products as it precipitates the reoccurrence of the condition. (Lewis, 2012).
- Restore normal body weight by maintaining a well balance diet rich in calories, protein, and vitamins.

5. Prevention of infection

- The nurse should always wash hands thoroughly before and after carrying out any procedure on the patient to prevent the spread of infection.
- The nurse should always teach patient on ways to maintain personal hygiene.
- Educate patient to eat food cooked from home rather than buying from outside to minimize infections.
- Patient should be instructed to wash hands immediately after visiting toilet and before and after handling food.
- Patient should always avoid the use of contaminated water and food and also avoid eating raw fruits and vegetables without washing them.

- Linens soiled with stool should be disinfected to prevent the spread of the disease. Isolation of patients should be done to prevent the spread of the disease.
- Barrier nursing should be ensured to prevent cross infection.
- Proper disposal of stools should be ensured and good hand washing practice should also be encouraged.

6. Monitoring and observation of patients to prevent complication

- Vital signs, (temperature, pulse, respiration and blood pressure) should be monitored thoroughly to know whether the condition is improving or deteriorating.
- The nurse should observe for the amount of urine passed and its degree of concentration.
- She should also observe for the presence of blood or mucus in the stool.
- Weigh patient daily to check if there is any weight loss.
- Patient should also be monitored for the desired and side effects of the drugs.
- When patient is on intravenous infusion, it should be monitored.
- There should be frequent assessment of the intravenous site for infiltration.

7. Elimination

- Bowel elimination should be encouraged by serving bed pan on request.
- Encourage patient to take in fruits and more fluids to facilitate bowel elimination.
- Patient should be encouraged to have regular bladder elimination.

8. Prevention

- Patient’s vomitus and stools should be well disposed off after being disinfected.
- Proper barrier nursing should be practiced. (By using mask, gloves and gowns)

- Hand washing must not be omitted in any way
- Personal hygiene should be practiced by cutting finger nails short, shaving of hair when applicable.
- All cooking utensils should be washed and cleaned before usage.
- Ensure and encourage clean environment for cooking and storage of food.
- Proper cleanliness in the ward must be done to prevent complications. (Cahill 1996)

Patient / Family Teaching and Education

- Educate the patient on the need to wash food properly and to heat food properly before eating.
- Advise patient to always wash the hand before eating and after visiting the toilet.
- Educate patient about the early signs and symptoms of diarrhea and dehydration.
- Advice patient not to expose foods to flies.
- Educate patient on the need for hygienic practices
- Educate patient and family on the need to avoid defecation in the bush. (Joel, 2006)
- Reassure patient.
- Provide bed rest
- Monitor patient for intake and output
- Administer all drugs as ordered
- Observe for signs of perforation for the necessary measures to be taken. Example;
    - severe pain on touch
    - distention of the abdomen
    - intake exceeds output

Prevention

- Educate patient on signs and symptoms.
- Educate on the need to avoid spicy foods.
- Educate on the need for follow up.
- Educate on the need to take prophylactic drugs as ordered. Example; Metronidazole, Albendazole
- Educate on personal hygiene i.e.
    - washing hands with soap and water after visiting the toilet.
    - washing hands with soap and water before and after eating.
    - cutting of finger nails and keeping them clean.
- Avoid drinking from unknown sources, such as streams and wells without boiling the water first.
- Cook food completely and properly.
- Store food appropriately in coolers.

PROGNOSIS

Symptoms usually go away without any treatment in a few days.

COMPLICATIONS

- Dehydration
- Perforation
- Renal failure
- Stenosis

1.12 VALIDATION OF DATA

Validation of data can be defined as the process checking the accuracy or legitimacy of the data gathered so that it will be free from errors and misinterpretations. Information collected from Mrs. M.F were similar to those the relatives told me, also during my home visit most of the information given to me by Mrs. M.F and her family at the hospital were confirmed by other relatives in the house.

Data presented by Mrs. M.F and her 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 I asked previously and the same response was given. Upon this I therefore believe the information gathered was valid.

CHAPTER TWO

ANALYSIS OF DATA

2.0 INTRODUCTION

Analysis is the detailed study of a result in order to understand more about it (Hornby, 2006). Analysis of data is a systematic examination and evaluation of data or information which entails comparing the results of the investigation carried out with standards in the literature review.

The chapter forms the second phase of the patient/family care study. It also entails comparing the causes, clinical manifestations, treatments and complications of the patient's condition (Enteritis) with those stated in textbooks.

It gives the pharmacology of drugs prescribed by the medical officer for Mrs. M.F. This chapter also talks about the patient/family strengths, the health problems identified and nursing diagnoses formulated for given care to Mrs. M.F.

2.1 COMPARISON OF DATA WITH STANDARDS

A. Diagnostic Investigations/Test

It is a procedure performed to confirm or determine the presence of disease in an individual suspected of having the disease, usually following the report of symptoms (Wikipedia, 2017).

The following laboratory investigations were ordered by the doctor;

- Blood for malaria parasite.
- Blood for full blood count.
- Urine for routine examination.
- Urine for pregnancy test

Table 1: Diagnostic Investigation Conducted for Mrs. M.F as Compared with Literature Review

Diagnostic Investigation in Literature Review	**Diagnostic Investigation conducted for Mrs. M. F**
Full Blood Count	Full Blood Count was done for patient
Stool for Routine Examination	Stool for Routine Examination was done for patient
Barium meal	Barium meal was not done for patient

Urine for pregnancy test was not found in the diagnostic investigation in the literature review, but it was ordered to verify if patient was pregnant or not.

Urine for routine examination was not found in the diagnostic investigation in the literature review but was ordered for patient to rule out genitourinary infection.

Table 2: Diagnostic Investigations/Tests Compared with Standards

Date	Specimen	Investigation	Result	Normal Value	Interpretation	Remarks
09/11/21	Blood	Hemoglobin level	11.7g/dl	Females; 11.5 – 16.5 g/dl	Hemoglobin level at normal range, Indicating that patient is not anemic	The result was normal hence, no treatment was given.
09/11/21	Blood	White Blood Cell (WBC) count	5.2 [10^x3/ul]	4.00-11.00 [10^x3/ul]	Normal white blood cell count, This indicates that there are no systemic infections.	The result was normal hence, no treatment was given.
09/11/21	Blood	Neutrophil count	79.00	40.00 – 70.00	High Neutrophil count indicates infection	Antibiotics administered (ciprofloxacin and metronidazole)
09/11/21	Blood	Platelet count (PLT)	240	140- 440	Normal Platelet count, indicate no bleeding disorders.	No treatment given.

