

HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT / FAMILY CARE STUDY IN GASTRITIS

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

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PREFACE

MODERN NURSING IS A PROFESSION THAT REQUIRES KNOWLEDGE, SKILLS AND ATTITUDE. THE ABILITY TO RENDER COMPREHENSIVE NURSING CARE RESTS ON THE NURSES' ABILITY TO ASSESS THE CLIENT'S CONDITION, ANALYSIS, PLAN, IMPLEMENT AND EVALUATE THE EFFECTS OF MANAGEMENT ON CLIENT HEALTH STATUS.

THE PATIENT/ FAMILY CARE STUDY IS A DETAILED ACCOUNT OF NURSING CARE RENDERED TO THE PATIENT AND FAMILY TO MEET THEIR NEEDS. THE STUDY IS DESIGNED TO GIVE A COMPREHENSIVE NURSING CARE TO BOTH PATIENT AND FAMILY FROM THE TIME OF ADMISSION TILL WHEN PATIENT IS FINALLY DISCHARGED TO GO HOME, AS WELL AS FOLLOW-UPS OR HOME VISITS FOR CONTINUITY OF CARE.

THE STUDY ALSO INVOLVES THE NURSING PROCESS WHICH INVOLVES ASSESSMENT OF PATIENT/ FAMILY, PLANNING OF CARE TO BE RENDERED, IMPLEMENTING THE PLAN AND EVALUATING CARE RENDERED TO PATIENT/ FAMILY.

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 WOULD BE USED TO NURSE PATIENTS WHO WILL COME UNDER HIS OR HER CARE IN THE NEAR FUTURE.

THE STUDY ALSO FORMS PART OF THE REQUIREMENTS OF THE NURSING AND MIDWIFERY COUNCIL OF GHANA FOR THE AWARD OF LICENCE IN GENERAL NURSING.

IN THIS STUDY, INITIALS OF PATIENT ARE USED FOR CONFIDENTIALITY.

ACKNOWLEDGMENT

MY ULTIMATE APPRECIATION GOES TO THE ALMIGHTY GOD FOR PROVIDING ME WITH STRENGTH AND KNOWLEDGE FOR THIS PROJECT TO MATERIALIZE.

SPECIAL THANKS GO TO MR. A.B., THE SUBJECT OF THE STUDY AND HIS FAMILY FOR THE SMOOTH INTERACTIONS AND CO-OPERATION.

I AM MUCH GRATEFUL TO MY SUPERVISOR FOR HER TIRELESS EFFORTS, SLEEPLESS NIGHTS, GUIDANCE AND CORRECTIONS FOR THIS SUCCESSFUL SCRIPT.

I AM ALSO GRATEFUL TO THE MEDICAL DOCTORS AND THE STAFF NURSES OF THE MALE WARD AT DORMAA PRESBYTERIAN HOSPITAL.

FURTHER, I WOULD LIKE TO EXTEND MY APPRECIATION TO MY WONDERFUL PARENTS, FOR THEIR UNENDING EMOTIONAL, MORAL, SPIRITUAL, AND FINANCIAL SUPPORT THROUGHOUT THE PERIOD OF THE STUDY.

LASTLY, I AM VERY GRATEFUL TO ALL THE PUBLISHERS AND AUTHORS WHOSE BOOKS I USED DURING THE COURSE OF MY STUDY.

MAY GOD BLESS THEM.

INTRODUCTION

THE PATIENT AND FAMILY CARE STUDY IS A STUDY CONDUCTED ON PATIENT/FAMILY USING THE NURSING PROCESS TO NURSING THE PATIENT AND FAMILY AS AN INDIVIDUAL, TAKING INTO ACCOUNT ALL THE NEEDS OF THE PATIENT NEEDS TO ARRIVE AT A DESIRED OUTCOME. IT ALSO TAKES INTO ACCOUNT OF PATIENT'S PSYCHOLOGICAL AND SOCIAL NEEDS IN PLANNING THE CARE.

ON THE 14TH NOVEMBER, 2021 AT 12:00PM, MR. A.B. WAS RECEIVED INTO THE MALE WARD FROM THE ACCIDENT AND EMERGENCY UNIT OF DORMAA PRESBYTERIAN HOSPITAL. PATIENT WAS DIAGNOSED OF GASTRITIS. WITH THE USE OF NURSING PROCESS, THE PROBLEMS IDENTIFIED WERE DEVELOPED INTO NURSING DIAGNOSIS WITH NURSING ORDERS WHICH WERE IMPLEMENTED TO HELP SOLVE THESE PROBLEMS AND PROMOTE RECOVERY.

USING THE NURSING CARE PLAN, EFFECTIVE NURSING CARE WAS CARRIED OUT ON THE PATIENT TO ENSURE FULL RECOVERY OF MR. A.B. AMONG THE CARE PROVIDED TO HIM WERE BED MAKING, MONITORING OF VITAL SIGNS (TEMPERATURE, PULSE, RESPIRATION, AND BLOOD PRESSURE), PROPER POSITIONING IN BED, ADMINISTRATION OF MEDICATION, AND PATIENT/FAMILY EDUCATION ON PERSONAL HYGIENE. HE WAS DISCHARGED

ON 18TH NOVEMBER, 2021 WHEN HIS CONDITION HAD IMPROVED AND WAS DECLARED FIT TO GO HOME WITH NO COMPLAINS.

GOALS WERE FULLY MET DURING EVALUATION OF CARE. THREE HOME VISITS WERE PAID TO HIM TO ASSESS PROGRESS OF HIS CONDITION AT HOME. THE FIRST HOME VISIT WAS ON 15TH NOVEMBER, 2021, SECOND HOME VISIT WAS ON 23RD NOVEMBER, 2021 AND THIRD HOME VISIT WAS ON 25TH NOVEMBER, 2021. HE REPORTED TO THE HOSPITAL FOR REVIEW ON THE 25TH NOVEMBER, 2021. THERE WAS TERMINATION OF CARE ON 12TH DECEMBER, 2021. THIS CARE STUDY COMPRISES OF SIX CHAPTERS AS FOLLOWS:

CHAPTER ONE DEALS WITH ASSESSMENT OF PATIENT AND HIS FAMILY. THIS INVOLVES COLLECTION OF DATA ABOUT THE PATIENT TO IDENTIFY HER PROBLEMS. CHAPTER TWO DEALS WITH ANALYSIS OF DATA. CHAPTER THREE COMPRISES THE PLANNING PHASE OF THE NURSING PROCESS AND HAS THE TABULATED PLAN OF CARE FOR THE STATED NURSING DIAGNOSES SPANNING THE OBJECTIVE CRITERIA, NURSING ORDERS, INTERVENTION AND EVALUATION. CHAPTER FOUR TACKLES THE ACTUAL IMPLEMENTATION OF THE CARE PLAN GIVING SUMMARY DESCRIPTIONS OF ACTIVITIES WHICH WERE UNDERTAKEN FROM THE MOMENT OF FIRST CONTACT WITH THE PATIENT AT THE TIME OF ADMISSION TO THE WARD TILL DISCHARGE AND SUBSEQUENT FOLLOW UP WITH HOME VISIT. IN CHAPTER FIVE, EVALUATION OF NURSING CARE GIVEN TO THE PATIENT AND HIS FAMILY FROM ENCOUNTER TILL TERMINATION OF NURSE-PATIENT RELATIONSHIP IS DISCUSSED. CHAPTER SIX FOCUSES ON THE SUMMARY AND CONCLUSION OF

THE CARE STUDY REPORT BY REVIEWING THEMATIC ISSUES THAT AROSE IN
THE CARE STUDY FROM ADMISSION TO LAST HOME VISIT AFTER DISCHARGE.

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CHAPTER ONE

ASSESSMENT OF CLIENT/FAMILY

1.0 INTRODUCTION

ASSESSMENT IS THE ACTION OR AN INSTANCE OF MAKING A JUDGMENT ABOUT SOMETHING (Merriam-Wester, 2020). IT IS THE FIRST STEP IN THE NURSING PROCESS. IT IS DONE THROUGH INTERVIEW, OBSERVATION, PHYSICAL ASSESSMENT, LABORATORY INVESTIGATIONS AND RADIOGRAPHIC REPORTS TO IDENTIFY PATIENT'S PROBLEMS AND

STRENGTHS TO ENABLE THE FORMULATION OF APPROPRIATE NURSING DIAGNOSIS AND INTERVENTIONS TO HELP CARE FOR THE PATIENT TO LIVE AN INDEPENDENT NORMAL LIFE. THIS ASSESSMENT COMPRISES OF CLIENT PARTICULARS, FAMILY MEDICAL AND SOCIO-ECONOMIC HISTORY, PATIENT'S DEVELOPMENTAL HISTORY, PATIENT'S LIFESTYLE/HOBBIES, PAST MEDICAL HISTORY, PRESENT MEDICAL HISTORY, ADMISSION OF PATIENT, PATIENT'S CONCEPT OF THE ILLNESS, LITERATURE REVIEW ON DISEASE CONDITION AND VALIDATION OF DATA.

1.1 BIOGRAPHICAL DATA

BIOGRAPHIC DATA REFERS TO INFORMATION ABOUT A PATIENT'S HISTORY AND BEHAVIORAL PATTERNS, GATHERED BY A THERAPIST OR MEDICAL PROFESSIONAL PRIMARILY FROM THE PATIENT BUT SOMETIMES FROM OTHERS WHO KNOW OR ARE RELATED TO HIM OR HER (American Psychological Association, 2020).

MR. A.B. IS THE PATIENT FOR THE CARE STUDY. HE IS 47 YEARS OLD AND WAS BORN ON 10TH MARCH, 1974. HE WAS BORN AT DWAHO IN THE BONO REGION OF GHANA TO MR. K.B. AND MADAM Y.G. HE PRESENTLY RESIDES AT JERICHO A SUBURB OF DORMAA AHENKRO WITH HOUSE NUMBER DAJ/J/191. MR. A.B. IS A CHRISTIAN WHO WORSHIPS WITH SECOND CHANCE MINISTRY. HE IS DARK IN COMPLEXION, 1.81M TALL AND WEIGHS 80KG ON ADMISSION WITH A BMI OF 24.4KG/M². HE CURRENTLY DOES NOT HAVE ANY PARTNER. HE HAS ONE CHILD, WHO IS ALIVE AND HEALTHY. HIS NEXT OF KIN IS HIS SON. MASTER A.D. MR. A.B. HAS FOUR SIBLINGS, ALL FOUR OF THEM ARE ALIVE PRESENTLY. HIS HIGHEST EDUCATIONAL QUALIFICATION IS JUNIOR SECONDARY SCHOOL, FINANCIAL DIFFICULTIES WAS THE MAIN REASON HE

COULD NOT CONTINUE HIS EDUCATION. HE SPEAKS BONO TWI FLUENTLY AND A LITTLE BIT OF ENGLISH. MR. A.B. IS REGISTERED WITH THE NATIONAL HEALTH INSURANCE AUTHORITY. HE HAS NO PHYSICAL DISABILITIES.

1.2 FAMILY'S MEDICAL HISTORY

MEDICAL HISTORY FOCUSES ON THE PATIENT'S HEALTH THROUGHOUT LIFE, INCLUDING CONGENITAL OR ACQUIRED ILLNESSES AND DISORDERS. THE OBJECT IS TO UNCOVER, WHERE POSSIBLE, CLUES TO THE CAUSE OF THE PATIENT'S CURRENT CONDITION (American Psychological Association, 2020). ACCORDING TO PATIENT, MR. A.B., THERE IS NO KNOWN GENETIC, CHRONIC OR FAMILIAL DISEASE SUCH AS HYPERTENSION, DIABETES MELLITUS OR ANY MENTAL DISORDERS IN THE FAMILY. BOTH PARENTS AND SIBLINGS ARE ALIVE AND IN GOOD HEALTH. ACCORDING TO PATIENT AND RELATIVES THEY BUY OVER-THE-COUNTER DRUGS TO TREAT THEIR HEADACHES, FEVERS AND ALSO USE TRADITIONAL MEDICINES BUT IF SYMPTOMS PERSIST, THEY VISIT THE HOSPITAL FOR TREATMENT ON OUT-PATIENT BASIS. BASED ON THIS INFORMATION I EDUCATED THE PATIENT AND RELATIVES ON THE EFFECTS OF THE USE OF OVER THE COUNTER DRUGS AND URGED THEM TO GO FOR MEDICAL CARE FROM ANY HEALTH CENTER WHEN THEY ARE SUFFERING FROM ANY CONDITION. PATIENT HAS BEEN HOSPITALIZED ON TWO OCCASIONS AT DENMIDA HEALTH SERVICES, DORMAA AHENKRO. THESE HOSPITALIZATIONS WERE AS A RESULT OF MALARIA. THERE ARE NO KNOWN ALLERGIES IN THE FAMILY.

1.3 FAMILY SOCIO-ECONOMIC HISTORY

SOCIO ECONOMIC HISTORY REFERS TO THE POSITION OF AN INDIVIDUAL OR GROUP ON THE SOCIOECONOMIC SCALE, WHICH IS DETERMINED BY A COMBINATION OF SOCIAL AND ECONOMIC FACTORS SUCH AS INCOME, AMOUNT AND KIND OF EDUCATION, TYPE AND PRESTIGE OF OCCUPATION, PLACE OF RESIDENCE, AND IN SOME SOCIETIES OR PARTS OF SOCIETY- ETHNIC ORIGIN OR RELIGIOUS BACKGROUND (American Psychological Association, 2020).

ACCORDING TO MR. A.B. THERE IS A FRIENDLY RELATIONSHIP AMONG THE FAMILY MEMBERS. PATIENT'S HOSPITALIZATION NEEDS ARE CATERED FOR BY HIMSELF. PATIENT AND FAMILY MEMBERS ARE ALSO REGISTERED WITH THE NATIONAL HEALTH INSURANCE SCHEME (NHIS) WHICH THEY COME ALONG WITH ANYTIME THEY VISIT THE HOSPITAL WHEN SICK. MR. A.B.S FAMILY IS WELL KNOWN FOR THEIR HOSPITALITY AND GENEROSITY TOWARDS THEIR NEIGHBORS AND VISITORS. PATIENT AND HIS ENTIRE FAMILY ARE CHRISTIANS. THEY ENGAGE THEMSELVES IN RELIGIOUS ACTIVITIES SUCH AS CHRISTMAS AND EASTHER. MOST OF THE FAMILY MEMBERS ARE EMPLOYED. THE INCOME LEVELS OF PATIENT AND RELATIVES ARE SAID TO BE APPRECIABLE. MEMBERS IN THE FAMILY ARE NOT SOCIALLY KNOWN FOR ALCOHOLISM, SMOKING AND ANTI-SOCIAL BEHAVIORS. NO ALLERGIES ARE KNOWN TO PATIENT OR ANY OF THE FAMILY MEMBERS. PATIENT AND FAMILY CONFORM TO THE TRADITIONS AND TABOOS GOVERNING THE COMMUNITY, LIKE NOT ATTENDING FARM ON FRIDAY'S.

1.4 PATIENT'S DEVELOPMENTAL HISTORY

ACCORDING TO MCINTOSH (2013), DEVELOPMENT IS THE PROCESS IN WHICH SOMEONE OR SOMETHING GROWS OR CHANGES AND BECOMES MORE ADVANCED. GROWTH IS THE SERIES OF PHYSICAL CHANGES THAT OCCUR FROM CONCEPTION THROUGH MATURITY. MATURATION IS THE BIOLOGICAL PROCESSES INVOLVED IN AN ORGANISM'S BECOMING FUNCTIONAL OR FULLY DEVELOPED (American Psychological Association, 2020).

PATIENT WAS ABLE TO TELL ME ABOUT HIS DEVELOPMENTAL HISTORY AS TOLD BY HIS MOTHER. ACCORDING TO MR. A.B., HIS MOTHER HAD A SPONTANEOUS VAGINAL DELIVERY AT FULL TERM WITHOUT ANY COMPLICATIONS WITH THE HELP OF TRADITIONAL BIRTH ATTENDANT. PATIENT DID NOT HAVE ANY MEDICAL CONDITION SUCH AS SPINAL BIFIDA, DOWN SYNDROME, CLEFT PALATE OR CLEFT LIP, HYDROCEPHALUS, CONGENITAL HEART DISEASE AT BIRTH. THE BACILLI CALMET GUERIN (BCG) SCAR WHICH PROVES CHILDHOOD IMMUNIZATION AGAINST THE CHILDHOOD VACCINE PREVENTABLE DISEASES WAS SEEN ON HIS RIGHT SHOULDER. PATIENT RAN THROUGH THE NATURAL DEVELOPMENTAL MILESTONE. HE STARTED CRAWLING AT THE 8TH MONTH AND ALTER SIMPLE WORDS LIKE "MAMA", "DADA". HE WALKED AT AGE ONE, DEVELOPED MILK TEETH AT THE 18TH MONTH AFTER BIRTH AND BREAST FEEDING WAS STOPPED AT AGE TWO. HE THEREFORE DEVELOPED MOTOR AND MENTAL ABILITIES NORMALLY. BY THE AGE OF TWO, HE WAS ABLE TO TALK AND WAS VERY ACTIVE. HE BEGUN TO DEVELOP THE SECONDARY SEXUAL CHARACTERISTICS SUCH AS DEEP VOICE, BROADER SHOULDERS AND GROWTH OF PUBIC HAIR AROUND AGE FOURTEEN. PATIENT STARTED SCHOOLING AT THE AGE OF FIVE AND

COMPLETED JUNIOR SECONDARY SCHOOL AT THE AGE OF EIGHTEEN. HE THEN ENTERED INTO BUSINESS IN THE YEAR 1971 AT AGE 22 YEARS AND LATER TRAVELED TO GERMANY AT AGE 32. PATIENT SAID HE WAS AN AVERAGE STUDENT IN ACADEMICS. CURRENTLY, PATIENT IS NOT MARRIED BUT HAS ONE CHILD.

ACCORDING TO ERIK ERICKSON'S PSYCHOSOCIAL DEVELOPMENT WHICH ENCOMPASSES EIGHT STAGES, PATIENT IS NOW IN HER MIDDLE AGE GROUP WHERE THERE IS CONFLICT BETWEEN GENERATIVITY VERSUS STAGNATION (40 TO 65 YEARS), ADULTS HAVE AN URGE TO CONTRIBUTE TO THE NEXT GENERATION. THE MOTIVATION IS TO CREATE AND/OR MATURE THOSE WHO WILL FOLLOW. GENERATIVITY IS ALL ABOUT SHARING, GIVING AND CONTRIBUTING TO THE GROWTH OF OTHERS. IF THE NEED IS NOT FULFILLED, THE ADULT STAGNATES. FAILURE TO DO THIS AT THE AGE (BETWEEN 40 AND 65YEARS) IS TERMED AS STAGNATION. IN RESPECT TO PATIENT'S SUPPORTIVE EFFORT TOWARDS THE SUCCESS OF HIS ENTIRE FAMILY. I AM SINCERELY CONVINCED THAT PATIENT IS IN THE GENERATIVITY DIMENSION OF ERICKSON'S PSYCHOSOCIAL DEVELOPMENT.

