HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM.

A CLIENT/FAMILY CARE STUDY ON ACUTE GASTRITIS

BOSEAH SANDRA MITCHELL
4120210074

A PATIENT/FAMILY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT FOR THE AWARD OF A LICENSE TO PRACTICE AS A REGISTERED NURSE.

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PREFACE

Patient/family care study is a detailed account of nursing care rendered to the client and family to meet their health needs.

The study is carried out to enable the student nurse put into practice the knowledge and skills acquired from the three-year training period in school to ascertain how best the theoretical knowledge could be used to nurse patient who will come under his/her care.

The study enables the student nurse to utilize the knowledge and skills acquired from the various courses in medical, surgical, public health, and paediatric nursing to give effective nursing care to client, with reference to his/her condition.

It also helps the student nurse to acquire more knowledge and insight about a specific disease condition.

This forms part of the final assessment of the student nurse at the end of the three-year training programme before the award of a Registered General Nursing license by the Nursing and Midwifery' Council of Ghana.

ACKNOWLEDGEMENT

I wish to express my sincere gratitude to the Almighty God for granting me the knowledge and guidance in conducting this study successfully.

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I wish to thank the authors and publishers from whose books I was able to compile the necessary information for the writing of this care study

I thank all my friends especially, Yeboah Mary, Boakye Mary, Aborteh Felicia, and others for their prayers as well as their moral support upon this study.

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GOD BLESS YOU ALL!!!

INTRODUCTION

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

Miss. A.D., a 32-year-old lady was the client in the study. She was admitted on the 12th of December, 2022 at the municipal, with the diagnosis of Acute Gastritis.

On admission, she presented with general body weakness, abdominal pains, headache, nausea and vomiting and loss of appetite after appropriate nursing interventions, client's condition had improved and problems identified were solved at the time of discharge on 16rd December, 2022

Follow up visits after discharge maintained the relationship between client, family, and me until client was eventually handed over to her elder sister in the client's home for continuity of care.

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

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

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

Planning of care for patient/family can be found in the third chapter of the care study.

It involved setting of objectives and the nursing care plans for objectives set.

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

The fifth chapter, evaluation of care was done consisting of statement of evaluation, amendment of nursing care for partially met or unmet outcome criteria, termination of care,

The final chapter dealt with summary and conclusion followed by, bibliography and appendix.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment of patient and family is the first step in the nursing process. It is the systematic method of collection of vital information from the patient, relatives, health team and medical note on laboratory investigation report, to determine patient health status and identifying the actual or potential health problem.

1.1 Patient's Particulars

Advanced English Dictionary (2018), defines patient particulars as facts or details about the patient which are written down and kept as a record.Miss A.D is a 32year old woman born on 24th August,1990 at Yamfo and is a native of Yamfo but stays at Asufufu in Sunyani. She speaks Twi only and stays with her fiancée together with two of her siblings .She is the last born of her parents with ten children in which 3 of her siblings are dead. She is light-skinned and slim in stature. Her height is 1.7 meters and weighs 65Kg with no physical impairment. Miss A.D is not married but has a man in her life and the both partners are getting to know each other very well. She is a Farmer and also sells foodstuffs such as ; cassava, plantain, tomatoes and a whole lot which she sometimes gains from her farm. According to her , she stopped school at primary six [6] due to financial difficulties at home .Miss A.D's parents Mr. A.G and Mrs. A.C are both alive.

1.2 Patient/ Family's Medical History

Miss A.D. said her grandmother is a known hypertensive patient who is on treatment. The rest of her siblings always get minor ailments. Aside these, there are no known mental and chronic diseases in the rest of the family. She and her family treat minor illnesses such as headache, body pains with over the counter medications bought from a nearby pharmacy and sometimes resort to traditional herbs when needed. Miss A.D's and other members of the family have never been admitted to Sunyani Municipal Hospital for some time now. According to Miss A.D. she has no known allergies to any animal, food or drug. Patient also mentioned that she usually takes alcoholic beverages such as Adonko bitters and Alomo.

She indicated that she takes tramadol as well to help her sleep. Patient was educated on the health risk associated with taking these drugs

1.3 Family's Socio- Economic History

According to Miss.AD, the family have been living peacefully and united with each other. Miss. A.D. is a young intelligent, smart, and energetic lady, due to her unique features, she has knowledge in doing a lot of things like sewing and braiding of hair. She works as a trader. This earns her 50 to100 cedis on better days which she uses to sustain her life and support the family by providing basic needs such as shelter, food and clothing. Miss. A.D. is a registered member of the National Health Insurance Scheme (NHIS). She stated clearly that her family is one of a peaceful type. She also said even though they believe in God, they also believe in taboos, myths and respect people from other religious backgrounds.

1.4 Patient's Developmental History

According to Sid. Israel (2020), development is the process that creates growth, progress, positive change or the addition of physical, economic, environment, social and demographic components. Growth is the progressive development of a living thing, especially the process by which the body reaches its point of complete physical development. Maturation refers to the process of aging. That is the physical growth and development of the body, brain and nervous system. According to Miss. A.D., her mother told her she was delivered at 39 weeks' completed weeks of gestation at Sunyani Municipal Hospital at Sunyani through Spontaneous Vaginal Delivery (SVD) without complications. She was immunized against the vaccine preventable diseases. She was breastfed for some time and her mother resorted to supplementary feeds because of lack of knowledge on exclusive breastfeeding. She never had any congenital diseases. She had a normal developmental milestone. According to Miss. A.D., her mother told her she sat with aid at three months of age and started crawling when she was eight months. She stood with support at the tenth month and without support at twelve months. At age two she started pronouncing words like 'mama' and 'dada' and she could dress with assistance. She started showing signs of adolescent stage at age 12 and according to her, she started showing her secondary sexual characteristics such as growth of pubic hair at age 16. She started schooling at age 5 and dropped out of school when she got to primary six [6]. According to Miss A.D. she stopped schooling because she had no one to

cater for her needs and due to that she lost interest in education. Her occupation as a trader came with the help of her sister when she was aged 20.

According to the psychosocial theory of personality development (Eric Erikson, 1950). Miss A.D. is in Intimacy vs. Isolation stage (20-30).

According to Erikson, this is the stage which we share oneself with another person of either sex without fear of losing personal identity. Intimacy is centred on forming loving and intimate relationship with other people. Isolation on the other hand, occurs when that person fails to find a partner. They now feel alone and might create a feeling of inferiority. Miss A.D. share personal identity without fear and form love and intimate relationship with other people, therefore she is in intimacy stage. Based on the type of work Miss A.D. is doing she is able to care for herself and her boyfriend and also support the family. She can direct her energies without conflict to the resolution of social issues.

1.5 Patient's Lifestyle and Hobbies.

Miss A.D. wakes up between 5 and 6 am every day. She brushes her teeth and greets the rest of her family in the house. She then empties her bowels and takes her bath around 7am. After which she prepares tea as her breakfast and leaves for work to attend to her customers when she has enough foodstuffs from her farm to sell in the market. She enjoys groundnut soup with fufu and also jollof rice and Chicken. According to Miss A.D., she returns from the workplace around 6:00pm takes her bath and her supper. She sleeps around 9:00pm but sleep late whenever there is a telenovela which she enjoys watching with her friends. She and her family worships on Sundays. According to Miss A.D., she dislikes kenkey and stew.

According to her, she is interested in dancing to music of her interest such as gospel and RnB music. She is also interested in visiting waterfalls and attending church activities. According to her, she does not normally feel well if she sees herself in the hospital setting and she perceives that being in the hospital increases risk of becoming ill. She has good communication with the rest of her family and anybody who comes her way.

1.6 Patient's Past Medical History

Patients past medical history involve patient's health status prior to the presenting problems she brought to the hospital (Hinkle & Cheener, 2016). According to Miss A.D. and family, she never had any congenital disease. Miss A.D. revealed that she never experienced any childhood ailments such as poliomyelitis, measles and tetanus but however suffers from

minor illness like abdominal pains, headaches, fever and general body pains which subsides after taking over- the- counter drugs and education was given for my patient to put a stop to this by revealing the effects of such drugs to her. She has never been involved in any car accident. She also revealed that she has no known allergies. She is a registered member of the National Health Insurance Scheme and she always gets access to health care whenever she attends to Hospital.

1.7 Patient's Present Medical History

Miss A.D. was well until Friday, December 9, 2022 when she was feeling dizzy, vomiting, experiencing headache, loss of appetite and having abdominal pains. According to her, the onset was sudden and the problem occurred whenever she finished eating. She said her pain was always felt in her abdomen and sometimes in the epigastric region. She therefore went to the Yamfo Health Centre for treatment. With no improvement in the treatment, she was rushed to the Emergency Unit of Sunyani Municipal Hospital on the 10th December, 2022 at 13:15pm at Sunyani in the company of her elder sister. On examination, she was weak and febrile. Upon investigations and assessments, she was diagnosed as having Acute Gastritis by Dr R.U. and was detained at the Emergency Unit for further treatment.

1.8 Admission of the Patient

Admission is the permission given to a person to enter a place, or permission given to a person to enter an organization. It is also the act of entering a place(Collins English Dictionary, 2020). In the context of health, it is the process of keeping a patient in a hospital for the management and treatment of a disease or illness.

Miss A.D. was admitted to the female medical ward of Sunyani Municipal Hospital, Sunyani on 12th December, 2022 at 15:45pm. She was brought to the ward as a Trans in - patient from emergency unit of Sunyani Municipal Hospital with diagnosis of Acute gastritis. She was ambulant on arrival and was accompanied by one nurse and a relative and so was welcomed and made comfortable at the nurse's station. I introduced myself and other staff nurses and colleagues at the ward on duty to her. I collected the hospital card they came with and confirmed her identity by mentioning her name and age on the hospital card which she responded. The patient was immediately received into an already prepared bed.

All necessary information such as client particulars were recorded in the admission and discharge book

Client vital signs was checked and recorded as follows,

Temperature	36.9 degree Celsius
Heart Rate	80 beats per minute
Respiration	20 cycles per minute
Blood pressure	120/60 millimetres of mercury
SPO2	99%

Patient's weight was 65 kilograms on admission.

Patient presented with general body weakness, abdominal pains, headache, nausea and vomiting and loss of appetite. Patient was encouraged to take in small frequent meals at least every 2 – 3 hours during the day, patient was encouraged to take in small amount of oral fluids during the day and also vomitus bowl was giving to patient anytime she felt like vomiting. Patient was reassured and was made comfortable in bed. I told her that her admission will last for few days and she will be discharge home. Patient relative was oriented to the ward and it annex and hospital routines, visiting hours, meal time, and ward rounds were explained to the patient and her relative. Patient was introduced to other cubicle mates. All valuables were kept in her locker such as Cup, infusions, mobile phone. She is a registered national health insurance scheme member so I made her understand the policy was going to take most of her bills. Medications ordered and served were;

1. Intravenous Tramadol 100mg in 500mls of Dextrose in Normal Saline stat dose
2. Intravenous Omeprazole 80mg stat then 40mg bd x 24 hours
3. Intravenous Metoclopramide 10mg tds x48 hours
4. Intravenous Buscopan 40mg stat then 20mg bd x 24hours
5. Intravenous Ciprofloxacin 400mg bd x 24 hours
6. Infusion Ringers Lactate 500mls x 24 hours
7. Injection Diclofenac 75mg stat
8. Suspension Nugel 15mls tds x 7 days
9. Tab Buscopan 20mg tds x 6days
10. Capsule Omeprazole 20mg bd x 4 days.