B. **The cause of patient's illness**

From the history taking from my patient, physical examinations performed on my patient and the laboratory investigation carried out, Mrs. M.F's condition can be confirmed to be caused by infections as indicated in the elevation of neutrophil count.

C. **Treatment given to patient**

The following treatments were prescribed for my patient.

- IV Ringers Lactate (R/L) 1.5L x24 hours.
- IV Normal Saline (NS) 1L x24 hours.
- Intravenous Ciprofloxacin 400mg bd x 48 hours.
- Intravenous Metronidazole 500mg tds x48 hours.
- Tablet Paracetamol 1g tds x 7.
- Injectable Hyoscine 40mg stat.
- Intravenous Tramadol 100mg stat

Table 3: Medical Treatments Prescribed for Mrs. M.F as Compared with Literature Review

Medical Treatments in The Literature Review	**Medical Treatments Prescribed for Mrs. M. F**
Analgesics (Tab Paracetamol)	Analgesics (Tab Paracetamol, IV Tramadol) were given for patient.
Anti – emetics	Anti –emetics was not given for patient.
Intravenous fluids and electrolyte replacement (IV Normal Saline, Dextrose Normal Saline and Ringers Lactate)	Intravenous fluids and electrolyte replacement (IV Normal saline solution and Ringer's lactate) were prescribed for patient
Antimicrobial agents (Ciprofloxacin, Metronidazole and Cefuroxime)	Antimicrobial agents (IV Ciprofloxacin and Metronidazole) were prescribed for the patient.
Rehydration agents (Oral rehydration solution)	Rehydration agent (oral rehydration solution (ORS) were not prescribed for the patient.

Injectable Hyoscine 40mg stat. was not found in the medical treatments in the literature review, but it was prescribed to relief abdominal pain caused by spasm in the intestinal muscle of the patient. The rest of the drugs given to the patient can be found in the literature review.

The treatment given was in line with the standard treatment for managing Enteritis.

Pharmacology of drugs

The medical treatment that was given to Mrs. M.F is outlined in the Table below. It consists of date of the order, the drug name, the standard dosage and route of administration, the dosage and route of administration for the patient, classification, desired effect, actual effect observed and remarks.

Table 4: Pharmacology of Drugs Prescribed

Date	Name of drug	Standard Dosage and Route of Administration	Dosage and route of administration for the patient	Classification of drug	Desired effect	Actual effect of the drug observed	Side effect(s)/ Remarks
09/ 11/22	Ringers Lactate	Dosage Depends on patient's fluid and electrolyte imbalance levels. Route Intravenous	1.5 liter × 24 hours, intravenously	Intravenous fluid (Electrolyte and Water)	To maintain fluid and electrolyte balance.	Patient's fluid and electrolyte was maintained as patient did not show any sign of fluid and electrolyte imbalance such as decreased skin turgor, oedema, and hyperventilation.	Oedema. Oedema was not observed in patient.
09/ 11/22	Normal Saline	Dosage Depends on the patient's fluid and	1 liter × 24 hours,	Intravenous fluid	To maintain fluid volume and energy.	Dehydration was prevented and energy	Low pH, venous irritation and thrombophlebitis.

		electrolyte imbalance levels. <u>Route</u> Intravenous	intravenously .	(Electrolyte and Water)		maintained as well as circulatory volume.	No side effect was observed in patient
09/ 11/22	Ciprofloxacin	<u>Dosage</u> 400- 750 mg every 12 hours for 7- 14 days <u>Route</u> Oral and IV	400mg bd x 48 hours, Intravenously	Antibiotics (Quinolones)	To treat bacterial Enteritis caused by the following among others: Staphylococci aureus, Vibrio cholerae, Salmonella typhi	Bacteria that caused patient's Enteritis were controlled.	Dizziness, drowsiness and insomnia, stomach pains or discomfort, diarrhea, nausea and vomiting and photosensitivity. No side effect was observed in patient

09/ 11/22	Metronidazole (Flagyl)	Dosage 400- 800mg three times daily. Route Oral and IV.	500mg tds x 48 hours, Intravenously	Antibacterial and Antiprotozoal	For acute intestinal infection	Patient's intestinal infection was controlled.	No side effect was observed in patient
09/ 11/22	Paracetamol (Acetaminophen)	Dosage 0.5- 1g every 4 – 6 hours; maximum daily dose is 4g. Route Oral	1g tds x 7, Orally	Antipyretic and Analgesic (non-narcotic)	To relieve pain by preventing inflammation and decreasing body temperature.	Patient's abdominal pain was relieved.	No side effect was observed in patient.

D. Clinical Manifestations Exhibited by Mrs. M.F

The comparison of the clinical manifestation in the literature review with those manifested by patient is shown in table for below.

Table 5: Clinical manifestation exhibited by Mrs. M.F as compared with literature review.

Clinical Manifestations in Literature Review	**Clinical Manifestations presented by Mrs. M.F**
Frequent diarrhea stools	Patient experienced frequent diarrhea stools (four times in a day)
Nausea and vomiting	Patient experienced nausea and vomiting
Abdominal pain and cramping	Patient experienced Abdominal pain and cramping
Headache with chills	Patient did not experience Headache with chills
Fever	Patient did experience Fever
General malaise	Patient experience General malaise
Dizziness	Patient experienced dizziness
Fatigue	Patient did not experience Fatigue
Loss of appetite	Patient experienced loss of appetite
Muscle pain	Patient did not experience Muscle pain

E. Complications Developed by My Patient.

Complication is an unfavorable evolution or consequence of a health condition as a result of a procedure, treatment or illness.

The literature review points out: Dehydration, Perforation, Renal failure, Stenosis as the complications for the condition. Mrs. M.F did not experience any of the stated complications since she reported to hospital early enough for treatment and also had right medical nursing management.

