PREFACE

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

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

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

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

Patient /Family initial have been used instead of their full names to ensure privacy and confidentiality as part of the ethics of the nurses and midwives council.

ACKNOWLEDGEMENTS

My first and foremost thanks goes to the Almighty Allah for his direction, strength and protection.

I express my gratitude to Mrs. D.K. and her family for not hesitating in allowing their daughter to be used for the study and also for providing the necessary information throughout the study.

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I also appreciate the entire nursing staff at the Females' ward, Holy Family Hospital, Techiman especially the ward in-charge for helping me to get the necessary information to complete this study.

My appreciation also goes to my mother Mrs. Bintu Ibrahim and my father Mr. Karim Amadu for helping me financially to be able to complete the study. I also express my sincere gratitude to all friends most especially Mr. Tannor Amos, Boakye Issac, Ellen Antwi, Gifty , Phauzia and my colleagues of RGN 23 who were always there for me during the difficult times. I also thank Mr.Razark Issah for the support and encouragement.

Finally, I wish to extend my gratitude to the authors and publishers of the books I used as reference in writing this study.

INTRODUCTION

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

This study was carried out on Miss. G.T, an 18 years old lady who was admitted at the Female Medical ward at Holy Family Hospital, Techiman in the Bono East Region, with a diagnosis of gastroenteritis. Miss. G. T. was admitted on 11th of December 2022 and was discharged on the 15TH of December 2022. Miss. G.T. spent five days in the hospital. I introduced myself to her as a final year student who would like to use her as my client for my patient/family care study. I told her instead of her full name, I will rather use her initials for the purpose of confidentiality which she agreed.

On admission, patient complained of vomiting, nausea, anorexia, headache, abdominal discomfort and dizziness. Patient temperature was taken and recorded as follows, Temperature 38.1oc, Blood pressure 110/70mmHg, pulse 100 bpm, respiratory 25cpm, spo2 100%, RBS 5.4, patient was reassured of competent nursing care and interventions were made. Patient was discharged with no complications due to the effective medical and nursing care rendered to her. Home visit were made during admission and after discharge to ensure continuity of care, and to educate client and family on the disease condition. I chose G.T. for my care study in order to learn more about gastroenteritis.

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

Chapter 1: Assessment of patient and family

Chapter 2: Analysis of data

Chapter 3: Planning of patient and family care

Chapter 4: Implementation of patient and family care plan

Chapter 5: Evaluation of care rendered to patient and family

Chapter 6: summary and conclusion.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.1 Introduction

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

1.2 Patient's Particulars

Patient's particulars are defined as the biographical state of an individual within a geographical area at a particular time (Myers, 2006). Miss. G. T, an 18year old lady from Aworowa in the Bono East Region was born on May 14th, 2003 at Wenchi Methodist Hospital in the Bono region. She was born to Mr. A.K and Mrs. D. K. She is the second born among four children, of which two are girls and two are boys. She is fair in complexion with round face and a pointed nose. She weighs 45.0kg and has a height of 150cm. Miss G.T. has no physical impairment. She is a student. She is schooling at Akumfi Ameyaw Senior High School. She lives with her grandmother at Aworowa.

According to Miss G.T, she had stayed with her grandmother from when she was 3 years of age till now, although her parents are alive. Miss G.T. uses her grandmother as her next of kin. She is a Christian who attends Pentecost. She is Bono by tribe. Miss G.T. speaks twi (Bono) and English

1.3 Family's Medical History

According to Miss. G.T., there is no known chronic or hereditary disease such as diabetes, hypertension, asthma, mental illness or epilepsy in the family. Her grandmother who was present during patient history taking said that, her husband died a natural death some years ago. She said sometimes her family members do suffer from minor conditions like common cold, fever, headache and they intervene by going to the hospital instead of over the counter drugs, due to the advice a friend gave her concerning those drugs. She emphasized that neither she nor any of her family members have any allergies.

1.4 Family socio-economical history

According to my client, she gets support from her grandmother who was a teacher but now on pension and sometimes her Mother who is also a trader supports her financially. My patient source of funding her medical care is from the National Health Insurance (NHIS). She also said she has good interpersonal relationship with her neighbors same as her schoolmates and participates in almost all kind of school, community and religious activities.

1.5 Patient's Developmental History

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

According to Miss. G.T's grandmother, she was delivered at term through spontaneous vaginal delivery at Wenchi Methodist Hospital on the 14th of May, 2003 with no complications of pregnancy. She has no congenital malformation such as cleft lip or cleft palate. She was breastfed but was introduced to supplementary foods as well when she turns six months. She was breastfed for one year. According to her grandmother, she started sitting when she was four months and it did not take up to a month for her to crawl with her teeth erupting that same month and by the tenth month she started walking. Immunization against childhood disease such as tetanus, poliomylitis and others were given at the required month. There is a scare on her right upper arm indicating that she was immunized against tuberculosis. However she could not trace her immunization card. She saw her first menstrual period when she was 13years old (Menarche). According to miss G.T., her grandmother took her from her mother when she was three years until now. She said every week her grandmother gives her money which she use some to buy cloths, pads and other things that she needs. She started schooling when she was three years at Aworowa with her grandmother.

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

1. Trust versus Mistrust (birth to 1 year)

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

3. Initiative versus guilt (3 to 5 years)

4. Industry versus Inferiority (6 to 11 years)

5. Identity versus Role confusion (12 to 18)

6. Intimacy versus Isolation (19 to 40)

7. Generativity versus Stagnation (40 to 65 years)

8. Integrity versus Despair (65 to death)

Miss G.T. falls under Identity versus Role Confusion (12 to 18) since she is 18 years of age ; This stage is characterized by the adolescent questions of "who am I ", during which time they are conflicted with dozens of values and ideas of who they should be and what they should think.

1.6 Patient's Lifestyle/Hobbies

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

According to miss G.T., she usually goes to bed around 10:00pm after studying and wakes up around 5:30am every day except on weekends. She brushes her teeth with tooth brush and pepsodent, sweep, visits the toilet, takes her bath with cold water and prepare for school. She normally takes porridge as breakfast around 10:00am and takes launch at 12:30pm and after closing from school, she goes back home and prepare food for the family to eat. During weekends, she wakes up around 8:00am, washes her clothes and cleans the house. On Saturday evening, she goes to the chapel with her friends to sweep there for Sunday services. On Sundays, she goes to church with her grandmother and after awards she comes home to rest. She eliminates her bowel and bladder when she feels the urge to do so. Even though, rice with stew is her favorite but she eats all kinds of food. She said she is not fun of making many friends but she spends most of her time with the few friends that she is having during her leisure time.

1.7 Patient's Past Medical/Surgical History

Patient's past medical history provides information on client's state of health and illness before the present complaints (Bailliere's Nurses Dictionary, 2019). According to miss. G.T., she never experienced any childhood illness. However she usually suffers from minor illness such as headache, fever, common cold but goes to the hospital for treatment. She has no allergies.

1.8 Patient's Present Medical/Surgical History

According to miss G.T., on 10TH of December, 2022 after super around 6:40pm, she started experiencing abdominal discomfort, vomiting and diarrhea. The following day she became weak and could not do anything for herself. She told her grandmother and she was sent to Techiman Holy Family Hospital on the 11th of December, 2022. She was detained at the Emergency Unit and later was admitted to the Female Medical Ward.

1.9 Admission of patient

Admission of a patient means allowing and facilitating a patient to stay in the hospital unit or ward for observation, investigation and treatment of the disease he/she is suffering from (Potter &Perry, 2016). On 11th of December, 2022, patient was admitted into the Female Medical Ward around 2:30pm from the Emergency Unit accompanied by a nurse and a relative with a diagnosed of Gastroenteritis by Doctor A. D. They were welcomed and received warmly. Patient was given a bed which was already prepared and she was made comfortable in bed. Her valuables were collected and kept in her locker beside her bed. On observation, she was alert and conscious but weak. Her vital signs were checked and recorded as follows:

Temperature: 38.1 degree Celsius ($_0$C)

Blood pressure 110/70 millimeter of mercury (mmHg)

Pulse 100 beat per minute (bpm)

Respiratory 25 cycles per minute (cpm)

SpO2 100%

RBS 5.4 mmol/L

Weight 45.0 kilogram (kg)

IV Paracetamol 500mls was set up to subsides her temperature and the following laboratory Investigations were requested by the Doctor:

1. Full Blood Count (FBC)

2. Stool for routine examination

3. Blood test for malaria parasite

4. Serum electrolyte

5. Urine for pregnancy test

The following drugs were prescribed for her:

- IV Paracetamol 1g tid for 24hours
- Iv Metoclopramide 5mg tid for 2hours
- IV Ciprofloxacin 400mg bd for 2hours
- IV Ringers 3 liter for 3days
- IV Metronidazole 500mg tid for 24hours

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

1.9 Patient's Concept about illness

During my interaction, miss G.T. made it known to me that, the sickness is a natural phenomenon and that she would be well without any complications.