The following investigations were ordered and done before patient was admitted to the ward;

1. Urine for routine examination
2. Blood specimen for malaria parasite

3. Blood for full blood count

Planning for patient discharge began right from the day of admission as I started educating the patient and relatives about the causes, symptoms, effect, treatment and complications of the condition. She was informed that co-operation with the health team was greatly needed for full and early recovery of the patient.

Her relative was assisted to arrange her personal items into the bed side locker. When the patient was stable, I went to engage her and the relative in a therapeutic conversation where I made my intention known to her that I am a final year student from Holy Family Nursing and Midwifery Training College-Berekum, writing a care study and if given their consent, I would care for Miss. A.D. until full recovery is attained.

I explained to them in simple language, what it will entail and promised to make information gathered confidential.

I made patient and family understand that other health care members will play their role in the care of Miss. A.D. but will mostly have an encounter with them and that in my absence other colleagues will continue the care. Patient/family care study is to enable me render to her individualized comprehensive nursing care until discharged. I informed them that it was a requirement by the Nursing and Midwifery Council that had to fulfil as a partial fulfilment for a ward of license to practice as professional Registered General Nurse in the country. I told them that I will be coming for home visiting for 3 times to see how she is doing. She was very happy and agreed to my request and promised to co-operate fully in caring for her.

I decided to use the client for my care study because I wanted to have more knowledge on Gastritis due to the fact that my own kid sister was also diagnosed of such a condition when she was just 14years old and as such I wanted to use this opportunity to learn how to take care of a patient with Acute Gastritis using the nursing care plan.

1.9 Patient/ Family Concept of Her Illness

She could not figure out the cause of her condition and believes every human beings are bound to fall sick at times. So would never attribute it to any external causes such as witchcraft or any supernatural powers.

Miss A.D. however believed that her prayers and treatment will let her recover fully.

I reassured her and told her that with the help of the healthcare team and the drugs given, her pains will subside and she will be discharge home safely

1.10 Literature Review on Gastritis

ANATOMY AND PHYSIOLOGY REVIEW OF THE DIGESTIVE SYSTEM

According to Waugh and Grant (2016), the following is the brief review of the Anatomy and Physiology of the digestive system; the literature review is carried out to compare the data gathered by the nurse and the view point of other studies in relation to the disease condition. This will help the nurse to compare experiences since there will be the need to use various literature and textbooks in order to expand her view and knowledge about the disease condition. It includes definition, incidence, causes, types, pathophysiology, clinical features, management, treatment, prevention and complication.

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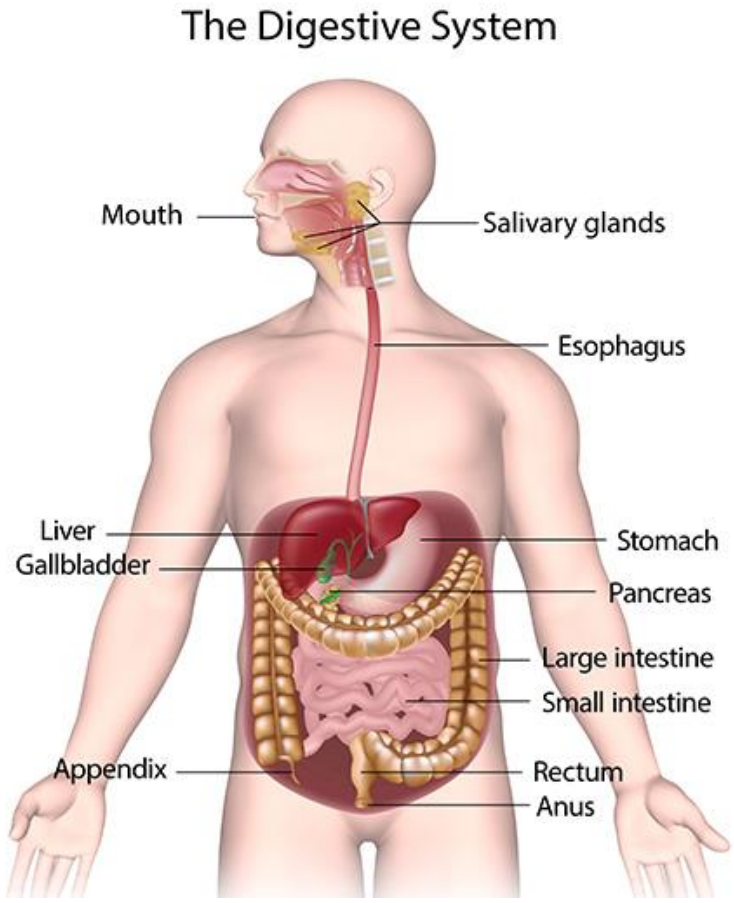

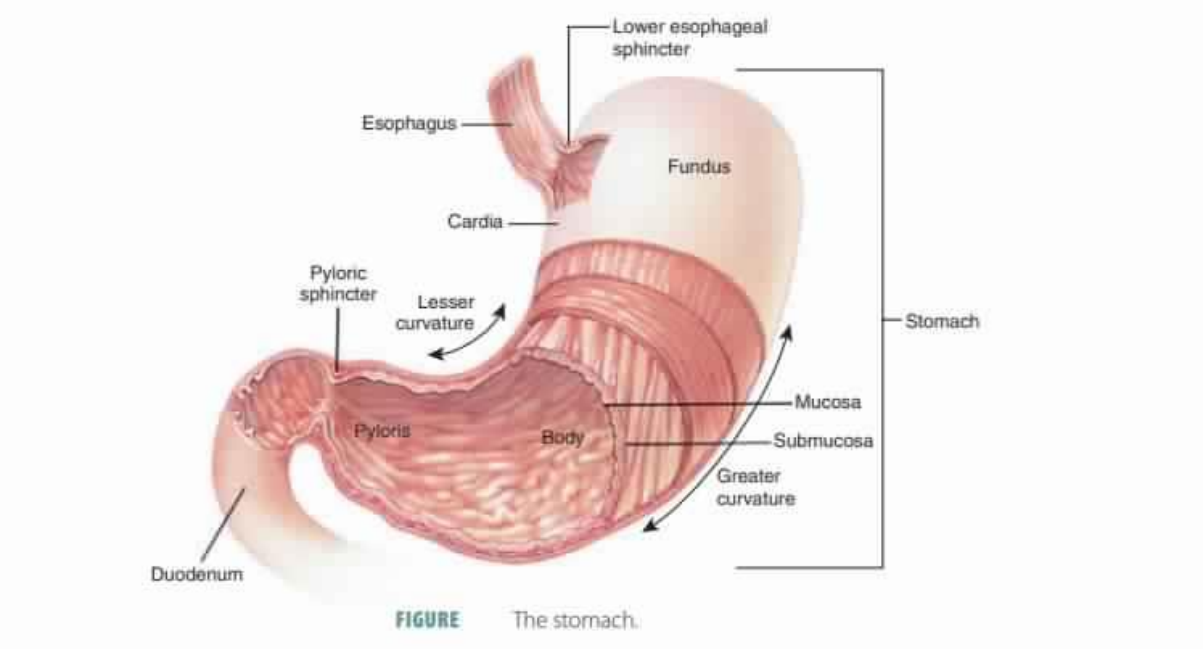

FIGURE The stomach.

Position of the stomach:

The **stomach** is a muscular organ located on the left side of the upper **abdomen**. The **stomach** receives food from the oesophagus. As food reaches the end of the oesophagus, it enters the **stomach** through a muscular valve called **the lower oesophageal sphincter**. The stomach secretes acid and enzymes that digest food. The stomach muscles contract periodically, churning food to enhance digestion.

The pyloric sphincter is a muscular valve that opens to allow food to pass from the stomach to the small intestine.

Structure of the stomach

The stomach has three layers of muscle: an outer longitudinal layer, a middle circular layer, and an inner oblique layer. The inner lining consists of four layers: the serosa, the muscularis, the submucosa, and the mucosa. The mucosa is densely packed with gastric glands, which contain cells that produce digestive enzymes, hydrochloric acid, and mucus.

The absorption of food, water, and electrolytes by the stomach is practically negligible, but iron and highly fat-soluble substances such as alcohol and some drugs are absorbed directly. Secretions and movements of the stomach are controlled by the vagus nerve and the sympathetic nervous system; emotional stress can alter normal stomach functions.

Common stomach disorders include peptic ulcer, cancer, and gastritis.

Definition of Gastritis

According to Hinkle and Cheever (2018) Gastritis is an acute or chronic inflammation, irritation, or erosion of the lining of the gastric or stomach mucosa. It is a common gastrointestinal problem. It may be acute that is lasting for several hours to few days or chronic resulting from repeated exposure to irritating agents or recurring episodes of acute gastritis.

Incidence of Gastritis

It is stated that ten out of every thousand people suffer acute gastritis and three out of every thousand suffer chronic gastritis. There is great incidence in clients who are heavy smokers and drinkers.

Types of Gastritis

- Acute gastritis
- Chronic gastritis

Among the two types, Miss A.D. suffered from acute gastritis

Acute Gastritis

Acute gastritis is the inflammation of the stomach mucosa which may last for several hours to few days. It can also cause pain and also a benign self-limiting inflammation and superficial erosion of the gastric mucosa.

Causes/Risk Factors

According to Hinkle and Cheever (2018) the following are causes of acute gastritis. It is often caused by dietary indiscretion- this may result from a contaminated food or an irritating food eaten. Other causes may include;

1. Prolong use of NSAIDS
2. Alcohol abuse
3. Endotoxins from infecting bacteria such as salmonella, E. coli
4. Exposure to ionizing radiation
5. Ingestion of corrosive acids or alkaline
6. Bile reflux
7. Ingestion of irritating foods such as hot pepper
8. Severe infections with helicobacter pylori
9. Stress reactions

10. Certain food poisonings (infectious and chemical)
11. Fungal infection
12. Certain drugs (cocaine)
13. Radiation therapy

Chronic Gastritis

Hinkle and Cheever (2018) define chronic gastritis as a result of exposure to irritating agents or recurring episodes of acute gastritis. It is also a progressive irreversible atrophy of the gastric mucosa and glandular tissue of the stomach.

Types of Chronic Gastritis

According to Hinkle and Cheever (2018) the following are types of chronic gastritis.

Type A Gastritis or Autoimmune Atrophy Gastritis

Antibodies to detect intrinsic and parietal factors are produced; these antibodies destroy gastric mucosa cells resulting in tissue atrophy. Loss of HCl acid, pepsin and intrinsic factors

Type B Gastritis or Simple Atrophy Gastritis

This is more common. The incidence increases with age (70 years and above) it results from H. pylori colonization of the gastric mucosal layers.

Causes/Risks Factors

According to Lewis, M.S and Pisegna, J.R. (2017) the following are causes of chronic gastritis.

1. Chronic intake of alcohol
2. Excessive cigarrete smoking
3. Recurrent acute gastric
4. Metabolic conditions like uraemia
5. Bacterial infection (Helicobacter pylori)
6. Exposure to toxins such as lead
7. Autoimmune diseases such as pernicious anemia

Pathophysiology of Gastritis

Acute gastritis is characterized by disruption of the mucosal lining by local irritations. This allows hydrochloric acid and pepsin to come in contact with gastric tissue resulting in irritation, inflammation and superficial erosion. The gastric mucosa rapidly regenerates generally making acute gastritis self-limiting with resolution and healing occurring within few days

In chronic gastritis, the gastric mucous membrane becomes oedematous and hyperaemic (congested with fluid and blood) and undergoes superficial erosion. It secretes a scanty amount of gastric juice, containing very little acid but much mucus. Superficial ulceration may occur as a result of erosive disease and may lead to haemorrhage (Nasser, H., et al 2019).