2.2 PATIENT'S HEALTH PROBLEMS

A health problem is the difference between the desire state of complete physical, mental and social wellbeing and the unmet health needs of the patient. The problem could be actual or potential life processes that can cause over reaction to the patient's health. The following were the health problems identified during Mrs. M.F admission to the hospital

1. Patient complained of abdominal pains
2. Patient temperature was high
3. Patient complained of vomiting
4. Patient complained of loss of appetite
5. Lack of knowledge on the condition
6. Patient was anxious
7. Patient complained of difficulty in sleeping(insomnia)

2.3 PATIENT/FAMILY STRENGTHS

Patient's strengths are the assets or resources and abilities that can help him/her to recover quickly or cope with the disease condition. These include healthy physiological functioning,

emotional, social and spiritual support of the person and adequate financial support in a healthy environment. On interaction with the patient, their strengths as a family were identified as;

1. Patient could measure the intensity of his abdominal pain
2. Patient could tolerate tepid sponging
3. The patient could tolerate sips of liberal fluids to replace the lost ones (vomiting)
4. Patient could eat 1/4 of meal served
5. The patient/family showed interest in gaining knowledge on disease condition and treatment
6. He was able to cope with hospitalization
7. Patient could sleep for some few hours

2.4 NURSING DIAGNOSIS

Nursing diagnosis is a statement of a health problem or the potential for which the nurse is competent to intervene and manage. The following nursing diagnoses were formulated.

1. Acute pain (abdominal pain) related to infection of Salmonella Typhi
2. Hyperthermia (high 37.5 0^{c}) related to infection of Salmonella Typhi
3. Risk for fluid volume deficit related to vomiting
4. Imbalance nutrition (less than body requirement) related to loss of appetite
5. Sleeping pattern disturbance (insomnia) related to change of environment
6. Anxiety related to unknown outcome of disease condition (Hospitalization)
7. Knowledge deficit related to unknown outcome of the disease

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 INTRODUCTION

Planning is the third stage of nursing care process. This is the process of thinking about and organizing the activities required to achieve a goal. This component of the nursing process also involves setting of objectives/outcome criteria that will help to solve the problems identified. The nursing care plan enables care to be continued and also interventions to be carried out to help the patient to be relieved of her problems. It involves the use of the nursing care plan to set objectives for patient and family. It is based on the potential and actual problems identified.

3.1 OBJECTIVES FOR PATIENT/FAMILY CARE/OUTCOME CRITERIA

1. Patient's fluid and electrolyte volume will be restored within 48 hours as evidence by:
    a. Nurse recording a balanced intake and output.
    b. The nurse observing patient to have signs of good hydration such as moist mucosa of the lips and the mouth and normal skin turgor.
2. Patient will be comfortable within 48 hours as evidence by:
    a. Patient reporting relief of abdominal pain.
    b. Nurse observing patient being calm in bed.
3. Patient's nutritional status will be restored within 72 hours as evidence by:
    a. Nurse observing patient eat 70% of meals served.
    b. Patient verbalizing that she could eat as she used to eat before her sickness.
4. Patient will be able to perform normal activities within 48 hours as evidence by:
    a. Nurse observing patient participate willingly in necessary or desired activities.
    b. Patient verbalizing that she does not feel weak.

5. Patient would have adequate information about the causes, management and prevention of the condition within 48 hours as evidence by:
    a. patient verbalizing basic understanding of causes, management and prevention of enteritis.
    b. Patient and family giving feedback information on knowledge acquired to the nurse.
6. Patient and family will be relieved of anxiety within 24 hours as evidence by:
    a. Patient/family participating in patients care and asking questions.
    b. The nurse observing relaxed facial expression of the patient/family.

Table 6: Nursing care plan for Mrs. M.F

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
09/11/21 2:30 pm	Potential fluid and electrolyte volume deficit related to excess loss of fluid through frequent diarrhea and vomiting.	Patient fluid and electrolyte volume will be restored within 48 hours as evidence: 1. The nurse recording a balanced intake and output of patient. 2.The nurse observing patient to have good signs of hydration such as moist mucosa of the lips and the mouth, normal skin turgor etc.	1. Monitor patient's intake and output. 2. Administer Intravenous fluids such as, ringers lactate and normal saline as prescribed. 3. Assess vital signs, signs and symptoms of dehydration and the laboratory investigations. 4. Encourage patient to drink at least 2-3 liters of fluid per day. 5. Collaborate with the nutrition team in the	1. Patient's intake and output was monitored. 2. Prescribed intravenous fluid such as, ringers lactate and normal saline was administered. 3. Vital signs, signs and symptoms of dehydration and the results of the laboratory investigation were assessed. 4. Patient was encouraged to drink at least 2-3 liters of fluid per day. 5. Collaboration with nutritional team was done	11/11/21 2:30 pm	Goal was fully met as: 1. the nurse recorded balanced intake and output of patient. 2. nurse observed patient having signs of hydration such as moist mucosa of the lips and mouth, normal skin turgor etc.	A.P

			provision of low sodium diet. 6. Provide frequent oral care.	in the provision of low sodium diet. 6. Frequent oral care was provided.			

Table 6: Nursing care plan for Mrs. M.F. cont'd

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
09/11/21 2:30 pm	Altered body comfort (restlessness) related to abdominal pain.	Patient will be comfortable within 48hours as evidenced by: 1. Patient reporting relief of abdominal pains. 2. The nurse observing patient been calm in bed.	1. Explain to patient/family the reasons for the pain and the available management. 2. Provide diversional therapy such as watching television and conversing with her. 3. Review factors that aggravate pain or alleviate pain.	1.The reasons for pain and available management were explained to patient/family. 2. Diversional therapy such as watching of television and engaging patient in conversation was done. 3. Factors to aggravate or alleviate pain were reviewed.	11/11/21 2:30 pm	Goal was fully met as: 1. patient reported relief of abdominal pains. 2. nurse observed patient to be calm in bed.	A.P

			4. Provide adequate rest. 5. Administer analgesics as prescribed. 6. Monitor effectiveness of pain medication. 7. Instruct patient to perform deep breathing exercise.	4. Adequate rest was provided for patient. 5. Paracetamol 1g tid was administered. 6. Effectiveness of pain medication was monitored. 7. Patient was instructed to perform deep breathing exercise.			