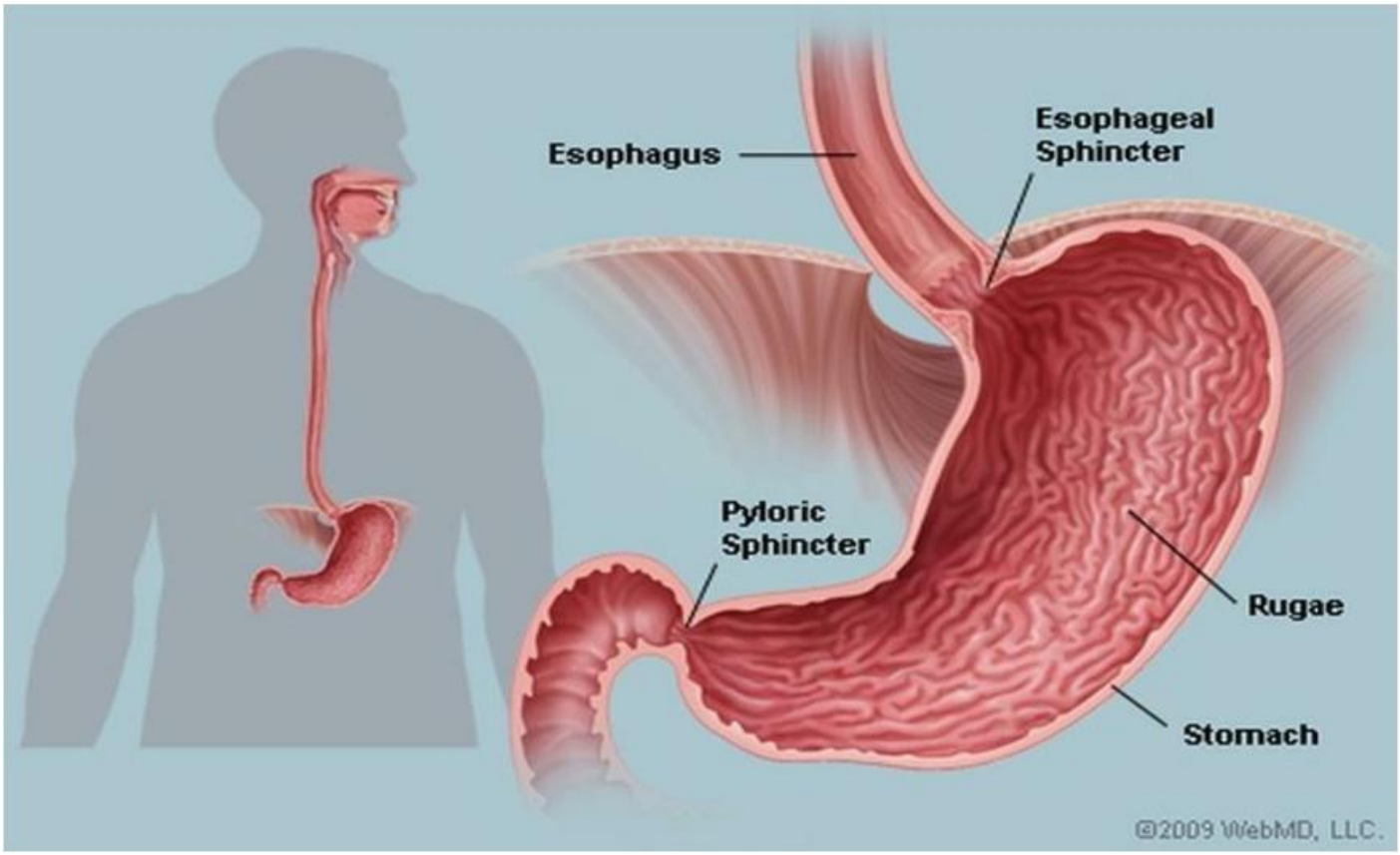
1.10 Literature Review on Gastroenteritis

Anatomy and physiology of the stomach

The stomach is situated in the left upper portion of the abdomen under the left lobe of the liver and the diaphragm, overlaying most of the pancreas. A hollow muscular organ with a capacity of approximately 1500ml, the stomach stores food during eating, secretes digestive fluids, and propels the partial digested food, or chyme, into the small intestine.

The gastroesophageal junction is the inlet to the stomach. The stomach has four anatomic region; the cardia (entrance), body, fundus and pylorus (outlet). Circular smooth muscle in the wall of the pylorus forms the pyloric sphincter and controls the opening between the stomach and the small intestine. The stomach is lined with columnar epithelial tissues. The small intestine is the longest segment of the GI tract, accounting for about two thirds of the total length. It folds back, providing approximately 7000cm of surface area for secretion and absorption, the process by which nutrient enters the bloodstream through the intestinal walls. It has three sections: The most proximal section is the duodenum, the middle section is the jejunum, and the distal section is the ileum. The ileum terminates at the ileocecal valve. This valve, or sphincter, controls the flow of digested material from the ileum into the cercal portion of the large intestine and prevents reflux of bacteria into the small intestine. Attached to the cecum is the vermiform appendix, an appendage that has little or no physiologic function. Emptying into the duodenum at the ampulla of vater is the common bile duct, which allows for the passage of both bile and pancreatic secretions. The large intestine consists of an ascending segment on the right side of the abdomen, a transverse segment that extends from right to left in the upper abdomen, and a descending segment on the left side of the abdomen. The sigmoid colon, the rectum, and the anus complete the terminal portion of the large intestine. A network of striated muscle that forms both the internal and external anal sphincters regulates the anal outlet (Hinkle & Cheever, 2014).

The Diagram Below Shows the Anatomy of the Stomach



Definition of Gastroenteritis

Gastroenteritis is a medical condition from inflammation of the gastrointestinal tract that involves both the stomach ("gastro") and the small intestine ("entero"). Gastroenteritis is inflammation of the mucosal lining of the stomach and intestine characterized by abdominal cramping, vomiting, nausea and diarrhea (Hinkle &Cheever, 2014).

Incidence/Epidemiology

Gastroenteritis occurs in persons of all ages and is a major cause of morbidity and mortality in most developing countries. It ranks second to common cold as a cause of loss of work time and fifth as the cause of death among children. It can be life threatening in the elderly. The very young, old and immune suppressed patients can become quite ill with this self-limiting condition (Hinkle &Cheever, 2014).

Causes/Aetiology

As specified by Walker and Whittlesea (2012), Gastroenteritis has many causes which include the following;

1. Bacteria such as; Escherichia coli, staphylococcus aurous, salmonella, Shigella, and clostridium perfringes.

2. Parasites such as; Ascaris, enterobius and trichivellaspiralis.

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

4. Amoeba like Entamoebahistolytica.

5. Reaction to some drugs like antibiotics.

6. Enzymes deficiencies.

7. Food allergies.

The major risk factor for gastroenteritis that is caused by food poisoning is improper handling and storage of food. Bacterial or viral food poisoning usually occurs within 16 hours after eating

contaminated food. The incubation period for gastroenteritis is between twelve hours to ten days (Lewis 2012).

Types of Gastroenteritis

Gastroenteritis can basically be classified into

1. Bacterial gastroenteritis
2. Viral gastroenteritis
3. Eosinophilic gastroenteritis

Bacterial Gastroenteritis

Bacterial gastroenteritis is a very common disorder with many causes, range from mild to severe, and usually manifest with symptoms of vomiting, diarrhea, and abdominal discomfort.

Bacterial gastroenteritis is usually self-limited, but improper management of an acute infection can lead to a protracted course.

Shigella, Salmonella and Campylobacter are the top three leading cause of bacterial gastroenteritis followed by Aero Monas Species. (Lewis, 2012).

Viral Gastroenteritis

Viral gastroenteritis is a common cause of morbidity and mortality worldwide.

Viral gastroenteritis ranges from a self-limited watery diarrheal illness (usually less than one week) associated with symptoms of nausea, vomiting, anorexia, malaise, or fever to severe dehydration resulting in hospitalization or even death.

Rotaviruses, caliciviruses, astroviruses and norovirus are thought to be the cause of viral gastroenteritis. Rotavirus attach and enter mature enterocytes at the tips of small intestinal villi thereby causing structural changes to the small bowel including villus shortening and mononuclear inflammatory infiltration in the lamina propria (Weller,2014).

Eosinophilic Gastroenteritis

Eosinophilic gastroenteritis is an uncommon inflammatory gastroenteritis disease affecting both adults and children.

It is characterized by eosinophilic infiltration in one or more areas of the gastrointestinal tract, mainly the stomach and duodenum.

The presents of abnormal gastrointestinal symptoms, most often abdominal pain, nausea, vomiting, diarrhea and weight loss. Atopy or food allergies are often present (Lewis, 2012).

Mode of transmission

Fecal-oral is the main mode of transmission. The human hand is the main medium for transmission aided by flies where these are prevalent or rampant. Infective material spread to the hands and then to the mouth (Lewis, 2012).

Pathophysiology

Gastroenteritis is caused by different organism and non-infectious agents. The gastrointestinal tract reacts to any of these varied causes in a related fashion (Lewis, 2012).

According to Silverman and Roy (2013), bacteria in the gastrointestinal tract use the following mechanism to bring about the disease condition.

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

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

C. Penetration and systematic invasion: there are local inflammations in which the organism tries to penetrate the mucosa and gain access to the systematic circulation.