Clinical Manifestations for Acute Gastritis

According to Lewis, M.S and Pisegna, J.R. (2017) acute gastritis may be asymptomatic but patient may present with;

1. Abdominal discomfort
2. Nausea and vomiting
3. Abdominal bloating
4. Headache
5. Lassitude
6. Anorexia
7. Hiccups and belching
8. Epigastric tenderness
9. Feeling of fullness

Clinical Manifestations for Chronic Gastritis

According to Sipponeon and Maaroos (2015) , the patient may complain of;

1. Epigastric heaviness after eating
2. Vague discomfort after eating (heart burns, belching of taste in the mouth)
3. Vitamin B 12 anaemia due to diminished intrinsic factor production by the parietal cells of the stomach.
4. Hypochlorhydria (a lower than normal amount of hydrochloric acid in the gastric juice)

5. . Intolerance to spicy foods or fatty foods.
6. Nausea and vomiting
7. Pain relieved by eating

Diagnostic Investigations

According to Hinkle and Cheever (2018), the following are Assessment Diagnostic findings;

1. Good history taking for symptoms
2. Physical assessment for signs of gastritis
3. Endoscopy for biopsy to detect H. Pylori infection
4. Full blood count (FBC) to determine anaemia and low blood count
5. Gastric juice analysis for H. Pylori
6. Histologic Helicobacter pylori examination of a tissue specimen obtained by biopsy
7. Serologic testing for antibodies against H. pylori agents
8. A 1-minute ultra-rapid urease test and breath test for detecting the presence of urease produced by H. pylori

Treatment/Management

AIMS: Fashner, J ; Gitu, AC (2015) describes the aims of treating gastritis to include;

1. Reduce the amount of acid in the stomach and allow the stomach lining to heal
2. To relieve symptoms such as abdominal pains and reduce complications.
3. To treat the underlying cause of the condition.
4. To promote comfort.

Medical Management

According to NIDDK (2015), Medical management is aimed at;

1. Diluting and neutralizing the offending agent
2. Reducing and controlling secretions
3. Protecting the mucosal barrier
4. Reducing the inflammatory process

The following medications can be served;

1. Proton pump inhibitors such as Omeprazole.
2. Intravenous fluids; to correct dehydration if patient cannot tolerate oral feeds
3. Discontinue the use of irritant agents such as aspirin and alcohol
4. Analgesics and Antipyretics such as tablet Paracetamol and Tramadol intravenous to relieve pain and fever.
5. Antibiotics. Examples are Ciprofloxacin if there is infection

6. Chronic gastritis is managed by modifying the patient's diet, promoting rest, reducing stress and initiating pharmacotherapy.

Nursing Management

According to Alexander, Pandol, Gorelick, et al (2016), the following are specific nursing management for gastritis.

Psychological Care

There is the need for continuous reassurance of patient and family about readiness of health care team to aid in treatment and the effectiveness of available medications and other supportive treatment modalities in bringing about speedy recovery and remission.

Reducing Anxiety

If the patient has ingested acids or alkalis, emergency measures may be necessary. The nurse offers supportive therapy to the patient and family during treatment and after the ingested acid or alkali has been neutralized or diluted. In some cases, the nurse may need to prepare the patient for additional diagnostic studies (endoscopies) or surgery. The patient may be anxious because of pain and planned treatment modalities. The nurse uses a calm approach to assess the patient and to answer all questions as completely as possible. It is important to explain all procedures and treatments based on the patient's level of understanding.

Rest and sleep

The following measures should be implemented to ensure good rest and comfortable sleep to promote recovery;

The nurse restricts or limits visitors when necessary and explains to the patient the need for rest and sleep in aiding speedy recovery. The environment should be properly ventilated and noise minimized to promote rest and sleep.

The nurse should put patient in well prepared, comfortable bed and make sure bed is free from creases and cramps. Carry out bulk nursing activities when applicable.

Encourage patient to take warm bath after meals and warm drinks before bed.

If patient has pain-related insomnia, serve prescribed analgesics to relieve pain. Also serve prescribed hypnotics and sleep inducers and monitor for therapeutic and adverse effects.

Ensuring elimination

Elimination needs in the patient with gastritis is equally important as is medications in recovery and remission of signs and symptoms. The nurse assesses patients' elimination pattern and monitor intake and output of patient. The nurse must monitor vomiting and observe vomitus for colour, consistency and content of the vomitus.

If vomiting is persistent, prevent dehydration of patient by rehydrating with prescribed intravenous infusion. The nurse should administer prescribed anti-emetics and monitor for therapeutic and adverse effects. To prevent infection from elimination, ensure emesis basins, bed pans and commodes served patient to meet elimination needs, contain disinfectants and such products of elimination are properly discarded.

Promoting Optimal Nutrition

For acute gastritis, the nurse provides physical and emotional support and helps the patient manage the symptoms, which may include nausea, vomiting, heartburn, and fatigue. The patient should take no foods or fluids by mouth (possibly for a few days) until the acute symptoms subside if possible, thus allowing the gastric mucosa to heal.

If intravenous therapy is necessary, the nurse monitors fluid intake and output along with serum electrolyte values. After the symptoms subside, the nurse may offer the patient ice chips followed by clear liquids. Introducing solid food as soon as possible may provide adequate oral nutrition, decrease the need for intravenous therapy, and minimize irritation to the gastric mucosa. As food is introduced, the nurse evaluates and reports any symptoms that suggest a repeat episode of gastritis.

The nurse discourages the intake of caffeinated beverages, because caffeine is a central nervous system stimulant that increases gastric activity and pepsin secretion. It also is important to discourage alcohol use. Discouraging cigarette smoking is important because nicotine reduces the secretion of pancreatic bicarbonate, which inhibits the neutralization of gastric acid in the duodenum (Pandol, 2016).

When appropriate, the nurse initiates and refers the patient for alcohol counselling and smoking cessation programs. Also ensure patient takes in a bland diet and serve small meals at frequent intervals.

Promoting Fluid Balance

Daily fluid intake and output are monitored to detect early signs of dehydration (minimal fluid intake of 1.5 L/day, minimal output of 30 mL/h). If food and oral fluids are withheld, IV fluids (3 L/day) usually are prescribed and a record of fluid intake plus caloric value (1 L of 5% dextrose in water_170 calories of carbohydrate) needs to be maintained.

Electrolyte values (sodium, potassium, chloride) are assessed every 24 hours to detect any imbalance.

The nurse must always be alert for any indicators of hemorrhagic gastritis, which include hematemesis (vomiting of blood), tachycardia, and hypotension. If these occur, the physician is notified and the patient's vital signs are monitored as the patient's condition warrants.

Relieving Pain

Measures to help relieve pain includes instructing the patient to avoid foods and beverages that may be irritating to the gastric mucosa and instructing the patient about the correct use of medications to relieve chronic gastritis.

The nurse must regularly assess the patient's level of pain and the extent of comfort achieved through the use of medications and avoidance of irritating substances.

Ensuring personal hygiene

Ensure patients hygienic needs are equally met as other medical needs of the patient are established. The following measures can be followed;

Ensure patient takes his/her bath twice a day. Assist or carry out bed bath when necessary.

Encourage patient to maintain adequate mouth care by brushing his/her teeth at least twice in a day to combat dryness or cracking of the lips and infections in the mouth.

Teach and encourage patient and relatives to observe hand washing techniques after visiting the toilet or coming into contact with patient fluids such as vomitus to prevent spread of Helicobacter pylori bacteria.

Ensure patient keeps a short and well-kept nails. Carry out hand and feet care when necessary.

Observation and monitoring

Continuously monitor vital signs including temperature, pulse, respiration and blood pressure and intervene when appropriate.

Monitor strict intake and output especially when vomiting persists.

Monitor patient for therapeutic and adverse effects of administered medications.

Assess and monitor patient for signs and symptoms of dehydration including, loss of skin turgor, dry mouth and persistent complains of thirst.

Teaching Patient Self-Care

According to Smeltzers and Bare (2016), the nurse evaluates the patient's knowledge about gastritis and develops an individualized teaching plan that includes information about stress management, diet, and medications. Dietary instructions take into account the patient's daily caloric needs, food preferences, and pattern of eating. The nurse and patient review foods and other substances to be avoided (e.g. Spicy, irritating, or highly seasoned foods; caffeine; nicotine; alcohol). Consultation with a dietician may be recommended. Providing information about prescribed antibiotics, bismuth salts, medications to decrease gastric secretion, and medications to protect mucosal cells from gastric secretions may help the patient to better understand why it is important to follow information given.

Health Education

Educate patient on disease condition including causes, signs and symptoms as well as prevention.

Educate patient on the need to cook food properly before eating

Educate patient to identify and avoid foods that irritate the stomach

Educate patient on the need to stick to and complete all prescribed medications

Educate patient to report to the nearest health facility in case signs and symptoms recur

Advise client to avoid smoking and alcoholism.

Nutrition and dietary Supplements

Following these nutritional tips may help reduce symptoms:

Eating antioxidant foods, including fruits (such as blueberries, cherries and tomatoes), and vegetables (such as garden eggs and cucumber)

Intake of foods high in B vitamins and calcium, such as almonds, beans, whole grains (if non-allergic), dark leafy greens (such as spinach and kale) and sea vegetables

Avoid refined foods such as white breads, pastas, and sugar

Use healthy oils, such as olive oil

Reduce or eliminate trans-fatty acids, found in commercially-baked goods, such as cookies, crackers, cakes, onion rings, donuts and margarine.

Avoid beverages that may irritate the stomach lining or increase acid production including coffee (with or without caffeine), alcohol and carbonated beverages.

Drink 6 to 8 glasses of filtered water daily

Identify and eliminate food allergies

The following supplements may help with digestive health:

A multivitamin daily, containing the antioxidant vitamins A, C, E, the B vitamins, and trace minerals, such as magnesium, calcium, zinc and selenium.

Omega-3 fatty acids, such as fish oil, may help decrease inflammation. Fish oil may increase the risk of bleeding.

Probiotic supplement (containing Lactobacillus acidophilus). Probiotics or friendly bacteria may help maintain a balance in the digestive system between good and harmful bacteria, such as Helicobacter pylori.

Probiotics may help suppress Helicobacter pylori infection, and may also help reduce side effects of taking antibiotics, the treatment for a Helicobacter pylori infection. People who have weakened immune systems, or who are taking immune-suppressive drugs, should take probiotics only under the direction of their physician (Wehbi et al., 2015)

Surgical Treatment

With reference from Pandol (2016), the following are the surgical treatment of gastritis.

1. **Pyloroplasty-** is surgery to widen the opening in the lower part of the stomach (pylorus) so that stomach contents can empty into the small intestine (duodenum).
2. **Gastrectomy-** it involves removal of a portion of the stomach most commonly the distal half or two third of the stomach resected.
3. **Antrectomy** – it is the removal of the stomach containing gastrin secreting cells. A portion of the stomach is anastomosed either to the duodenum (billroth1) or jejunum (billroth 2) usually a combination of these may be done.