1.5 PATIENT'S LIFESTYLE AND HOBBIES

LIFE STYLE IS DEFINED AS THE TYPICAL WAY OF LIFE OF AN INDIVIDUAL, GROUP, OR CULTURE (Merriam-Wester, 2020). MR. A.B. GOES TO BED AROUND 9:30 PM, HE ALWAYS WATCHES THE TELEVISION BEFORE GOING TO BED. HE WAKES UP AT 6:00AM. PATIENT SAID HE PRAYS BEFORE SLEEPING AND AFTER WAKING UP. HE MAINTAINS HIS ORAL HYGIENE WITH THE USE OF TOOTH BRUSH AND TOOTH PASTE TWICE A DAY. HE EMPTIES HIS BOWEL. HE

EXERCISES EVERY MORNING TO MAINTAIN HIS BODY IN A GOOD STATE AFTER WHICH HE TAKES HIS BATH WITH WARM WATER. FOR BREAKFAST, PATIENT MOSTLY TAKES MILO WITH WHEAT BREAD. HIS FAVOURITE MEAL IS RICE WITH STEW. HE NORMALLY SETS OFF TO CHECK ON HIS BUSINESSES AROUND 9:00AM.

ON SATURDAYS, IF HE DOES NOT GO TO WORK, HE STAYS HOME ALL DAY OR SOMETIMES VISITS HIS FRIENDS WITHIN THE NEIGHBOURHOOD. ON SUNDAYS, HE GETS READY FOR CHURCH AND AFTER CHURCH HE PREPARES HIMSELF FOR THE WEEKDAYS AHEAD. HE HAS A GREAT ADMIRATION FOR FOOTBALL AND HARDLY MISSES ANY SPORTS NEWS ON WONTUMI TV OR SUPER SPORTS. HE DESCRIBED HIMSELF AS AN INTROVERT BUT OCCASIONALLY ATTENDS FUNERALS AND WEDDINGS ON WEEKENDS.

PATIENT HAS NO KNOWN ALLERGY TO FOOD OR DRUGS. PATIENT CITED THAT HE MOSTLY TAKES THREE SQUARE MEALS PER DAY THUS BREAKFAST, LUNCH AND SUPPER. MR. A.B. DOES NOT HAVE ANY FIXATED HABIT SUCH AS DRINKING, SMOKING, GOSSIPING ETC. PATIENT INDICATED THAT HE SLEEPS A LOT WHENEVER HE IS STRESSED UP. PATIENT REVEALED THAT HE TENDS TO

LIKE THE USE OF NON-VERBAL COMMUNICATIONS SUCH AS EYE MOVEMENTS TO SPEAK TO HIS CHILD TO DESIST FROM GOING WRONG. PATIENT CITED THAT HE LIKES CALM AND QUITE PEOPLE BUT DISLIKES VIOLENT INDIVIDUALS. HIS MAJOR MEDIUM OF TRANSPORTATION IS HIS CAR.

WITH MY PERSONAL IMPRESSIONS AND FEELINGS ABOUT PATIENT IS THAT HE HAS GOOD COMMUNICATION SKILLS.

1.6 PATIENT'S PAST MEDICAL HISTORY

PAST MEDICAL HISTORY IS A RECORD OF A PAST MEDICAL PROBLEMS AND TREATMENTS THAT A PERSON HAS HAD (Merriam-Wester, 2020). PATIENT VERBALIZED THAT HE DID NOT SUFFER FROM ANY OF THE CHILDHOOD DISEASES LIKE TUBERCULOSIS, DIPHTHERIA, MEASLES AND OTHERS. PATIENT STATED THAT HE SOMETIMES EXPERIENCES HEADACHE, FEVER AND FLU WHICH HE USED TO BUY OVER-THE-COUNTER DRUGS FOR SELF-TREATMENTS. WHEN SYMPTOMS BECOME WORSE, HE ATTENDS THE NEAREST HOSPITAL. MR. A.B. SAID HE HAS NEVER HAD ANY MAJOR ACCIDENT BUT CITED THAT HE SOMETIMES EXPERIENCES MINOR FALLS. HE SAID HE USED TO TAKE PAIN MEDICATIONS FROM OVER-THE-COUNTER DRUG SELLERS TO ALLEVIATE SYMPTOMS BODY PAINS AFTER LONG HOURS OF WORK. MOREOVER, HE OFTEN TAKES IBUPROFEN OR PARACETAMOL FOR SELF-MEDICATION.

1.7 PATIENT'S PRESENT MEDICAL HISTORY

HISTORY OF PRESENT ILLNESS IS A COMPLETE, CLEAR, AND CHRONOLOGIC ACCOUNT OF THE PROBLEMS PROMPTING THE PATIENT TO SEEK CARE (BICKLEY & SZILAGYI, 2009).

PATIENT REVEALED HE WAS WELL UNTIL 13TH NOVEMBER, 2021. ACCORDING TO PATIENT, HE VISITED HIS FAMILY AT DWAHO IN THE MORNING, EVERYTHING WAS FINE AS HE WAS ABLE TO DRIVE FROM DORMAA AHENKRO TO DWAHO. HE RETURNED AROUND 4PM, SOME FEW HOURS LATER HE FELT UNWELL AND WENT TO A NEARBY PHARMACY SHOP. HE WAS GIVEN SOME PAIN MEDICATION TO TAKE HOME. ON 14TH NOVEMBER, 2021 AROUND 2AM, HE STARTED EXPERIENCING SEVERE ABDOMINAL PAIN, VOMITING AND

SWEATING PROFUSELY. HE WOKE HIS SON UP AND ASKED HIM TO HIM TO THE HOSPITAL. HE WAS BROUGHT TO THE ACCIDENT AND EMERGENCY UNIT OF DORMAA PRESBYTERIAN HOSPITAL FOR TREATMENT. THE MEDICAL OFFICER WHO ATTENDED TO HIM DIAGNOSED HIM OF GASTRITIS. HE WAS DETAINED AT THE ACCIDENT AND EMERGENCY UNIT FOR SOME HOURS BEFORE BEEN ADMITTED TO THE MALE WARD. AT THE EMERGENCY UNIT HE WAS MANAGED ON INTRAVENOUS LACTATED RINGERS 1L X 24HOURS, IV OMEPRAZOLE 80MG START AND INJECTION TRAMADOL 100MG START.

1.8 ADMISSION OF THE PATIENT

ADMISSION IS THE INITIATION OF CARE, USUALLY REFERRING TO INPATIENT CARE, EITHER LASTING FOR A DAY OR MORE (Esen, 2011). IT IS A CHANGE OF ENVIRONMENT TO THE PATIENT AND RELATIVES. THIS CHANGE OF ENVIRONMENT COULD EITHER BE ELECTIVE/PLANNED OR EMERGENCY/UNPLANNED.

ON THE 14TH NOVEMBER, 2021 AT 12:00PM, PATIENT WAS RECEIVED INTO THE MALE WARD OF DORMAA PRESBYTERIAN HOSPITAL FROM THE ACCIDENT AND EMERGENCY UNIT PER AMBULATION ACCOMPANIED BY A STAFF NURSE, AND A RELATIVE (SON) WITH THE DIAGNOSIS OF GASTRITIS. ON ARRIVAL, PATIENT AND RELATIVE TOGETHER WITH THE ACCOMPANYING STAFF NURSE AND STUDENT NURSE WERE WELCOMED. PATIENT WAS FULLY CONSCIOUS, FEBRILE AND ACTIVE. THE NEEDED INFORMATION ABOUT PATIENT WERE COLLECTED FROM THE NURSE TO ENSURE DATA ACCURACY. CONFIRMATION WAS DONE TO SEE IF HE WAS THE RIGHT PATIENT. HE WAS REASSURED TO ALLAY FEARS AND ANXIETY. HE WAS INTRODUCED TO THE STAFFS PRESENT AND WAS ASSURED OF THE COMPETENCE AND

HARDWORK OF THE STAFF WHO WERE GOING TO TAKE CARE OF HIM THROUGHOUT HIS STAY IN THE HOSPITAL AND THAT AFTER HIS TREATMENT, HE WILL NOT EXPERIENCE ANY ABDOMINAL PAINS AND WILL BE ABLE TO COPE WITH HIS NORMAL DAILY ACTIVITIES.

PATIENT WAS MADE COMFORTABLE IN AN ALREADY PREPARED ADMISSION BED AND HIS VITAL SIGNS WERE CHECKED AND RECORDED ACCURATELY AS FOLLOWS;

- | | |
|-------------------|---------------------|
| 1. TEMPERATURE | 37.8 ⁰ C |
| 2. PULSE | 68BPM |
| 3. RESPIRATION | 18CPM |
| 4. BLOOD PRESSURE | 110/70 MMHG |

PATIENT WEIGHED 80KG

A HEAD TO TOE PHYSICAL EXAMINATION WAS CONDUCTED ON PATIENT AND NO ABNORMALITIES WERE SEEN. PATENT WAS ORIENTED TO TIME, PLACE AND PERSON. DURING ASSESSMENT, HE COMPLAINED OF ABDOMINAL PAIN AT THE EPIGASTRIC REGION, NAUSEA AND VOMITING.

THE FOLLOWING TREATMENT PLAN WERE ORDERED:

1. INTRAVENOUS OMEPRAZOLE 40MG BD FOR 3 DAYS
2. TABLET PARACETAMOL 1G TID FOR 3DAYS
3. INTRAVENOUS NORMAL SALINE 0.9% 2 LITERS FOR 48 HOURS
4. INTRAVENOUS METRONIDAZOLE 500MG TDS FOR 24HOURS
5. INTRAVENOUS CIPROFLOXACIN 400MG BD FOR 24 HOURS
6. INTRAVENOUS METOCLOPRAMIDE 10MG TDS FOR 24HOURS

THESE INVESTIGATIONS HAD BEEN ORDERED AND CARRIED OUT ON
PATIENT;

1. FULL BLOOD COUNT
2. BLOOD FILM FOR MALARIA PARASITES
3. HELICOBACTER PYLORI TEST
4. WIDAL TEST

HIS PARTICULARS SUCH AS NAME, SEX, AGE, OCCUPATION, HEALTH INSURANCE STATUS AND RESIDENTIAL ADDRESS WERE RECORDED IN THE ADMISSION AND DISCHARGE BOOK. HIS NAME, SEX AND AGE WERE WRITTEN IN THE DAILY WARD STATE. HOSPITAL POLICIES REGARDING VISITING PERIODS, PAYMENT OF BILLS AND THE TIME VITAL SIGNS WILL BE CHECKED AND ADMINISTRATION OF MEDICATIONS WERE EXPLAINED TO HIM AND HIS RELATIVE. THEY WERE ALSO ORIENTED TO THE WARD ENVIRONMENT AND ITS ANNEXES. HE WAS ASKED TO GET HIS OWN BOWL, SPOON, DRINKING CUP, BATHING SPONGE, BUCKET, TOWEL, PYJAMAS AND OTHER TOILETRIES.

I REINTRODUCED MYSELF TO PATIENT AS A STUDENT NURSE OF THE HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM, WHO WOULD LIKE TO TAKE HIM AND HIS FAMILY FOR A PATIENT/FAMILY CARE STUDY. MR. A.B. AND HIS FAMILY WERE INFORMED THAT THE CARE STUDY IS A REQUIREMENT BY THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILLMENT TOWARDS THE AWARD OF LICENSE IN DIPLOMA IN REGISTERED GENERAL NURSING. I EXPLAINED TO THE PATIENT AND HIS FAMILY THE CONCEPT OF THE PATIENT/FAMILY CARE STUDY AND ASSURED THEM OF PRIVACY AND CONFIDENTIALITY.

IT WAS ADDED THAT A REPORT WILL BE WRITTEN AFTER THE ENTIRE EVENT. MR. A.B. AND HIS RELATIVE AGREED TO MY REQUEST AND ASSURED ME OF PROVIDING THE NECESSARY INFORMATION AND ASSISTANCE. I CONGRATULATED THEM ON SUCH A DECISION. DISCHARGE PLANNING WAS INITIATED WITH THE RELATIVES; THUS, THEY WERE TOLD THAT THE HOSPITAL WILL BE A TEMPORAL PLACE FOR THEIR CARE AND WOULD HAVE TO CONTINUE THE CARE AT HOME ONCE THERE IS AN IMPROVEMENT IN HIS CONDITION. I INFORMED THE WARD IN-CHARGE ABOUT MY INTEREST IN USING THIS PATIENT FOR MY CARE STUDY AND A PERMISSION WAS GRANTED FOR ME TO MOVE ON WITH THE STUDY. I DECIDED TO CHOOSE THIS PATIENT FOR THE STUDY BECAUSE I WANTED TO GET A DEEPER UNDERSTANDING ABOUT THE CAUSES, SIGNS AND SYMPTOMS, PREVENTION AND TREATMENT OF GASTRITIS AND TO BE ABLE TO DIFFERENTIATE IT FROM OTHER SIMILAR ABDOMINAL CONDITIONS.

1.9 PATIENT'S CONCEPT OF ILLNESS

PATIENT DID NOT KNOW WHAT ACTUALLY CAUSED HIS ILLNESS. HE ALSO DID NOT ATTRIBUTE IT TO ANY WITCHES AND WIZARDS. MR. A.B. WAS LOOKING FORWARD TO GETTING BETTER SOON. HE BELIEVED THAT WHEN HE COOPERATES WITH THE CARE BEING RENDERED TO HIM, HE WILL GET WELL AND LEAVE FOR HOME TO CONTINUE HIS WORK IN GOOD HEALTH.

1.10 LITERATURE REVIEW

ANATOMY AND PHYSIOLOGY OF THE STOMACH

THE STOMACH IS A J-SHAPED DILATED PORTION OF THE ALIMENTARY TRACT SITUATED IN THE EPIGASTRIC, UMBILICAL AND THE LEFT HYPOCHONDRIC REGIONS OF THE ABDOMINAL CAVITY (Wagh & Grant, 2014).

ORGANS ASSOCIATED WITH THE STOMACH.

ANTERIORLY- LEFT LOBE OF LIVER AND ANTERIOR ABDOMINAL WALL

POSTERIORLY- ABDOMINAL AORTA, PANCREAS, SPLEEN, LEFT KIDNEY AND
ADRENAL GLAND

SUPERIORLY- DIAPHRAGM, ESOPHAGUS AND LEFT LOBE OF LIVER

INFERIORLY- TRANSVERSE COLON AND SMALL INTESTINE

TO THE LEFT- DIAPHRAGM AND SPLEEN

TO THE RIGHT- LIVER AND DUODENUM.

STRUCTURE OF THE STOMACH.

THE STOMACH IS CONTINUOUS WITH THE ESOPHAGUS AT THE CARDIAC SPHINCTER AND WITH THE DUODENUM AT THE PYLORIC SPHINCTER. IT HAS TWO CURVATURES. THE LESSER CURVATURE WHICH IS SHORT AND LIES ON THE POSTERIOR SURFACE OF THE STOMACH AND IS THE DOWNWARD CONTINUATION OF THE POSTERIOR WALL OF THE ESOPHAGUS. JUST BEFORE THE PYLORIC SPHINCTER, IT CURVES UPWARDS TO COMPLETE THE J-SHAPE.

WHERE THE ESOPHAGUS JOINS THE STOMACH THE ANTERIOR REGION ANGLES ACUTELY UPWARDS, CURVES DOWNWARDS FORMING THE GREATER CURVATURE AND THEN SLIGHTLY UPWARDS TOWARDS THE PYLORIC SPHINCTER. IT IS DIVIDED INTO THREE REGIONS, THE FUNDUS, BODY AND THE PYLORUS.

WALLS OF THE STOMACH

THE STOMACH HAS FOUR LAYERS OF TISSUE. THESE ARE THE SEROSA (THE OUTER COVERING), MUSCLE LAYER, SUB MUCOSA AND THE MUCOSA LINING.

THE MUSCLE LAYER OF THE STOMACH HAS SOME MODIFICATIONS THAT

MAKE IT DIFFERENT FROM OTHER REGIONS OF THE ALIMENTARY TRACT,
THESE ARE;

1. AN OUTER LAYER OF LONGITUDINAL FIBRES
2. A MIDDLE LAYER OF CIRCULAR FIBRES
3. AN INNER LAYER OF OBLIQUE FIBRES

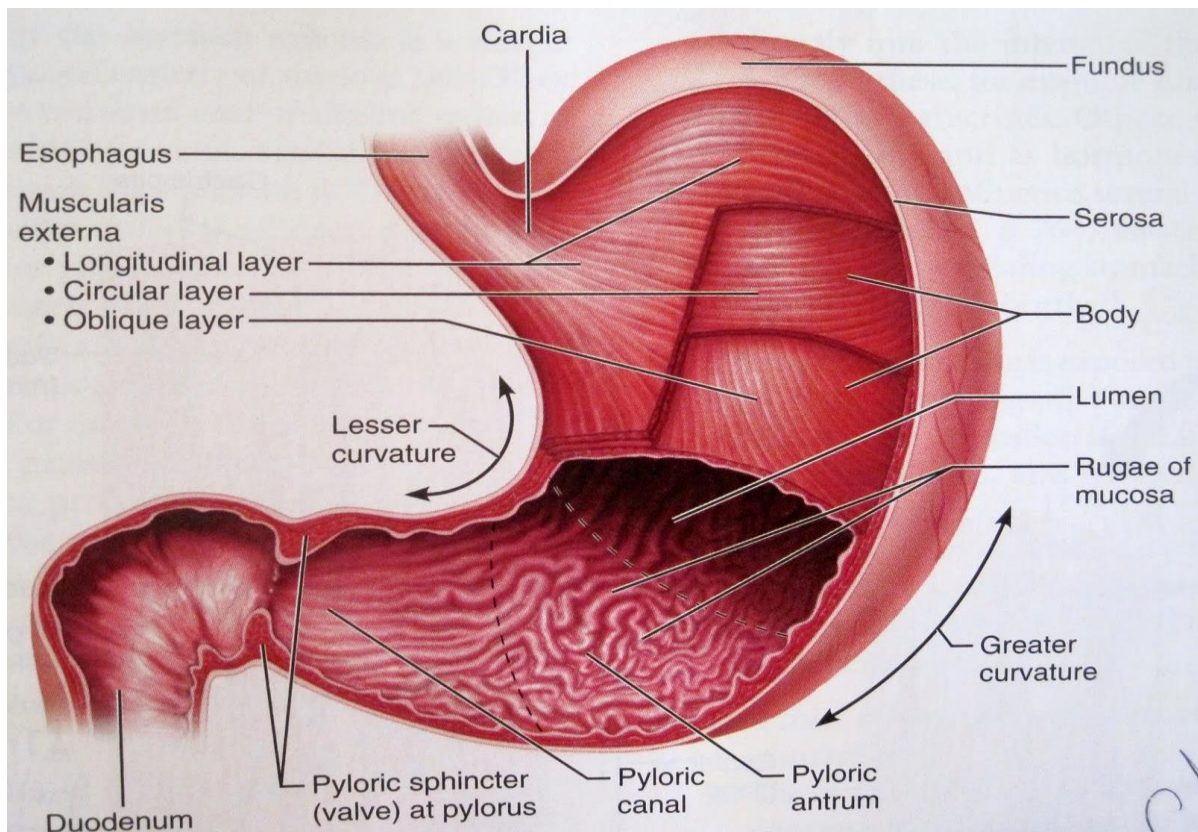


FIGURE 1: DIAGRAM OF THE STOMACH

SOURCE: (Pharma Tips, 2013)

GASTRITIS

GASTRITIS IS AN INFLAMMATION OF THE GASTRIC OR STOMACH MUCOSA. IT IS A COMMON GASTROINTESTINAL PROBLEM. GASTRITIS MAY BE ACUTE, LASTING SEVERAL HOURS TO FEW DAYS, OR CHRONIC, RESULTING FROM A REPEATED EXPOSURE TO IRRITATING AGENTS OR RECURRING EPISODES OF ACUTE GASTRITIS (Hinkle & Cheever, 2014) OR GASTRITIS IS INFLAMMATION OF

THE STOMACH MUCOSA AND CAN BE ACUTE OR CHRONIC (Williams & Hopper, 2015).