This inflammation process goes a long way to bring about stimulation and secretion of intestinal fluids. Because the mucosa lining of the GIT is inflamed, food cannot be retained and there is no alternative than to be vomited or passed out as watery stool. As a result of the excessive loss of water through vomiting and stool, dehydration becomes the order for the day and also the individual becomes very weak due to the inability to retain food. There is also scanty and concentrated urine because most of the fluid is passed out as stools and vomitus, (Weller, 2014). Also, inflammation reaction and the presence of toxin also stimulate a sympathetic nerve which stimulates salivation, nausea and vomiting. It further increase intestinal activities leading to diarrhea and abdominal pain, (Weller, 2014).

Persistent diarrhea and vomiting subsequently lead to depletion of body fluid and electrolyte especially bicarbonate reserves. It predisposes to acidosis, fluid volume deficit and circulatory collapse. This further leads to fluid shift from intracellular compartment to extracellular compartment resulting in to systematic shape which manifest as sunken eyes and dry mucous membrane.

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

Clinical features

The clinical features vary depending on the type of organism and level of gastrointestinal tract involved.

However, gastroenteritis in adults is usually a self-limiting, non-fatal disease.

General signs and symptoms include ;(Lewis, 2012).

1. Frequent diarrhea stools which may be bloody or mucous.

2. Nausea and vomiting

3. Abdominal pains and cramps

4. Loss of appetite

5. Headache with chills

6. Fever may be present

7. General malaise

8. Dizziness

9. The abdomen is often distended

10. Borborygmi (hyperactive bowel sounds) may be present

11. Pulse is rapid

12. Dehydration leading to; sunken eyes, weak pulse, low urine output, dry mucous membrane and low blood pressure

Signs and symptoms usually begin 12-72 hours after contracting the infectious agent, (Herdman & Kamitsuru, 2018) some bacterial infection may be associated with severe abdominal pain and may persist for several weeks.

Children infected with rotavirus usually make a full recovery within three to eight days.

However, in poor countries treatment for severe infections is often out of reach and persistent diarrhea is common (Lewis, 2012).

Diagnostic measures

According to (Sawyer, 2011): The following diagnostic investigations can be carried out to diagnose an individual of gastroenteritis

1. With the signs and symptoms

2. Blood culture identifies causative bacteria or parasites

3. Serum electrolyte estimation. Examples potassium and sodium calcium

4. Full blood count for white blood cells and neutrophil count

5. Stool for routine examination to identify the presence of blood of leukocytes in stool.

6. Gastric analysis to evaluate gastric acid output

7. Abdominal computed tomography scans helpful in diagnosing diseases that can present with diarrhea

8. Erythrocyte sedimentation rate: Helpful in determining the existence of the low- grade inflammation in irritable bowel syndrome patients.

Medical Management

According to (Hinkle & Cheever, 2014), Gastroenteritis when acute must be treated as a medical emergency for the following reasons,

1. To avoid the spread of disease to other people

2. To avoid the complications of the disease

3. Severe diarrhea is treated with oral rehydration salt (ORS) therapy in which physiological salt solutions are given orally to correct dehydrations and electrolyte imbalance

4. Hospitalization may be needed as the patient requires as support treatment consisting of bed rest, nutritional support and increase fluid which needs monitoring

5. Histamine-receptor antagonist such as cimetidine may be prescribed as they block gastric secretions

6. Antacid such as aluminum Hydroxide may be used as buffers which can be administered hourly.

7. Analgesics such as Budesonide and ibuprofen (NSAID) can also be given for abdominal pains.

8. Anti-emetic for example phenergan is given to reduce vomiting

9. Intravenous fluid and electrolyte replacement can be given.

The intravenous fluids which are normally given are normal saline, dextrose and ringer lactate.

10. Bismuth containing compound such as prochlorperazine, or thiobenzamide can be given

12. Antispasmodics examples Buscopan.

Nursing Management

The nursing managements are put under the following headings, (Lewis,)

A. Comfort and rest

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

1. Promote period of rest during symptomatic stages according to the level of fatigue. Maintain a well straighten bed, free from creases and crumbs to promote comfort.

2. Emotional support and divisional activities are necessary especially when recovery and convalescents are prolonged.

3. Encourage gradual resumption of activities and mild exercise during convalescence

B. Maintain adequate nutrition

1. It is always difficult for the patient to take in sufficient food and fluids due to nausea and vomiting.

2. If patient cannot tolerate fluids orally, then intravenous fluids should be instituted.

3. Hot or spicy food should be avoided when planning diet for patient. The appropriate soft diet may include rice porridge, white porridge and light soups.

4. There is the need to varied patient food to make it enjoyable.

5. Restore normal body weight by maintain a well balance diet rich in calories, protein and vitamins.

C. Prevention of infection

1. The nurse should always wash hands thoroughly before and after carrying out any procedure on the patient to prevent the spread of infection.

2. The nurse should always teach patient on ways to maintain personal hygiene.

3. Advice patient to eat food cooked from home rather than buying from outside to minimize infection

4. Patient should be instructed to wash hands immediately after visiting the toilet.

5. Patient should always avoid the use of contaminated water, food and eating of raw fruits and vegetables without washing them.

6. Linens soiled with stool should be disinfected to prevent the spread of the disease.

7. Barrier nursing should be ensured to prevent cross infection.

8. Proper disposal of stools should be ensured and hand washing practice should be encouraged.

D. Monitoring and observation of patient to prevent complication

1. Vital signs should be monitored thoroughly to know whether the condition is improving or deteriorating.

2. The nurse should observe for the amount of urine passed and its degree of concentration by monitoring the output.

3. The nurse should also observe for the presence of blood or mucus in the stool.

4. Client should be weighed weekly to check if there is any weight loss.

5. Patient should also be monitored for the desired and side effect of the drug.

6. When patient is on intravenous infusion, it should be monitored. There should be frequent assessment of the intravenous site for infiltration.

E. Elimination

1. Bowel elimination should be encouraged by serving bed pan on request.

2. Patient should be encouraged to have regular bladder elimination

3. Urinals should be served when necessary.

4. Observe vomitus for color, consistency and content of the vomitus. If vomitus is persistent prevent dehydration by encouraging client to take more fluid to replace the loss ones.

5. Aseptic techniques should be done to prevent infection

F. Prevention

According to (Smeltzer and Bare, 2012) the preventive measures for gastroenteritis include the following.

1. The patient is isolated from others to prevent cross infection.

2. Patient vomitus and stool should be well disposed.

3. Proper barrier nursing should be practice.

4. Hand washing must be performed regularly.

5. Personal hygiene should be practice by cutting finger nails short, shaving of hair when applicable.

6. All cooking utensils should be washed and cleaned before usage.

7. Ensure and encourage clean environment for cooking and storage of food items

8. Proper cleanliness in the ward must be done to prevent complication.

Patient /family teaching and education

According to Smelter and Bare (2012),

1. Educate the patient about the early signs of diarrhea and dehydration.

2. Let the patient know the need for personal and environmental hygiene.

3. Advice patient to always wash hands before eating and after visiting the toilet.

4. Food must be well heated before eating and fruits should be well washed properly.

5. Advice patient not to expose food to flies.

6. Educate patient and family on the need to avoid defecation in the bush.

Complications

If early treatment is not sought for, the following complications may develop.

1. Acute renal failure is due to frequent vomiting and diarrhea which may lead to dehydration, which in turn may decrease blood volume and hence reduced circulatory volume. This therefore decrease renal perfusion and may lead to renal failure.

2. Fluid and electrolyte imbalance as a result of diarrhea and vomiting may lead to loss of hydrogen ions from the stomach. Bicarbonate ions may also be lost through diarrhea which may cause imbalance in these electrolytes in the blood and may lead to acidosis or alkalosis.

3. Convulsions (in case of a child) due to inadequate blood supply to the brain and infections travelling to the brain causes problem to the brain which may lead to convulsion.

4. Malnutrition occurs when the body doesn't get enough nutrient e.g., poor diet and digestive condition.

5. Dehydration may occur as a result of diarrhea. In diarrhea, there is loss of bicarbonate ions from the intravascular component. The loss of these electrolytes goes along with plasma (water), causing the increase in osmotic/oncotic pressure. These cause fluid to shift from the extracellular and intracellular spaces, causing the cells to shrink causing dehydration.

6. Cardiac failure occurs as a result of decreased cardiac output. The heart is the first organ to receive oxygenated blood. In diarrhea, the patient losses fluid and subsequently lead to hypervolemia. This leads to decreased blood volume and hence decreased cardiac perfusion. This then leads to ischemia and may lead to cardiac failure.

7. Hypovolemic shock occurs as a result of fluid lost along with electrolytes. As the fluids are lost from the intravascular spaces, the volume of the blood reduces, causing reduction in cardiac output, and hence decreased perfusion to the vital organs, leading to shock.

1.11 Validation of data

Validation is defined according to (Weller,2014)., as the extent to which a data measures, indicator or method of data collection possesses the quality of being sound or true, as far as can be judged. In other words, validation refers to the process by which data retrieve is being confirmed.

Data collected from patient were the same to that of what the relatives said, also during the home visit most of the information given to me by patient and his family at the hospital were confirmed

by other relatives in the house. Data presented by patient and his diagnostic investigations carried out were similar to those in the literature review.

When the patient's condition became stable and all the relatives had calm down, I again asked them the same questions which were asked previously and the same response was given. Upon this I therefore believe the information gathered was authentic and valid for studies.