Prevention

Gastritis can be prevented by lifestyle changes such as avoidance of long term use of NSAIDS, alcohol, coffee, and drugs that reduces acid secretion and stress reductions techniques should be employed.

Complications

According to Hinkle and Cheever (2018) these complications can occur if a patient with gastritis is not treated immediately.

Peptic ulcer: A peptic ulcer is an excavation (hollowed-out area) that forms in the mucosal wall of the stomach, in the pylorus (the opening between the stomach and duodenum), in the duodenum (the first part of the small intestine), or in the oesophagus.

Gastric cancer: Is a cancer that develops from the lining of the stomach.

Haemorrhage: Is blood escaping from the circulatory system from the damaged blood vessels.

Perforation: Is a complete penetration of the wall of a hollow organ in the body, such as the gastrointestinal tract in the case of gastrointestinal perforation.

1.11 Validation of Data

Validation of data is the process of determining whether information gathered during the process of data collection is complete and accurate. Validation of data is also the act of confirming or verifying data collected from the patient and significant others in order to keep it free from error, bias or misinterpretations.

The study covers detailed information about Miss A.D., her family and her disease condition. Her subjective data was taken from her and her attendants. The data was obtained through observations, interviews and doctor's case history about her disease condition. Various text books were used to compile the literature review about the disease condition.

With references to the data collected from patient, literature review and all sources of information, the data is found to be accurate and relevant, clinical features exhibited by patient are similar to those in literature. This data is therefore valid for the study.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis is the process of breaking a complex topic or substances into smaller parts in order to gain a better understanding of it.

Analysis of data is the second stage of the nursing process, and it involves grouping the information collected at the assessment phase in simpler components. This allows an individual to come out with a conclusion about the patient health needs. The patient and family strengths are also identified and this forms a guide to arrive at a nursing diagnosis and to give appropriate care to the patient.

2.1 Comparison of Data with Standard

This involves the comparison of data collected and gathered from Miss A.D with standards. Both the objective and subjective collected has been compared with accepted norms. The areas concerned are the diagnostic investigation, aetiology of the condition, clinical features, treatment and complications if any.

Diagnostic Investigations/Tests

Diagnosis is the determination of the nature of a disease. Test is defined as an examination or trial. Investigations are procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatment. (Weller B.F., 2016).

The following diagnostic investigations were carried out on Miss A.D. when she was on admission:

1. Urine for routine examination
2. Blood specimen for malaria parasite
3. Blood for full blood count

Table 1:Comparison of diagnostic test done to literature review

Diagnostic tests from literature review	**Diagnostic tests carried out on patient**
Good history taking for symptoms	Was carried out
Physical assessment for signs of gastritis	Was carried out
Endoscopy for biopsy to detect H. Pylori infection	Was not carried out
Full blood count (FBC) to determine anaemia and low blood count	Was carried out
Gastric juice analysis for H. Pylori	Was not carried out
Histologic Helicobacter pylori examination of a tissue specimen obtained by biopsy	Was not carried out
Serologic testing for antibodies against H. Pylori agents	Was not carried out
A 1-minute ultra-rapid urease test and breath test for detecting the presence of urease produced by H. Pylori	Was not carried out

Not all diagnostic tests from the literature review were carried out because the physical examination and the tests conducted were able to confirm his condition.
Malaria test was carried out for my patient to rule out malaria.
Urine for routine examination showed normal values of Albumin and Sugar as; less than 30mg/l and 0 to 0.8mmol/l respectively. Though it was not in the literature review, it was ordered to rule out U.T.I in the patient.

Table 2: Diagnostic Investigations carried out on Miss A.D.

Date	Specimen	Investigations	Results	Normal Values	Interpretations	Remarks
12/12/2022	Urine	Albumin	Negative	Less than 30mg/L	Within normal albumen level in urine.	No treatment given
12/12/2022	Urine	Sugar	Negative	0 to 0.8 mmol/L	Within normal sugar level in urine.	No treatment given
		Deposits of white blood cell.	0-3	0-5	Within normal range.	No treatment given.
		Epithelial cells	3/High power field	1 – 5 squamous epithelial cells per high power field	Within normal range.	No treatment given.
12/12/2022	Blood	Malaria parasites	No parasites seen	Absence of malaria parasite	Specimen free from malaria parasites.	No treatment given.
12/12/2022	Blood	Full blood count (FBC)	HB level:13.1 g/dl WBC count: $6.14x10^3$/L	Female:12-16g/dl Male: 14-18g/dl $2.60\text{-}8.50x10^3$/ul	Within normal range. WBC within normal range	No treatment given

Causes of the Condition

The cause of Miss A. D.'s condition is as a result of prolonged intake of Alcoholic beverages and excessive intake of hot and spicy meals. Miss A.D. said because of the nature of her work, she usually engages herself in most social activities due to her most friendly behaviour of hers. She also stated that she ate a spicy meal when she attended one of her friends funeral ceremony the day before these signs and symptoms presented itself, it includes abdominal discomfort, feelings of extreme tiredness, excessive vomiting and feelings of abdominal fullness. These activities placed my client at risk of developing acute gastritis.

Clinical Manifestation

Table two below shows the comparison between the Clinical Manifestation of Miss A.D. on admission and with those in literature review.

Table 2: Clinical Manifestations of Miss A.D Compared with Literature Review.

Signs And Symptoms In Literature	**Signs And Symptoms Exhibited By Patient**
Abdominal discomfort	Abdominal discomfort was present
Nausea and vomiting	Patient experienced nausea and vomiting
Abdominal bloating	Patient did not present with this sign
Headache	Patient complained of headache
Anorexia	Patient experienced anorexia
Hiccups and belching	Patient did not present with these manifestations
Epigastric tenderness	Patient presented with epigastric tenderness on palpation.
Feeling of fullness	She complained of experiencing abdominal fullness
Lassitude	Patient experienced lassitude.

Statement of Comparison: The features presented by Miss A.D. have been compared to the accepted features of the condition and she exhibited more than half manifestations as stated above, which confirms her diagnosis.

Treatment

It is the mode of dealing with a patient or a disease Weller B.F., (2016). With reference to the treatment of Gastritis indicated in the literature review, the following specific medications were prescribed for the client.

The treatment given to Miss A.D. was medical treatment. The following were the drugs prescribed and given to her;

1) Intravenous Tramadol 100mg in 500mls of Dextrose Normal Saline(DNS) stat
2) Intravenous Omeprazole 80mg stat, then 40mg bd x 24hours
3) Infusion Ciprofloxacin 400mg bd x 24hrs
4) Intravenous Buscopan 40mg stat, then 20mg bd x 24 hrs.
5) Intravenous Metoclopramide 10mg tds x 48hrs
6) Infusion Ringers Lactate 500mls x 24 hours
7) Injection Diclofenac 75mg stat
8) Suspension Nugel 15mls tds x 7 days
9) Tab Buscopan 20mg tds x 6 days
10) Capsule Omeprazole 20mg bd x 4 days.

Table 3: Comparison of treatment outlined in literature review with those given to patient.

Treatment Outlined in Literature Review	**Treatment Given to Patient**
Antibiotics are given to Eradicating the H. Pylori bacteria in the gastric mucosa.	Intravenous Ciprofloxacin 400mg bd x 24hrs was administered.
Proton Pump Inhibitor such as Omeprazole were administered	Intravenous Omeprazole 80mg stat, then 40mg bd x 24hrs. To inhibit the secretion/production of acid in the stomach, was administered.
Analgesics and Antipyretics.	Injection Diclofenac 75mg stat. To resolve inflammatory process and also for relieve of pain and Intravenous Tramadol 100mg stat to relieve moderate to acute pain was administered.

Intravenous fluids.	Ringers Lactate 500mls x 24hrs. Balancing fluid and electrolyte was administered.
Irritant agents such as Aspirin and Alcohol.	Was not served.
Modifying patients diet, promoting rest, reducing stress and initiatiting pharmacotherapy.	Was carried out for Miss AD.

Statement of Comparison: the medications prescribed by the attending physician have been compared to the literature and five out of this drug, were given to Miss A.D. to stabilize her and release her from the pain indicating client received the right treatment for her condition.

Intravenous Metoclopramide which is an antiemetic was given to Miss AD to relieve patient of nausea and vomiting.

Table three below describes the pharmacology of drugs prescribed for Miss A.D.

Table 4: Pharmacology of Drugs Prescribed for Miss A.D.

Date	Drug	Dosage/Route of Administration (Literature)	Dosage/Route of Administration	Classification	Desired Effects	Actual Action Observed	Side Effects/Remedies
12/12/2022	Intravenous Tramadol	**Dosage** **Intravenous:** 50 – 100mg/ml **Route**, intramuscular, intravenously, orally	100mg stat Intravenously	Centrally acting Analgesics (weak opioid, serotonin-norepinephrine reuptake inhibitor)	It inhibits the reuptake of the natural neurotransmitters, norepinephrine and serotonin, and also binds weakly to μ-opoid receptors, blocking the transmission of pain signals to the brain.	Patent was relieved from acute pain as patient no more complain of pains and was peacefully sleeping in bed	Nausea, dizziness, vomiting and drowsiness No side effect was observed
12/12/2022 16/12/2022	Intravenous Omeprazole Capsule Omeprazole	**Intravenous:** 40mg twice daily **Route:** Intravenously, Orally 20mg twice daily for 4 days. Route; orally.	80mg stat, then 40mg bd x 24 hrs Intravenously 20mg twice daily for 4 days. Route; Orally	Proton Pump Inhibitor	Inhibit the secretion/production of acid in the stomach. Relieving gastric pain	Gastric acid production was inhibited. Therefore relieving gastric pains	Headache, diarrhoea, abdominal pains, dizziness and vomiting. None Observed

12/12/2022	Infusion Ringers Lactate	Amount depends on patient's fluid and electrolyte level and age as well as by doctor's prescription. **Route:** Intravenous	500mls x 24 hours Intravenously	Isotonic solution of sodium calcium and potassium chloride	It pulls the fluid into the vascular by osmosis resulting in an increase in vascular volume. It raises intravascular osmotic pressure and provides fluid, electrolytes and calories for energy.	Patient's mucus membrane was moist and skin turgor was normal	Pulmonary oedema, circulatory overloads leading to cardiac failure. None was observed.

Table 4: Pharmacology of drugs prescribed for Miss A.D. Con.t

Date	**Drug**	**Dosage/Route of Administration (Literature)**	**Dosage/Route Of Administration**	**Classification**	**Action**	**Actual Action Observed**	**Side Effects/Remedies**
12/12/2022	Intravenous Ciprofloxacin	Amount depends on the fluid and electrolyte level as well the age of the patient. **Route:** Intravenous, Orally, topical	**Dose:** 400mg bd x 24 hours **Route**; Intravenously	Quinolone antibiotics	It acts on bacterial topoisomerase II (DNA gyrase) and topoisomerase IV. It targets the alpha subunits of DNA gyrase which prevents it from supercoiling the bacteria DNA which prevents DNA replication.	Patient's infection was treated and no other signs of infection were present at the time of discharge	Nausea, diarrhoea, vomiting, heart burns chill, dry mouth None was observed

12/12/2022 16/12/2022	Intravenous Buscopan Tab Buscopan	20 – 40 mg three to four times daily. **Route:** Intravenously, intramuscular. 20 – 40 mg three to four times daily. **Route;** Oral.	40mg stat 20mg bd x 24 Intravenously 20mg tds x 6days Orally.	Antispasmodic	Relieve spasm of the smooth muscles in the gastro-intestinal tract	Patient was relieved of pain and vomiting as she was not vomiting and not complaining of pain anymore.	Constipation, dry mouth, flushing, dryness of the skin nausea and vomiting None was observed
12/12/2022	Intravenous Metoclopramide	10 – 20 mg two to three times daily; daily dose is 500 micrograms/kg **Route:** Orally, Intravenous, Intramuscular and nasal spray	10mg tds for 48 hours **Intravenously**	Antiemetic(dopamine antagonist)	It promotes gut motility by inhibiting presynaptic and postsynaptic D_2 receptors as well as presynaptic 5-HT_4 receptors. It promotes antiemetic effects by inhibiting of D_2 and 5- HT_3 receptors in the chemoreceptor trigger zone.	Patient was relieved from nausea and vomiting after drug administration by not vomiting again.	Drowsiness, dizziness, confusion. None was observed

Table 5: Pharmacology of Drugs Prescribed for Miss A.D.