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
10/11/21 9:00am	Activity intolerance related to general body weakness.	Patient will be able to perform normal activities within 48 hours as evidence by: 1. Nurse observing patient participating willingly in necessary or desired activities. 2. Patient verbalizing that she does not feel weak.	1. Assess patient hydration and nutritional status. 2. Reassure patient and family. 3. Encourage and ensure complete bed rest. 4. Ensure cluster nursing care that is performing all nursing care at once. 5. Assist patient with the performance of certain activities like brushing the teeth and bathing. 6. Provide health teaching to the patient	1. Patient hydration and nutritional status were assessed 2. Patient was reassured that he will regain strength for his daily activities with available measures 3. Complete bed rest was encouraged and ensured. 4. All nursing activities were performed at once. 5. Patient was assisted in the performance of certain activities like brushing the teeth and bathing.	12/11/21 11:00 am	Goal fully met as: 1.Nurse observed patient to participate willingly in necessary or desired activities and; 2. Patient verbalized that she does not feel weak.	A.P

			on how to arrange and prioritize activities to enhance patient's ability to participate in activity.	6. Health teaching on how to arrange and prioritize activities to enhance patient's ability to participate in activity was provided.			

Table 6: Nursing care plan for Mrs. M.F. cont'd

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
10/11/21 10:00am	Altered nutritional status (less than body requirements) related to loss of appetite.	Patient's nutritional status will be restored within 72 hours as evidenced by; 1. Nurse observing patient eat about 70 % of meal served. 2. Patient verbalizing she could eat well as she used to eat before her sickness	1. Encourage and ensure oral hygiene before and after meals. 2. Ensure patient's food intake regularly as she can tolerate. 3. Serve patient with her favorite meal. 4. Involve patient/ family in planning of her diet. 5. Serve food attractively and in a conducive environment. 6. Take away all nauseating substances away from patient.	1. Oral hygiene was encouraged and ensure before and after meals. 2. Patient food intake was ensured regularly as she can tolerate. 3. Patient's favorite meal was served in bits. 4. Patient/family was involved in planning of diet. 5. Food served was attractively and in a conducive environment. 6. All nauseating substances was taken away from patient.	13/11/21 9:00 am	Goal was fully met as: 1. nurse observed patient eat 70% of meal served. 2. patient verbalized; she can eat well as she used to eat before her sickness.	A.P

Table 6: Nursing care plan for Mrs. M.F. cont'd

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
11/11/21 10:00am	Anxiety (Patient/ family) related to unknown outcome of the disease (Enteritis)	Patient and family will be relieved of anxiety within 24 hours as evidence by: 1. Patient/family participating in patient's care. 2. The nurse observing relaxed facial expressions of patient/family.	1. Reassure patient/family that the disease is manageable and the staffs are ever ready to help in caring for her. 2. Assess their knowledge on the condition and its treatment. 3. Encourage them to express their fears and concerns.	1. Patient and family were reassured that the disease was manageable and that the staff was ready to help in care. 2. Their knowledge about the condition and its treatment were assessed. 3. They were encouraged to express their fears and concerns.	12/11/21 10:45am	Goal fully met as; 1. patient /family participated in patient care. 2.nurse observed patient/family had a relaxed facial expression	A.P

			4. Explain all procedures to them and encourage them to ask questions and answer them tactfully. 5. Introduce patient to other patients in the ward suffering from the same disease and are doing well. 6. Employ diversional therapy to destruct patient's attention from anxiety	4. All procedures were explained to them and they were encouraged to ask questions and tactful answers were given. 5. Patient was introduced to other patients in the ward who were suffering from the same disease and doing well. 6. Patient was engaged to watch her favorite TV program to help divert her attention.			

Table 6: Nursing care plan for Mrs. M.F. cont'd

Date and Time	Nursing diagnosis	Objective/Outcome criteria	Nursing orders	Nursing intervention	Date and Time	Evaluation	Sign
1/11/21 at 10:15am	Knowledge deficit related to inadequate information about the causes, management and prevention of the condition.	Patient will have adequate information about the causes, management and prevention of the condition within 48 hours as evidence by; 1.Patient verbalizing a basic understanding about the causes, management and prevention of the condition. 2. Patient and family giving feedback information on	1. Reassure Patient and family and establish rapport with them. 2. Assess their knowledge on her condition. 3. Inform Patient and family about ways of preventing the symptoms and some management for the disease. 4. Allow patient and family to ask questions for clarification.	1. Patient and family were reassured and rapport established with them. 2. Their knowledge on her condition was assessed. 3. Patient and family were informed about ways of preventing the symptoms and some management for disease. 4. Patient and family were allowed to ask questions for clarification.	12/11/21 At 10:15am	Goal fully met as: 1. patient verbalized a basic understanding about the causes, management and prevention of the condition. 2. patient and family gave feedback information on knowledge acquired to the nurse.	A.P

		knowledge acquired to the nurse.	5.Answer questions in simple understandable language without using professional jargons. 6. Ask Patient and family to summarize what they heard.	5. All questions were answered in simple understandable language without using professional jargons. 6. Patient and family were asked to summarize what they heard.			

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 INTRODUCTION

Implementation is the fourth phase of nursing process signifying giving of care in relation to defined nursing interventions and goals. During implementation, the nursing care is tested for effectiveness and accuracy (Weller, 2009). This chapter also includes the preparation of the patient and her family towards discharge, home visit and continuity of care.

4.1 SUMMARY OF THE ACTUAL NURSING CARE

Care of patient began on the day of admission on the 9th day of November 2021 and continued until discharge on 14th November, 2021. During her period of admission, daily routine nursing care such as bathing, mouth care and serving of prescribed medication were carried out. Also, specific care was rendered according to patient's needs.

Day of Admission, 9th November, 2021.

At 8:00am on the 9th day of November 2021, Mrs. M.F was brought to the Emergency Response Unit at Wenchi Methodist Hospital per ambulatory. She was accompanied by her husband. Patient and family were welcomed. Patient was given an already prepared simple unoccupied bed and was placed in a supine position. I introduced myself and the other staffs to the relative. Since the patient was very weak, I assisted them in arranging her personal items after permission granted. Head to toe examination was performed. On observation, patient was slightly weak. She also complained of passing watery stool for four times since 3:00am, vomiting, abdominal pains, general malaise, dizziness, nausea and loss of appetite. Patient's vital sign checked and recorded as below:

- Temperature: 37.5^0C
- Pulse: 76bpm
- Respiration: 19cpm
- Blood pressure: 101/57mmHg

Height and weight were also checked and recorded as follows;

- Weight: 53kg
- Height: 1.71m

Patient was diagnosed of Enteritis. Her particulars were therefore taken into the Admission and Discharge Book and Daily Ward State. Patient was introduced to the other roommates and I further introduced the procedure to the patient and relatives. Patient and family were reassured of being in safe hands of competent health team. The relative except the patient who was weak and dizzy were oriented to the ward. The patient was managed on the following medications;

- IV Ringers Lactate (R/L) 1.5L x24 hours.
- IV Normal Saline (NS) 1L x24 hours.
- Intravenous Ciprofloxacin 400mg bd x 48 hours.
- Intravenous Metronidazole 500mg tds x48 hours.
- Tablet Paracetamol 1g tds x 7.
- Injectable Hyoscine 40mg stat.
- Intravenous Tramadol 100mg stat

These medications were collected from the dispensary and administered.