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). This chapter forms the second phase of the patient/family care study. It entails comparing the results of the investigation carried out with standards in the literature review. It also involves comparing the causes, clinical manifestations, treatments and complications of the patient's condition (gastroenteritis) with those stated in textbooks. It gives the pharmacology of drugs prescribed by the medical officer for patient. This chapter also captures the patient/family strengths, the health problems identified and nursing diagnoses formulated for given care to patient.

2.1 Comparison of Data with standards

1. Diagnostic investigation/Tests.

2. Causes/Risk factors

3. Clinical features/Sign and Symptom.

4. Medical/Surgical treatment.

1. Diagnostic Investigation/Tests

The literature points out; Serum electrolyte estimation, Blood culture, Full blood count, Stool for routine examination, Gastric analysis**,** Erythrocyte sedimentation rate and Abdominal computed

tomography scan as the diagnostic measures for confirming gastroenteritis. The following investigations were carried out on patient to aid in the diagnosis and treatment;

1. Blood film for malaria parasite

2. Full blood count

3. Stool for routine examination

4. Serum Electrolyte

5. Urine pregnancy test

Table 1: Diagnostic Investigation Conducted for Miss. G.T. as compared with literature Review

Diagnostic investigation in Literature Review	**Diagnostic Investigation Conducted For Patient**
Serum Electrolyte Estimation	Serum electrolyte estimation was done for patient
Blood Culture	Blood culture was done for patient to identify causative bacteria or parasite
Full blood count	Full blood count was done for patient to check for infection
Urine routine examination	urine routine examination was done for patient
Gastric Analysis	Gastric Analysis was not done for patient
Erythrocyte Sedimentation rate	Erythrocyte sedimentation rate was not done for patient
Abdominal computed Tomography scan	Abdominal computed tomography scan was not done for patient

With reference to table 1.0, Gastric analysis, Erythrocyte sedimentation rate and abdominal computed tomography scan were not carried out because the diagnose was arrived at those diagnostic investigation that were ordered for her which were blood culture, serum electrolyte and full blood count. Blood film for malaria parasite was ordered to rule out malaria which shares some similar symptoms to gastroenteritis. Urine pregnancy test was carried out which shows negative.

Diagnostic Investigation/Test Carried on Miss G.T. Compared with Standard

Date	Specimen	Investigations	Results	Normal Value	Interpretations	Remarks
11/12/2022	Blood sample	Blood film for malaria parasites (MP's)	No malaria parasites seen.	No malaria parasites should be seen	Patient is not suffering from malaria	No treatment was given to patient.
11/12/2022	Blood	**Full Blood Count**				
		White blood cell count.	6.49	3-15	Normal value indicating absence of infection in the blood.	No treatment was given to patient.
		Neutrophil count	79.00%	2.0-7.5%	High Neutrophil count indicates infection.	Antibiotics such as Intravenous ciprofloxacillin 400mg, Intravenous Metronidazole 500mg were given.
		Hemoglobin (HB) level	12.0g/dl.	12-16	Patient was not anaemic.	No treatment was given to patient.

11/12/2022	Blood culture	blood culture to determine the specific type of bacteria or parasite affecting the intestines	No pathogen was present	No pathogen should be present	Patient does not have infection affecting the intestines	No treatment was given to patient.

N

Date	Specimen	Investigations	Results	Normal Value	Interpretations	Remarks
11/12/2022	Stools	Stool for routine examination to determine the specific type of bacteria or parasite affecting the intestines.	No pathogen was present	No pathogen should be present	Diseases causing organism was absent	No treatment was given to patient.
11/12/2022	Serum electrolyte	Sodium Potassium Serum chloride	131.5 3.44 96.1	135-145 3.5-5.5 98-108	Abnormal values indicating electrolyte imbalance	Fluids such as ringers lactate were given
11/12/2022	Urine pregnancy test	Urine test for pregnancy	Negative	no result should be seen	Patient is not pregnant	No treatment was given to patient

The cause of patient's illness

From the history taking and physical examinations performed on Miss. G. T. and the laboratory investigation carried out, Miss. G.T's condition can be confirmed to be caused by infections as indicated in the elevation of neutrophil count. Miss G.T's condition could be attributed to poor sanitation and unhygienic preparation of food resulting in contamination.

Specific Medical Treatments Given to Patient

The following treatments were given to Patient;

1. Intravenous Metronidazole 500miligrams tid 24hours
2. Intravenous Ringers lactate 3 liter over 24 hours.
3. Intravenous Ciprofloxacin 400miligrams bd for 2hours.
4. Intravenous Paracetamol 1gram tid for 24hours.
5. Intravenous metoclopramide 5miligram tid for 2hours

Pharmacology of Drugs

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

Table 3: A Comparison of Specific Medical Treatment Prescribed to Patient Compared with Literature Review

Medical Treatments in The Literature Review	**Medical Treatments Prescribed for Patient**
Histamine – Receptor Antagonist (Cimetidine)	Histamine- Receptor Antagonist was not given to patient.
Antacids (Magnesium Oxide)	Antacids were not given to patient.
Analgesics Budesonide and Ibuprofen	Analgesics (IV Paracetamol) were given to patient to relief pain.

Anti – emetics (Phenegan)	Anti –emetics were given to patient.
Intravenous fluids and electrolyte replacement (Ringers Lactate)	Intravenous fluids and electrolyte (Ringers Lactate) was given to patient
Containing compounds (Thiobenzamide Bismuth)	Bismuth containing compounds were not prescribed for patient.
Antimicrobial agents (Ciprofloxacin, Metronidazole and Cefuroxine)	Antimicrobial agents (IV Ciprofloxacin and Metronidazole) were prescribed for the patient
Rehydration agents (Oral rehydration solution)	Rehydration agent (oral rehydration solution) was not prescribed for the patient.
Antispasmodics (Buscopan)	Antispasmodics (Buscopan) was not given to patient.

The medications ordered for the patient was in line with literature which aided in effective management of patient condition and aided his speedy recovery without complications

Clinical Manifestations Exhibited by Patient

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

Table 5: Comparison of patient's Clinical Manifestation with Literature review

Clinical Manifestation in Literature	**Clinical Manifestation Exhibited by Miss.G.T.**
Frequent diarrhoea stools	Patient experienced diarrhoeal stool (4 times in a day)
Nausea and vomiting	Patient experienced nausea and vomiting
Abdominal pain and cramping	Patient experienced Abdominal pain and cramping
Fatigue	Patient did not experience fatigue.
Headache with chills	Patient did not experience Headache with chills

Fever	Patient experienced Fever
General malaise	Patient experienced General malaise
Dizziness	Patient did not experienced dizziness
Distended abdomen	Patient did not experience distended abdomen
Borborygmi	Patient did not experience borborygmi
Dehydration	Patient had a risk of developing dehydration
Anorexia	Patient experienced anorexia

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

Table 4: Shows Pharmacology of Drugs Given Miss G.T.

Date	Drug	Dosage/Route Of Administration in literature review	Dosage/Route of Administration to Patient.	Desired Effect	Actual Action Observed	Side Effects/Remarks	Classification
11/12/22	Metronidazole	**Dosage**: 500mg every 8 hours x 48 **Route**: Intravenously	**Dosage**: 500mg every 8 hours x 48 **Route**: intravenously	Disrupts DNA, inhibiting nucleic acid synthesis.	Diffuses into the organism, inhibits protein synthesis by interacting with DNA and causes a loss of helical DNA strands breakage	Anorexia, dry mouth, diarrhea, constipation, dizziness. None of the above effect was observed.	Antibacterial, antiprotozoal
11/12/20 22	Ringers Lactate	**Dosage:** 3liter over 2hours; **Route:** Intravenously	**Dosage:** 3liter over 2hours; **Route:** Intravenously	To restore fluids and electrolytes balance and expand plasma volume	To hydrate patient to prevent dehydration	Fluid overload, example pulmonary edema. No side effect was observed	Electrolytic and fluid balance
11/12/20	Ciprofloxacin	**Dosage:**	**Dosage:**	It inhibits	Is an active	Nauseas and	Antibiotic

22		400mg every 12hourly in 2hours **Route:** Intravenously	400mg every 12hourly in 2hours **Route:** Intravenously	relaxation of DNA; Inhibits DNA gyrase in susceptible organisms; promotes breakage of double stranded DNA.	against gram +, - by inhibition of bacterial DNA gyrase and topoisomerrase	vomiting, constipation, rash, flatulence. Headache, abdominal pain. No side effect was observed on patient.	(Fluoroquinolone)
11/12/22	Buscopan (Hyoscine butylbromide)	**Dosage**: 40mg stat **Route:** Intravenously	**Dosage**: 40mg stat **Route:** Intravenously	It suppresses spasms and contractions thereby blocking the action of acetylcholine on the receptors found within the smooth muscle walls of gastro and urinary tract	Patient was relieved of abdominal pains.	Nausea and vomiting, constipation, dry mouth, dizziness and reduced ability to sweat. No such side effects were observed on patient.	Antispasmodics Anticholinergic
11/12/22	IV Paracetamol	**Dosage;** 0.5- 1g every 4 – 6 hours; maximum daily dose is 4g.	**Dosage**: 1gram 8hourly for 5days.	To relieve pain by blocking generation of pain impulses, probably	Patient was relieved of fever.	Dizziness, urticarial, liver damage and disorientation.	Antipyretics/Analgesics

		Route; intravenously		by inhibiting prostaglandin synthesis in the central nervous system.		Patient exhibited none of these side effects.	
11/12/22	IV Metoclopramide	Dosage: 5mg Route;	Dosage : 5mg 8hours for 24hours	Promotes gut motility by inhibition of presynaptic and postsynaptic D_2 receptors.	Patient was relief from nausea and vomiting	Drowsiness, weakness, headache. Patient exhibited none of these side effects.	Prokinetic agents

Complications Developed by Patient.