Date	Drug	Dosage/Route of Administration (Literature)	Dosage/Route Of Administration	Classification	Desired Effects	Actual Action Observed	Side Effects/Remedies
12/12/22	Injection Diclofenac	75mg intramuscularly qid if necessary **Route:** Route: Orally, Rectal, Intramuscular, and topical	75mg stat Intramuscularly	Non-Steroidal Anti-Inflammatory drug, analgesic antipyretics	It inhibits cyclooxygenase-1 and 2, the enzymes responsible for production of prostaglandins. These molecules inhibit pain and inflammation.	Patient pain subsided as patient showed cheerful facial expression	Dizziness, anxiety, diarrhoea, vomiting No side effect observed

12/12/22 16/12/2022	Suspension Nugel Suspension Nugel	15mls three times daily **Route: Orally** 15mls three times daily **Route: Orally**	15mls tds x 7 days **Orally** 15mls three times daily for 7 days. **Orally**	Anti-dopaminergic agent	It neutralizes acidity, increasing the pH, or reversibly reduce or block the secretion of acid by gastric cells to reduce acidity in the stomach and also neutralizing the stomach acid that causes heartburn.	Patient did not nauseate nor vomit and did not complain of gastrointestinal disturbances again	Headache, dizziness, dry mouth None was observed

Complications

Complication is an accident or second disease process arising during the course of or following primary disease but not necessarily connected with it.

With regards to the reviewed literature, Miss A.D. did not get any complication during her hospitalization. This could be well attributed to client's early report to the hospital for treatment. Miss. A.D. gave no complains that conceded with any of the complications.

2.2 Patient/Family Strengths

Strength refers to the ability, capability or resource that can aid the patient to cope with stress especially health problems thereby contributing to his or her speedy recovery. This could be physical, psychological, social and spiritual.

During Miss A. D.'s care, the following strengths were exhibited;

1. Patient can verbalize the extent of pain (12/12/2022)
2. Client was able to take 100mls of porridge. (12/12/2022)
3. Patient was able to take water and some non-irritating soft drinks. (12/12/2022)
4. Patient was able to sleep for about 2 hours during the night. (13/12/2022)
5. Patient was able to verbalize her fears (13/12/2022)
6. Patient verbalized the importance of acquiring adequate knowledge on gastritis. (14/12/2022)

2.3 Patient's Health Problems

The problems identified on Miss A.D. include the following;

1. Patient complains of abdominal pains. (12/12/2022)
2. She complained of loss of appetite (anorexia). (12/12/2022)
3. Patient had nausea and vomiting. (12/12/2022)
4. Patient had difficulty sleeping. (13/12/2022)
5. Patient was anxious (13/12/2022)
6. Patient had deficient knowledge on her condition. (14/12/2022)

2.4 Nursing Diagnosis

Nursing diagnosis is a statement about the patient's actual or potential health concerns that can be managed through independent nursing interventions. The statement is made by associating the health problems with the likely causes of the problem.

These statements are concise, clear and patient centred. The following nursing diagnoses were made on Miss A.D. during her period of hospitalization.

1. Abdominal pain related to inflammation of gastric mucosa. (12/12/2022)
2. Imbalanced nutrition; less than body requirement related to inadequate dietary intake as evidenced by insufficient interest in food. (12/12/2022)
3. Risk for deficient fluid volume as evidenced by nausea and vomiting.(12/12/2022)
4. Insomnia related to noise at the ward and interruptions from nursing procedures. (13/12/2022)
5. Anxiety related to change in patient health status as evidenced by absent eye contact and lack of cooperation. (13/12/2022)
6. Deficient knowledge related to inadequate information as evidenced by inadequate knowledge on acute gastritis cause, treatment and prevention. (14/12/2022)

CHAPTER 3

PLANNING FOR PATIENT / FAMILY CARE

Introduction.

Planning is the third step which involves prioritization of patient's problems, setting of objectives and outcome criteria and outlining the methods of solving those problems. It also includes a statement of specification used to achieve goals specified and documentation of the care plan. It also aims towards designing measures or interventions required to prevent, reduce or eliminate the patient's health problems that were identified during the analysis.

3.1 Objectives for Patient/Family Care

A goal or an objective of nursing care is the desired outcome of the nursing intervention. Outcome criteria on the other hand are statements that describe the standard against which the goal was set. The set goals should be specific, measurable, achievable, and realistic and time bound.

1. (12/12/2022) Patient would be relieved of abdominal pain within 48 hours of hospitalization as evidenced by;
    a. Patient verbalizing that she is relieved of abdominal pain.
    b. Nurse observing patient having a cheerful facial expression.

2. (12/12/2022) Patient would be able to attain and maintain adequate nutrition status within 48 hours as evidenced by;
    a. Patient verbalizing that she has gained appetite for food.
    b. Nurse observing that patient takes in at least two thirds of 500ml of porridge served.

3. (12/12/2022) Patient nausea and vomiting would subside within 24 hours as evidenced by;
    a. Patient verbalizing that she is relieved of nausea and vomiting.
    b. Nurse observing patient with a cheerful facial expression.

4. (13/12/2022) Patient would regain her normal sleeping pattern within 24 hours of hospitalization as evidenced by;
    a. Patient verbalizing that she was able to sleep with reduced feelings of severe headache and had a cheerful facial expression.
    b. Nurse observing patient sleep for 6-8 hours at night without interruption.

5. (13/12/2022) Patient and family would express a relieve of fear and anxiety within 24 hours as evidenced by;
    a. Patient verbalizing that she no longer feels anxious.
       Nurse observing that patient interacting with other patient.

6. (14/12/2022) Patient and family will gain adequate knowledge on acute gastritis within the period of hospitalization as evidenced by;
    a. Patient and relatives being able to provide correct answers to questions posed to them with regard to the causes and management of gastritis.
    b. Nurse observing that patient and relatives practice knowledge gained on acute gastritis.

Table 5: Nursing Care Plan

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation Statement	Sign
12/12/22 15:55pm	Abdominal pain related to inflammation of gastric mucosa	Patient would be relieved of abdominal pain within 48 hours of hospitalization as evidenced by; 1. Patient verbalizing that she is relieved of abdominal pain. 2. Nurse observing a cheerful facial expression.	1. Assess the frequency and duration of pain using the numerical rating scale. 2. Serve regular scheduled, frequent meals in small quantities. 3. Assist patient to assume comfortable position. 4. Encourage the intake of copious fluids that do not irritate the gastric mucosa. 5. Educate patient on measures taken to resolve the problem. 6. Administer prescribed analgesic.	1. Patients rated pain as '6' on numerical rating scale 2. Jollof rice and chicken was served to patient in small quantities and alternated with yam and kontonmire stew ate regular intervals. 3. Patient was put into fowler's position. 4. Patient took milo and 3 litres of water within 24 hours 5. Patient was educated on avoidance of irritative foods such as pepper soup and alcoholic drinks 6. Prescribed Intravenous Tramadol 100mg in DNS was administered.	14/12/22 15:55pm	Goals fully met as: 1. Patient verbalizing that she is relieved of abdominal pain. 2. Nurse observed a cheerful facial expression.	BSM

Table 5: Nursing Care Plan Con.t

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/Time	Evaluation Statement	Sign
12/12/22 16:00pm	Imbalanced nutrition less than body requirement related to inadequate dietary intake as evidenced by insufficient interest in food	Patient would be able to attain and maintain adequate nutrition within 48 hours as evidenced by; 1. Patient verbalizing that she has gained appetite for food. 2. Nurse observing that patient takes in at least two thirds of 500ml of porridge served.	1. Assess the cause of the anorexia. 2. Plan diet with patient. 3. Give mouth care to patient before eating. 4. Assist patient to empty his bowel whenever the need arises. 5. Serve small meals at frequent intervals and allow patient enough time to chew and swallow. 6. Encourage the intake of non- irritating fruits.	1. The cause of the anorexia, and dietary regimen was assessed. 2. Diet was planned with patient. 3. Patient was assisted to brush her teeth with tooth paste (Pepsodent) and brush before eating. 4. Patient was assisted to empty his bowel whenever the need arises. 5. Small meals at frequent intervals were served and patient was given enough time to chew and swallow. 6. The intake of non- irritating fruits such as banana and pawpaw were encouraged.	14/12/22 16:00pm	Goals fully met as; 1. Patient verbalized that she had gained appetite for food. 2. Nurse observed that patient took in at least two thirds of 500ml of porridge served.	BSM

Table 5: Nursing Care Plan Con.t

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/Time	Evaluation Statement	Sign
12/12/22 16:10pm	Risk for deficient fluid volume as evidenced by nausea and vomiting.	Patient nausea and vomiting would subside within 24 hours as evidenced by; 1. Patient verbalizing that she is relieved of nausea and vomiting. 2. Nurse observing patient have a normal skin turgor.	1. Reassure patient and relative. 2. Assist patient to clean her mouth. 3. Plan meals with client. 4. Encourage intake of oral fluid at least 150mls per hour. 5. Monitor intake and output and balance every 24 hours. 6. Encourage intake of bismuth containing biscuits, ginger (tea), and lemon drinks to manage nausea.	1. Patient and relatives were reassured of competent nursing care. 2. Patient was assisted to perform oral hygiene with toothbrush and pepsodent. 3. Meals were planned with client. 4. Patient was encouraged and served oral fluid of at least 150mls per hour. 5. Intake and output was monitored, recorded and balanced 24 hours. Fluid intake was 4,500mls while output was 4,120mls. 6. Client sipped ginger tea and lemon frequently and took in bismuth containing biscuit to manage nausea. .	13/12/22 16:10pm	Goals fully met as nurse observed; 1. Patient having a cheerful facial expression 2. Patient verbalizing that she is relieved of nausea.	BSM

Table 5: Nursing Care Plan Con.t

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation Statement	Sign
13/12/22 8:00am	Insomnia related to noise at the ward and interruptions from nursing procedures.	Patient would regain her normal sleeping pattern within 24 hours of hospitalization as evidenced by; 1. Patient verbalizing that she was able to sleep well with no disturbances. 2. Nurse observing patient sleep for 6-8 hours at night without interruption.	1. Reassure patient and family. 2. Assess sleep pattern of patient. 3. Encourage regular evening routines that promote sleep. 4. Ensure a noise-free and calm environment. 5. Prepare and make a comfortable bed for the patient to enhance quality of sleep. 6. Plan sleep/activity periods.	1. Patient and family were reassured. 2. A complete sleep history of patient was obtained which indicated that patient normally sleeps for at least 10 hours at night and day a daytime nap for at least 30minutes uninterrupted. 3. Medication and activities were done quickly for patient to rest and sleep. 4. The ward was kept calm and conducive for sleep. 5. A simple warm occupied bed was made for patient. 6. A plan was developed to enable patient sleep. In line with her sleep history, she was to have 10 hours sleep at night uninterrupted and 30minutes of nap during the day.	14/12/22 8:00am	Goal fully met as; 1. Patient verbalizing that she was able to sleep well with no headache. 2. Nurse observed patient sleep for 7-8 hours at night without interruption.	BSM