INCIDENCE

EPIDEMIOLOGIC STUDIES REFLECT THE WIDESPREAD INCIDENCE OF GASTRITIS. IN THE UNITED STATES, IT ACCOUNTS FOR APPROXIMATELY 1.8-2.1 MILLION VISIT TO DOCTOR'S OFFICES EACH YEAR. IT IS ESPECIALLY COMMON IN PEOPLE OLDER THAN 60 YEARS (Williams & Hopper, 2015).

CAUSES OF GASTRITIS

AS CITED BY WILLIAMS AND HOPPER (2015) THE FOLLOWING ARE THE CAUSES OF GASTRITIS

1. DIET

✓ ALCOHOL

✓ SPICY FOODS

2. MICROORGANISMS

✓ HELICOBACTER PYLORI

✓ SALMONELLA

3. MEDICATIONS

✓ ASPIRIN

✓ NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

✓ CORTICOSTEROIDS

✓ DIGITALIS

✓ CHEMOTHERAPY DRUGS

4. STRESS: THE STRESS RESPONSE TO THE ILLNESS CAUSES REDUCED BLOOD FLOW TO THE STOMACH AND SMALL INTESTINE, RESULTING IN

ISCHEMIA AND DAMAGE TO THE MUCOSA. THE DAMAGED MUCOUS BARRIER THEN ALLOWS ACID SECRETIONS TO CREATE ULCERATION

- ✓ PHYSIOLOGICAL
- ✓ PSYCHOLOGICAL
- 5. TRAUMA
- 6. OTHER FACTORS
 - ✓ REFLUX OF BILE
 - ✓ SMOKING
- ✓ NASOGASTRIC SUCTIONING
- 7. ENDOSCOPIC PROCEDURES

PATHOPHYSIOLOGY

AS DISCUSSED IN HINKLE AND CHEEVER (2014); WILLIAMS AND HOPER (2015), GASTRITIS RESULTS WHEN THE PROTECTIVE MUCOSAL BARRIER IS BROKEN DOWN AND ALLOWS AUTODIGESTION FROM HYDROCHLORIC ACID AND PEPSIN TO OCCUR. THE GASTRIC MUCOUS MEMBRANE BECOMES EDEMATOUS AND HYPEREMIC (CONGESTED WITH FLUID AND BLOOD) AND UNDERGOES SUPERFICIAL EROSION. SUPERFICIAL ULCERATION MAY OCCUR AND CAN LEAD TO HEMORRHAGE. WITH SEVERE GASTRITIS, THE GASTRIC MUCOSA CAN BECOME GANGRENOUS AND PERFORATE, WHICH CAN LEAD TO PERITONITIS (INFECTION OF THE PERITONEUM). SCARRING MAY ALSO OCCUR, RESULTING IN PYLORIC OBSTRUCTION.

CLINICAL MANIFESTATIONS OF ACUTE GASTRITIS

HINKLE AND CHEEVER (2014) MENTIONED THE FOLLOWING AS CLINICAL MANIFESTATIONS OF ACUTE GASTRITIS;

1. ONSET OF FEVER
2. ABDOMINAL DISCOMFORT
3. HEADACHE
4. LASSITUDE
5. NAUSEA
6. ANOREXIA
7. VOMITING AND
8. HICCUPPING

CLINICAL MANIFESTATIONS OF CHRONIC GASTRITIS

HINKLE AND CHEEVER (2014) MENTIONED THE FOLLOWING AS CLINICAL MANIFESTATIONS OF CHRONIC GASTRITIS;

1. ANOREXIA
2. HEARTBURN AFTER EATING
3. BELCHING
4. A SOUR TASTE IN THE MOUTH
5. NAUSEA AND VOMITING
6. MILD EPIGASTRIC DISCOMFORT
7. INTOLERANCE TO SPICY OR FATTY FOODS
8. SLIGHT PAIN THAT IS RELIEVED BY EATING.

NOTE: PATIENTS WITH CHRONIC GASTRITIS FROM VITAMIN DEFICIENCY USUALLY HAVE EVIDENCE OF MALABSORPTION OF VITAMIN B12 CAUSED BY THE PRODUCTION OF ANTIBODIES THAT INTERFERE WITH THE BINDING OF VITAMIN B12 TO INTRINSIC FACTOR. HOWEVER, SOME PATIENTS WITH CHRONIC GASTRITIS HAVE NO SYMPTOMS (Hinkle & Cheever, 2014).

ASSESSMENT AND DIAGNOSTIC INVESTIGATIONS

HINKLE AND CHEEVER MENTIONED THE FOLLOWING AS ASSESSMENT AND
DIAGNOSTIC INVESTIGATIONS OF GASTRITIS;

1. HISTORY AND PHYSICAL EXAMINATION WHICH WOULD REVEAL
ABDOMINAL PAIN OR MILD EPIGASTRIC TENDERNESS
2. AN UPPER GI ENDOSCOPY
3. HISTOLOGIC EXAMINATION OF A TISSUE SPECIMEN OBTAINED BY
BIOPSY
4. H. PYLORI TEST
5. FULL BLOOD COUNT

MEDICAL MANAGEMENT

THE GASTRIC MUCOSA IS CAPABLE OF REPAIRING ITSELF AFTER AN EPISODE
OF GASTRITIS. AS A RULE, THE PATIENT RECOVERS IN ABOUT 1 DAY,
ALTHOUGH THE APPETITE MAY BE DIMINISHED FOR AN ADDITIONAL 2 OR 3
DAYS (Williams & Hopper, 2015).

- INTRAVENOUS FLUIDS MAY NEED TO BE ADMINISTERED IF THE
SYMPTOMS PERSIST.
- COMMON ANTACIDS SUCH AS ALUMINUM HYDROXIDE IS USED TO
NEUTRALIZE ACIDS.
- ANALGESIC AGENTS SUCH AS PARACETAMOL AND TRAMADOL.
- ANTI-SPASMODIC ANALGESICS SUCH AS HYOSCINE BUTYL BROMIDE
MAY BE USED TO RELIEVE THE ABDOMINAL PAIN
- ANTIBIOTICS SUCH AS AMOXICILLIN, CLARITHROMYCIN,
TETRACYCLINE OR METRONIDAZOLE
- ANTIDIARRHEA SUCH AS BISMUTH SUBSALICYLATE

- HISTAMINE 2 RECEPTOR ANTAGONIST IS GIVEN TO REDUCE GASTRIC SECRETION. E.G. CIMETIDINE AND RANITIDINE.
- PROTON PUMP INHIBITORS ARE GIVEN TO ELIMINATE ACID SECRETIONS. E.G. OMEPRAZOLE, LANSOPRAZOLE
- PROSTAGLANDIN E₁ ANALOGUE IS GIVEN TO FORM A PROTECTIVE COAT THAT PREVENTS FURTHER EXCAVATION. E.G. SUCRALFATE, MISOPROSTOL.
- ANTIEMETICS TO CONTROL VOMITING

SURGICAL MANAGEMENT

IN EXTREME CASES OF THE CONDITION, EMERGENCY SURGERY MAY BE REQUIRED TO REMOVE GANGRENOUS OR PERFORATED TISSUE. A GASTRIC RESECTION OR GASTROJEJUNOSTOMY (ANASTOMOSIS OF THE JEJUNUM TO THE STOMACH TO DETOUR AROUND THE PYLORUS) MAY BE NECESSARY TO TREAT PYLORIC OBSTRUCTION, A NARROWING OF THE PYLORIC ORIFICE, WHICH CANNOT BE RELIEVED BY MEDICAL MANAGEMENT. FIBEROPTIC ENDOSCOPY MAY BE NECESSARY.

NURSING MANAGEMENT

SPECIFIC NURSING MANAGEMENT OF PATIENT WITH GASTRITIS IS AS
FOLLOWS (Hinkle & Cheever, 2014);

REDUCING ANXIETY

- THE NURSE MUST USE 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.

PROMOTING OPTIMAL NUTRITION

- FOR ACUTE GASTRITIS, THE PATIENT SHOULD TAKE NO FOODS OR FLUIDS BY MOUTH –POSSIBLY FOR A FEW DAYS UNTIL THE ACUTE SYMPTOMS SUBSIDE, THUS ALLOWING THE GASTRIC MUCOSA TO HEAL.
- IF IV THERAPY IS NECESSARY, MONITOR FLUID INTAKE AND OUTPUT ALONG WITH SERUM ELECTROLYTE VALUES. AFTER THE SYMPTOMS SUBSIDE, THE NURSE MAY OFFER PATIENT WITH ICE CHIPS FOLLOWED BY CLEAR LIQUIDS. INTRODUCING SOLID FOOD AS SOON AS POSSIBLE MAY PROVIDE ADEQUATE ORAL NUTRITION, DECREASE THE NEED FOR IV THERAPY AND MINIMIZE IRRITATION TO THE GASTRIC MUCOSA. AS FOOD IS INTRODUCED, THE NURSE OBSERVES AND REPORTS ANY SYMPTOMS THAT SUGGEST A REPEAT EPISODE OF GASTRITIS.
- DISCOURAGE THE INTAKE OF CAFFEINATED BEVERAGES, ALCOHOL INTAKE, CIGARETTE SMOKING.

PROMOTING FLUID BALANCE

- DAILY FLUID INTAKE AND OUTPUT ARE MONITORED TO DETECT
EARLY SIGNS OF DEHYDRATION.
- IF FOOD AND ORAL FLUIDS ARE WITH-HELD, IV FLUIDS USUALLY ARE
PRESCRIBED AND A RECORD OF FLUID INTAKE PLUS CALORIC VALUE
NEEDS TO BE MAINTAINED. ELECTROLYTE BALANCE ARE ASSESSED
EVERY TWENTY-FOUR 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 MUST BE NOTED AND THE VITAL SIGNS ARE MONITORED AS
THE PATIENT'S CONDITION WARRANTS.

RELIEVING PAIN

- INSTRUCTING PATIENT TO AVOID FOODS THAT MAY BE IRRITATING TO
THE GASTRIC MUCOSA AND INSTRUCTING THE PATIENT ABOUT THE
CORRECT USE OF MEDICATIONS TO RELIEVE CHRONIC GASTRITIS.
- REGULARLY ASSESS THE PATIENT'S LEVEL OF PAIN AND THE EXTENT
OF COMFORT ACHIEVED THROUGH THE USE OF MEDICATIONS AND
AVOIDANCE OF IRRITATING SUBSTANCES.

PROMOTING HOME AND COMMUNITY- BASED CARE

- EVALUATE PATIENT'S KNOWLEDGE ABOUT GASTRITIS AND DEVELOP
AN INDIVIDUALIZED TEACHING PLAN THAT INCLUDES INFORMATION
ABOUT STRESS MANAGEMENT, DIET AND MEDICATIONS.
- REVIEW WITH THE PATIENT ABOUT FOODS AND OTHER SUBSTANCES
TO BE AVOIDED. CONSULTATION WITH A DIETICIAN MAY BE
RECOMMENDED.

- THE IMPORTANCE OF COMPLETING THE MEDICATION REGIMEN AS PRESCRIBED TO ERADICATE H. PYLORI INFECTION MUST BE REINFORCED TO THE PATIENT AND ANY CAREGIVERS.

CONTINUING CARE

- REINFORCE PREVIOUS TEACHING AND CONDUCT ONGOING ASSESSMENT OF THE PATIENT'S SYMPTOMS AND PROGRESS
- PATIENT WITH MALABSORPTION OF VITAMIN B12 NEED INFORMATION ABOUT LIFELONG VITAMIN B12 INJECTIONS.
- FINALLY, EMPHASIZE THE IMPORTANCE OF KEEPING FOLLOW-UP APPOINTMENT WITH HEALTH CARE PROVIDERS.

COMPLICATIONS

HINKLE AND CHEEVER MENTIONED THE FOLLOWING AS COMPLICATIONS OF GASTRITIS;

1. HEMORRHAGE: RESULTS FROM SUPERFICIAL ULCERATION OF THE GASTRIC MUCOSA.
2. HYPOVOLEMIC SHOCK: RESULTS FROM DECREASED INTRAVASCULAR VOLUME DUE TO FLUID LOSS
3. PERFORATION: INVOLVES THE EROSION OF THE ULCER THROUGH THE GASTRIC SEROSA INTO THE PERITONEAL CAVITY WITHOUT WARNING. IT IS AN ABDOMINAL CATASTROPHE AND REQUIRES IMMEDIATE SURGERY.
4. PERITONITIS: INFLAMMATION OF THE LINING OF THE ABDOMINAL CAVITY, USUALLY AS A RESULT OF A BACTERIAL INFECTION OF AN

AREA IN THE GASTROINTESTINAL TRACT WITH LEAKAGE OF
CONTENTS INTO THE ABDOMINAL CAVITY

1.11 DATA VALIDATION

VALIDATION IS DEFINED AS THE PROCESS OF ESTABLISHING THE TRUTH OR LOGICAL COGENCY OF SOMETHING (American Psychological Association, 2020). IT SIMPLY MEANS THE ACT OF CHECKING AND CONFIRMING THE ACCURACY OF AN INFORMATION RECEIVED. INFORMATION GIVEN BY PATIENT WERE CONTINUOUSLY ASSESSED BY ASKING SAME QUESTIONS IN DIFFERENT WAYS FROM MR. A.B. AND RELATIVES AND THE ANSWERS GIVEN WERE SAME. THE HOME VISIT I EMBARKED ON AND THE INTERACTION I HAD WITH OTHER FAMILY MEMBERS OF THE PATIENT CONFIRMED THE INFORMATION GIVEN TO ME BY MY PATIENT. THERE WERE NO CONTRADICTIONARY ANSWERS. MOREOVER, THE INFORMATION GATHERED FROM THE DOCTOR'S NOTES, NURSE'S RECORDS, INVESTIGATIONS CARRIED OUT AND THE RESULTS AND LITERATURE REVIEW OF THE CONDITION STRONGLY CONFIRMS THE VALIDITY OF THE INFORMATION GATHERED. THIS IMPLIES THAT, THE INFORMATION/DATA COLLECTED WAS VALID AND ACCURATE.

CHAPTER TWO

ANALYSIS OF DATA

2.0 INTRODUCTION

ANALYSIS REFERS TO A COMPREHENSIVE EXAMINATION OF ANYTHING COMPLEX IN ORDER TO FIND OUT ITS NATURE OR TO DETERMINE ITS ESSENTIAL FEATURES (MERRIAM-WESTER, 2020).

IT ALSO INVOLVES GROUPING IDENTICAL MATERIALS MEANINGFULLY FOR THE PURPOSE OF IDENTIFICATION.

THIS IS THE SECOND STAGE OF THE NURSING PROCESS AND IT DEALS WITH COMPARING DATA OBTAINED ON THE PATIENT WITH STANDARDS TO HELP DETERMINE ANY DEVIATION FROM NORMAL PHYSIOLOGICAL FUNCTIONS OF THE BODY AND THIS HELP THE NURSE FORMULATE APPROPRIATE NURSING INTERVENTION. THIS CHAPTER ENTAILS COMPARISON OF DATA WITH STANDARDS, PATIENT/FAMILY STRENGTHS, PATIENT/FAMILY HEALTH PROBLEMS AND THE CORRESPONDING NURSING DIAGNOSIS.

2.1 COMPARISON OF DATA WITH STANDARD

THIS IS WHERE THE DATA COLLECTED ON THE HEALTH OF THE PATIENT IS COMPARED WITH THOSE IN THE LITERATURE REVIEW. THESE INCLUDES DIAGNOSTIC INVESTIGATIONS, CAUSES, SIGNS AND SYMPTOMS, TREATMENTS AND COMPLICATIONS.