With regards to the complications outlined under the literature review Miss. G.T 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

Patient and family strengths refers to the resources that can enable them to cope with stressful conditions leading to patient's recovery. These involve the activities that contribute to the well-being of patient and her family as well as her speedy recovery.

1. Patient temperature subsides after taking cold drink.
2. Patient could verbalize the frequency of loose stool passed.
3. Patient was able to indicate location of the pain.
4. Patient could walk to bathroom with assistand.
5. Patient and family could answer questions on some of the risk factors of gastroenteritis.
6. Patient can sleep within 3 hours at night.

2.3 Patient /Family Health Problems

Problem is defined as a situation, person that needs attention and needs to be deal with or solved from (Weller, 2014) data collected during assessment, the following health problems were noticed on patient:

1. (11/12/22), Patient had high body temperature (Pyrexia, 38.0 oC).
2. (11/12/22), Patient experienced diarrhea and vomiting.
3. (11/12/22), Patient complained of abdominal pain.
4. (11/12/22), Patient and relatives have no knowledge about the disease condition.

5. (12/12/222), Patient looked very weak

6. (12/12/22), Patient complained of difficulty in sleeping.

2.4 Nursing Diagnosi

According to Weller (2014), 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. These nursing diagnoses were formulated based on the health problems that were identified.`

1. Pyrexia (38.0oC) related to inflammation of the stomach and intestinal mucosa. (11/12/22)

2. Risk for fluid and electrolyte volume deficit as evidenced by passage of loose unformed stools (four times). (11/12/22).

3. Acute abdominal pain related to inflammatory process in the stomach and intestine (11/12/22).

4. Activity intolerance related to weakness evidence by inability to perform activities of daily living (grooming himself, bathing) (12/12/22).

5. Insomnia related to unfamiliar environment. (12/12/22).

6. Knowledge deficit related to the causes, signs, symptoms, management and prevention of gastroenteritis as evidenced by inability of the patient to answer basic questions on the illness. (12/12/22)

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's actual 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 Objectives and Outcome Criteria for Patient/Family Care

According to Weller (2014), objective is defined as a specific result that a person aims to achieve within a time frame and with available resources. In general, objectives are more specific and easier to measure than goals.

As a result of the patient/family health problems identified, the following objectives were set for the patient/family.

1. Patient's body temperature would be reduced to normal (36.2^0C – 37.2^0C) within 24hours as evidenced by:

a. Nurse recording patient's temperature within the normal range (36.2^0C to 37.2^0C).

b. Patient verbalizing that she is not feverish.

2. Patient would maintain normal fluid and electrolyte volume throughout the period of hospitalization as evidenced by:

a. The nurse observing patient has a normal skin turgor and normotensive blood pressure.

b. Patient verbalizing that vomiting and diarrhea have subsided.

3. Patient would be relieved of abdominal pains within 48 hours of hospitalization as evidenced by,

a. The nurse observing patient been calm in bed with a relaxed facial expression.

b. Patient Patient rating pain as 0 on the 0-10 numeric rating scale.

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

a. verbalizing that she no longer has any feeling of bodily weakness.

b. Nurse observing that patient can bath, groom and walk unassisted.

5. Patient normal sleeping pattern would be restored within 24 hours as evidenced by;

a. Patient verbalizing that she had uninterrupted sleep.

b. Nurse observing that patient had uninterrupted sleep for 6-8 hours at night.

6. Patient and family would gain adequate knowledge on gastroenteritis within the period of hospitalization as evidenced by;

a. Patient and family being able to provide correct answers to questions posed to them with on the causes, management and prevention of gastroenteritis.

b. Nurse observing that patient and relatives practice knowledge gained on gastroenteritis.

Nursing Care Plan

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

Table 6: Nursing Care Plan for Miss. G.T.

Date and Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	Sign
11/12/22 03:10pm	Pyrexia(38.0oC) related to inflammation of the stomach intestinal mucosa as evidenced by rise in body temperature and patient feeling warm to touch.	Patient's temperature would fall within the normal range (36.20C to 37.20C) within 24hours as evidenced by; (a) Nurse recording patient's temperature within the normal range (36.2oC to 37.2oC). (b) Patient verbalizing that she is not feverish.	1) Monitor patient vital signs 4 hourly. 2) Reassure patient and relatives of competent nursing care. 3) Change heavy and tight clothing into light ones. 4) Ensure enough ventilation by opening windows and switching on fans 5) Serve cold drinks	1) Patient vital signs were monitored especially temperature. 2) Patient and relatives were reassured on measures that will help solve problem. 3) Patient heavy clothing was changed to light ones. 4) Windows were opened and the fans were switched on.	12/12/22 11:45am	Goal was fully met as nurse recorded a temperature of 37.1 oC and patient verbalized he is no more warm to touch.	

			and liberal fluid. 6. Serve prescribed antipyretic agents such as paracetamol and prescribed antibiotics	5) Cold drinks and liberal fluids were served 6) Antipyretics and antibiotics such as iv. Paracetamol 1g and Ciprofloxacin 400mg was served.			

Table 6: Nursing Care Plan for Miss. G.T. Cont'd

Date and Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	Sign
11/12/22 02:50pm	Risk for fluid and electrolyte volume deficit as evidenced by passage of loose unformed stools 4 times a day	Patient will maintain normal fluid and electrolyte volume throughout the period of hospitalization as evidenced by, a). The nurse observing patient has a normal skin turgor.	1. Assess for signs and symptoms of dehydration. 2. Strictly monitor intake and out put. 3. Assess blood pressure and pulse every four hourly . 4. Assess characteristics of diarrhea stools. 5. Administer isotonic intravenous fluids.	1. Patient was assessed for signs and symptoms of dehydration. 2. Intake and output were strictly monitored. 3. Patient blood pressure and pulse were regularly assessed. 4. Patient diarrheal stools were assessed. 5. Prescribed intravenous isotonic fluids were	12/13/22 10:00am	Goal fully met as the nurse observed a normal skin turgor and patient verbalized that she no more pass diarrhea stools.	

		b). Patient verbalizing vomiting and diarrhea have subsided.	6. Administer prescribed antimotility drugs and antibiotics.	administered. 6.prescribed antimotility drugs and antibiotics were administered Ciprofloxacin 400mg was served.			

Date and Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	Sign
11/12/22 3:40pm	Acute abdominal pain related to inflammatory process in the stomach and intestine as evidenced by patient complains of pains in the abdomen for the four days.	Patient will be relieved of abdominal pains within 48 hours of hospitalization as evidenced by, a). The nurse observing patient been calm in bed with a relaxed facial expression. b). Patient rating pain as 0 on the 0-10 numeric rating scale	1. Reassure patient of competent nursing care 2. Assess the level of pain on a pain rating scale. 3. Respond immediately to patient complains of pain. 4. Monitor therapeutic effect of treatment given. 5. Serve prescribed pain medications.	1. Patient was reassured of competent nursing care. 2. The level of pain was assessed on a pain scale of 0 - 10. Patient rated on 6 on numeric rating scale. 3. Patient complains of pains were immediately attended to 4. The therapeutic effect of the drug was monitored 5. Prescribed pain medication iv Paracetamol 1g was served.	12/12/22 01:00pm	Goal fully met as nurse observed patient exhibit relaxed facial expression in bed and patient rated pain as 0 on the 0-10 numeric rating scale	

Date and Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	Sign
12/12/22 **08:15am**	Activity intolerance related to weakness as evidenced by inability to perform activities of daily living such grooming self	Patient would regain his strength for daily activities within 48 hours as evidenced by; b). Patient verbalizing that she no longer has any feeling of bodily weakness. a). Nurse observing that patient bathing, grooming and getting dressed unassisted	1. Assess patient's hydration and nutritional status. 2. Reassure patient and family that measures would be ensured to help regain her strength. 3. Assist patient with the performance of certain activities like brushing the teeth and bathing.	1. Patient hydration and nutritional status were assessed as patient was given enough fluids and balanced diet. 2. Patient was reassured that he will regain strength for his daily activities with available measures such as assisting patient to perform daily activities. 3. Patient was always assisted in performance of activities like bathing and brushing of his teeth.	13/12/22 1:30pm	Goal was fully met as nurse observed patient participating willingly in necessary and desired activities and patient also verbalized that she does not feel weak anymore	

			4. Encourage patient to carry out activities she can tolerate with rest periods when tired. 5. Place items of daily use close to patient. 6.Engage patient in passive range of exercise	4. Patient was encouraged to carry out activities he could tolerate such as walking around bed with rest periods when tired. 5. Items of daily use such as comb, mirror were kept close to patient. 6) patient was engaged in passive range of activity like walking from bed to nurses' station, flexion and extension of hands etc.			