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation Statement	Sign
13/12/22 9:00am	Anxiety and fear related to change in patient health as evidenced by absent eye contact and self-report of anxiety	Patient and family would express a relieve of fear and anxiety within 24 hours as evidenced by; 1. Patient verbalizing that she no longer feels anxious. 2. Nurse observing that patient interacting with other patient.	1. Reassure the patient on disease condition 2. Give patient and family clear, concise explanation of every procedure. 3. Provide proper orientation to the new environment. 4. Acknowledge relative anxiety and she legitimate concerns over patient health. 5. Assess the type and level of anxiety and clinical features of anxiety. 6. Educate patient and relative on treatment modalities and alternatives of gastritis if any.	1. Patient was reassured on disease condition 2. Procedure was explained to patient and family. 3. Relative was oriented to the ward and its environment to promote comfort and decrease anxiety. 4. Relative anxiety was acknowledged an average of 10 minutes was spent with her by the nurse twice per shift to offer understanding, trust and empathy. 5. Hamilton's anxiety scale of clinical questions was used assessing the patient and relative anxiety. 6. Patient and family was educated on the treatment of gastritis such as the administration of proton pump inhibitors.	14/12/22 9:00am	Goal fully met as 1. Patient verbalizing that she no longer felt anxious. 2. Nurse observing that patient interacting with other patient.	BSM

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation Statement	Sign
14/12/22 10:00am	Deficient knowledge related to inadequate information as evidenced by; Inadequate knowledge on acute gastritis cause, treatment and prevention.	Patient and family will gain adequate knowledge on acute gastritis within the period of hospitalization as evidenced by; 1. Patient and relatives being able to provide correct answers to questions posed to them with regard to the causes and management of gastritis. 2. Nurse observing that patient practice knowledge gained on acute gastritis.	1. Reassure the patient on disease condition. 2. Assess patient's level of knowledge about the disease condition. 3. Educate patient on the disease condition. 4. Encourage patient to ask question. 5. Use visual aids to help in understanding. 6. Evaluate patients understanding on the condition.	1. Patient was reassured on disease condition. 2. Patient level of knowledge about the disease condition was assessed and patient was able to mentioned three preventive measures of the disease condition. 3. Patient was educated on the disease condition. 4. Patient was encouraged to ask question when understanding was not clear. 5. Patient was showed visual aids to help understanding. E.g. diagrams on the affected organs. 6. Questions were asked to assess patient's understanding of the teaching on the condition.	15/12/22 10:00am	Goals fully met as: 1. Patient was able to provide correct answers to the question posed to her with regard to the causes and management of gastritis. 2. Nurse observed patient practice knowledge gained on acute gastritis.	BSM

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

Implementation is the process of putting the nursing care plan which includes medical and nursing determined interventions into action. It is the action taken based on the findings in the care plan. This helps to attain desired outcomes.

The goal of this stage is to achieve client's independence.

This chapter deals with a summary of actual nursing care rendered to patient and her family, right from the day of admission till the time of discharge. (i.e. putting the nursing care plan into action) preparation of patient and family towards discharge and rehabilitation and follow up/home visit and continuity of care.

4.1 Summary of Actual Nursing Care Rendered to Miss A.D. and Her Family

This depicts the actual nursing care given to Miss A.D. and her family. This subsection is discussed under the days of hospitalization.

First day of Admission (12/12/2022)

Miss A.D. was admitted to the female medical ward of Sunyani Municipal Hospital, Sunyani on 12th December, 2022 at 15:45pm. She was brought to the ward as a Tran's in-patient from emergency unit of Sunyani Municipal Hospital. She was ambulant on arrival and was accompanied by one nurse and a relative and so was welcomed and made comfortable at the nurse's station. The patient was immediately received into an already prepared bed. All necessary information such as client particulars were recorded in the admission and discharge book.

Vital Signs were checked and recorded as;

Temperature	36.9 degree Celsius
Heart Rate	80 beats per minute
Respiration	20 cycles per minute
Blood pressure	120/60 millimetres of mercury

SPO_2 99%

Patient's weight on admission was 65kg.

Medications ordered and served were;

- Intravenous tramadol 100mg in 500mls of Dextrose Normal Saline stat dose
- Intravenous omeprazole 80mg stat 40mg bd x24hours
- Intravenous Buscopan 40mg stat 20mg bd x 24hours
- Infusion ciprofloxacin 400mg bd x 24 hours
- Intravenous metoclopramide10mg tds x 48hours
- Suspension Nugel 15 mls tds x 7 days
- Injection Diclofenac 75mg stat
- Infusion Ringers Lactate 500mls x 24 hours
    - Tab Buscopan 20mg tds x 6days
    - Capsule Omeprazole 20mg bd x 4 days.

The following investigations were ordered and done;

- Urine for routine examinations
- Blood specimen for malaria parasite
- Blood for full blood count

Patient presented with general body weakness, abdominal pains, headache, nausea and vomiting and loss of appetite. Patient was encouraged to take in small frequent meals at least every 2 – 3 hours during the day, patient was encouraged to take in small amount of oral fluids during the day and also vomitus bowl was giving to patient anytime she felt like vomiting. Patient was reassured and was made comfortable in bed. I told her that her admission will last for few days and she will be discharge home. Patient relative was oriented to the ward and hospital routines, visiting hours, meal time, and ward rounds were explained to the patient and her relative.

In managing the pain, intravenous line was passed on her and intravenous Tramadol 100mg in 500mls of dextrose normal saline intravenously as stat dose. Patient and her family promised to co-operate fully with the nurses and doctors and to adhere to all instructions.

At 3:55pm, after Miss A.D. and family were relaxed, she complained of abdominal pains. Abdominal pain related to inflammation of gastric mucosa was formulated as a nursing

diagnosis for her. Patient would be relieved of abdominal pain within 48 hours was an objective made for her on that day. The following interventions were carried out on the patient. Patient's frequency and duration of pain was assessed using the rating scale of 0-10, frequent meals in small quantities were served, patient was assisted to assume a comfortable position, patient was encouraged to take copious fluids that do not irritate the gastric mucosa, prescribed medications, Intravenous Tramadol 100mg was administered.

At 4:00pm, patient had no appetite for food. A nursing diagnosis was formulated as Imbalanced nutrition less than body requirement related to inadequate dietary intake as evidenced by insufficient interest in food.

An objective was established that patient would be able to attain and maintain adequate nutrition within 48 hours. The following intervention was carried out; the cause of the anorexia, and dietary regimen were assessed, diet was planned with patient, mouth care to patient was given before eating, patient was assisted to empty her bowel whenever the need arose, small meals at frequent intervals were served and patient was given enough time to chew and swallow, the intake of non- irritating fruits such as banana, watermelon and pawpaw were encouraged.

At 4:10pm she was vomiting profusely. A nursing diagnosis was formulated as; Risk for deficient fluid volume as evidenced by nausea and vomiting. An objective was established that; Patient nausea and vomiting would subside within 24 hours. Nursing interventions carried out on the patient were as follows; patient was reassured, patient was assisted to perform oral hygiene, intake of oral fluid was encouraged, intake and output were monitored and recorded and balanced 24 hours and Client sipped ginger tea and lemon frequently and took in bismuth containing biscuit to manage nausea. Patient's skin turgor was also observed for any signs of dehydration.

Patient had banku with okro stew, conversed with other patients at the ward and finally rested for about an hour before taking her bath.

At 6pm, patient's vital signs were checked and recorded and she was made comfortable in bed.

I handed her over to one of the nurses and informed of my intentions to leave since it was getting late, then I left.

Second Day of Admission (13/12/2022)

I visited Miss A.D. at 5:40am and she was already up but was on bed. Enquiry was made about her night and she responded she had a sound sleep with a broad smile. She was able to bath without assistance but was assisted to maintain her oral care.

At 6:00am, vital signs were checked and recorded as follows;

Temperature	36.9 degrees Celsius
Pulse	80 Beats per Minute
Respiration	20 Cycles per Minute
Blood Pressure	120/60 millimetres of mercury

Patient took porridge and bread as breakfast around 7:50am and I reassured her of competent nursing care.

The due medications were served and documented.

On ward rounds the doctor prescribed suspension Nugel 15mls tds x 7 for Miss A.D. The patient was assured of possible discharge if the condition remains stable.

Patient was encouraged to engage in playing with her phone and other client on the ward which she did, and Paracetamol tablet 1g was administered as prescribed to the patient. At lunch, Miss A.D. took banku and groundnut soup. She was made comfortable in bed and allowed to walk around whenever she feels to do so.

The due medications were served and documented. After an interaction with them, I informed her sister of her possible discharge if her condition improves. I informed them of visiting their home with the company of her sister to enable me familiarize with their environment which they readily agreed.

At 8:00am, a nursing diagnosis was formulated as Insomnia related to noise at the ward and interruptions from nursing procedures. An objective was set as; Patient would regain her normal sleeping pattern within 24 hours. The following interventions were made; patient and family were reassured, the ward was kept calm and conducive for sleep, a simple warm occupied bed was made for patient.

Medication and activities were done quickly for patient to rest and sleep, a complete sleep history of patient was obtained which indicated that patient normally sleeps for at least 10 hours at night and day a daytime nap for at least 30minutes uninterrupted.

At 9:00am patient was observed to be anxious, therefore a nursing diagnosis was formulated as; Anxiety and fear related to change in patient's health. An objective was set as; patient and family would express a relieve of fear and anxiety within 24 hours. The following interventions were done as; patient was reassured on the disease condition, procedure was

explained to patient, patients' relatives were oriented to the ward and its environment to promote comfort and decrease anxiety, patient and family was educated on the treatment of acute gastritis.

At lunch, Miss A.D. took banku and groundnut soup. She was made comfortable in bed and allowed to walk around whenever she feels to do so.

Vital signs were checked and recorded. Medications were served and documented. Patient was assisted to bath and she was encouraged to brush her teeth and had a small rest around 4:00pm.

At 4:10pm, I evaluated an objective set as nausea and vomiting would subside within 24hours on the 12th of December was met as nurse observed that patient had a cheerful facial expression.

At 4:30pm, I handed over the patient to the afternoon nurse and I inform her that I am going to the market after which I will come back. She was informed to consult the afternoon nurse in case she needs anything.

At 5:45pm, I visited her and reassured her that with the help of the competent staff and cooperation of the other family members, her condition will subside.

At 6pm, patient's vital signs were checked and recorded and patient ate a small bowl of rice with stew and egg for supper.

Medications were served and documented in the nurse's notes. Patient was reassured and made comfortable in bed.

Third Day of Admission (14/12/2022)

Miss A.D. was seen in the morning around 5:30am. By the time I got there, when she was still in bed sleeping. I woke her up and she was assisted to brush her teeth with water and pepsodent.