The following laboratory investigations were ordered by the doctor;

- Blood for malaria parasite.
- Blood for full blood count.
- Urine for routine examination.
- Urine for pregnancy test

Patient and relatives were told about the use of National Health Insurance Scheme that not all drugs are being covered by National Health Insurance Scheme. Patient's relative was also told about visiting hours and the things the patient may need during her stay at the ward in the next visit. After patient regaining enough strength, I introduced myself to her as a student nurse and informed patient that am a student at the Holy Family Nursing and Midwifery Training College, Berekum and conducting a case study at the hospital which is part of the requirement for getting license to become a professional nurse and that her maximum cooperation and concern will be required. Patient and relative accepted and assured me of their co-operation and I thanked them. Permission was also sort from the Nurse In-Charge which was given.

At 2:30pm, patient was still passing diarrhea stools with vomiting. A nursing diagnosis of potential fluid and electrolyte volume deficit related to excess loss of fluid through frequent diarrhea and vomiting was made and an objective to restore the fluid and electrolyte volume within 48 hours was set. The nursing interventions carried out include Monitor patient's intake and output, administering prescribed intravenous fluids such as ringers' lactate and dextrose normal saline, assessing vital signs, signs and symptoms of dehydration and the results of the laboratory investigations, providing and encouraging patient to drink water at least 2-3L of fluid

per day, collaborating with the nutrition team in the provision of low sodium diet and provide frequent oral care.

Additionally, patient complained of discomfort and a nursing diagnosis of altered body comfort (restlessness) related to abdominal pain and an objective to make her comfortable within 48 hours was set. Nursing interventions such as explaining to patient/family the reasons for the pain and the available management, providing diversional therapy such as watching television and conversing with her, reviewing factors that aggravate pain, encouraging adequate rest, administering analgesics as prescribed, monitoring effectiveness of pain medication and instructing patient to perform deep breathing exercise were carried out.

At 6:00pm her vital signs were checked and recorded as,

- Temperature 37.2^0C
- Pulse 70 bpm
- Respiration 22 cpm
- Blood pressure 110/70 mmHg

Mrs. M.F was able to take a cup of rice porridge as supper. Intravenous Ciprofloxacin 400mg, Intravenous Metronidazole 500mg and Tablet Paracetamol 1g was served at 6:00pm. She took her bath and went to bed around 9:35 pm. All interventions carried out were documented.

Second Day of Admission, 10th November, 2021.

Mrs. M.F woke up as early as 5:10 am; she brushed her teeth and visited the toilet. She took her bath and was served with oats and bread as breakfast.

At 6:00am routine vital signs were checked and her medications were served accordingly and recorded. The vital signs were recorded as follows:

- Temperature 37.2^0C

- Pulse 74 bpm
- Respiration 28cpm
- Blood pressure 126/60 mmHg

I reported to the ward at 7:00am and had a conversation with the patient and relatives.

At 9:00am, I realized that my patient could not tolerate certain activities and also could not perform certain activities on her own. Nursing diagnosis of activity intolerance related to general body weakness was made and an objective was set to enable patient to perform normal activities and tolerate activities within 48 hours.

Nursing interventions that were implemented to achieve the goal included; encouraging and ensuring complete bed rest for patient, all nursing activities were performed at once, patient was assisted in the performance of certain activities like brushing the teeth and bathing, health teaching on how to arrange and prioritize activities to enhance patient ability to participate in activity was provided.

During the ward rounds at 10:00 am the Medical Officer attended to Mrs. M.F and ordered that treatment should be continued and was encouraged to take liberal fluids.

Mrs. M.F told me she has lost her appetite as she could not eat much of her meal served after the ward rounds. An objective was set to restore Mrs. M. F's nutritional status within 72 hours.

I encouraged and ensured oral hygiene before and after meals, ensured patient's food intake was regular as she could tolerate, served patient with her favorite meal in bits, involved patient/ family in planning of her diet, served food attractively and administered prescribed medications, such as multivitamins.

In the afternoon, routine vital signs were checked and medications served. Her lunch was boiled plantain and "kontomire" stew which she only ate just five fingers.

In the evening, routine vital signs were also checked and medication served. She went to bed around 9.45pm. All interventions carried out were documented.

Third Day of Admission, 11th November, 2021.

Mrs. M.F woke up around 5: 30am, emptied her bowels and took her bath. She took porridge and bread as her breakfast. At 6:00am routine vital signs and medications were served.

I realized at 10:00 am that both Mrs. M.F and her family members at the ward were very anxious because of the unknown outcome of the illness. An objective to relief patient/family of anxiety within 24 hours was set.

Nursing interventions implemented included reassuring patient/family that the disease is manageable and the staffs are ever ready to help in caring for her, assessing their knowledge on the condition and its treatment, encouraging them to express their fears and concerns, explaining all procedures to them and encouraging them to ask questions and answered them tactfully and introducing patient to other patients in the ward suffering from the same disease and are doing well.

At 10:15am, I found out that Patient had deficient knowledge about the causes, management and prevention of the condition. A nursing diagnosis of knowledge deficit related to inadequate information about the causes, management and prevention of the condition was made. Nursing interventions such as patient and family were reassured and rapport established with them, patient/family were asked about some of the causes of the condition, patient and family were informed that hand washing and observing good personal hygiene can help prevent the spread of the infection, patient asked about some of the risk factors for the condition and she was answered correctly, all questions were answered in simple understandable language without using

professional jargons, patient and family were asked to summarize what they heard were implemented.