Table 6: Nursing Care Plan for Miss. G.T. cont

Date and Time	**Nursing Diagnosis**	**Objective/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	**Sign**
12/12/22 08:15am	Insomnia related to change of environment as evidenced by patient having	Patient normal sleeping pattern will be restored within 24 hours as evidenced by; a). Patient verbalizing that she had	1. Reassure patient that her sleep pattern will be restored. 2. Orient patient to the ward annexes 3. Ensure warm bath at night to induce sleep.	1. Patient was reassured that her sleep pattern will be restored with available measures. 2. patient was oriented to the ward annexes 3 .Patient was provided with warm water when bathing to	13/12/22 8:15	Goal fully met as patient verbalized that she sleeps well at night and nurse visualized that the patient slept throughout	

		uninterrupted sleep b). Nurse observing that patient has uninterrupted sleep for 6-8 hours at night.	4.Ensure comfortable bed and good ventilation 5. Plan and carry out nursing activities together. 6. Restrict visitors to prevent distraction of patient sleep	induce sleep. 4. Patient bed was properly made free from creases and ward windows were opened to ensure ventilation. 5. Nursing procedures were carried out at a go. 6. Visitors were restricted to prevent distraction of patient sleep		the night	

Date and time	Nursing Diagnosis	Objectives/ Outcome criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	sign
12/12/22 2:10pm	Knowledge deficit related to the causes, signs, symptoms, management and prevention of gastroenteritis as evidenced by inability of the patient to answer basic questions on the illness.	Patient and family would gain adequate knowledge on gastroenteritis within the period of hospitalization as evidenced by; a. Patient and family being able to provide correct answers to questions posed to them with on the causes, management and prevention of gastroenteritis. b. Nurse observing that patient and relatives practice knowledge gained on	1. Assess their knowledge on the condition 2. Inform patient and family about ways of preventing the symptoms and some management for the disease. 3. Allow patient/family to ask questions for clarification. 4. Answer questions in simple understanding language without using medical jargons 5. Ask patient and family to summarize what they heard.	1. Their knowledge on her condition was assessed 2. Patient and family were informed about ways of preventing the symptoms and some management for the disease. 3. Patient/family was allowed to ask questions for clarifications on issues about the disease. 4. All questions were answered in simple, plain and clear language without the use of professional jargons. 5. Patient and family were asked to give feedback on what they heard.	15/12/22 10:30am	Goal fully met as patient/family were able to verbalized the causes, management and preventions of the condition and family cooperated in the management of the patient	

		gastroenteritis.	6. Assess patient/family motivation and willingness in learning	6. Patient/family motivation and willingness were assessed			

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

This chapter forms the fourth part of the patient/family care study. Implementation is the actualization of the nursing care plan through nursing intervention (Hinkle & Cheever, 2014). It gives the vivid account of the actual nursing care that was rendered to the patient/family from the day of admission until discharge based on the patient's health problems identified. 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

For the purpose of organization, the actual nursing care rendered to the patient and family has been discussed on daily basis.

First day of admission; 11th of December 2022

On 11th of December, 2022 patient was admitted into the Female Medical ward around 2:30pm from the Emergency unit accompanied by a nurse and a relative with the diagnosis of Gastroenteritis. They were welcomed and received warmly. Patient was given a bed which was already prepared and she was made comfortable in bed. On observation, she was alert and conscious but weak. At 2:50pm, patient complained of frequent watery stools and vomiting as well.

Nursing diagnosis of risk for fluid volume deficit related to diarrhea and vomiting was formed. An objective was set to help maintain normal fluid volume throughout her stay in the hospital. In order to achieve this, the following measures were carried out on my patient:

1. Patient was assessed for signs and symptoms of dehydration.

2. Intake and output of fluid was strictly monitored.

3. Patient's blood pressure and pulse were regularly assessed to detect abnormality.

4. Patient's diarrhea stools were assessed for other abnormalities such as color, mucus, blood and amount.

5. Prescribed iv fluid and antibiotics were administered.

6. Patient's vitals were checked and recorded as shown in the appendix

Physical examination was performed on the patient from her head to toe and assessment revealed that patient was warm to touch (38.1 ^{o}C)

At 3:10pm, patient had high body temperature (fever) (38.1^{0}c). A nursing diagnosis of Pyrexia (38.1^{o}C) related to inflammation of the stomach and intestinal mucosa as evidenced by rise in body temperature and patient feeling warm to touch was made and a goal was set to bring patient temperature to normal (36.2^{0}C-37.2^{0}C) within 24 hours. The following nursing interventions were carried out; adequate room ventilation was ensured by opening windows and sw itching on fans, IV Paracetamol 1gram was administered as prescribed and temperature was checked every 30 minutes afterward and recorded 37.8^{o}C.

Upon interacting with patient around 3:40pm, patient complained of abdominal pains. A nursing diagnosis of acute abdominal pain related to inflammatory process in the stomach and intestine was formed. An objective was set to help relieve patient's abdominal pains within 48 hours. The following nursing interventions were carried out: Patient complains of pains were immediately attended to, The therapeutic effect of the drug was monitored, Prescribed pain medication iv Paracetamol 1g was served. She was also orientated to the ward annexes. Patient and family were informed of the ward protocols the rules and regulations including visiting hours and meal time. She was asked to get her personal items that

would be needed during the period of admission. Patient was then introduced to the other clients who were on the ward. I reintroduced myself to patient as a final year student nurse of the Nursing and Midwifery Training College, Berekum, who would like to take her and her family for my care study. Patient and her relative were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of license to practice as a Registered General Nurse. I explained to the patient and her relatives 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. Patient and her relatives agreed. I then expressed my gratitude to them. Discharge planning was initiated with the relatives; thus, they will continue the care at home once she is well. I decided to choose this patient for the study because I wanted to know more about gastroenteritis. Patient was made comfortable in bed. At 6:00pm, patient vitals was checked and recorded as stated in the appendix. According to the night nurses, patient's 10:00 vital signs was checked and recorded as shown in the appendix.

Second Day of Admission, 12th December, 2022

According to patient's relative, Patient wokes up around 5:30am, she took her bath and brushes her teeth.On the second day of admission, at 7:00am. I went to the ward to continue with my nursing care for patient, her morning vital signs had already been checked and recorded as indicated in the appendix. At 8:15am, patient complained of body weakness and further observation on patient in relation to how she carried out her activities revealed that patient has general bodily weakness as she could not fully perform daily activities. A nursing diagnosis of Activity intolerance related to bodily weakness as evidenced by inability to perform activities of daily living such as grooming self was formulated. An objective to help patient regain her strength for daily activities within 48 hours was set and the following interventions were carried out: Patient nutritional and hydration status were assessed, patient and family were reassured that she would regain strength for her daily activities with available measures, patient was always assisted in performance of activities like bathing and

brushing of her teeth, patient was encouraged to carry out activities she could tolerate such as walking around bed with rest periods when tired, patient was encouraged on how to increase her willingness to gradually increase activity and items of daily use such as comb.

At 8:30 am, Patient also complained that she was not able to sleep throughout the night. A nursing diagnosis of disturbed sleeping pattern(insomnia) related to change of environment as evidence by patient having less sleep. An objective to help patient restore her normal sleeping pattern within 24 hours was set. The following interventions were carried out to achieve the said objective; patient was reassured that her sleeping pattern would be restored after interventions are carried out, volumes of television sets at the ward were switched off, patient was provided with warm water when bathing in the evening to induce sleep, patient's bed was properly made free from creases and ward windows were opened to ensure ventilation. Visitors were restricted to prevent interruption of patient's sleep, nursing procedures were planned and carried out together to prevent disturbance of patient sleep. Patient was reviewed by the ward doctor and he ordered to continue treatment.

At 9:35 am, Patient had her breakfast which was Hausa porridge with bread as she was able to consume half of the food. Her 10:00am vital signs were checked and recorded as shown in the appendix. At 11:45am the goal set on the 11th December, 2022 to enable patient maintain her normal body temperature that is (36.2^{0}C to 37.1^{0}C) within 24hours was evaluated and it was fully met as evidenced by the nurse recording body temperature within the normal range of (36.2-37.1^{o}C). She was encouraged to have rest and monitoring continued. Her 02:00pm medications of iv Paracetamol 1-gram, and intravenous Metronidazole 500mg were served. Vital signs checked and recorded as shown in the appendix.

At 2:10pm, patient and relatives were engaged in an interaction and it was realized that patient and her grandmother did not have adequate knowledge on patient's condition (gastroenteritis). A nursing

diagnosis was formulated as: Knowledge deficit related to the causes, signs, symptoms, management and prevention of gastroenteritis as evidenced by inability of the patient to answer basic questions on the illness. Interventions carried out were; patient and family were reassured and rapport established, their knowledge on the condition was assessed. Patient and family were informed about ways of preventing the symptoms and some management for the disease. Patient and family were allowed to ask questions for clarifications on issues about the disease. All questions were answered in simple, plain and clear language without the use of professional jargons. Patient and family were asked to give feedback on what they heard. During procedure, patient and her grandmother were cooperative. They participated by asking a lot of questions and were able to answer questions asked after the education, patient was then made comfortable in bed.

I embarked on my first home visit after work with the aid of the direction given to me by miss G.T. . The purpose was to know 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 poor sanitation that can lead to her condition. According to the night nurses, patient took her supper which was fufu with light soup at 5:20pm. Her 6:00pm vital signs was checked and recorded as shown in the appendix. She took her bath after eating around 7:00pm. Her 10:00pm vitals was checked and recorded as shown in the appendix and due medications were served. Patient was made comfortable in bed and slept at 10:30pm.