After which she was able to take her bath with soap, water and sponge and she was congratulated for her efforts since she was weak on admission. Miss A.D. still asked me when she would get better and discharged home. I continued to assure her that, it would be a bit sooner since she was doing much better than the previous days. She was made aware that although she was doing better, Doctor would decide as to when she would be discharged. The usual nursing care as for the other days continued.

At 6:00am, vital signs were checked and recorded as follows;

Temperature	36.7 degrees Celsius
Pulse	76 Beats per Minute
Respiration	21 Cycles per Minute
Blood Pressure	130/70 millimetres of mercury

The due medications were administer and documented in the treatment sheet. Her nutritional needs as well as rest and comfort were cared for.

At 6:30am, patient was able to care for herself independently. She was once again reminded about the need to report signs and symptoms of recurrence and complications to the hospital as early as possible.

At 8:00am, I evaluated the objective set on the 13th December, that patient would regain her normal sleeping pattern within 24 hours of hospitalization. Goal was met as nurse observed patient sleep for 6-8 hours at night without interruption.

At 8:20am, Doctor came on rounds and informed her about possible discharge the following day. Miss A. D.'s heart was really filled with so much joy that she started shedding tears. Patient verbalized that she could perform her daily activities of living such as bathing and the rest.

At 9:00am, evaluation was done for the objective set to relive patient anxiety. Goal was fully met as patient and family were able to verbalize that she is no longer anxious.

Education on personal hygiene, dietary modification and good lifestyle were given. Prescribed medication was administered for the patient on the said time and she was served with Hausa porridge with bread for breakfast and she was made comfortable in bed.

At 10:00am, patient also had no knowledge on her disease condition. A nursing diagnosis was Deficient knowledge related to inadequate information. An objective was also established as Patient and family will gain adequate knowledge on acute gastritis within the period of hospitalization. The following interventions were carried out; patient was reassured, patient level of knowledge about the disease condition was assessed, patient was educated on the condition, patient was encouraged to ask a question when understanding was not clear, patient was showed visual aids to aid understanding, E.g. diagrams on the affected organs, questions were asked to assess patient's understanding of the teaching on the condition.

Capsule omeprazole 20mg, Tablet Paracetamol 1g and Suspension Nugel 15mls were administer and documented in the treatment sheet.

At 3:55pm, I evaluated the objective set on the 12th December, to relieve patient of abdominal pain. The goal was fully met as; patient had a cheerful facial expression and verbalized of absence of pain.

At 4:00pm, the objective set on the 12th December, that patient would be able to attain and maintain adequate nutrition within 48 hours was evaluated. Goal was met as patient verbalized that she gained appetite for food.

She slept for about 2hours and woke up around 6:30pm, her vital signs were checked and recorded, her aunty visited her and she was happy to see her. I had a conversation with them regarding the possible discharge the next day.

At 7:00pm, Miss A.D. took fufu and palm nut soup as supper. She found interest watching a Ghanaian movie which was telecast on Adom TV on the ward television. The environment was made comfortable for her to induce sleeping and she slept around 8:45pm.

At 10pm in the night, the due medications were administered and documented in the treatment sheet. I wished her good night and left the hospital immediately since it was getting dark and handed her over to one of the staffs before leaving.

Fourth Day of Admission (15/12/2022)

This was Miss A.D. fourth day of admission. After a long sleep over night, Miss A.D. woke up around 5:55am to maintain her personal hygiene that is bathing and frequent mouth care was encouraged in order to promote good appetite. Education on the need to eat adequately to build the body defences for early recovery was provided to client and all due medications were administer as prescribed and documented. She was served with porridge with sugar and bread.

At 6:30am her vital signs were checked and recorded as follows;

Temperature	36.8 degrees Celsius
Pulse	69 Beats per Minute
Respiration	23 Cycles per Minute
Blood Pressure	130/70 millimetres of mercury

During the ward rounds at 8:30am, Miss A.D. verbalized she had a sound sleep in the night. She made no new complains. Client was served with porridge and bread for breakfast.

At 10:00am, goal set to enable patient gain knowledge was evaluated. Goal was fully met as; patient was able to answer more than half of the questions asked.

She also had Banku with okro stew and fish for lunch which confirmed her good appetite. She also requested for heaven juice drink some few minutes after taking her lunch.

Prescribed medications were administered and documented. Her Aunty came with Miss A. D.'s junior brother to visit her. She was happy to see them especially her beloved brother Mr. N. M. They had a lot of conversations. I went there and asked her of her choice of meal and she said she would like to eat fufu which her elder sister brought some from home which she ate with her junior brother. After which, she escorted them at the gate by herself and came to the ward. The due medications were administered. After which, she came out of bed to watch television and retired to bed around 9:00pm.

Fifth Day of Admission (16/12/2022) Day of Discharge

On the 16th December, 2022 was Miss A.D. fifth day on the ward. I got there around 6:00am to check on her. On arrival, she was already awake from bed and had already performed her mouth care and took her bath. At 6:00am medication was about to be administered but she refused the drugs because she has not eaten and her relative went home but did not returned early with her food.

A staff nurse who felt sympathy for her offered a portion of her food for her to take before she could take the drugs.

Her vitals were checked and recorded as;

Temperature	36.5 degree Celsius
Pulse	74 beat per minute
Respiration	19 cycles per minute
Blood pressure	110/70 millimetres of mercury.

The Doctor came for rounds around 8am, Miss A.D. was looking very cheerful than she used to be and was conversing with her relative who was with her on the ward.

Doctor informed her she will be discharged home. Miss A.D. felt very happy when she was informed by the doctor she would be discharged home. She had already attended to her personal hygiene. The doctor upon seeing the kind of her improvement made, discharged her home and asked her to come for review the next week 22nd December, 2022.

Despite the benefits of the National Health Insurance, she was asked to settle some bills at the accounts. Her bills were worked out for her to pay and have the privilege to go home. The bill cost her Ghc 300.00 which her relative paid. She was discharged with Tablet Buscopan 20mg three times daily for 6 days, capsule omeprazole 20mg twice daily for 4 days and suspension Nugel 15mls tds x 7days. Explanation on how to take the drugs was given as well as their action and side effects.

She was advised to report any signs of recurrence or complications to the hospital for the necessary treatment.

Advice on dietary modification, reduction of stress, maintenance of good personal hygiene, avoidance of the intake of mucosal irritants such as spices and alcohol, and the avoidance of the intake of over the counter drugs were given to Miss A.D. and her relative.

They were made aware of the second home visit that would be paid to them on that same day because of the issue at hand, which they agreed and were very pleased. I reminded them of the review date which was on the 22nd December, 2022. Miss A.D. and her relative expressed

their sincere gratitude to all the nursing staff on duty for the proper care and attention rendered to her during the period of hospitalization to the ward. Afterwards I helped her to pack her belongings and escorted them to the hospital gate where they bored a taxi and we bid each other good bye and they left.

The admission was entered in the Admission and Discharge book as well as daily ward state.

I returned to the ward to remove the bed linen, the pillow, mattress and the bed side locker were disinfected making them ready for use once again.

4.2 Preparation of Patient and Family for Discharge and Rehabilitation

The preparation of patient towards discharge started from the day of admission to the day of discharge. The preparation of my patient and family towards discharge was aimed at educating the patient to accept her condition, how to maintain her health status and prevent further illness when she goes home. The possible duration of hospitalization was discussed with my patient and family. They were encouraged to express their fears and ask questions. The causes, signs and symptoms, treatment and prevention were explained to them. The need for personal and environmental hygiene and the need to report early to a health centre when any abnormality in relation to her condition or any other condition that is noticed in the family as stressed.

The needs to take her drugs, come for review and follow up after discharge were emphasized. When the day for discharge was due, I informed them. The review date was made known to them. She was discharged on 16th December, 2022. As at 11:30am, I assisted them to pack their things. She and her relative expressed their profound gratitude to the staff and I bid them good bye. I told them I will be visiting them, and they were happy to hear that.

4.3 Follow Ups/Home Visits /Continuity of Care

Home visit is a type of visit paid to patients or clients in their homes to assist them lead a healthy life, prevent illness or disabilities and ensure continuity of care. It helps to assess the client in a normal situation using her/her own items. By so doing, the patient is relaxed and co-operate with the care. Early detection and prevention of some conditions are made.

First Home Visit (13/12/2022)

I paid my first visit when my patient was still in the hospital. I chose that because it would help me to know how to prepare my patient towards discharge. The aim of this visit is to verify the information about the patient's home for subsequent visits, to see if there is any problem in the house that could serve as a predisposing factor for the patient's illness and to identify any health facility nearby in case of referral. After planning with Miss A.D. and her elder sister Mrs C.O, they gave me the direction to their house.

I left the ward around 2pm to the Rex junction where I picked a Taxi. From Rex to Asufufu is about 20 minutes journey. Within 20 minutes' I was able to alight at the town. After alighting at the Asufufu, I asked of a spot named 'daddy's spot where I alighted which is the landmark at the area where she stay. I was directed to the area, with the help of the house number (PLT/NO, 52, SEC 11 BLK C), I was able to locate the house. I got there around 3:10pm. When I got to the house, I greeted everyone in the house. I introduced myself to the relatives a man and two young girls and the other house members in the house. The house was in apartments ,which I wondered whether I was at the right house because due to our conversations earlier I expected to see a small house with lots of people inside ,but to my dismay the house I was directed to was very huge and nice with 5 bedrooms and a hall. The corridors and the hall were in tiles. After they have welcomed me, I asked of their welfare including their health status. I also asked if this was Miss AD's father's house but she laughed at me so loudly which I also did same ignorance of what made her so happy. She finally stopped laughing and told me this was Miss AD's house which she rented together with her fiancée due to their own hardwork earned money and that they had being staying together for some years now , and that she was staying with him until the illness started. Afterwards I asked Miss AF one of the girls at the house of their source of water which was pipe borne except when taps are not flowing, when they fetch water from a nearby mechanised borehole. I observed that they had a good water storage system. Their environment was well kept and their toilet facility was the water closet type which they were already keeping it clean when I intentionally asked permission to use it. I congratulated them for that. They told me they dispose their refuse into a tractor every morning and pay.

Based on the observations and enquiries I made, I encouraged them to continue keeping their environment clean and take care of their personal hygiene especially the children in the house whenever they close from school.

The need to open their windows for proper ventilation was emphasized to prevent diseases among the children.

They were advised to immunize their children and report any illness early to the hospital. The need to use insecticide treated mosquito net especially for the children was stressed.
Apart from there I educated them on the causes, signs and symptoms, prevention and treatment of gastritis and encouraged them not to take more irritative and highly seasoned foods. I answered all questions that were asked and lastly informed them to receive their beloved warmly and co-operate with her as she would be coming home soon. After this I asked permission to leave which was granted to me. I returned to the hospital around 6:00pm.

Second Home Visit (16/12/2022)

The date for my second home visitation was 16th December, 2022.I chose to pay them my second home visit on the same day of discharge because of the issue at hand. The aim of this visit is; to ensure that patient is adhering to treatment regimen, and to remind patient patient of review date. I got to the house at 3:30pm. They were all happy to see me again. After exchange of greetings, I asked her of the progress of her health. She testified that, she was very strong. I thanked her and I reminded them of the education given them and the date for her next review which was 22nd December, 2022. I asked them about the medications which she brought them for me to see and indeed she followed what I told her to do.
After our discussions, I bid them good bye and left to the hospital.