She took rice and groundnut soup as her launch. At 2:30pm, I evaluated Mrs. M. F's fluid and electrolyte volume deficit and the altered body comfort that were diagnosed on the 9th November, 2021. I recorded a balanced intake and output, observed patient to have moist mucosa of the lips and mouth and a normal skin turgor. I also observed patient to be calm in bed. Based on this my goals were fully met.

I embarked on my first home visit to Mrs. M. F's house. In the evening, routine vital signs and medications were served. She ate fufu and light soup and 2 slices of oranges after 15minutes. But she was able to eat one and half of the fufu served. She went to bed at 10:00 pm**.**

Fourth Day of Admission, 12th November, 2021.

Mrs. M.F woke up around 5:00am; she emptied her bowel and later brushed her teeth and had her bath. She took warm Milo drink and bread as her breakfast.

At 10:15am, I evaluated yesterday's objective that was set to relieve patient/family of anxiety. The nursing diagnosis of knowledge deficit related to inadequate information about the causes, management and the prevention of the condition to help patient gain adequate information about the causes, management and prevention of the condition within 24 hours. Goal was fully met.

During the ward rounds, my patient complained of feeling some mass at left iliac region so, she was told to do an abdominal X-ray for investigation. The patient, accompanied by a relative and I went for the X-ray examination. Upon returning, I evaluated the objective set on 10th November, 2021 for the nursing diagnosis; activity intolerance related to general body weakness. The goal set was fully met as; I observed patient participate willingly in necessary or desired activities and patient verbalizing that she does not feel weak.

In the afternoon, she ate banku and okro soup as launch. Her vital signs were checked and recorded. In the evening, she took her favorite diet, rice with beans stew and 2 slides of watermelon 15 minutes later. She was able to tolerate all the meals served. She had her bath and slept at 10:45pm after watching the late news. The interventions carried out were entered into appropriate document to ensure continuity of care.

Fifth Day of Admission, 13th November, 2021.

On the fifth day of admission, patient

complained of having no new problems indicating progress in condition. Patient and family looked cheerful. Vital sign checked and recorded as follows;

- Temperature 36.2°C
- Pulse 80bpm
- Respiration 24cpm
- Blood pressure 120/70 mmHg

At 9:00am, the objective that was set on the 10th November, 2021 to restore patient's nutritional status within 72 hours was evaluated. The goal was fully met as patient was able to eat about % of meal served.

The doctor reviewed the X-ray which provided evidence of a normal abdomen. Mrs. M.F confirmed she was well. She was finally discharged and was asked to continue taking the rest of the drugs; tab paracetamol 1g tds x 7 and ORS 4 sachets were added to be taken at home. She was asked to come for review on 20th November, 2021. She was educated on how to take her drugs, side effect of the drugs and the need to report any illness.

All her bills were fully settled. All activities were documented for continuity of care and for references. My 2nd home visit on the 18th of November, 2021 was discussed with patient and she

agreed. They took a taxi at the entrance and were bid farewell. After the patient had been discharged, the bed side locker and the bed were disinfected. All dirty articles were removed and placed in the dirty linen bin.

4.2 THE PREPARATION OF PATIENT/FAMILY FOR DISCHARGE AND REHABILITATION.

Preparation of patient/family for discharge started from the day of admission when I told my patient that the hospital was not going to be her permanent living environment but she will be discharged home soon after the competent care that will be rendered to her makes her fit to resume her normal activities.

On 13th November, 2021, during the ward rounds the Medical Officer discharged her. Patient/family were educated to report to the hospital if patient fall ill; and also take the medications as prescribed. They were also reminded of the date for review which was on the 20th November, 2021. I told them about my home visit on the 18th of November, 2021.

Patient and family were given education and teaching which included; washing their hands before and after eating and after visiting the toilet with soap and water, food must be well heated before eating while cold foods must be eaten cold, fruits must also be washed properly, not to expose foods to flies, the need to avoid defecation in the bush and to avoid the habit of starvation.

Her name was entered into the admission and discharge book and also the ward census chart. All her bills were covered by health insurance. I assisted her to arrange her things into her luggage. They left the entrance around 1:00pm on the day of discharge.

4.3 FOLLOW UP/HOME VISIT/CONTINUITY OF CARE

Home visit is a family – nurse contact which allows the health worker to assess the home and family situation in order to provide the necessary nursing care and health related services. 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 her family and their health practices in order to provide the appropriate health teaching.

First Home Visit: 11th November, 2021.

On 11th November, 2021, while my patient was on admission, I made my first home visit. A planned visit was made to Dagomba lane, a community at Wenchi in the Bono Region where my patient lives. I was taken home by her sister-in-law who waited for me at the local police station. The time was 9:30am when we got to the house.

The visit was purposely to validate any data collected from Mrs. M.F and her relatives, inspect her environment and to identify any factor that could have led to her illness. Two other relatives who used to visit her at the hospital came out from their rooms. They already knew who I was, therefore I did not introduce myself.

Upon entering the house, I noticed the house is a completed self-contained with 6 bed rooms, a toilet and a wash room. It was built with blocks and roofed with aluminum sheets. The house has two entrances. Some of the rooms are with plane wood ceiling and the kitchen, the toilet and the bath rooms were also ceiled.

Their source of water is the borne- hole in the community, but there is a barrel situated at the center of the house for water storage and preservation. The draining system in the house was very good but it was not covered. The building is supplied with electricity. On observation the house was swept that morning. The rubbish container had been emptied that morning. Upon further inspection, ventilation in the building was adequate. As I saw every room with four windows, two placed opposites to each other.

I entered Mrs. M. F's room with her permission. Her room was well furnished with television, bed, chairs and a wooden center table. She had chamber and hall. Her bed had no insecticide treated mosquito net (ITNs). I asked about it and her sister-in-law confirmed she did not sleep under one. I asked her sister-in-law about the information that Mrs. M.F provided and she gave the same history as Mrs. M.F gave me.

With permission, I entered the kitchen and toilet. I saw that they were both tidy. The toilet had a water closet and a mini barrel with water used to flush out the water closet. They have a domestic waste disposal container, which is emptied every morning to the community refuse disposal site.

Her sister-in-law was educated on the need to cover the barrel in the compound. I told her to try and make sure they wash the utensils in the evening after eating. She was told the need to keep the environment clean as it could be a cause for her sister-in-law's illness. I educated her on the need to sleep under an insecticide treated net, I commented on the condition of the house and gave the same education and recommendations to Mrs. M.F. I reassured them of her health and asked for permission to leave. She thanked me and assured me that she will ensure that all what I said will be done before I come for my next home visit. I also thanked her and she bid me farewell.