A. DIAGNOSTIC TESTS/INVESTIGATIONS

DIAGNOSIS IS THE PROCESS OF IDENTIFYING AND DETERMINING THE NATURE OF A DISEASE OR DISORDER BY ITS SIGNS AND SYMPTOMS, THROUGH THE USE OF ASSESSMENT TECHNIQUES (E.G., TESTS AND EXAMINATIONS) AND

OTHER AVAILABLE EVIDENCE (American Psychological Association, 2020). THESE INVESTIGATIONS WERE CARRIED OUT ON PATIENT;

1. FULL BLOOD COUNT
2. BLOOD FILM FOR MALARIA PARASITES
3. HELICOBACTER PYLORI TEST
4. WIDAL TEST

TABLE 1: COMPARISON OF TEST DONE ON PATIENT TO LITERATURE

TEST IN LITERATURE REVIEW	TEST DONE ON PATIENT
1. HISTORY AND PHYSICAL EXAMINATION	1. HISTORY WAS TAKEN AND PHYSICAL EXAMINATION REVEALED ABDOMINAL PAIN
2. UPPER GI ENDOSCOPY	2. UPPER GI ENDOSCOPY WAS NOT DONE
3. HISTOLOGIC EXAMINATION	3. HISTOLOGIC EXAMINATION WAS NOT DONE
4. H. PYLORI TEST	4. H. PYLORI TEST WAS DONE
5. FULL BLOOD COUNT	5. FULL BLOOD COUNT WAS DONE
6. BLOOD FILM FOR MALARIA PARASITE WAS NOT IN LITERATURE REVIEW	6. BLOOD FILM FOR MALARIA PARASITE WAS DONE
7. WIDAL TEST WAS NOT IN LITERATURE REVIEW	7. WIDAL TEST WAS DONE

FROM THE TABLE ABOVE, IT IS NOTED THAT HISTORY AND PHYSICAL EXAMINATION, FULL BLOOD COUNT, H. PYLORI TEST WERE CARRIED OUT ON MR. A.B. TO HELP IN THE CONFIRMATION OF PATIENT'S CONDITION. NOT ALL THE DIAGNOSTIC INVESTIGATIONS WERE CARRIED OUT ON PATIENT AS INDICATED IN THE TABLE.

BLOOD FILM FOR MALARIA PARASITE WAS CARRIED OUT BECAUSE PATIENT HAD A HIGH BODY TEMPERATURE AND THE POSSIBILITY OF MALARIA NEEDED TO BE RULED OUT. WIDAL TEST WAS DONE TO RULE OUT TYPHOID OR FEVER INFECTION.

ORDERED DATE	SPECIMEN	INVESTIGATIONS	RESULTS	NORMAL VALUES	INTERPRETATION	REMARKS
15/11/21	BLOOD	FULL BLOOD COUNT HAEMOGLOBIN	15.8G/DL	MALES: 12G/DL - 18G/DL FEMALES: 11G/DL - 16G/DL	HAEMOGLOBIN LEVEL WAS NORMAL	PATIENT WAS ENCOURAGED TO EAT NUTRITIOUS MEALS
		HAEMATOCRIT	47.4%	MALES: 41.5% - 50.5% FEMALES: 36.9% - 44.6%	HAEMATOCRIT COUNT WAS NORMAL	NO TREATMENT GIVEN
		RED BLOOD CELL	5.7X10 ¹² /L	MALES: 4.5 X10 ¹² /L - 5.9 X10 ¹² /L FEMALES: 4.1 X10 ¹² /L-5.1 X10 ¹² /L	RBC COUNT WAS NORMAL	NO TREATMENT GIVEN
		WHITE BLOOD CELL	5.5X10 ⁹ /L	4.5 X10 ⁹ /L - 10.0 X10 ⁹ /L	WBC COUNT WAS NORMAL	NO TREATMENT GIVEN
15/11/21	BLOOD	HELICOBACTER PYLORI TEST	POSITIVE	NEGATIVE	PATIENT HAD HELICOBACTER PYLORI INFECTION	INTRAVENOUS CIPROFLOXACIN 400MG BD FOR 24 HOURS

15/11/21	BLOOD	BLOOD FILM FOR MALARIA PARASITE	NEGATIVE	NEGATIVE	NORMAL: NO PARASITES DETECTED	NO TREATMENT GIVEN
15/11/21	BLOOD	WIDAL TEST	NEGATIVE	NEGATIVE	NORMAL: NO SALMONELLA TYPHI DETECTED	NO TREATMENT GIVEN

TABLE 2: RESULTS OF DIAGNOSTIC INVESTIGATIONS DONE ON MR. A.B.

B. CAUSES OF PATIENT'S CONDITION

FROM THE CAUSES OF GASTRITIS STATED IN THE LITERATURE REVIEW, IT CAN BE REVIEWED THAT PATIENT'S CONDITION CAN BE ASSOCIATED WITH HELICOBACTER PYLORI INFECTION.

C. CLINICAL MANIFESTATIONS EXHIBITED BY MR. A.B.

TABLE 3: CLINICAL MANIFESTATIONS EXHIBITED BY MR. A.B. AS COMPARED WITH LITERATURE REVIEW

CLINICAL MANIFESTATION IN THE LITERATURE REVIEW	CLINICAL FEATURES EXHIBITED BY MR. A.B.
1. FEVER	1. PATIENT PRESENTED WITH FEVER (37.8°C)
2. ABDOMINAL DISCOMFORT	2. PATIENT PRESENTED WITH ABDOMINAL DISCOMFORT
3. HEADACHE	3. PATIENT DID NOT COMPLAIN OF HEADACHE
4. LASSITUDE	4. PATIENT DID NOT EXPERIENCE LASSITUDE
5. NAUSEA	5. PATIENT COMPLAINED OF NAUSEA
6. ANOREXIA	6. PATIENT COMPLAINED OF APPETITE LOSS
7. VOMITING	7. PATIENT VOMITED
8. HICCUPPING	8. PATIENT DID NOT EXPERIENCE HICCUPS
9. HEARTBURN AFTER EATING	9. PATIENT DID NOT COMPLAIN OF HEARTBURN AFTER EATING
10. BELCHING	10. NO BELCHING WAS EXHIBITED BY PATIENT
11. A SOUR TASTE IN THE MOUTH	11. PATIENT FELT SOUR TASTE IN THE MOUTH
12. MILD EPIGASTRIC DISCOMFORT	12. PATIENT COMPLAINED OF EPIGASTRIC PAIN
13. INTOLERANCE TO SPICY OR FATTY FOODS	13. PATIENT DID NOT EXPERIENCE INTOLERANCE TO SPICY OR FATTY FOODS

14. SLIGHT PAIN THAT IS RELIEVED BY EATING.	14. PATIENT'S PAIN WAS NOT RELIEVED BY EATING
--	--

TAKING REFERENCE FROM THE TABLE ABOVE, PATIENT PRESENTED SOME CLINICAL MANIFESTATIONS AS STATED IN THE LITERATURE REVIEW SUCH AS ABDOMINAL DISCOMFORT, NAUSEA AND VOMITING, ANOREXIA, EPIGASTRIC PAIN AND OTHERS. HOWEVER, MR. A.B DID NOT EXPERIENCE CLINICAL MANIFESTATIONS SUCH AS BELCHING, HICCUPPING, HEARTBURN AFTER EATING, AND DIARRHEA.

D. SPECIAL PHARMACOLOGICAL TREATMENT GIVEN TO MR. A.B.

ACCORDING TO WELLER (2014), TREATMENT REFERS TO THE MODE OF DEALING WITH A PATIENT OR DISEASE. THE FOLLOWING MEDICATIONS WERE GIVEN TO PATIENT TO ENHANCE THE RESTORATION OF HEALTH STATUS TO NORMAL DURING HIS PERIOD OF HOSPITALIZATION;

1. INTRAVENOUS OMEPRAZOLE 40MG BD FOR 3 DAYS
2. TABLET PARACETAMOL 1G TID FOR 3 DAYS
3. INTRAVENOUS NORMAL SALINE 0.9% 2 LITERS FOR 48 HOURS
4. INTRAVENOUS METRONIDAZOLE 500MG TDS FOR 24HOURS
5. INTRAVENOUS CIPROFLOXACIN 400MG BD FOR 24 HOURS
6. INTRAVENOUS METOCLOPRAMIDE 10MG TDS FOR 24HOURS
7. INTRAVENOUS BUSCOPAN 40MG BD FOR 24 HOURS
8. INTRAVENOUS DNS 1 LITER FOR 24 HOURS
9. CAPSULE CLARITHROMYCIN 500MG BD FOR 7DAYS
10. CAPSULE AMOXICILLIN 500 MG TDS FOR 7DAYS
11. SUSPENSION NUGEL 'O' 15MLS TDS FOR 7DAYS

TABLE 4: PHARMACOLOGICAL TREATMENT GIVEN TO MR. A.B. COMPARED WITH LITERATURE REVIEW

MEDICAL TREATMENT IN LITERATURE REVIEW	TREATMENT GIVEN TO MR. A.B.
1. INTRAVENOUS FLUIDS	1. IV NORMAL SALINE AND IV DNS WERE GIVEN
2. ANTACIDS E.G.; MAGNESIUM TRISILICATE, ALUMINUM HYDROXIDE.	2. SUSPENSION NUGEL 'O' WAS GIVEN.
3. ANALGESIC AGENTS SUCH AS PARACETAMOL AND DICLOFENAC	3. TABLET PARACETAMOL WAS GIVEN
4. ANTI-SPASMODIC ANALGESICS SUCH AS HYOSCINE BUTYL BROMIDE	4. IV BUSCOPAN WAS GIVEN

TABLE 4: PHARMACOLOGICAL TREATMENT GIVEN TO MR. A.B.

COMPARED WITH LITERATURE REVIEW CONT'D...

5. ANTIBIOTICS SUCH AS AMOXICILLIN, CLARITHROMYCIN, TETRACYCLINE OR METRONIDAZOLE	5. IV METRONIDAZOLE, IV CIPROFLOXACIN, CAPS CLARITHROMYCIN AND CAPS AMOXICILLIN WERE GIVEN
6. ANTIDIARRHEA SUCH AS BISMUTH SUBSALICYLATE	6. NONE WAS ORDERED FOR PATIENT
7. HISTAMINE 2 RECEPTOR ANTAGONIST E.G. CIMETIDINE AND RANITIDINE.	7. NONE WAS ORDERED FOR PATIENT
8. PROTON PUMP INHIBITORS E.G. OMEPRAZOLE, LANSOPRAZOLE	8. IV OMEPRAZOLE WAS GIVEN

9 PROSTAGLANDIN E ₁ ANALOGUE E.G. SUCRALFATE, MISOPROSTOL	9. NONE WAS ORDERED FOR PATIENT
10 ANTIEMETICS	10. IV METOCLOPRAMIDE WAS GIVEN

FROM THE ABOVE TABLE, THE TREATMENTS GIVEN TO PATIENT WERE IN LINE
WITH THE LITERATURE.

TABLE 5: PHARMACOLOGY OF DRUGS ADMINISTERED TO MR. A.B.

DATE	DRUG	DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT/ REMEDIES
15/11/21	OMEPRAZOLE	DOSAGE 40MG EVERY 12 HOURS; MAXIMUM 120MG DAILY ROUTE IV, ORAL	DOSAGE 40MG TWICE DAILY X 3 DAYS ROUTE INTRAVENOUSLY	PROTON PUMP INHIBITOR	IT INHIBITS THE PARIETAL CELL H+ / K+ ATP PUMP, THE FINAL STEP OF ACID PRODUCTION.	PATIENT'S CONDITION IMPROVED	CONSTIPATION, DIZZINESS, DIARRHEA HEADACHE, FLATULENCE. PATIENT EXPERIENCED NO SIDE EFFECTS.

15/11/21	PARACETAMOL	DOSAGE 0.5–1 G EVERY 4–6 HOURS; MAXIMUM 4G PER DAY ROUTE ORAL, RECTAL AND IV.	DOSAGE 1G TDS X 3 DAYS ROUTE ORALLY	ANTI-PYRETIC/ ANALGESIC	HAS A CENTRAL ANALGESIC EFFECT THAT IS MEDIATED THROUGH ACTIVATION OF DESCENDING SEROTONERGIC PATHWAYS.	PATIENT HAD A REDUCTION IN PAIN AND TEMPERATURE	DARK URINE, SKIN REACTIONS, LIVER DAMAGE FOLLOWING OVERDOSE. PATIENT EXPERIENCED NO SIDE EFFECTS.
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TABLE 5: PHARMACOLOGY OF DRUGS ADMINISTERED TO MR. A.B. CONT'D...

DATE	DRUG	DOSAGE/ ROUTE OF	DOSAGE/ ROUTE OF	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION	SIDE EFFECT REMEDIES
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		ADMINISTRATION (LITERATURE)	ADMINISTRATION GIVEN TO PATIENT			OBSERVED	
15/11/21	INTRAVENOUS NORMAL SALINE (0.9%)	AMOUNT DEPENDS ON PATIENT'S FLUID AND ELECTROLYTE LEVEL. ROUTE INTRAVENOUSLY	DOSAGE 1.5 LITRES FOR 24 HOURS ROUTE INTRAVENOUSLY	ISOTONIC SOLUTION	TO CORRECT FLUID AND ELECTROLYTE IMBALANCE	PATIENT'S BODY FLUIDS AND ELECTROLYTES WERE RAISED	OVER HYDRATION HYPOCALCAEMIA NONE OF THE SIDE EFFECTS WERE OBSERVED
15/11/21	METOCLOPRAMIDE HYDROCHLORIDE	DOSAGE USUAL DOSE IS 10 MG, REPEATED UP TO 3 TIMES DAILY; MAX. DAILY	DOSAGE 10MG TDS FOR 24 HOURS	PROKINETIC AGENT (ANTIEMETIC)	RESULTS IN INCREASED GASTRIC EMPTYING BY ENHANCING	PATIENTS VOMITING WAS RESOLVED	FEELING DROWSY, SLEEPY PROBLEMS, CONFUSION NONE OF THE

		DOSE IS 500 MICROGRAMS/KG ROUTE IV, IM, ORAL	ROUTE INTRAVENOUSLY		ANTRAL CONTRACTIONS AS WELL AS DECREASING POSTPRANDIAL FUNDUS RELAXATION		SIDE EFFECT WERE OBSERV
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TABLE 5: PHARMACOLOGY OF DRUGS ADMINISTERED TO MR. A.B. CONT'D...

DATE	DRUG	DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT/ REMEDIES
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15/11/21	METRONIDAZOLE (FLAGYL)	DOSAGE 500 MG EVERY 8 HOURS USUALLY TREATED FOR 7 DAYS ROUTE ORAL AND IV.	DOSAGE 500MG TDS X 24 HOURS ROUTE INTRAVENOUSLY	NITROIMIDAZOLE DERIVATIVES	IT INHIBITS NUCLEIC ACID SYNTHESIS BY FORMING NITROSO RADICALS, WHICH DISRUPT THE DNA OF MICROBIAL CELLS.	PATIENTS CONDITION IMPROVED.	ATAXIA, ERYTHEMA MULTIFORME. NONE OF THESE SIDE EFFECTS WERE OBSERVED.
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15/11/21	CIPROFLOXACIN	DOSAGE 400 MG EVERY 12 HOURS ROUTE ORAL, IV	DOSAGE 400MG BD FOR 24 HOURS ROUTE INTRAVENOUSLY	A BROAD-SPECTRUM ANTIBIOTIC OF THE FLUOROQUINOLONE CLASS	AN ANTIBIOTIC USED TO TREAT A NUMBER OF BACTERIAL INFECTIONS	PATIENT CONDITION IMPROVED	HEARTBURN, DIARRHOEA, PALE SKIN. NONE OF THESE SIDE EFFECTS WERE OBSERVED.
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TABLE 5: PHARMACOLOGY OF DRUGS ADMINISTERED TO MR. A.B. CONT'D...

DATE	DRUG	DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT/ REMEDIES
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15/11/21	HYOSCINE BUTYL BROMIDE	DOSAGE 20 MG, THEN 20 MG AFTER 30 MINUTES; MAXIMUM 100 MG PER DAY ROUTE ORAL, IV, IM.	DOSAGE 40MG BD X 24 HOURS ROUTE INTRAVENOUSLY	ANTISPASMODIC ANTICHOLINERGIC	EXERTS A SPASMOLYTIC ACTION ON THE SMOOTH MUSCLE OF THE GASTROINTESTINAL, BILIARY AND GENITO-URINARY TRACTS.	PATIENT'S CONDITION BECAME BETTER	DRY MOUTH, TROUBLE URINATING, ANAPHYLAXIS, PATIENT EXPERIENCED NO SIDE EFFECTS.
15/11/21	DNS	DOSAGE AMOUNT DEPENDS ON HYDRATION STATUS OF PATIENT ROUTE INTRAVENOUS	DOSAGE 1 LITRE X 24 HOURS ROUTE INTRAVENOUSLY	ISOTONIC SOLUTION	PROVIDES SUPPLEMENTARY CALORIES AND FLUIDS	CLIENT WAS HYDRATED AND ENERGY RESTORED.	APNOEA, MUSCLE PAIN, FLUID OVERLOAD. NONE OF THESE SIDE

								EFFECTS WERE OBSERVED.
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TABLE 5: PHARMACOLOGY OF DRUGS ADMINISTERED TO MR. A.B. CONT'D...

DATE	DRUG	DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECTS/ REMEDIES
17/11/21	AMOXICILLIN	DOSAGE: 500 MG 3 TIMES A DAY ROUTE:	DOSAGE 500 MG TDS FOR 7DAYS ROUTE	PENICILLINS- BROAD- SPECTRUM	TO INHIBIT BACTERIA GROWTH	PATIENT'S CONDITION IMPROVED	BLACK HAIRY TONGUE, DIZZINESS, HYPERKINESIA

		ORAL AND IV	ORALLY				NONE OF THESE SIDE EFFECTS WERE OBSERVED.
17/11/21	CLARITHROMYCIN	DOSAGE 500 MG TWICE DAILY ROUTE IV, ORAL	DOSAGE: 500MG BD FOR 7DAYS ROUTE ORALLY	MACROLIDE	TO INHIBIT BACTERIA GROWTH	PATIENT'S CONDITION IMPROVED	BURPING, DRY MOUTH, ORAL DISORDERS. NONE OF THESE SIDE EFFECTS WERE OBSERVED.

TABLE 5: PHARMACOLOGY OF DRUGS ADMINISTERED TO MR. A.B. CONT'D...

DATE	DRUG	DOSAGE/ ROUTE OF	DOSAGE/ ROUTE OF ADMINISTRATION	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT/ REMEDIES
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		ADMINISTRATION (LITERATURE)	GIVEN TO PATIENT				
17/11/21	SUSPENSION NUGEL O	DOSAGE 15MLS TWO TIMES DAILY FOR ADULTS, ROUTE ORAL	SUSPENSION NUGEL O 15MLS TID × 7 ROUTE ORALLY	ANTACID SUSPENSION.	ANTACIDS EITHER DIRECTLY NEUTRALIZE ACIDITY, INCREASING THE PH, OR REVERSIBLY REDUCE OR BLOCK THE SECRETION OF ACID BY GASTRIC CELLS TO REDUCE	PATIENT WAS RELIEVED FROM ABDOMINAL PAINS	CHALKY TASTE, CONSTIPATION, DIARRHEA. PATIENT EXPERIENCED NO SIDE EFFECTS.

					ACIDITY IN THE STOMACH.		
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E. COMPLICATIONS

WITH REFERENCE TO THE COMPLICATIONS LISTED IN THE LITERATURE REVIEW, MR. A.B. EXHIBITED NO COMPLICATION DUE TO THE APPROPRIATE MEDICAL AND NURSING CARE RENDERED AND HIS COOPERATION TO THE TREATMENT REGIMEN.