Third Day of Admission, 13th December, 2022

According to patient's relative, Patient wokes up around 5:30am, she took her bath and brushed her teeth. At 6:00am, routine vital signs were checked accordingly and recorded by the night nurses. The vital signs were recorded as stated in the appendix.

During the ward rounds at 7:40am, the medical officer attended to patient and plan was to continue with treatment regimen.

At 08:05am, as part of the nursing actions, patient was encouraged to take in fluids to correct her fluid deficits.

At 08:15am, an evaluation of the objective set on 12th December, 2022 to restore patients sleeping pattern within 24 hours was done and goal was fully met as patient verbalized that she slept well and the night nurse testified that the patient slept throughout the night.

At 1:30pm, the objective set to help patient perform normal activities on (12/12/22) was evaluated and goal was fully met as nurse observed patient participating willingly in necessary and desired activities and patient also verbalized that she does not feel weak anymore.

Patient was served with rice with light soup and meat for lunch. She was made comfortable in a well straightened bed after taking her meals. Vital signs were checked and recorded at 2:00pm as shown in the appendix. Patient was later handed over to the afternoon nurses for continuity of care.

From the afternoon nurses, Patient due 6:00pm medications were administered and vital signs were checked and recorded as shown in the appendix..

Patient was observed to perform her personal hygiene (bath and oral care) and was handed over to the night nurses.

At 10pm, patient's vital signs were checked and recorded. Patient slept around 10:40pm.

Fourth Day of Admission, (14th December, 2022)

Patient slept soundly during the night according to night staff and wokes up at 6:00am. Her 6:00am vital signs was checked and recorded as shown in the appendix. Patient was served with porridge with koose for breakfast at 7:30am.

During the ward routine rounds at 08:00am, treatment was to be continued and possible discharge to be considered the following day. Patient and relatives were informed about possible discharge the next day and were educated on the significance of follow up and the need to continue treatment at home. At 10:00am, vital signs were checked and recorded as shown in the appendix. Patient was encouraged to have enough rest.

Her vital signs at 2:00pm were checked and recorded. Due medications were served and the necessary documentations were done. Patient consumed two balls of banku with groundnut soup for lunch and was later handed over to the afternoon nurses for continuity of care. According to patient and afternoon nurses, in the evening, patient took her supper which was yam and kontomire stew, it was observed that patient was able to eat more than two-third of food served. Patient then had her bath and also maintained her oral hygiene. Patient's 6:00pm vital signs were checked and recorded as shown in the appendix. She performed her evening prayers and afterwards she was made comfortable to sleep. She slept around 10:00pm.

Day of Discharge (15th December, 2022)

According to the night nurse, patient wokes up early around 5:40am feeling strong and better. Her personal hygiene had already been kept and maintained. Her 06:00am vital signs was checked and recorded as shown in the appendix.

At 10:00am, patient's vital signs was checked and recorded as shown in the appendix .An evaluation of the objective set to help maintain normal fluid and electrolytes level within the period of hospitalization was evaluated and goal was fully met as the nurse observed a normal skin turgor.

At 10:30am, an e valuation of the objective set on December 12th, 2022 to help patient and family gain adequate knowledge on gastroenteritis within period of hospitalization as evidenced by; patient and family being able to provide correct answers to questions posed to them on the causes, management and prevention of gastroenteritis, nurse observing that patient and relatives practice knowledge gained on gastroenteritis was done and goal was met fully as evidenced by Patient memorizing what he was taught on the condition. During routine ward rounds, patient was discharged since her condition was stable and had no complains. Patient was informed and the bills were assessed to be paid. Patient was educated on her drugs as well as maintaining good personal hygiene and the need for follow ups and regular check-ups. I also reminded patient on the need to avoid over the counter drugs. No new medications were prescribed. Patient was informed to come for review on the December 21st, 2022. The need to continue with medications and review date were emphasized. They were helped to pack their belongings. Bed linens were sent to the laundry, the mattress and pillow were as well decontaminated. Patient and the family bade the ward inmates and staff goodbye. I accompanied patient to the hospital entrance. 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.

4.2 The Preparation of Patient/Family for Discharge and Rehabilitation.

The preparation of my patient/family for discharge started on the day of admission till discharge. Miss G. T., and family were reassured that she would fully recover and return to their community because the nursing and medical staffs are ready to render quality care for them. Patient was advised that even though, she had come to seek treatment, there were several things to be learnt from the hospital which could improve her health and that of her relatives. The cause of the patient's sickness was explained to her. She was told of the preventive measures of the condition so as to prevent possible recurrence of the condition. She was also told that the condition is treatable. Emphasis was put on the need to practice strict personal hygiene such as keeping finger nails neat and short when preparing food. She was educated to feed on nutritious diet and prepare foods at a hygienic environment.

She was educated on how to take her medications at home and she was educated on the need to come for review because it would be confirmed how fully she had recovered. She was also advised to report at the hospital immediately if any health related problem arises before the date set for the review.

4.3 Follow Up/Home Visit/Continuity of Care

Follow up or home visit is a friendly but purposely visit to the home of the patient with the aim of preventing diseases, promoting and maintaining health prolonging life though health education counseling, nursing care and rehabilitation. It aims at assessing the use of available resources at home as well as in the community that could be used to solve actual and potential health problems. Again, it helps monitor patient's progress in health after discharge.

4.3.1 First home visit; (12th of December, 2022)

On the 12th of December, 2022 at around 3pm, I made my first home visit to my client's family house while she was still on admission at Aworowa a suburb of Techiman in the Bono East region. The purpose of my visit was to find out how the family were doing and to familiarize myself with their

home environment, identify their health problems, identify risk factors associated with her disease, confirm information provided by patient and relative and plan with them how they could improve on their health before my patient returns home. The direction to the house was given to me by the patient. On reaching the entrance of the house, I took a glance at the surroundings of the house. I entered the house and I saw my patient's grandmother who was preparing to go back to the hospital and one of her sisters. I greeted them. I took a quick glance at the house environment while I was prepared a seat as well as a glass of water. I introduced myself once again to them as a third-year student nurse who was caring for their relative at the hospital. I informed them that I have come to visit them in order to find out any information that can help in the management of my patient. My patient's grandmother said she was in a hurry so she left us for the hospital. The house contains only two bed rooms and a kitchen. The house is been painted green. It has been roofed with iron sheets. Their source of water supply was pipe borne built in front of the house. They stored their water in a large barrel which was well covered and kept just at the entrance of the kitchen. There is a garden in front of the house. Although their house was surrounded with weeds but it was a little hygienic. Their toilet facility was an aqua privy type with one hole and a container for collecting the toilet papers. The toilet was cleaned, however the hole and the container were well covered. She said they normally burn the toilet papers when the container is full. Lastly, I congratulated them on their hygiene and were encouraged to maintain it after the education on good personal and environmental hygiene was given. I told them of my next visit and bade them goodbye and left the house.

4.3.2 Second Home Visit: 18th December, 2022

I made the visit on this day in the morning around 11:35am. and was very happy to see patient and the family. She was very well and her condition had improved greatly. The purpose of the visit was to assess the health of patient and to see whether the education given during admission and first home

visit were being followed. There was a warm reception on arrival and they were very happy to see me again. A seat and a glass of water were offered and I was very grateful to see her doing very well.

After assessing the surrounding, I congratulated them for keeping to the health education given. The barrel was well cleaned and fittingly covered with a lid. The signs and symptoms, causes, prevention and complications of Gastroenteritis could easily be repeated to me by patient and the relatives. Patient was encouraged to do more in order to promote her health. I also asked them if they have any concern to express in the care to be given to patient at the house and they said they have no concern. I reminded them of the review date which was on the 21st December, 2022 and its importance. I then asked permission and left there around 01:05pm for the house and I was escorted by patient.

Review (21st December, 2022)

On Wednesday 21st December, 2022 Patient and her grandmother were met at the Out-Patient Department of Techiman Holy Family Hospital at 9:00am looking cheerful and lovely as noted from their facial expression. I accompanied them to go for patient's folder. The vital signs were checked and recorded as shown in the appendix.

At the Out-Patient Department, patient was seen by the medical officer. Upon assessment, patient was healthy. Patient did not have complains. No medication was given to her. She was informed not to hesitate to report to the hospital if she encounters any health problem. She was also encouraged to practice personal and environmental hygiene to protect her self from getting diseases.Patient was assured of a third home visit. I then accompanied them to the lorry station which is about three minutes' walk from the hospital entrance where they took a taxi to their home.

4.3.3 Third Home Visit: (8th January, 2023)

The main reason for conducting the third home visit was to: Assess the general condition of patient and family, reinforce the need to comply with treatment regimen and finally terminate care and to hand over the patient.

On the said date, I set off around 1:30pm with a taxi. Patient and family were doing well as they looked cheerful and had no complaitns. The environment was tidy as there were no rubbish around.there was no valnurable person like pregnant women or children in the house. I terminated my care and handed over patient to Nurse A. J., who works at Holy Family Hospital. I thanked them for their cooperation which made my study a success. Patient's grandmother commended me for good work done and accepted to continue the care of patient at home. I however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick rather than relying on self-medication. After interacting with patient and family for a while, I reemphasized on health education that had been given to them already. Since it happened to be my last day of therapeutic relationship with miss G.T. and family. I told them that since Miss G.T.is fully recovered, therefore I am handling over the care to Mr A. J. the care has therefore being terminated. I terminated my care and thanked them for their cooperation which made my study a success. Patient and her family expressed their gratitude by showing how grateful they were to me for the support and care given to them. I eventually sought permission to leave and bade them the final farewell at 3:20pm.