I left the house around 10:45am and got to the hospital around 12:10pm.

Second Home Visit: 18th November, 2021.

My second home visit came on 18th November, 2021. The visit was to find out whether the education given the patient and her family during the period of hospitalization and first home visit had been adhered to. It was also intended to assess the health of the patient, her compliance with medication and to remind her of the review date. I left the hospital around 9:00am. I arrived at the house around 9:45am. I met and I greeted her and I was offered a seat and water while she informed a few her relatives present of my arrival. After drinking the water, I was asked my mission as

custom demands. I told them I came to pay her a visit to know how she is doing and also to find out if she has been sleeping under an insecticide treated net as told.

She told me she has bought a new insecticide net. I also checked to see if her drugs were well taken and asked them questions about the health education, I gave them on the day of discharge. They answered me correctly as expected. Before I left, I reminded her about the review on 20nd November, 2021 and told them I will be coming for another home visit. I sought for permission to leave. I went back to the hospital at almost 11:30 pm.

Third Home Visit: 24th November, 2021.

My third and last home visit was made on the 24th November, 2021. The visit was to terminate the care by introducing the family to the Public Health Nurse who will continue with the care.

We left the hospital around 2:15pm and arrived at the house around 3:05am. Patient told me she has bought a new insecticide to battle against mosquitoes. The barrel was covered and they assured it will be covered always with a lid. I asked them questions about the health education I gave them on the day of discharge. They answered me correctly as expected. I congratulated them for the care they had rendered to Mrs. M.F and thanked them for their cooperation.

I told Mrs. M.F and her family because I am a student and I will have to go back to campus to continue my education. The public health nurse was introduced to them for continuity of care and they were very thankful. I encouraged them to give her the same cooperation they gave me.

Patient and family were thanked for their co-operation throughout my study and this ended our interaction and terminated her care. I promised to always come and pay them unofficial visits.

I sought for permission to leave and it was granted. They escorted us out of the compound and we came back to the hospital.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 INTRODUCTION.

Evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process, (Bare and Smeltzer, 2008).

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

5.1 STATEMENT OF EVALUATION

Evaluation is a systematic and objective assessment of an on-going or completed project which helps to determine the relevance and fulfilment of objectives, efficiency, effectiveness, impact and sustainability. Throughout the period of admission, six health problems were recorded and objectives were set to solve them. Below is the summary of the interventions carried out and to what extent the goals were met.

1: Mrs. M. F's fluid and electrolyte volume was restored within 48 hours.

On 9th November, 2021 (day of admission), at 2:30pm Mrs. M.F passed diarrhea stools with vomiting. She had a potential fluid and electrolyte volume deficit related to excess loss of fluid through the frequent diarrhea and vomiting. A goal was set to restore Mrs. M.F's fluid and electrolyte volume within 48 hours. Patient's intake and output was monitored. Intravenous fluids such as ringers' lactate and normal saline were administered as prescribed. Patient's vital signs, sign and symptoms of dehydration and the results of the laboratory investigations were assessed.

She was provided and encouraged to drink water of at least 2-3L per day. The nutritional team was collaborated in the provision of low sodium diet. Frequent oral care was provided. The goal was met fully on 11th November, 2021 at 2:30pm.

2. Mrs. M.F regained her comfort within 48 hours.

Patient complained of abdominal pains on 9th November, 2021 at 2:30 pm. She experienced altered body comfort (restlessness) related to abdominal pain. A goal was set to regain patient's comfort within 48 hours. The reasons for pain and available management were explained to patient/family. Diversional therapy such as watching of television and engaging patient in conversation was done. Factors that aggravate or alleviate pain were reviewed. Adequate rest was provided for patient. Prescribed analgesics were administered. Effectiveness of pain medication was monitored. Patient was instructed to perform deep breathing exercise. On the 12th November, 2021 goal was fully met.

3. Mrs. M.F nutritional status was restored within 72 hours.

Mrs. M.F could not meet her normal nutritional uptake because she had lost her appetite. As a result, an objective was set to restore her nutritional status within 72 hours.

Oral hygiene was encouraged and ensured before and after meals. Patient's food intake was ensured regularly as she can tolerate. Patient's favorite meal was served at regular time. Patient/ family were involved in planning of her diet. Food was served attractively. Goal was met within 72 hours as I observed patient eat 70 % of meal served.

4. Mrs. M.F was able to perform normal activities within 48 hours.

Mrs. M.F complained of general bodily weakness. Therefore, on the 10th November, 2021 at 8:00am a nursing diagnosis of activity intolerance related to general body weakness was made. A goal was set to enable patient be able to perform normal activities within 48 hours. Patient was

told to always stay in bed and her needs were provided as she was in bed. Checking of vital signs, administration of drugs and bed making were all performed at once. Patient was assisted in brushing the teeth and bath. Patient was told to first engage in important and critical activities before doing those that are less important. On 13th November, 2021 at 10:00am, goal was fully met.

5. Mrs. M.F and family were relieved of anxiety within 24 hours.

On 11th November, 2021 at 10:45am Mrs. M.F and family were anxious related to the unknown outcome of the disease. A goal was set to allay their anxiety within 24 hours. Nursing interventions carried out were reassuring patient/family that the disease is manageable and the staff is ever ready to help in caring for her. Their knowledge on the condition and its treatment was assessed. They were encouraged to express their fears and concerns. All procedures were explained to them and they were encouraged to ask questions which were answered tactfully. On the 12th November, 2021 at 10:45pm the goal set was fully met.

6. Mrs. M.F/family gained adequate information about the causes, management and prevention of the condition within 48 hours

Mrs. M.F had deficient knowledge about the causes, management and prevention of the condition. Therefore, on the 11th November, 2021 at 10:15am a nursing diagnosis of knowledge deficit related to inadequate information about the causes, management and prevention of the condition was made. A goal was set to help patient and family gain adequate information about the causes, management and prevention of the condition within 48 hours. Patient and family were reassured and rapport established with them, patient/family were asked about some of the causes of the condition; patient and family were informed that hand washing and observing good personal hygiene can help prevent the spread of the infection, patient asked about some of the risk factors

for the condition and she was answered correctly, all questions were answered in simple understandable language without using professional jargons; patient and family were asked to summarize what they heard.