2.2 PATIENT/FAMILY STRENGTHS

STRENGTH REFERS TO THE QUALITY OR STATE OF BEING STRONG (Merriam-Wester, 2020). THE FOLLOWING STRENGTHS WERE OBSERVED ON PATIENT DURING THE TIME OF NURSING CARE.

1. PATIENT COULD COMMUNICATE, VERBALLY THE LOCATION OF HIS PAIN.
2. PATIENT COULD VERBALIZE THE EXTENT OF HOW HOT HE WAS.
3. PATIENT COULD TOLERATE SIPS OF WATER.
4. PATIENT COULD TOLERATE A QUARTER OF MEAL SERVED ORALLY.
5. PATIENT COULD SIT UP IN BED WITHOUT ASSISTANCE
6. PATIENT SHOWED INTEREST IN GAINING KNOWLEDGE ON HIS CONDITION AND TREATMENT.

2.3 PATIENT'S HEALTH PROBLEMS

PROBLEM IS DEFINED AS A QUESTION RAISED FOR INQUIRY, CONSIDERATION, OR SOLUTION (Merriam-Wester, 2020). DURING ASSESSMENT, MR. A.B. PRESENTED WITH THE FOLLOWING HEALTH PROBLEMS:

1. PATIENT FELT PAIN AT THE ABDOMEN (14/11/21)
2. PATIENT HAD FEVER (37.8⁰C) (14/11/21)
3. PATIENT WAS VOMITING (14/11/21)
4. PATIENT EXPERIENCED LOSS OF APPETITE (15/11/21)

5. PATIENT COMPLAINED OF BODY WEAKNESS (15/11/21)
6. PATIENT HAD LITTLE KNOWLEDGE ABOUT THE CONDITION (16/11/21)

2.4 NURSING DIAGNOSIS

ACCORDING TO HINKLE AND CHEEVER (2014), NURSING DIAGNOSIS IS THE ORGANIZATION, ANALYSIS, SYNTHESIS AND SUMMARIZATION OF DATA COLLECTED AND DETERMINES THE PATIENT'S NEED FOR CARE.

1. ACUTE PAIN RELATED TO ACUTE INFLAMMATION OF THE GASTRIC MUCOSA (14/11/21)
2. HYPERTHERMIA (37.8⁰C) RELATED TO INFLAMMATORY PROCESS (GASTRITIS) (14/11/21)
3. RISK FOR DEFICIENT FLUID VOLUME RELATED TO EXCESSIVE FLUID LOSS THROUGH VOMITING. (14/11/21)
4. IMBALANCED NUTRITION LESS THAN BODY REQUIREMENT RELATED TO INSUFFICIENT DIETARY INTAKE (15/11/21)
5. PARTIAL SELF-CARE DEFICIT RELATED TO BODY WEAKNESS (16/11/21)
6. DEFICIENT KNOWLEDGE RELATED TO LITTLE KNOWLEDGE ABOUT THE CONDITION, PROCEDURE AND TREATMENT OF GASTRITIS (16/11/21)

CHAPTER THREE

PLANNING FOR CLIENT AND FAMILY CARE

3.0 INTRODUCTION

PLANNING IS THE PROCESS IN WHICH THE NURSE AND PATIENT TOGETHER CONSIDER THE GOALS TO ACHIEVE IN MEETING THE PATIENT'S POTENTIAL PROBLEMS IN EVERYDAY LIFE AND DRAW AN INDIVIDUAL CARE PLAN (Weller, 2014). PLANNING FOR PATIENT/FAMILY CARE IS THE THIRD STAGE OF THE NURSING PROCESS. A NURSING CARE PLAN COMMENCES WITH THE NURSING DIAGNOSIS, THE GOALS AND OBJECTIVES. ONCE THESE GOALS ARE IDENTIFIED, UNIQUE NURSING ACTIONS ARE OUTLINED TO ACHIEVE THE GOALS AND OBJECTIVES. IT IS BASED ON THE POTENTIAL AND ACTUAL PROBLEMS IDENTIFIED. THE NURSE FURTHER GOES ON TO EVALUATE THE CARE GIVEN TO FIND OUT WHETHER SET GOALS AND OBJECTIVES ARE FULLY MET, PARTIALLY MET OR UNMET.

3.1 OBJECTIVES/OUTCOME CRITERIA FOR PATIENT AND FAMILY CARE

OBJECTIVES ARE WHAT THE NURSE AND PATIENT WANT TO ACHIEVE IN TERMS OF OBSERVABLE PATIENT RESPONSES RATHER THAN NURSING ACTIVITIES.

BASED ON THE HEALTH PROBLEMS IDENTIFIED ON PATIENT, THE FOLLOWING NURSING OBJECTIVES WERE SET FOR MR. A.B. AND HIS RELATIVES DURING THEIR TIME OF CARE.

1. PATIENT WOULD BE RELIEVED OF ABDOMINAL PAIN WITHIN 24 HOURS AS EVIDENCED BY;

- a. PATIENT VERBALIZING HE IS RELIEVED OF PAIN.
- b. NURSE REVIEWING PAIN LEVEL USING THE PAIN RATING SCALE OF 0-10.

2. PATIENT WOULD BE RELIEVED OF FEVER WITHIN 24 HOURS AS EVIDENCE BY;

- a. NURSE OBSERVING THAT PATIENT'S BODY TEMPERATURE FALLS WITHIN NORMAL RANGE (36.2^oC-37.2^oC).
- b. PATIENT VERBALIZING THAT HE HAS BEEN RELIEVED OF HIGH BODY TEMPERATURE.

3. PATIENT WOULD MAINTAIN NORMAL FLUID VOLUME AND ELECTROLYTE BALANCE THROUGHOUT THE PERIOD OF HOSPITALIZATION AS EVIDENCED BY:

- a. NURSE OBSERVING PATIENT HAS A NORMAL SKIN TURGOR.
- b. PATIENT VERBALIZING THAT HE NO MORE FEELS NAUSEOUS AND VOMITS NO MORE.

4. PATIENT WOULD HAVE GOOD NUTRITION AS REQUIRED WITHIN 72 HOURS AS EVIDENCED BY;
 - a. NURSE OBSERVING PATIENT CONSUME AT LEAST TWO/THIRDS OF MEAL SERVED.
 - b. PATIENT VERBALIZING HE CAN EAT WELL.
5. PATIENT WOULD BE ABLE TO PERFORM SELF-CARE ACTIVITIES WITHOUT ASSISTANCE WITHIN 48 HOURS AS EVIDENCED BY;
 - a. PATIENT VERBALIZING THAT HE CAN PERFORM SELF – CARE ACTIVITIES WITHOUT ASSISTANCE.
 - b. NURSE OBSERVING PATIENT PERFORM ACTIVITIES OF DAILY LIVING WITHOUT ASSISTANCE
6. PATIENT AND FAMILY WOULD GAIN ADEQUATE KNOWLEDGE ON GASTRITIS WITHIN 12 HOURS AS EVIDENCED BY;
 - a. PATIENT AND RELATIVES VERBALIZING UNDERSTANDING OF WHAT THEY ARE TAUGHT ON GASTRITIS.
 - b. NURSE OBSERVING THAT PATIENT AND RELATIVES PRACTICE WHAT WAS TAUGHT.

TABLE 6: NURSING CARE PLAN FOR PATIENT

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
14/11/21 12:10P M	ACUTE PAIN RELATED TO ACUTE INFLAMMA TION OF THE GASTRIC MUCOSA	PATIENT WOULD BE RELIEVED OF ABDOMINAL PAIN WITHIN 24 HOURS AS EVIDENCED BY; 1. PATIENT VERBALIZING HE IS RELIEVED OF PAIN. 2. NURSE REVIEWING	1. ASSESS PAIN USING THE PAIN RATING SCALE (0-10). 2. MONITOR VITAL SIGNS 4 HOURLY 3. ENCOURAGE FREQUENT FLUID INTAKE. 4. REDUCE NOISE AND IMPROVE ADEQUATE	1. PATIENTS PAIN WAS ASSESSED TO BE WITHIN 7 PER THE NUMERICAL PAIN RATING SCALE 2. PATIENTS VITAL SIGNS WERE MONITORED 4 HOURLY AND WERE WITHIN NORMAL RANGE 3. SIPS OF WATER WAS SERVED AT FREQUENT INTERVALS. 4. ALL FORMS OF NOISE WERE REDUCED BY RESTRICTING VISITORS, AND WINDOWS WERE	15/11/21 12:10PM	GOALS FULLY MET AS PATIENT VERBALIZED THAT HE DOES NOT FEEL THE PAIN ANYMORE AND NURSE REVIEWED PATIENTS PAIN USING THE PAIN RATING	

		PAIN LEVEL USING THE PAIN RATING SCALE OF 0-10.	VENTILATION AT THE WARD.	OPENED TO ALLOW IN FRESH AIR.		SCALE 0-10 AND PATIENT INDICATED NO PAIN.	
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TABLE 6: NURSING CARE PLAN FOR PATIENT

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
			5. ENCOURAGE FREQUENT BUT SMALL INTAKE OF FOOD IN BETWEEN MEALS. 6. TEACH RELAXATION TECHNIQUES TO HELP ALLEVIATE PAIN.	5. FREQUENT BUT SMALL INTAKE OF FOOD WAS ENCOURAGED 6. RELAXATION TECHNIQUES WERE TAUGHT TO PATIENT LIKE THE KNEE-CHEST POSITION			

			7. ADMINISTER PRESCRIBED DRUGS.	7. INTRAVENOUS OMEPRAZOLE 40MG AND INTRAVENOUS HYOSCINE BUTYLBROMIDE 40MG WERE ADMINISTERED TO RELIEVE HIS OF ABDOMINAL PAINS.			
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TABLE 6: NURSING CARE PLAN FOR PATIENT CONT'D...

DATE/ TIME	NURSING DIAGNOSES	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
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14/11/21 12:20P M	HYPERTHERMIA (37.8°C) RELATED TO INFLAMMATORY PROCESS OF GASTRITIS	PATIENT WOULD BE RELIEVED FROM FEVER WITHIN 24 HOURS AS EVIDENCE BY; 1. NURSE OBSERVING THAT PATIENT'S BODY TEMPERATURE FALLS WITHIN NORMAL	1. REASSURE THE PATIENT THAT MEASURES WILL BE PUT IN PLACE TO RESTORE HIS BODY TEMPERATURE TO NORMAL. 2. INSTRUCT PATIENT TO REMOVE TIGHT CLOTHING'S 3. PROVIDE ADEQUATE ROOM VENTILATION. 4. MONITOR TEMPERATURE EVERY 30 MINUTES.	1. PATIENT WAS REASSURED THAT MEASURES WILL BE PUT IN PLACE TO RESTORE HIS TEMPERATURE TO NORMAL. 2. PATIENT WAS INSTRUCTED TO REMOVE ANY TIGHT CLOTHING'S TO HELP REDUCE HIM TEMPERATURE 3. WINDOWS WERE OPENED TO ENHANCE ADEQUATE VENTILATION. 4. TEMPERATURE WAS CHECKED EVERY MINUTES	15/11/21 12:20PM	GOAL FULLY MET AS IT WAS OBSERVED THAT PATIENTS' BODY TEMPERATURE HAS FALLEN WITHIN NORMAL RANGE(36.8°C) AND PATIENT VERBALIZED THAT HE HAS BEEN RELIEVED OF
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		RANGE (36.2°C-37.2°C)		CONTINUOUSLY FOR 2 HOURS.		HIGH BODY TEMPERATURE	
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TABLE 6: NURSING CARE PLAN FOR PATIENT CONT'D...

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
		2. PATIENT VERBALIZING THAT HE HAS BEEN	5. SERVE COLD DRINKS. 6. ADMINISTER PRESCRIBED ANTI-PYRETIC AND ANTIBIOTICS AND OBSERVE FOR SIDE EFFECTS.	5. COLD DRINKS SUCH AS MALT WAS GIVEN TO PATIENT 6. TABLET PARACETAMOL 1G AND IV			

		RELIEVED OF HIGH BODY TEMPERAT URE		METRONIDAZOLE 500MG WERE ADMINISTERED.			
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TABLE 6: NURSING CARE PLAN FOR PATIENT CONT'D...

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIG N
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<p>14/11/20 12:30P M</p>	<p>RISK FOR DEFICIENT FLUID VOLUME RELATED TO EXCESSIVE FLUID LOSS THROUGH VOMITING</p>	<p>PATIENT WOULD MAINTAIN NORMAL FLUID VOLUME AND ELECTROLYTE BALANCE THROUGHOUT THE PERIOD OF HOSPITALIZAT ION EVIDENCED BY;</p>	<p>1. ASSESS THE POSSIBLE SIGNS OF DEHYDRATION SUCH AS WEAKNESS, THIRST, DECREASED SKIN TURGOR, ETC. AND MONITOR INTAKE AND OUTPUT. 2. ASSESS THE BALANCE OF FLUID EVERY 24HOURS. 3. ENCOURAGE PATIENT TO EAT AND DRINK LITTLE BUT OFTEN TO REDUCE CHANCES OF VOMITING.</p>	<p>1. THE POSSIBLE SIGNS OF DEHYDRATION SUCH AS WEAKNESS, THIRST, DECREASED SKIN TURGOR, ETC. WERE ASSESSED AND INTAKE AND OUTPUT WERE MONITORED. 2. FLUID BALANCE WAS ASSESSED FOR EVERY 24HOURS. 3. PATIENT WAS ENCOURAGED TO EAT AND DRINK LITTLE BUT OFTEN TO REDUCE CHANCES OF VOMITING.</p>	<p>18/11/21 12:30PM</p>	<p>GOAL FULLY MET AS NURSE OBSERVED PATIENT HAD A NORMAL SKIN TURGOR AND PATIENT VERBALIZED HE VOMITS NO MORE.</p>	
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		1. NURSE OBSERVING PATIENT HAS A NORMAL SKIN TURGOR					
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TABLE 6: NURSING CARE PLAN FOR PATIENT CONT'D...

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
		2. PATIENT VERBALIZI NG HE NO MORE FEELS NAUSEOUS	4. ENCOURAGE CLIENT TO AVOID CONSUMING FOODS AND BEVERAGES THAT CONTAIN CAFFEINE. 5. ADMINISTER PRESCRIBED ANTI-EMETICS.	4. PATIENT WAS ENCOURAGED TO AVOID CONSUMING FOODS AND BEVERAGES THAT CONTAIN CAFFEINE.			

		OR VOMITS NO MORE.	6. DOCUMENT PROCEDURES PERFORMED INTO THE NURSES' NOTES.	5. PRESCRIBED ANTI- EMETIC, IV METOCLOPRAMIDE 10MG WAS ADMINISTERED. 6. THE PROCEDURE PERFORMED WAS DOCUMENTED INTO THE NURSES NOTES.			
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TABLE 6: NURSING CARE PLAN FOR PATIENT CONT'D...

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
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<p>15/11/21 8:00AM</p>	<p>IMBALAN CED NUTRITIO N LESS THAN BODY REQUIRE MENT RELATED TO INSUFFICI ENT DIETARY INTAKE</p>	<p>PATIENT WOULD HAVE GOOD NUTRITION WITHIN 72 HOURS AS EVIDENCED BY; 1. PATIENT VERBALIZING HE HAS GAIN APPETITE FOR FOOD.</p>	<p>1. DISCUSS WITH PATIENT AND FAMILY ABOUT THE IMPORTANCE OF FOOD FOR THE BODY. 2. MONITOR THE AMOUNT OF FOOD INTAKE. 3. PROVIDE A VARIED DIET TO STIMULATE PATIENT'S APPETITE. 4. PROVIDE FOOD IN SMALL PORTIONS BUT FREQUENTLY. 5. EDUCATE CLIENT ON THE NEED TO TAKE IN</p>	<p>1. PATIENT AND FAMILY WERE EDUCATED ABOUT THE IMPORTANCE OF FOOD FOR THE BODY. 2. THE AMOUNT OF FOOD INTAKE WAS MONITORED. 3. A VARIED DIET WAS PROVIDED ACCORDING TO PATIENT'S DIET TO STIMULATE HIS APPETITE. 4. FOOD WAS PROVIDED IN SMALL PORTIONS BUT FREQUENTLY. 5. CLIENT WAS EDUCATED ON THE NEED TO TAKE IN NUTRITIONALLY RICH DIETS.</p>	<p>18/11/21 8:00AM</p>	<p>GOAL FULLY MET AS PATIENT VERBALIZED HE HAS GAINED APPETITE FOR FOOD AND NURSE OBSERVED PATIENT CONSUME AT LEAST TWO/THIRDS OF MEAL SERVED.</p>	
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			NUTRITIONALLY RICH DIETS.				
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TABLE 6: NURSING CARE PLAN FOR PATIENT CONT'D...

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
		2. NURSE OBSERVING PATIENT CONSUME AT LEAST TWO/THIRDS OF MEAL SERVED.	6. SERVE FOODS IN AN ATTRACTIVE MANNER. 7. DOCUMENT PROCEDURES PERFORMED INTO THE NURSES NOTES.	6. FOODS WERE SERVED IN AN ATTRACTIVE MANNER. 7. PROCEDURES WERE DOCUMENTED AS PERFORMED INTO THE NURSES' NOTES.			

TABLE 6: NURSING CARE PLAN FOR PATIENT CONT'D...

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
15/11/21 8:35AM	PARTIAL SELF-CARE DEFICIT RELATED TO BODY WEAKNESS	PATIENT WOULD BE ABLE TO PERFORM SELF – CARE ACTIVITIES WITHOUT ASSISTANCE	1. REASSURE PATIENT OF COMPETENT NURSING CARE	1. PATIENT WAS REASSURED THAT MEASURES WILL BE PUT IN PLACE TO ASSIST HIM DURING BATH. 2. PATIENT STRENGTH FOR SELF- CARE ACTIVITIES WAS ASSESSED	17/11/21 8:35AM	GOAL FULLY MET AS PATIENT WAS ABLE TO PERFORM ACTIVITIES OF DAILY LIVING	

		<p>WITHIN 48 HOURS AS EVIDENCED BY;</p> <p>1. PATIENT VERBALIZING THAT HE CAN PERFORM SELF – CARE ACTIVITIES WITHOUT ASSISTANCE.</p>	<p>2. ASSESS PATIENT STRENGTH FOR SELF-CARE ACTIVITIES</p> <p>3. PERFORM ASSISTED BATHROOM BATH AND GROOM PATIENT.</p> <p>4. ENSURE PATIENTS ITEMS FOR SELF-CARE ARE PUT WITHIN REACH OF PATIENT</p>	<p>3. PATIENT WAS ASSISTED WITH GATHERING BATHING SUPPLIES SUCH AS SOAP, SPONGE, TOWEL, AND WATER AND PATIENT WAS GROOMED AND MADE COMFORTABLE IN BED.</p> <p>4. PATIENT ITEMS FOR SELF-CARE WERE PUT WITHIN HIS REACH</p>		<p>WITHOUT ASSISTANCE AND NURSE OBSERVED PATIENT PERFORMING ACTIVITIES OF DAILY LIVING WITHOUT ASSISTANCE.</p>	
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TABLE 6: NURSING CARE PLAN FOR PATIENT CONT'D...