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 (Hinkle & Cheever, 2014). The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to patient and family.

5.1 Statement of Evaluation

According to Bare (2011), evaluation is defined as the final stage in the learning process and is a measure of the degree to which the patient has mastered the learning objective. Patient was admitted to the Females Ward with the diagnosis of Gastroenteritis. All goals and objectives were fully met. Below is the summary of the interventions carried out and to what extent the goals were met:

1. Patient's body temperature was reduced to normal

On 11/12/2022 at 3:10pm, patient had high body temperature (fever), a nursing diagnosis of Pyrexia (38.1^{o}C) related to inflammation of the stomach and intestinal mucosa was made. An objective was set to enable patient restore her normal body temperature that is 36.2^{o}C-37.2^{o}C within 24hours.The following nursing interventions were carried out; adequate room ventilation was ensured by opening windows, IV Paracetamol 1gram was administered as prescribed and temperature was checked 30 minutes afterward and recorded as 37.8^{o}c, cold drinks and liberal fluids were to be served, temperature was checked every 4 hours and recorded. Evaluation was made on 12th December 2022.

Goal was fully met as evidenced by Nurse recording body temperature of 37.1$_{o}$ C and patient verbalized she is no more feverish.

2. Patient's normal fluid and electrolyte level was maintained.

On admission 11th December, 2022 at 2:50 pm, Patient complained of frequent watery stools and vomiting as well. A nursing diagnosis of risk for fluid volume deficit related to diarrhea and vomiting were formed. An objective was set to help maintain normal fluid volume levels throughout her stay in the hospital. The following nursing interventions were carried out; patient was assessed for signs and symptoms of dehydration; patient was educated on the importance of fluids to the body. Copious intake of fluid was encouraged, patient vomitus was assessed, isotonic intravenous fluids were administered, and prescribed antibiotics and anti-emetics were administered.

On 15th of December 2022, an evaluation of the objective set to help relieve patient of vomiting and diarrhoea within the period of hospitalization was evaluated and goal was fully met as the nurse observed a normal skin tu rgor.

3. **Patient regained strength for her daily activities.**

On 12th of December, 2022 patient gave a verbal complaint of generalized body weakness, so a nursing diagnosis of activity intolerance related to weakness as evidenced by inability to perform activities of daily living such as grooming self was formulated. A goal was set to help patient regain strength for her daily a ctivities within 48hours. The following interventions were carried out to meet the objective set; patient mobility level was assessed prior to exercise, patient was reassured that she will regain strength for her daily activities with available measures, patient was always

assisted in performance of activities like bathing and brushing of her teeth, patient was encouraged to carry out activities she could tolerate such as walking around bed with rest periods when tired.

On 13th of December 2022, at 1:30pm, the objective set to help patient perform normal activities was evaluated and goal was fully met as nurse observed patient participating willingly in necessary and desired activities and patient also verbalized that she does not feel weak anymore.

4. Patient sleep pattern was restored.

On 12th December, 2022 at 08:15am patient indicated that she did not have a restful sleep. A nursing diagnosis of Insomnia related to change of environment as evidenced by patient having Less sleep and an objective to help restored patient sleeping pattern to normal (6-8) within 24 hours was set. Nursing interventions carried out were as follows: patient was reassured that her sleep pattern will be restored with available measures, television sets on the ward were lowered, patient was provided with warm water when bathing to induce sleep, patient bed was properly made free from creases and ward windows were opened to ensure ventilation and nursing procedures were carried out together to prevent disturbance of patient sleep.

on 13th December 2022, the objectives were evaluated and goal was fully met as patient verbalized that she had uninterrupted sleep and nurse observed that patient had uninterrupted sleep for 6-8 hours at night.

5. **Patient/family gained knowledge on gastroenteritis.**

On 12th December, 2022 at 10:30am patient was engaged in an interaction and it was realized that patient and her relative had less knowledge on gastroenteritis. A nursing diagnosis formulated as; Knowledge deficit related to the causes, signs, symptoms, management and prevention of gastroenteritis as evidenced by inability of the patient to answer basic questions on the illness.

(gastroenteritis). Interventions carried out were; patient and family were reassured and rapport established with them, their knowledge on her condition was assessed, patient and family were informed about ways of preventing the symptoms and some management for the disease, patient and family were allowed to ask questions for clarifications on issues about the disease bothering their minds and lastly, all questions were answered in simple, plain and clear language without the use of medical jargons. Patient and family were asked to give feedback on what they heard and all procedures carried out on patient were document in the nurses' note accordingly.

On 15th December, 2022 at 10:30am the objective set to enable patient gain adequate knowledge on gastroenteritis within the period of hospitalization as evidenced by; patient and family being able to provide correct answers to questions posed to them on the causes, management and prevention of gastroenteritis, nurse observing that patient and relatives practice knowledge gained on gastroenteritis was evaluated and goal was met fully.

5.2 Amendment of the Nursing Care Plan

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

Every nurse-patient relationship at the hospital needs to be terminated. However, this is a very difficult step to take after a good rapport has been established. Because of this, the reality of termination of care has to be made known to both patient and family from the day of admission. Care of patient and family ended on the 8th January, 2023 which was my last home visit. This ended the interaction between the health team, patient and her family. The preparation for termination started

on day of admission through discharge, review to the third home visit. Patient was clinically ill on admission but became stable before discharge. During these periods, patient and family were educated on various topics such as; patient and family were encouraged to practice personal and environmental hygiene, always wash their hands with soap under running water after visiting the patient, foods should be heated and covered with well-fitting lids from flies and fruits should be washed before taken. I congratulated the family for the care they had rendered to patient. They were thanked for their co-operation and patient was handed over to a nurse who works at Holy Family Hospital for continuity of care. They were informed that now that patient's 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 difficult bidding them farewell. I left around 3:20.

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

On the 11/12/22, an 18year old lady was admitted to the female's ward at Holy Family Hospital, Techiman. Patient complained of having high body temperature, excessive vomiting, diarrhea, insomnia and abdominal pain. Laboratory investigations such as full blood count, blood film for malaria parasite and stool for routine examination were conducted to confirm the cause of the condition (gastroenteritis).

During the period of admission, patient was put on intravenous medications including;

1. Intravenous Ringers Lactate (3) liter over 24 hours.
2. Intravenous metronidazole 500miligrams tid 24hours.
3. Intravenous Ciprofloxacin 400miligrams bd for 24hours
4. Intravenous Paracetamol 1gram tid for 24hours.
5. Intravenous metoclopramide 5miligram tid for 2hours

The health problems identified were: high body temperature (Pyrexia, 38.0 ^{o}C), diarrhoea and vomiting, abdominal pain, body weakness, difficulty sleeping and inadequate knowledge about the disease condition.

Some of the nursing interventions carried out were reassurance, adequate ventilation, thorough education on the disease condition and assisting patient in maintaining personal hygiene. Adequate rest and sleep, nutrition, and exercises were also ensured. Patient was encouraged to continue care at home after discharge.

On the 21st of December, 2022 patient reported for review as scheduled and she had greatly improved. Three home visits were embarked on. The first home visit was done while patient was still on admission on 12th December , 2022, second home visit was on the 18th December, 2022 and third home visit was on the 8th January, 2023. Patient spent five days at the ward and was discharged on 15th of December 2022. The care of patient and her family were terminated on the 8th of January, 2023, during the third home visit when patient had fully recovered.

6.2 Conclusion

It has given me in depth knowledge on the causes, signs and symptoms, diagnosis, treatment and prevention of gastroenteritis. In conclusion, my choice of nursing patient has greatly increased my knowledge into her condition, 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 gastroenteritis using the nursing process.

I therefore recommend that every health institution employs the use of the nursing process, so as to enable them provide individualized, holistic and comprehensive nursing care to help decrease re-occurrences 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 much insight into the condition under study.

APPENDIX

TABLE: VITAL SIGNS OF MISS. G. T.

Date	Time	Temperature (^{0}C)	Pulse (cpm)	Respiration (bpm)	Blood pressure(mmHg)
11/12/2022	2:30pm	38.1	100	25	110/70
	6:00pm	37.8	100	24	110/70
	10:00pm	37.5	91	22	120/80
12/12/2022	6:00am	36.7	100	21	128/70
	10:00am	36.9	100	22	120/60
	2:00pm	37.1	100	22	120/70
	6:00pm	36.2	99	24	110/80
	10:00pm	36.1	100	22	110/80
13/12/2022	6:00am	36.8	100	22	120/70
	10:00pm	36.3	100	21	120/70
	2:00pm	37.2	90	22	120/70
	6:00pm	36.8	100	24	110/80
	10:00pm	36.4	100	24	120/70
14/12/2022	6:00am	36.1	100	22	120/70
	10:00am	36.9	85	20	110/70
	2:00pm	36.3	90	21	120/80
	10:00pm	37.0	70	21	120/70
15/12/2022	6:00am	36.2	80	22	100/70
	10:00am	36.2	80	21	100/70
21/12/22	10:00am	36.2	90	22	120/70

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