On 12th November, 2021 at 10:15am, goal was fully met.

5.2 AMENDMENT OF THE NURSING CARE PLAN

With the individualized comprehensive nursing care and support from other members of the health team and co-operation of Mrs. M.F and family, all the goals set were fully achieved. The care plan was therefore not amended.

5.3 TERMINATION OF CARE

This forms the last aspect of the interaction with patient and family. To avoid anxiety, patient and family were prepared psychologically from the day of admission through discharge, to after discharge.

My third and last home visit was made on the 24th November, 2021. The visit was to terminate the care by introducing the family to the Public Health Nurse who is to continue with the care.

We left the hospital around 2:15pm and arrived at the house around 3:05am. Patient told me she has bought a new insecticide to battle against mosquitoes. The barrel was covered and they assured it will be covered always with a lid. I asked them questions about the health education I gave them on the day of discharge. They answered me correctly as expected. I congratulated them for the care they had rendered to Mrs. M.F and thanked them for their cooperation.

I told Mrs. M.F and her family because I am a student and I will have to go back to campus to continue my education. The public health nurse was introduced to them for continuity of care and they were very thankful. I encouraged them to give her the same cooperation they gave me.

Patient and family were thanked for their co-operation throughout my study and this ended our interaction and terminated her care. I promised to always come and pay them unofficial visits.

I sought for permission to leave and it was granted. They escorted us out of the compound and we came back to the hospital.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 INTRODUCTION

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

6.1 SUMMARY

Summary is an overview of content that provides a reader with the overarching theme, but does not expand on specific details. Mrs. M.F was admitted on 9th November, 2021 into the Accident and Emergency Unit of Wenchi Methodist Hospital at 8:00m. Her vital signs on the day of admission read: Temperature – 37.5^{0}C, Pulse – 76 bpm, Respiration –19cpm, Blood pressure – 1101/57 mmHg.

She spent a total of five (5) days at the hospital. During her period of hospitalization six (6) health problems were identified. Nursing diagnosis was stated for each of the problems and objectives/outcome criteria were set. Nursing interventions such as reassuring patient/family that the disease is manageable and the staffs is ever ready to help in caring for her, administering intravenous fluids, providing adequate rest and encouraging and ensuring oral hygiene before and after meals were rendered to help achieve all the set goals.

The following laboratory investigations were conducted for my patient;

- Blood for malaria
- Blood for full blood count
- Urine for routine examination

- Urine for pregnancy test

During her period of hospitalization, she was served with the following drugs and IV fluids:

- IV Ringers Lactate (R/L) 1.5L x24 hours.
- IV Normal Saline (NS) 1L x24 hours.
- Intravenous Ciprofloxacin 400mg bd x 48 hours.
- Intravenous Metronidazole 500mg tds x48 hours.
- Tablet Paracetamol 1g tds x 7.
- Injectable Hyoscine 40mg stat.
- Intravenous Tramadol 100mg stat

On 9th November,2021, during general ward rounds, the condition of Mrs. M.F had improved tremendously upon further examination by the doctor and hence was discharged. Patient was asked to come for review on the 20th November, 2021. Tab Paracetamol 1g tds x 7 days and ORS 4 sachets were prescribed for her to be taken home.

Patient and family were given education and teaching which include; the early signs of diarrhea and dehydration, the need for personal and environmental hygiene, advise to always wash the hand before eating and after visiting the toilet, food must be well heated before eating and fruits also washed properly, not to expose foods to flies and the need to avoid defecation in the bush.

Three (3) Home visits were made to be able to monitor her condition and find out if she had adhered to the treatment and education given. She was finally handed over to the public health nurse on 24th November, 2021.

6.2 CONCLUSION

In conclusion, my choice of nursing Mrs. M.F has strengthened my knowledge into her condition, enteritis. It has given me in depth knowledge on the causes, signs and symptoms, diagnosis, treatment, complications and possible prevention of the disease condition.

This study has also enabled me gain knowledge on how to practically care for a patient with enteritis using the nursing process.

I therefore recommend that every health institution should employ the use of the nursing process, so as to enable them provide individualized, holistic and comprehensive nursing which will help decrease re-occurrence of diseases in our hospitals as well as reducing mortality rate.

I also recommend that every nursing student should be given the opportunity to embark on the patient/family care study to enable them obtain more insight on the condition under study.

APPENDIX

Table 7: Vital Signs of Mrs. M.F

Date	Time	Temperature (^{0}C)	Pulse (bpm)	Respiration (cpm)	Blood Pressure (mmHg)
09/11/21	2:00pm	37.5	76	19	101/57
	06:00pm	37.2	70	22	110/70
	10:00pm	37.2	80	24	130/70
10/11/21	06:00am	37.2	74	28	120/60
	10:00am	36.9	80	24	120/70
	02:00pm	37.0	68	26	110/70
	06:00pm	35.5	78	27	124/60
	10:00pm	36.8	60	24	120/70
11/11/21	06:00am	35.5	70	24	130/70
	10:00am	36.6	64	31	120/70
	02:00pm	35.9	66	27	110/60
	06:00pm	36.1	68	33	110/70
	10:00pm	36.4	76	29	120/70
12/11/21	06:00am	36.0	70	25	120/80
	10:00am	35.2	78	27	120/70
	02:00pm	35.3	68	20	1200/80
	06:00pm	35.7	72	31	110/80
	10:00pm	36.2	66	27	120/80
13/11/21	06:00am	36.2	80	24	120/70
	10:00am	37.2	82	28	110/70

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OTHERS

Patient's Record Number: 5644/19, Methodist Hospital – Wenchi.

SIGNATORIES

1. NAME OF CANDIDATE: ADUSI POKU

SIGNATURE: .....

DATE: 4TH OCTOBER, 2022

2. NAME OF SUPERVISOR: MR. JOSEPH APPIAH

SIGNATURE: .....

DATE: 04/10/2022

3. WARD-IN-CHARGE, FEMALES' WARD, METHODIST HOSPITAL- WENCHI

NAME: MR. KWADWO SARFO KANTANKA

SIGNATURE: .....

DATE: 04/10/2022

4. NAME OF PRINCIPAL: MONICA NKRUMAH

SIGNATURE: .....

DATE: 05/10/2022

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

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