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
		2. NURSE OBSERVING PATIENT PERFORMING ACTIVITIES OF DAILY LIVING WITHOUT ASSISTANCE.	6. CARE FOR PATIENT'S HANDS AND FEET. 7. ASSIST AND ENCOURAGE PATIENT TO PERFORM SELF-CARE ACTIVITIES 8. EDUCATE ON THE NEED TO PERFORM SELF-CARE ACTIVITIES	5. PATIENT'S HANDS AND FEET WERE CARED FOR USING WARM WATER INTO WHICH HE SOAKED HIS FEET AND HANDS. 7. PATIENT AS ASSISTED AND ENCOURAGED TO PERFORM SELF-CARE ACTIVITIES 8. PATIENT WAS EDUCATED ON THE NEED TO PERFORM SELF-CARE ACTIVITIES			

TABLE 6: NURSING CARE PLAN FOR PATIENT CONT'D...

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
16/11/21 8:00AM	DEFICIENT KNOWLEDGE RELATED TO LITTLE KNOWLEDGE ABOUT THE CONDITION, PROCEDURE AND	PATIENT AND RELATIVES WOULD BE ABLE TO UNDERSTAND THE CONDITION, WITHIN 12 HOURS AS EVIDENCED BY; 1. PATIENT AND RELATIVES BEING ABLE TO PROVIDE	1. ASSESS THE MOTIVATION AND WILLINGNESS OF THE PATIENT AND RELATIVES TO LEARN. 2. CREATE A CONDUCIVE LEARNING ENVIRONMENT. 3. ESTABLISH GOOD INTERPERSONAL	1. ASSESSMENT ON THE MOTIVATION AND WILLINGNESS OF THE PATIENT AND RELATIVES TO LEARN WAS DONE. 2. A CONDUCIVE LEARNING ENVIRONMENT WAS ENSURED. 3. A GOOD INTERPERSONAL RELATIONSHIP WITH	16/11/21 8:00PM	GOAL FULLY MET AS PATIENT AND RELATIVES BEING ABLE TO PROVIDE CORRECT ANSWERS TO QUESTIONS THEY ARE	

TREATMENT OF GASTRITIS	CORRECT ANSWERS TO QUESTIONS THEY ARE ASKED REGARDING THE FEATURES,	RELATIONSHIP WITH PATIENT AND RELATIVES. 4. QUESTION THE PATIENT REGARDING PREVIOUS EXPERIENCE AND HEALTH TEACHING.	PATIENT AND RELATIVES WAS ESTABLISHED. 4. THE PATIENT WAS QUESTIONED REGARDING PREVIOUS EXPERIENCE AND HEALTH TEACHING.	ASKED REGARDING THE FEATURES, MANAGEMENT AND CARE OF GASTRITIS.
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TABLE 6: NURSING CARE PLAN FOR PATIENT CONT'D...

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
		MANAGEMENT AND CARE OF GASTRITIS.	5. IDENTIFY ANY EXISTING MISCONCEPTIONS	5. EXISTING MISCONCEPTIONS REGARDING MATERIAL TO		NURSE OBSERVED PATIENT AND	

		<p>2. NURSE OBSERVING PATIENT AND RELATIVES PRACTICE WHAT WAS TAUGHT.</p>	<p>REGARDING MATERIAL TO BE TAUGHT.</p> <p>6. EDUCATE PATIENT AND RELATIVES ON THE CONDITION IN LANGUAGE THEY CAN UNDERSTAND WELL.</p> <p>7.ALLOW PATIENT AND RELATIVES TO ASK QUESTIONS TO CLEAR DOUBT AND ANSWER THEM TACTFULLY.</p>	<p>BE TAUGHT WERE IDENTIFIED.</p> <p>6. PATIENT AND RELATIVES WERE EDUCATED ON THE CONDITION IN THE LANGUAGE THEY CAN UNDERSTAND WELL, THUS IN 'TWI'.</p> <p>7. PATIENT AND RELATIVES WERE ALLOWED TO ASK ANY QUESTION TO CLEAR DOUBTS AND TACTFUL ANSWERS WERE PROVIDED.</p>		<p>RELATIVES PRACTICE WHAT WAS TAUGHT.</p>	
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CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 INTRODUCTION

IMPLEMENTATION IS THE PROCESS BY WHICH THE NURSE AND THE PATIENT PUT INTO PRACTICE THE PLANNED CARE. IT INVOLVES PUTTING INTO ACTION THE NURSING AND MEDICAL ORDERS TO MEET THE PATIENT'S NEEDS. DURING THE PROCESS OF IMPLEMENTATION, THE PATIENT IS THE CENTRAL FOCUS OF ACTIVITIES. THIS CHAPTER FORMS THE FOURTH PART OF THE PATIENT/FAMILY CARE STUDY. IT ENTAILS CARRYING OUT BOTH MEDICAL AND SURGICAL INTERVENTIONS. THE PATIENT AND RELATIVES ARE ENCOURAGED TO PARTICIPATE BY PLAYING THEIR ROLE IN PATIENT'S RECOVERY. THE NURSE SHOULD BEAR IN MIND THE INDIVIDUALITY OF PATIENT AND FAMILY.

4.1 SUMMARY OF ACTUAL NURSING CARE RENDERED TO PATIENT

THE NURSING MANAGEMENT OF THE PATIENT STARTED ON THE DAY OF ADMISSION WHICH WAS 14TH NOVEMBER, 2021 TO THE DAY OF DISCHARGE ON 18TH NOVEMBER, 2021. THE MANAGEMENT AIMED AT ALLEVIATING PATIENT'S ABDOMINAL PAIN AND TREATING OTHER PRESENTING SIGNS AND SYMPTOMS OF THE CONDITION, TREATING UNDERLYING CAUSE AND PREVENTING COMPLICATIONS. DURING THE PERIOD OF ADMISSION, DAILY ROUTINE CARE WAS CARRIED OUT SUCH AS PAIN MANAGEMENT, BED MAKING, MAINTAINING THE PERSONAL HYGIENE, SERVING OF PRESCRIBED MEDICATION TO THE PATIENT AMONG OTHERS.

4.1.1 FIRST DAY OF ADMISSION (14TH NOVEMBER, 2021)

ON THE 14TH NOVEMBER, 2021 AT 12:00PM, PATIENT WAS RECEIVED INTO THE MALE WARD OF DORMAA PRESBYTERIAN HOSPITAL FROM THE ACCIDENT AND EMERGENCY UNIT PER AMBULATION ACCOMPANIED BY A STAFF NURSE, AND A RELATIVE (SON) WITH THE DIAGNOSIS OF GASTRITIS. ON ARRIVAL, PATIENT AND RELATIVE TOGETHER WITH THE ACCOMPANYING STAFF NURSE AND STUDENT NURSE WERE WELCOMED. PATIENT WAS FULLY CONSCIOUS, FEBRILE AND ACTIVE. THE NEEDED INFORMATION ABOUT PATIENT WERE COLLECTED FROM THE NURSE TO ENSURE DATA ACCURACY. CONFIRMATION WAS DONE TO SEE IF HE WAS THE RIGHT PATIENT.

HE WAS REASSURED TO ALLAY FEARS AND ANXIETY. HE WAS INTRODUCED TO THE STAFFS PRESENT AND WAS ASSURED OF THE COMPETENCE AND HARDWORK OF THE STAFF WHO WERE GOING TO TAKE CARE OF HIM THROUGHOUT HIS STAY IN THE HOSPITAL AND THAT AFTER HIS TREATMENT, HE WILL NOT EXPERIENCE ANY ABDOMINAL PAINS AND WILL BE ABLE TO COPE WITH HIS NORMAL DAILY ACTIVITIES.

PATIENT WAS MADE COMFORTABLE IN AN ALREADY PREPARED ADMISSION BED AND HIS VITAL SIGNS WERE CHECKED AND RECORDED ACCURATELY AS FOLLOWS;

- | | |
|-------------------|---------------------|
| 1. TEMPERATURE | 37.8 ⁰ C |
| 2. PULSE | 68BPM |
| 3. RESPIRATION | 18CPM |
| 4. BLOOD PRESSURE | 110/70 MMHG |

PATIENT WEIGHED 80KG

A HEAD TO TOE PHYSICAL EXAMINATION WAS CONDUCTED ON PATIENT AND NO ABNORMALITIES WERE SEEN. PATENT WAS ORIENTED TO TIME, PLACE AND PERSON. DURING ASSESSMENT, HE COMPLAINED OF ABDOMINAL PAIN AT THE EPIGASTRIC REGION, NAUSEA AND VOMITING.

THE FOLLOWING TREATMENT PLAN WERE ORDERED:

1. INTRAVENOUS OMEPRAZOLE 40MG BD FOR 3 DAYS
2. TABLET PARACETAMOL 1G TID FOR 3DAYS
3. INTRAVENOUS NORMAL SALINE 0.9% 2 LITERS FOR 48 HOURS
4. INTRAVENOUS METRONIDAZOLE 500MG TDS FOR 24HOURS
5. INTRAVENOUS CIPROFLOXACIN 400MG BD FOR 24 HOURS
6. INTRAVENOUS METOCLOPRAMIDE 10MG TDS FOR 24HOURS

THESE INVESTIGATIONS HAD BEEN ORDERED AND CARRIED OUT ON PATIENT;

1. FULL BLOOD COUNT
2. BLOOD FILM FOR MALARIA PARASITES
3. HELICOBACTER PYLORI TEST
4. WIDAL TEST

HIS PARTICULARS SUCH AS NAME, SEX, AGE, OCCUPATION, HEALTH INSURANCE STATUS AND RESIDENTIAL ADDRESS WERE RECORDED IN THE ADMISSION AND DISCHARGE BOOK. HIS NAME, SEX AND AGE WERE WRITTEN IN THE DAILY WARD STATE. HOSPITAL POLICIES REGARDING VISITING PERIODS, PAYMENT OF BILLS AND THE TIME VITAL SIGNS WILL BE CHECKED AND ADMINISTRATION OF MEDICATIONS WERE EXPLAINED TO HIM AND HIS RELATIVE. THEY WERE ALSO ORIENTED TO THE WARD ENVIRONMENT AND

ITS ANNEXES. HE WAS ASKED TO GET HIS OWN BOWL, SPOON, DRINKING CUP, BATHING SPONGE, BUCKET, TOWEL, PYJAMAS AND OTHER TOILETRIES.

AT 12:10PM, UPON ASSESSMENT AND CONVERSATION WITH PATIENT HE COMPLAINED OF ABDOMINAL PAIN HENCE A NURSING DIAGNOSIS OF ACUTE PAIN RELATED TO ACUTE INFLAMMATION OF THE GASTRIC MUCOSA WAS MADE FOR PATIENT. AS SUCH AN OBJECTIVE WAS SET TO HELP PATIENT TO BE RELIEVED FROM PAIN WITHIN 24 HOURS. THE FOLLOWING INTERVENTIONS WERE CARRIED OUT: PATIENTS PAIN WAS ASSESSED TO BE WITHIN 7 PER THE NUMERICAL PAIN RATING SCALE, PATIENTS VITAL SIGNS WERE MONITORED 4 HOURLY AND WERE WITHIN NORMAL RANGE, SIPS OF WATER WAS SERVED AT FREQUENT INTERVALS, ALL FORMS OF NOISE WERE REDUCED BY RESTRICTING VISITORS, AND WINDOWS WERE OPENED TO ALLOW IN FRESH AIR, FREQUENT BUT SMALL INTAKE OF FOOD WAS ENCOURAGED, RELAXATION TECHNIQUES WERE TAUGHT TO PATIENT LIKE THE KNEE-CHEST POSITION AND INTRAVENOUS OMEPRAZOLE 40MG AND INTRAVENOUS HYOSCINE BUTYLBROMIDE 40MG WERE ADMINISTERED TO RELIEVE HIS OF ABDOMINAL PAINS.

AT 12:20PM, PATIENT HAD A HIGH BODY TEMPERATURE HENCE THE NURSING DIAGNOSIS OF HYPERTHERMIA (37.8⁰C) RELATED TO INFLAMMATORY PROCESS OF GASTRITIS WAS MADE. THE FOLLOWING INTERVENTIONS WERE CARRIED OUT TO HELP RESTORE PATIENTS NORMAL TEMPERATURE WITHIN 24 HOURS: PATIENT WAS REASSURED THAT MEASURES WILL BE PUT IN PLACE TO RESTORE HIS TEMPERATURE TO NORMAL, PATIENT WAS INSTRUCTED TO REMOVE ANY TIGHT CLOTHING'S TO HELP REDUCE HIS TEMPERATURE, WINDOWS WERE OPENED TO ENHANCE ADEQUATE VENTILATION,

TEMPERATURE WAS CHECKED EVERY MINUTES CONTINUOUSLY FOR 2 HOURS, COLD DRINKS SUCH AS MALT WAS GIVEN TO PATIENT AND TABLET PARACETAMOL 1G AND IV METRONIDAZOLE 500MG WERE ADMINISTERED. AT 12:30PM, PATIENT WAS SEEN VOMITING, PRODUCING COPIOUS SALIVA AND COMPLAINING OF FEELING NAUSEATED. A NURSING DIAGNOSIS OF RISK FOR DEFICIENT FLUID VOLUME RELATED TO EXCESSIVE FLUID LOSS THROUGH VOMITING WAS MADE FOR PATIENT AND AN OBJECTIVE WAS SET TO HELP PATIENT MAINTAIN NORMAL FLUID VOLUME AND ELECTROLYTE BALANCE THROUGHOUT THE PERIOD OF HOSPITALIZATION. THESE INTERVENTIONS WERE CARRIED OUT: POSSIBLE SIGNS OF DEHYDRATION SUCH AS WEAKNESS, THIRST, DECREASED SKIN TURGOR, ETC. WERE ASSESSED AND INTAKE AND OUTPUT WERE MONITORED, FLUID BALANCE WAS ASSESSED FOR EVERY 24HOURS, PATIENT WAS ENCOURAGED TO EAT AND DRINK LITTLE BUT OFTEN TO REDUCE CHANCES OF VOMITING, PATIENT WAS ENCOURAGED TO AVOID CONSUMING FOODS AND BEVERAGES THAT CONTAIN CAFFEINE, PRESCRIBED ANTI-EMETIC; INTRAVENOUS METOCLOPRAMIDE 10MG WAS ADMINISTERED AND THE PROCEDURE PERFORMED WAS DOCUMENTED INTO THE NURSES NOTE. AT 5:30PM, PATIENT TOOK AMPESI WITH GARDEN EGGS STEW AS HIS SUPPER. VITAL SIGNS WERE CHECKED AT 6:00PM AND RECORDED AS INDICATED IN THE APPENDIX. PATIENT WAS THEN LEFT IN THE HANDS OF THE NIGHT NURSES TO CONTINUE IN THE RENDERING OF CARE TO PATIENT. AT 10:00PM, HIS VITAL SIGNS WERE CHECKED AND RECORDED AS INDICATED IN THE APPENDIX, DUE MEDICATIONS WERE SERVED. PATIENT SLEPT AROUND 10:30PM.

4.1.2 SECOND DAY OF ADMISSION (15TH NOVEMBER, 2021)

ON THE SECOND DAY OF ADMISSION, PATIENT WOKE UP AT 5:20AM, PATIENT OBSERVED HIS PERSONAL HYGIENE AND HIS BED WAS STRAIGHTENED TO BE FREE FROM CREASES AND CRUMPS. AT 6:00AM, HIS DUE MEDICATIONS WERE ADMINISTERED. VITAL SIGNS WERE RECORDED AS FOLLOWS:

TEMPERATURE	36.3 DEGREE CELSIUS
PULSE	57 BEAT PER MINUTE
RESPIRATION	19 CYCLES PER MINUTE

BLOOD PRESSURE 130/80MMHG

AT 8:00AM PATIENT REVEALED TO ME THAT HE HAD LOST APPETITE AND COULDN'T CONSUME SUFFICIENT AMOUNT OF THE FOOD HE IS PROVIDED WITH, HENCE A NURSING DIAGNOSIS OF IMBALANCED NUTRITION LESS THAN BODY REQUIREMENT RELATED TO INSUFFICIENT DIETARY INTAKE WAS MADE FOR PATIENT. THE FOLLOWING INTERVENTIONS WERE IMPLEMENTED: PATIENT AND FAMILY WERE EDUCATED ABOUT THE IMPORTANCE OF FOOD FOR THE BODY, THE AMOUNT OF FOOD INTAKE WAS MONITORED, A VARIED DIET WAS PROVIDED ACCORDING TO PATIENT'S DIET TO STIMULATE HIS APPETITE, FOOD WAS PROVIDED IN SMALL PORTIONS BUT FREQUENTLY, PATIENT WAS EDUCATED ON THE NEED TO TAKE IN NUTRITIONALLY RICH DIETS, FOODS WERE SERVED IN AN ATTRACTIVE MANNER AND PROCEDURES WERE DOCUMENTED AS PERFORMED INTO THE NURSES' NOTES.

AT 8:35AM, PATIENT COMPLAINED OF BEEN WEAK HENCE THE NURSING DIAGNOSIS OF PARTIAL SELF-CARE DEFICIT RELATED TO BODY WEAKNESS WAS MADE. AN OBJECTIVE WAS SET SO THAT PATIENT WILL BE ABLE TO PERFORM SELF-CARE ACTIVITIES WITHOUT ASSISTANCE WITHIN 48 HOURS OF

HOSPITALIZATION. THE FOLLOWING INTERVENTIONS WERE CARRIED OUT; PATIENT WAS REASSURED THAT MEASURES WILL BE PUT IN PLACE TO ASSIST HIM DURING BATH, PATIENT STRENGTH FOR SELF-CARE ACTIVITIES WAS ASSESSED, PATIENT WAS ASSISTED WITH GATHERING BATHING SUPPLIES SUCH AS SOAP, SPONGE, TOWEL, AND WATER AND PATIENT WAS GROOMED AND MADE COMFORTABLE IN BED, PATIENT ITEMS FOR SELF-CARE WERE PUT WITHIN HIS REACH, PATIENT'S HANDS AND FEET WERE CARED FOR USING WARM WATER INTO WHICH HE SOAKED HIS FEET AND HANDS, PATIENT AS ASSISTED AND ENCOURAGED TO PERFORM SELF-CARE ACTIVITIES, PATIENT WAS EDUCATED ON THE NEED TO PERFORM SELF-CARE ACTIVITIES.