Review Day (22/12/2022)

Miss A.D came for review on 22nd December, 2022. She looked healthier and stronger .Miss A.D came with no complains but the general condition was stable. She was encouraged by Dr. R.U to eat regularly and frequently and avoid highly seasoned foods, coffee, tea and highly alcoholic beverages .She was also advised not to engage in more stressful activities. She was declared fit by Dr. R.U and no new drugs were prescribed for her. She was advised to report with any health problem to the hospital and should avoid self-medication.I informed her of my last visit to them and which was on the 28th December, 2022.

Third Home Visit (28th December, 2022)

On 28th December, 2022, I paid my third visit to Miss A.D. My aim of that visit was to terminate my care for her and her family. I reached there at 12:00pm. After exchange of greetings, I made them aware of my aim which was to terminate my care as explained to her during admission. I asked of her health status and she said she is well and has even started working. Although it was quite a sad event for my care to be terminated, they were very

grateful and appreciated my care for them. Without any further questions, I asked permission and left.

I handed over to her elder sister who was present at that time to continue the care because the condition is acute and so did not require any follow up. Which she accepted to do so.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO MISS A.D AND FAMILY.

5.0 Introduction

Evaluation is defined as an on-going comparison or appraisal of the degree to which the outcomes have been accomplished. It provides important feedback for changing priorities and revising the care plan.

5.1 Statement of Evaluation

Miss A.D was admitted on 12th December, 2022 with a diagnosis of Acute Gastritis. During her five-days of hospitalization, the nursing care plan drawn in chapter 3 was used which helped me to set many goals and objectives related to the assessment made on her. This enhanced proper nursing care and a speedy recovery. All the six goals or objectives were met at set time and date. The following health problems were identified, nursing care plan was drawn and the objectives achieved are as follows;

Miss A.D was relieved of abdominal pain within 48 hours

After Miss A.D and family were relaxed, she complained of abdominal pains. At 3:55pm on 12th December, Abdominal pain related to inflammation of gastric mucosa was formulated as a nursing diagnosis for her. Patient would be relieved of relieved of abdominal pain within 48 hours. The following interventions were carried out on the patient. Patient's frequency and duration of pain was assessed using the rating scale of 0-10, frequent meals in small quantities were served, patient was assisted to assume a comfortable position, patient was encouraged to take copious fluids that do not irritate the gastric mucosa, prescribed medications, intravenous tramadol 100mg was administered.

On the 14th December, 2022 at 3:55pm, I evaluated the objective set on the 12th December, to relieve patient of abdominal pain. The goal was fully met as; patient had a cheerful facial expression and verbalized of absence of pain.

Miss A.D. was able to attain and maintain adequate nutritional status within 48 hours.

At 4:00pm on 12th December, patient had no appetite for food. A nursing diagnosis was formulated as; imbalanced nutrition less than body requirement related to inadequate dietary intake as evidenced by insufficient interest in food.

An objective was established that patient would be able to attain and maintain adequate nutrition within 48 hours. The following intervention was carried out; the cause of the anorexia, and dietary regimen were assessed, diet was planned with patient, mouth care to patient was given before eating, patient was assisted to empty her bowel whenever the need arose, small meals at frequent intervals were served and patient was given enough time to chew and swallow, the intake of non-irritating fruits such as; banana, watermelon and pawpaw were encouraged.

On the 14th December, 2022 at 4:00pm, the objective set on the 12th December, to help patient be able to attain and maintain adequate nutrition within 48 hours was evaluated. Goal was fully met as patient verbalized that she gained appetite for food.

Nausea and vomiting subsided within 24 hours

On 12th December at 4:10pm, she was vomiting profusely. A nursing diagnosis was formulated as risk for deficient fluid volume as evidenced by nausea and vomiting. An objective was established that patient's nausea and vomiting would subside within 24 hours. Nursing interventions carried out on the patient were as follows; patient was reassured, patient was assisted to perform oral hygiene, intake of oral fluid was encouraged, intake and output were monitored and recorded and balanced 24 hours and client sipped milo frequently and took in bismuth containing biscuits to manage nausea.

At 4:10pm on 13th December, the objective set as nausea and vomiting would subside within 24hours on the 12th of December was evaluated. Goal was met as nurse observed that patient had a cheerful facial expression

Patient regained her normal sleeping pattern within 24 hours.

At 8:00am on 13th December, a nursing diagnosis was formulated as; Insomnia related to noise at the ward and interruptions from nursing procedures. An objective was set as; patient would regain her normal sleeping pattern within 24 hours. The following interventions were made; patient and family were reassured, the ward was kept calm and conducive for sleep, a simple warm occupied bed was made for patient, medication and activities were done quickly for patient to rest and sleep, a complete sleep history of patient was obtained which indicated that patient normally sleeps for atleast 8 to 9 hours at night and day and daytime nap for atleast 30 minutes uninterrupted, vital signs were checked and recorded.
Capsule omeprazole 20mg and tablet Paracetamol 1g were served and documented.

At 8:00am on 14th December, the objective set on the 13th December, as patient would regain her normal sleeping pattern within 24 hours of hospitalization was evaluated. Goal was fully met as nurse observing patient sleep for 6-8 hours at night without interruption.

Miss A.D. was relieved of anxiety within 24 hours

At 9:00am on 13th December, patient was anxious. A nursing diagnosis was formulated as; anxiety and fear related to change in patient's health as evidenced by absent eye contact and self-report of anxiety. Patient verbalizing that she no longer felt anxious. An objective was established that patient would express a relieved of fear and anxiety within 24 hours. The following intervention was carried out; patient was reassured on disease condition, procedure was explained to patient and family, relative was oriented to the ward and its environment to promote comfort and decrease anxiety. Patient and family was educated on the treatment of gastritis.

The objective set on the 13th December, 2022 as patient would express a relive of fear and anxiety was evaluated on the next day, 14th December at 9:00am. Goal was fully met after two hours of interaction and patient and family were able to verbalize that she is no longer anxious.

Patient had adequate knowledge on acute gastritis disease within the period of hospitalization.

At 10:00am on 14th December, patient also had no knowledge on her disease condition. A nursing diagnosis was; deficient knowledge related to inadequate information on disease condition. An objective was also established as; patient and family will gain adequate knowledge on acute gastritis within the period of hospitalization. The following interventions were carried out; patient was reassured, patient's level of knowledge about the disease

condition was assessed, patient was educated on the condition, patient was encouraged to ask questions when understanding was not clear, patient was showed visual aids to aid understanding, eg: diagrams on the affected organs, questions were asked to assess patient's understanding of the teaching on the condition.

At 10:00am on the 15th of December, the objective set on the 14th December, as patient and family would gain knowledge on Acute Gastritis was evaluated. Goal was fully met as; patient was able to answer more than half of the questions asked.

5.2 Amendment of nursing care plan for partially met or unmet outcome criteria

This is usually done in cases of partially met or unmet goals. In this case, all objectives were met and as such no amendment of care plan was carried out.

Termination of care.

During my interaction with my patient in the admission process, I informed her that, a time will come that my care for her will be terminated. After she had been declared fit on 16th December, 2022 by the doctor, I informed her of my last visit on the 28th December, 2022. When I visited her, I made her and the family aware that my care for her has ended since she has been declared fit. I congratulated the family for the care they had rendered to Miss A.D. They were thanked for their co-operation and patient was handed over to her sister. It was a moment to remember when I told them of my intention to leave and then I bid them farewell and left.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

Summary

This patient and family care study gives an account of the holistic care rendered to Miss A.D. from the 12th December, 2022 to 16th December, 2022.

She was admitted at Female Medical Ward at Sunyani Municipal Hospital, for some days after her diagnosis, Acute Gastritis.

The laboratory investigations include; Urine Routine Examination (R/E), blood specimen for malaria parasite and blood for full blood count.

Medical treatment of the condition includes:

- IV Tramadol 100mg in 500mls of Dextrose Normal Saline (DNS)
- IV Ringers Lactate 500mls x 24 hours
- INJ. Diclofenac 75mg stat
- IV Omeprazole 80mg stat, then 40mg bd x24 hours
- IVF Ciprofloxacin 400mg bd x 24 hours
- IV Buscopan 40mg stat, then 20mg bd x 24 hours
- IV Metoclopramide 10mg tds x 48 hours
    - Suspension Nugel 15mls tds x 7 days
    - Tab Buscopan 20mg tds x 6days
    - Capsule Omeprazole 20mg bd x 4 days

Through the use of the nursing care plan, her problems were identified, goals were set and all her needs were met. This contributed to her speedy recovery and she was discharged home happily on 16th December, 2022 without any complications.

First home visit was on the 13thof December, Second home visit was on the 16th of December, review date on the 22nd of December my third home visit on the 28th of December, 2022 respectively.

Follow up care continued until she was declared medically fit. And finally, client was handed over to her elder sister on the 28th December, 2022 marking the termination of the care. Miss

A.D. and her family gained deeper understanding into the causes, signs and symptoms, management and prevention and management of her condition (acute gastritis).

6.1 Conclusion

I would like to conclude that, the nursing process is the best approach that should be adopted in the rendering of individualized care to patients and their families.
Based on this approach, a comprehensive nursing care was rendered to Miss A.D. and her family. This made it possible for her to go through the care safely. This study has helped me to gain much knowledge on the management of some abdominal conditions. Also I have learnt how to nurse patients with this condition and other ones using the nursing process.
I therefore recommend that every student nurse should also embark on patient/family care study and it will help them.

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PATIENT'S FOLDER NUMBER; BR-A01-AAK9348(SUNYANI MUNICIPAL HOSPITAL)

APPENDIX

Table: Vital Signs of Miss A.D.

Date	**Time**	**Temperature (ºC)**	**Pulse (BPM)**	**Respiration (CPM)**	**Blood Pressure (mmHg)**
12/12/2022	15:45pm	36.9	80	20	120/60
	18:00pm	37.0	84	19	120/70
	22:00pm	36.8	81	21	110/70
13/12/2022	6:00am	36.9	80	20	120/60
	10:00am	36.8	79	22	120/80
	02:00pm	37.1	85	19	110/80
	06:00pm	37.0	84	20	120/70
	10:00pm	36.8	81	22	110/70
14/12/2022	6:00am	36.7	76	21	130/70
	10:00am	36.9	80	22	120/80
	02:00pm	37.1	84	19	110/80
	06:00pm	37.0	81	20	120/90
	10:00pm	36.7	77	18	110/70
15/12/2022	6:00am	36.8	69	23	130/70
	10:00am	36.4	80	18	120/80
	02:00pm	36.9	88	19	110/80
	06:00pm	36.2	79	21	120/90
	10:00pm	37.2	84	19	100/80

16/12/2022	6:00am 10:00am	36.5 36.4	74 79	19 22	110/70 120/80

SIGNATORIES

1. **THE STUDENT NURSE**

   Name: **BOSEAH SANDRA MITCHELL**

   Signature: .....

   Date: 6TH JULY, 2023

2. **THE SUPERVISOR, (HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM).**

   Name: **Mr. DRAMANI AYAMBA.**

   Signature: .....

   Date: 06/07/2023

3. **NURSE IN-CHARGE OF THE FEMALES' WARD, (MUNICIPAL HOSPITAL, SUNYANI).**

   Name: MADAM SELINA ACHEAA

   Signature: .....

   Date: 10/07/2023

4. **THE PRINCIPAL, (HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM).**

   Name: **MONICA NKRUMAH**

   Signature: .....

   Date: 17th July, 2023

   PRINCIPAL
   HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE
   BEREKUM