AT 9:00AM, THE MEDICAL TEAM CAME FOR WARD ROUNDS AND THE PLAN WAS TO CONTINUE THE TREATMENT.

AT 9:15AM, PATIENT WAS SERVED WITH PORRIDGE AND WHEAT BREAD. VITAL SIGNS WERE CHECKED AT 10:00AM AND RECORDED AS FOLLOWS:

TEMPERATURE	36.3 DEGREE CELSIUS
PULSE	62 BEATS PER MINUTES
RESPIRATION	24 CYCLES PER MINUTES
BLOOD PRESSURE	120/80MMHG

AT 12:10PM EVALUATION OF THE SET OBJECTIVE TO RELIEVE PATIENT FROM PAIN ON 14TH NOVEMBER, 2021 WAS DONE AND GOAL WAS FULLY MET AS PATIENT VERBALIZED THAT HE DOES NOT FEEL THE PAIN ANYMORE AND NURSE REVIEWED PATIENTS PAIN USING THE PAIN RATING SCALE 0-10 AND PATIENT INDICATED NO PAIN.

AT 12:20PM EVALUATION OF THE SET OBJECTIVE TO RESTORE PATIENTS BODY TEMPERATURE ON 14TH NOVEMBER, 2021 WAS DONE AND GOAL WAS FULLY MET AS IT WAS OBSERVED THAT PATIENTS' BODY TEMPERATURE HAS FALLEN WITHIN NORMAL RANGE (36.8°C) AND PATIENT VERBALIZED THAT HE HAS BEEN RELIEVED OF HIGH BODY TEMPERATURE.

AT 1:30PM, PATIENT WAS SERVED WITH HIS LUNCH WHICH WAS FRIED RIPE PLANTAIN AND BEANS STEW WITH FISH.

AT 2:00PM, PATIENTS VITAL SIGNS WERE CHECKED AND RECORDED AS INDICATED IN THE APPENDIX.

I GAVE PATIENT AND HIS RELATIVES A PRIOR NOTICE THAT I WOULD WANT TO GO AND SEE THEIR PLACE OF RESIDENCE AND PERMISSION WAS GRANTED AFTER WHICH THEY GAVE ME THE DIRECTION TO THEIR HOUSE.

AT 10:00PM, HIS VITAL SIGNS WERE CHECKED AND RECORDED, DUE MEDICATIONS WERE SERVED. PATIENT SLEPT AROUND 10:30PM.

4.1.3 THIRD DAY OF ADMISSION (16TH NOVEMBER, 2021)

PATIENT WAS SEEN AT EXACTLY 6:30AM IN BED LISTENING TO NEWS ON HIS PHONE RADIO. HIS VITAL SIGNS WERE ALREADY CHECKED AND RECORDED AS STATED IN THE APPENDIX AND ALL DUE MEDICATIONS TO BE GIVEN WERE ALSO ADMINISTERED BY THE NIGHT NURSES.

HE HAD HIS BATH AROUND 7:15AM. A COMFORTABLE BED WAS MADE FOR PATIENT WITH CLEAN SHEETS AND PILLOW CASE. PATIENT WAS THEN ASSISTED TO TAKE ABOUT 400MLS OF BROWN PORRIDGE. DURING WARD ROUNDS, PATIENT MADE NO NEW COMPLAINS AND THE PLAN WAS TO CONTINUE HIS TREATMENT.

PATIENT HAD HIS BREAKFAST AT 7:30AM WHICH WAS MILO AND BREAD.
AT 8:00AM, I HAD A CHAT WITH PATIENT ABOUT HIS CONDITION (GASTRITIS)
AND REALIZED HE HAD LITTLE KNOWLEDGE ABOUT THE CONDITION HE
PRESENTED WITH AT THE HOSPITAL. HE SHOWED INTEREST IN BEING A
LEARNER TO KNOW MORE ABOUT HIS CONDITION, BASED ON THAT, THE
NURSING DIAGNOSIS OF DEFICIENT KNOWLEDGE RELATED TO LITTLE
KNOWLEDGE ABOUT THE CONDITION, PROCEDURE AND TREATMENT OF
GASTRITIS WAS FORMULATED. AN OBJECTIVE WAS SET TO ENABLE PATIENT
DEMONSTRATE UNDERSTANDING OF THE CONDITION (GASTRITIS) WITHIN
12HOURS. THE NURSING ACTIONS THAT WERE EXECUTED INCLUDE THE
FOLLOWING: ASSESSMENT ON THE MOTIVATION AND WILLINGNESS OF THE
PATIENT AND RELATIVES TO LEARN WAS DONE, A CONDUCIVE LEARNING
ENVIRONMENT WAS ENSURED, A GOOD INTERPERSONAL RELATIONSHIP
WITH PATIENT AND RELATIVES WAS ESTABLISHED, THE PATIENT WAS
QUESTIONED REGARDING PREVIOUS EXPERIENCE AND HEALTH TEACHING,
EXISTING MISCONCEPTIONS REGARDING MATERIAL TO BE TAUGHT WERE
IDENTIFIED, PATIENT AND RELATIVES WERE EDUCATED ON THE CONDITION
IN THE LANGUAGE THEY CAN UNDERSTAND WELL, THUS IN 'TWI', AND
FINALLY, PATIENT AND RELATIVES WERE ALLOWED TO ASK ANY QUESTION
TO CLEAR DOUBTS AND TACTFUL ANSWERS WERE PROVIDED.
PATIENT WAS REVIEWED BY THE MEDICAL TEAM AT 9:00AM ON WARD
ROUNDS AND THE PLAN WAS TO CONTINUE TREATMENT.
AT 2:00PM, HIS VITAL SIGNS WERE CHECKED AND RECORDED AS INDICATED
IN THE APPENDIX.

AT 2:20PM, PATIENT TOOK HIS LUNCH WHICH WAS AMPESI AND TOMATO STEW.

AT 6:00PM, HIS VITAL SIGNS WERE CHECKED AND RECORDED, PATIENT TOOK HIS SUPPER WHICH WAS JOLLOF RICE WITH CHICKEN. HE STAYED GLUED TO THE WARD TELEVISION AFTERWARDS.

ON 16TH NOVEMBER, 2021 AT 8:00PM EVALUATION OF THE SET OBJECTIVE TO HELP PATIENTS AND RELATIVES GAIN ADEQUATE KNOWLEDGE ON GASTRITIS AT 8:00AM WAS DONE AND GOAL WAS FULLY MET AS PATIENT AND RELATIVES BEING ABLE TO PROVIDE CORRECT ANSWERS TO QUESTIONS THEY ARE ASKED REGARDING THE FEATURES, MANAGEMENT AND CARE OF GASTRITIS AND NURSE OBSERVED PATIENT AND RELATIVES PRACTICE WHAT WAS TAUGHT.

AT 10:00PM, VITAL SIGNS WERE CHECKED AND RECORD, DUE MEDICATIONS WERE ADMINISTERED. PATIENT SLEPT AROUND 10:20PM.

4.1.4 FORTH DAY OF ADMISSION (17TH NOVEMBER, 2021)

PATIENT WAS SEEN IN BED IN GOOD HEALTH AND WAS RESPONDING TO TREATMENT GIVEN. PATIENT WAS SITTING IN BED WITH A CHEERFUL FACIAL EXPRESSION. I GREETED PATIENT AND ASKED ABOUT HIS HEALTH CONDITION, PATIENT WAS HAPPY TO TELL ME HE WAS DOING WELL. THE USUAL ROUTINE NURSING CARE WAS PROVIDED AND DOCUMENTED IN THE NURSES' NOTES.

AT 8:35AM EVALUATION OF THE SET OBJECTIVE TO HELP PERFORM SELF – CARE ACTIVITIES WITHOUT ASSISTANCE WITHIN 48 HOURS WAS DONE AND GOAL WAS FULLY MET AS PATIENT WAS ABLE TO PERFORM ACTIVITIES OF

DAILY LIVING WITHOUT ASSISTANCE AND NURSE OBSERVED PATIENT PERFORMING ACTIVITIES OF DAILY LIVING WITHOUT ASSISTANCE.

AT 9:00AM, THE MEDICAL TEAM CAME FOR WARD ROUNDS AND THE PLAN WAS TO CONTINUE THE TREATMENT.

PATIENT GAVE NO NEW COMPLAINS PER MY CONVERSATION WITH HIM, LIKEWISE DURING WARD ROUNDS. THE FOLLOWING ORAL MEDICATIONS WERE ORDERED FOR PATIENT CAPSULE CLARITHROMYCIN 500MG BD FOR 7DAYS, CAPSULE AMOXICILLIN 500 MG TDS FOR 7DAYS AND SUSPENSION NUGEL 'O' 15MLS TDS FOR 7DAYS. AND DISCHARGED WAS TO BE CONSIDERED THE FOLLOWING DAY.

PATIENT WAS INFORMED ABOUT HIS POSSIBLE DISCHARGE THE FOLLOWING DAY, HE WAS VERY EXCITED TO HEAR THE NEWS.

AT 2:00PM, HIS VITAL SIGNS WERE CHECKED AND RECORDED AS TEMP- 36.5, PULSE- 92B/M, RESP-20 C/M AND BLOOD PRESSURE- 120/80MMHG. THE NECESSARY NURSING CARE CONTINUED AND PATIENT AND RELATIVES ALSO COOPERATED.

PATIENT HAD HIS SUPPER AROUND 5:30PM WHICH WAS AMPESI WITH TOMATO STEW. HIS 6:00PM VITAL SIGNS WERE CHECKED AND RECORDED; HE OBSERVED HIS PERSONAL HYGIENE IN THE EVENING.

AT 10:00PM, HIS DUE MEDICATIONS WERE ADMINISTERED AS WELL AS CHECKING AND RECORDING OF HIS VITAL SIGNS. PATIENT SLEPT AFTERWARDS.

4.1.5 FIFTH DAY OF ADMISSION/DAY OF DISCHARGE (18TH NOVEMBER, 2021)

ON THIS BRIGHT MORNING OF THURSDAY, MR. A.B. WAS DOING VERY WELL IN HEALTH WHEN SEEN AT 7:00AM. WE EXCHANGED PLEASANTRIES, PATIENT AND FAMILY REPORTED NO NEW COMPLAINS.

AT 8:00AM EVALUATION OF THE SET OBJECTIVE TO HELP PATIENT HAVE NUTRITION ON 15TH NOVEMBER, 2021 WAS DONE AND GOAL WAS FULLY MET AS PATIENT VERBALIZED HE HAS GAINED APPETITE FOR FOOD AND NURSE OBSERVED PATIENT CONSUME AT LEAST TWO/THIRDS OF MEAL SERVED.

AT 9:55AM, PATIENT WAS REVIEWED BY DR. S. AND PATIENT WAS GENERALLY WELL WITH NO NEW COMPLAINTS. DOCTOR INFORMED PATIENT THAT HE WILL BE DISCHARGED. THE TREATMENT PLANS WERE AS FOLLOWS; COUNSELLING WITH THE DIETICIAN, CONTINUE CURRENT MEDICATIONS. HE WAS EDUCATED ON THE NEED TO TAKE THE REST OF HIS MEDICATIONS AND HOW TO TAKE THE MEDICATIONS, SIDE EFFECT OF THE MEDICATIONS AND THE NEED TO REPORT ANY ILLNESS AND ABNORMALITIES WERE MADE KNOWN TO HIM. HE WAS ALSO ENCOURAGED TO REPORT ANY UNUSUAL FEELINGS THAT HE WILL EXPERIENCE BEFORE THE DATE OF REVIEW IF ANY. I CALLED THE DIETICIAN THROUGH THE WARD PHONE TO COME AND SEE PATIENT BEFORE HE LEAVES FOR HOME. I, TOGETHER WITH THE DIETICIAN PROVIDED MR. A.B. AND HIS FAMILY WITH A CLEAR AND UNDERSTANDABLE EDUCATION SPECIFICALLY CREATING AWARENESS ON HIS DIETS. ALL HIS BILLS WHICH WERE NOT COVERED BY NHIA WERE FULLY SETTLED. PATIENT WAS INFORMED TO COME FOR REVIEW ON THE 25TH NOVEMBER, 2021. PATIENT WAS EDUCATED ON THE IMPORTANCE OF COMING FOR REVIEW ON THE SAID DATE. I ASSISTED IN PACKING PATIENT'S BELONGINGS,

PERFORMED DISINFECTION OF PATIENTS BED AND LOCKER TO ENHANCE
INFECTION PREVENTION.

AT EXACTLY 11:55AM, PATIENT AND RELATIVES LEFT THE WARD.

AT 12:30PM EVALUATION OF THE SET OBJECTIVE TO MAINTAIN PATIENT
NORMAL FLUID AND ELECTROLYTE BALANCE ON 14TH NOVEMBER, 2021 WAS
DONE AND GOAL WAS FULLY MET AS NURSE OBSERVED PATIENT HAD A
NORMAL SKIN TURGOR AND PATIENT VERBALIZED THAT HE VOMITS NO
MORE.

4.2 PREPARATION OF PATIENT/FAMILY FOR DISCHARGE AND REHABILITATION

PREPARATION FOR DISCHARGE COMMENCED FROM THE TIME OF ADMISSION
AT THE HOSPITAL, AT 12:00PM ON 14TH NOVEMBER, 2021, TILL THE LAST DAY
OF DISCHARGE, 18TH NOVEMBER, 2021. THE PATIENT AND FAMILY WERE
INFORMED THAT STAYING IN THE HOSPITAL WAS FOR A TEMPORAL PERIOD
OF TIME. EDUCATION OF PATIENT AND FAMILY ON THE CAUSES, CLINICAL
FEATURES, TREATMENT AND MANAGEMENT OF GASTRITIS WERE
REEMPHASIZED. THIS WAS AIMED AT HELPING THE PATIENT AND RELATIVES
IN THE PROVISION OF ADEQUATE CARE. PRIOR TO PATIENT DISCHARGE,
HEALTH EDUCATION WAS GIVEN TO THE PATIENT AND RELATIVES ON THE
IMPORTANCE OF AVOIDING SELF- MEDICATION AND ENSURING PROPER
PERSONAL HYGIENE. ALSO, I EMPHASIZED ON THE NEED FOR PATIENT TO
AVOID IRRITATING OR CONTAMINATED DIETS, AVOIDING SMOKING,
ALCOHOLISM, CAFFEINATED BEVERAGES AS WELL AS FOODS THAT CONTAIN
HIGH AMOUNT OF ACID OR ALKALI. PATIENT WAS ENCOURAGED TO TAKE IN
FOOD RICH IN THE ESSENTIAL FOOD NUTRIENTS AND EATING WELL

BALANCED DIETS. PATIENT AND HIS FAMILY WERE ALSO EDUCATED ON THE NEED TO MAINTAIN PERSONAL AND ENVIRONMENTAL HYGIENE TO HELP IMPROVE IMMUNITY. A GREAT EMPHASIS WAS MADE ON THE NEED TO CONTINUE WITH HIS MEDICATION AND TO REPORT TO THE HOSPITAL IF ANY PROBLEM DOES OCCUR. PATIENT WAS INFORMED TO COME FOR REVIEW ON THE 25TH NOVEMBER, 2021. NECESSARY INFORMATION WERE DOCUMENTED INTO THE ADMISSION AND DISCHARGE BOOK AS WELL AS THE WARD STATE. I PROMISED THEM OF ANOTHER HOME VISIT IN THE COMING DAYS. I THEN ACCOMPANIED THEM TO THE HOSPITAL ENTRANCE AND WE SAID GOODBYE TO EACH OTHER.

4.3 FOLLOW UP/ HOME VISITS/ CONTINUITY OF CARE

HOME VISITING IS A LONG-ESTABLISHED METHOD OF ENABLING PATIENTS AND FAMILIES COPE WITH CHANGES IN THEIR LIVES. IT SHOULD BE PLANNED CAREFULLY ESPECIALLY WITH THE FIRST VISIT AS IT CAN FOSTER CORDIAL RELATIONSHIP, BUILD AND ASSIST NURSES TO DEMONSTRATE THE CONTRIBUTIONS THEY CAN MAKE IN ENABLING PATIENTS RELATIVES TO DEAL WITH THEIR CURRENT HEALTH NEEDS.

HEALTH EDUCATIONS PERTAINING TO THE CONDITION, DIET, SELF-MEDICATION, PERSONAL AND ENVIRONMENTAL HYGIENE, THE NEED TO GO FOR REGULAR MEDICAL CHECK -UPS AND EARLY REPORTING TO THE HEALTH FACILITY WHEN ANY PROBLEM IS DETECTED, THE NEED TO COMPLY WITH MEDICATIONS, THE NEED TO REPORT ON THE REVIEW DATE AS ORDERED AND ALSO THE SIGNIFICANCE OF SLEEPING UNDER INSECTICIDES TREATED NET WERE GIVEN TO PATIENT AND FAMILY. HOME VISITS WERE DONE BEFORE AND AFTER PATIENT'S DISCHARGE.

FIRST HOME VISIT (15TH NOVEMBER, 2021)

FIRST HOME VISIT WAS MADE ON 15TH NOVEMBER, 2021 ON MONDAY WHILE PATIENT WAS STILL ON ADMISSION. I GAVE A PRIOR NOTICE TO PATIENT AND OTHER FAMILY MEMBERS AND THEY WILLINGLY GAVE ME THE PERMISSION.

THE AIM OF THE VISIT WAS TO KNOW PATIENT'S HOME FOR SUBSEQUENT VISITS AND ALSO TO SEE IF THERE IS ANY PROBLEM IN THE HOUSE THAT COULD SERVE AS A PREDISPOSING FACTOR FOR PATIENT'S ILLNESS AND TO IDENTIFY ANY HEALTH FACILITY NEARBY, ALSO TO VALIDATE DATA OBTAINED. I LEFT THE WARD AT EXACTLY 4:00PM TO PATIENT'S HOUSE. HE PRESENTLY RESIDES AT JERICHO A SUBURB OF DORMAA AHENKRO IN THE BONO REGION OF GHANA WHERE HE OWNS A SELF-CONTAIN BUILT WITH BRICKS AND PAINTED PINK AND WHITE AND ROOFED WITH ALUMINUM SHEET. VENTILATION WAS VERY GOOD SINCE EACH ROOM IN THE HOUSE HAD ENOUGH TWO WINDOWS. THE WIDOWS WERE WELL COVERED WITH NET WHICH PREVENTS MOSQUITOES FROM ENTERING THE ROOM. THEY WERE EDUCATED TO ALWAYS KEEP THE LOUVERS CLEAN. THE ENVIRONMENT WAS HYGIENIC WITH A NEAT COMPOUND THAT WAS NEATLY SWEEPED AND THE BATHROOM WAS ALSO NEAT AND WELL-SCRUBBED. THE TOILET WAS A WATER CLOSET WITH THE WATER PIPE IN IT WORKING WHICH ALLOWS HIM TO FLUSH. THEIR SOURCE OF WATER IS FROM A TAP AND THEY HAVE ACCESS TO ELECTRICITY. THEIR REFUSE IS COLLECTED IN A WELL-COVERED DUSTBIN OUTSIDE THE COMPOUND WHICH IS EMPTIED BY THE ZOOMLION WASTE TRUCK ON WEEKLY BASIS. I FOUND OUT ON THE FIRST HOME VISIT THAT PATIENT'S HOUSE WAS CLOSE TO A HEALTH FACILITY BY NAME SAVIOR CLINIC. I TOOK THE OPPORTUNITY TO INTRODUCE MYSELF TO A COMMUNITY

NURSE AT THE FACILITY AND TOLD HER ABOUT HANDING THE PATIENT
OVER TO HER. SHE AGREED TO MY REQUEST.

SECOND HOME VISIT (23RD NOVEMBER, 2021)

THIS WAS DONE ON TUESDAY, 23RD NOVEMBER, 2021 FIVE DAYS AFTER
PATIENT'S DISCHARGE AT 10:00AM. THIS WAS DONE TO ASSESS HIS HEALTH
STATUS AFTER DISCHARGE AND OFFER THE NECESSARY HEALTH EDUCATION
AND ALSO REMIND PATIENT OF THE REVIEW DATE AND ENCOURAGE HIM TO
COMPLY WITH IT. ON ARRIVAL, I WAS WELCOMED WARMLY BY PATIENT AND
FAMILY TO THE HOUSE. ON ASSESSMENT PATIENT LOUVER BLADES WERE
WELL DUSTED AS THEY WERE EDUCATED TO DO. THE ENVIRONMENT WAS
NEAT AND THEY WERE COMMENDED FOR THAT.

PATIENT EXPLAINED THAT, THERE WAS MARKED IMPROVEMENT IN HIS
CONDITION SINCE HE IS ADHERING STRICTLY TO THE DRUG REGIMEN, DIET
AND LIFESTYLE MODIFICATION. PATIENT AND FAMILY WERE ABLE TO GIVE
POSITIVE FEEDBACK ON ALL EDUCATION GIVEN DURING THE PERIOD OF
ADMISSION. PATIENT AND FAMILY WERE FURTHER EDUCATED ON ENOUGH
REST AND SLEEP AND THE NEED FOR GOOD DIETARY HABIT AND A HEALTHY
LIFESTYLE.

PATIENT WAS REMINDED AGAIN OF THE DAY FOR HIS REVIEW WHICH WAS
25TH NOVEMBER, 2021 AND TOLD NOT TO HESITATE TO COME TO THE
HOSPITAL WHEN ANY SIGNS OF DISCOMFORT SET IN BEFORE THE REVIEW
PERIOD. PATIENT WAS ALSO INFORMED ABOUT THE TERMINATION OF CARE
ON MY NEXT HOME VISIT AND HANDING OVER OF CARE TO THE COMMUNITY
HEALTH NURSE.

I LATER ASKED FOR PERMISSION TO LEAVE WHICH WAS GRANTED TO ME.

REVIEW (25TH NOVEMBER, 2021)

ON THURSDAY 25TH NOVEMBER, 2021, PATIENT WAS MET AT THE OUT PATIENT DEPARTMENT OF DORMAA PRESBYTERIAN HOSPITAL AT 8:20AM LOOKING CHEERFUL AND LOVELY AS NOTED FROM FACIAL EXPRESSION. I ACCOMPANIED HIM TO GO AND VERIFY THE HOSPITAL IDENTIFICATION NUMBER ON HIS CARD AS DONE BY EVERY PATIENT WHO VISITS THE HOSPITAL. THE VITAL SIGNS WERE CHECKED AND RECORDED AS FOLLOWS;

- TEMPERATURE 36.0 DEGREE CELSIUS
- PULSE 80 BEATS PER MINUTE
- RESPIRATION 20 CYCLES PER MINUTE
- BLOOD PRESSURE 110/80MMHG

AT THE OUT PATIENT DEPARTMENT, PATIENT WENT TO CONSULTING ROOM 3. UPON ASSESSMENT BY THE DOCTOR, MR. A.B. WAS HEALTHY. PATIENT HAD NO COMPLAINS AND PHYSICAL EXAMINATION PERFORMED BY THE MEDICAL OFFICER PROVED THAT PATIENT WAS NOT IN ANY SORT OF DISCOMFORT. I REINFORCED THE EDUCATION THAT I HAD ALREADY GIVEN TO HIM AND HIS FAMILY. PATIENT THANKED ME FOR MY CARE AND CONCERN SO FAR. I ASSURED HIM OF A THIRD VISIT. I ESCORTED THEM TO THE HOSPITAL ENTRANCE.

THIRD HOME VISIT (12TH DECEMBER, 2021)

ON SUNDAY, 12TH DECEMBER, 2021, THE LAST HOME VISIT WAS PAID TO MR.

A.B AND HIS FAMILY.

MY MAIN REASONS FOR CONDUCTING THE THIRD HOME VISIT WERE TO SEE HOW MR. A.B. WAS DOING AT HOME, ASSESS THE GENERAL CONDITION OF

PATIENT'S FAMILY, REINFORCE THE NEED TO COMPLY WITH TREATMENT
REGIMEN AND EVENTUALLY TERMINATE CARE.

ON THE SAID DATE, I PICKED A TAXI AROUND 8:00AM. I GOT TO THEIR PLACE AROUND 8:20AM. ON ARRIVAL THE FAMILY WERE HAPPY TO SEE ME. PATIENT AND FAMILY WERE DOING WELL AS THEY LOOKED CHEERFUL AND HAD NO COMPLAINS. THE ENVIRONMENT WAS TIDY AS THERE WERE NO RUBBISH NOR STAGNANT WATER AROUND. I HANDED OVER PATIENT TO THE NURSE WHICH I MET AT THE SAVIOR CLINIC DURING MY FIRST HOME. THE ENTIRE FAMILY COMMENDED ME FOR GOOD WORK DONE AND ACCEPTED TO CONTINUE THE CARE OF MR. A.B. AT HOME. HOWEVER, I RE-ENFORCED THAT THEY SHOULD ALWAYS REPORT TO THE NEAREST HEALTH FACILITY OR HOSPITAL WHENEVER THEY FALL SICK AND THEY SHOULD NOT PRACTICE SELF-MEDICATION. AFTER INTERACTING WITH PATIENT AND FAMILY FOR A WHILE, I REEMPHASIZED ON HEALTH EDUCATIONS THAT HAD BEEN GIVEN TO THEM ALREADY. SINCE IT WAS MY LAST DAY OF THERAPEUTIC RELATIONSHIP WITH CLIENT AND FAMILY, I TERMINATED MY CARE AND THANKED THEM FOR THEIR COOPERATION WHICH HAS MADE MY STUDY A SUCCESS. AGAIN, PATIENT AND HIS FAMILY EXPRESSED THEIR GRATITUDE BY SHOWING HOW GRATEFUL THEY WERE TO ME FOR THE SUPPORT AND CARE GIVEN TO THEM. I FINALLY SOUGHT PERMISSION TO LEAVE AND BID THEM THE FINAL FAREWELL. I BOARD A TAXI AND RETURNED TO MY PLACE.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 INTRODUCTION

EVALUATION IS THE ACT OF CONSIDERING OR EXAMINING SOMETHING IN ORDER TO JUDGE ITS VALUE, QUALITY, IMPORTANCE, EXTENT OR CONDITION. THIS IS THE FIFTH STAGE OF THE NURSING PROCESS THAT SEEKS

TO TEST THE EFFECTIVENESS OF THE NURSING CARE RENDERED TO THE PATIENT AND THE FAMILY. THE CHAPTER TALKS ABOUT THE FOLLOWING; STATEMENT OF EVALUATION, AMENDMENT OF THE PATIENT/FAMILY CARE PLAN FOR PARTIALLY MET AND UNMET OBJECTIVES AND TERMINATION OF CARE.

5.1 STATEMENT OF EVALUATION

THE NURSING CARE WAS BASED ON THE NURSING PROCESS. DURING THE PERIOD OF HIS STAY AT THE HOSPITAL A NURSING CARE PLAN WAS DESIGNED TO AID IN DELIVERY OF QUALITY CARE TO THE CLIENT WITH EMPHASIS ON THE NURSING DIAGNOSIS. DURING THE NURSING CARE, ACTUAL AND POTENTIAL PROBLEMS WERE IDENTIFIED, OBJECTIVES WERE SET, PLANS FOR PATIENT'S AND FAMILY CARE IMPLEMENTED AND LATER EVALUATED.

1. PATIENT WAS RELIEVED OF ABDOMINAL PAIN

ON THE 14TH NOVEMBER, 2021 AT 12:10PM, UPON ASSESSMENT AND CONVERSATION WITH PATIENT HE COMPLAINED OF ABDOMINAL PAIN HENCE A NURSING DIAGNOSIS OF ACUTE PAIN RELATED TO ACUTE INFLAMMATION OF THE GASTRIC MUCOSA WAS MADE FOR PATIENT. AS SUCH AN OBJECTIVE WAS SET TO HELP PATIENT TO BE RELIEVED FROM PAIN WITHIN 24 HOURS. THE FOLLOWING INTERVENTIONS WERE CARRIED OUT: PATIENTS PAIN WAS ASSESSED TO BE WITHIN 7 PER THE NUMERICAL PAIN RATING SCALE, PATIENTS VITAL SIGNS WERE MONITORED 4 HOURLY AND WERE WITHIN NORMAL RANGE, SIPS OF WATER WAS SERVED AT FREQUENT INTERVALS, ALL FORMS OF NOISE WERE REDUCED BY RESTRICTING VISITORS, AND WINDOWS WERE OPENED TO ALLOW IN FRESH AIR, FREQUENT BUT SMALL

INTAKE OF FOOD WAS ENCOURAGED, RELAXATION TECHNIQUES WERE TAUGHT TO PATIENT LIKE THE KNEE-CHEST POSITION AND INTRAVENOUS OMEPRAZOLE 40MG AND INTRAVENOUS HYOSCINE BUTYLBROMIDE 40MG

WERE ADMINISTERED TO RELIEVE HIS OF ABDOMINAL PAINS.

ON 15TH NOVEMBER, 2021 AT 12:10PM EVALUATION OF THE SET OBJECTIVE TO RELIEVE PATIENT FROM PAIN ON 14TH NOVEMBER, 2021 WAS DONE AND GOAL WAS FULLY MET AS PATIENT VERBALIZED THAT HE DOES NOT FEEL THE PAIN ANYMORE AND NURSE REVIEWED PATIENTS PAIN USING THE PAIN RATING SCALE 0-10 AND PATIENT INDICATED NO PAIN.

2. PATIENTS NORMAL BODY TEMPERATURE WAS RESTORED

ON THE 14TH NOVEMBER, 2021 AT 12:20PM, PATIENT HAD A HIGH BODY TEMPERATURE HENCE THE NURSING DIAGNOSIS OF HYPERTHERMIA (37.8⁰C) RELATED TO INFLAMMATORY PROCESS OF GASTRITIS WAS MADE. THE FOLLOWING INTERVENTIONS WERE CARRIED OUT TO HELP RESTORE PATIENTS NORMAL TEMPERATURE WITHIN 24 HOURS: PATIENT WAS REASSURED THAT MEASURES WILL BE PUT IN PLACE TO RESTORE HIS TEMPERATURE TO NORMAL, PATIENT WAS INSTRUCTED TO REMOVE ANY TIGHT CLOTHING'S TO HELP REDUCE HIS TEMPERATURE, WINDOWS WERE OPENED TO ENHANCE ADEQUATE VENTILATION, TEMPERATURE WAS CHECKED EVERY MINUTES CONTINUOUSLY FOR 2 HOURS, COLD DRINKS SUCH AS MALT WAS GIVEN TO PATIENT AND TABLET PARACETAMOL 1G AND IV METRONIDAZOLE 500MG WERE ADMINISTERED.

ON 15TH NOVEMBER, 2021 AT 12:20PM EVALUATION OF THE SET OBJECTIVE TO RESTORE PATIENTS BODY TEMPERATURE ON 14TH NOVEMBER, 2021 WAS DONE AND GOAL WAS FULLY MET AS IT WAS OBSERVED THAT PATIENTS'

BODY TEMPERATURE HAS FALLEN WITHIN NORMAL RANGE (36.8°C) AND PATIENT VERBALIZED THAT HE HAS BEEN RELIEVED OF HIGH BODY TEMPERATURE.

3. PATIENT'S VOMITING CEASED

ON THE 14TH NOVEMBER, 2021 AT 12:30PM, PATIENT WAS SEEN VOMITING, PRODUCING COPIOUS SALIVA AND COMPLAINING OF FEELING NAUSEATED. A NURSING DIAGNOSIS OF RISK FOR DEFICIENT FLUID VOLUME RELATED TO EXCESSIVE FLUID LOSS THROUGH VOMITING WAS MADE FOR PATIENT AND AN OBJECTIVE WAS SET TO HELP PATIENT MAINTAIN NORMAL FLUID VOLUME AND ELECTROLYTE BALANCE THROUGHOUT THE PERIOD OF HOSPITALIZATION. THESE INTERVENTIONS WERE CARRIED OUT: POSSIBLE SIGNS OF DEHYDRATION SUCH AS WEAKNESS, THIRST, DECREASED SKIN TURGOR, ETC. WERE ASSESSED AND INTAKE AND OUTPUT WERE MONITORED, FLUID BALANCE WAS ASSESSED FOR EVERY 24HOURS, PATIENT WAS ENCOURAGED TO EAT AND DRINK LITTLE BUT OFTEN TO REDUCE CHANCES OF VOMITING, PATIENT WAS ENCOURAGED TO AVOID CONSUMING FOODS AND BEVERAGES THAT CONTAIN CAFFEINE, PRESCRIBED ANTI-EMETIC; INTRAVENOUS METOCLOPRAMIDE 10MG WAS ADMINISTERED AND THE PROCEDURE PERFORMED WAS DOCUMENTED INTO THE NURSES NOTE. ON 18TH NOVEMBER, 2021 AT 12:30PM EVALUATION OF THE SET OBJECTIVE TO MAINTAIN PATIENT NORMAL FLUID AND ELECTROLYTE BALANCE ON 14TH NOVEMBER, 2021 WAS DONE AND GOAL WAS FULLY MET AS NURSE OBSERVED PATIENT HAA A NORMAL SKIN TURGOR AND PATIENT VERBALIZED THAT HE VOMITS NO MORE.

4. PATIENTS NORMAL NUTRITIONAL STATUS WAS RESTORED

ON 15TH NOVEMBER, 2021 AT 8:00AM, PATIENT REVEALED TO ME THAT HE HAD LOST APPETITE AND COULDN'T CONSUME SUFFICIENT AMOUNT OF THE FOOD HE IS PROVIDED WITH, HENCE A NURSING DIAGNOSIS OF IMBALANCED NUTRITION LESS THAN BODY REQUIREMENT RELATED TO INSUFFICIENT DIETARY INTAKE WAS MADE FOR PATIENT. THE FOLLOWING INTERVENTIONS WERE IMPLEMENTED: PATIENT AND FAMILY WERE EDUCATED ABOUT THE IMPORTANCE OF FOOD FOR THE BODY, THE AMOUNT OF FOOD INTAKE WAS MONITORED, A VARIED DIET WAS PROVIDED ACCORDING TO PATIENT'S DIET TO STIMULATE HIS APPETITE, FOOD WAS PROVIDED IN SMALL PORTIONS BUT FREQUENTLY, PATIENT WAS EDUCATED ON THE NEED TO TAKE IN NUTRITIONALLY RICH DIETS, FOODS WERE SERVED IN AN ATTRACTIVE MANNER AND PROCEDURES WERE DOCUMENTED AS PERFORMED INTO THE NURSES' NOTES.

ON 18TH NOVEMBER, 2021 AT 8:00AM EVALUATION OF THE SET OBJECTIVE TO HELP PATIENT HAVE NUTRITION ON 15TH NOVEMBER, 2021 WAS DONE AND GOAL WAS FULLY MET AS PATIENT VERBALIZED HE HAS GAINED APPETITE FOR FOOD AND NURSE OBSERVED PATIENT CONSUME AT LEAST TWO/THIRDS OF MEAL SERVED.

5. PATIENT ENERGY FOR DAILY ACTIVITIES WAS RESTORED

ON 15TH NOVEMBER, 2021 AT 8:35AM, PATIENT COMPLAINED OF BEEN WEAK HENCE THE NURSING DIAGNOSIS OF PARTIAL SELF-CARE DEFICIT RELATED TO BODY WEAKNESS WAS MADE. AN OBJECTIVE WAS SET SO THAT PATIENT WILL BE ABLE TO PERFORM SELF-CARE ACTIVITIES WITHOUT ASSISTANCE WITHIN 48 HOURS OF HOSPITALIZATION. THE FOLLOWING INTERVENTIONS

WERE CARRIED OUT; PATIENT WAS REASSURED THAT MEASURES WILL BE PUT IN PLACE TO ASSIST HIM DURING BATH, PATIENT STRENGTH FOR SELF-CARE ACTIVITIES WAS ASSESSED, PATIENT WAS ASSISTED WITH GATHERING BATHING SUPPLIES SUCH AS SOAP, SPONGE, TOWEL, AND WATER AND PATIENT WAS GROOMED AND MADE COMFORTABLE IN BED, PATIENT ITEMS FOR SELF-CARE WERE PUT WITHIN HIS REACH, PATIENT'S HANDS AND FEET WERE CARED FOR USING WARM WATER INTO WHICH HE SOAKED HIS FEET AND HANDS, PATIENT AS ASSISTED AND ENCOURAGED TO PERFORM SELF-CARE ACTIVITIES, PATIENT WAS EDUCATED ON THE NEED TO PERFORM SELF-CARE ACTIVITIES.

ON 17TH NOVEMBER, 2021 AT 8:35AM EVALUATION OF THE SET OBJECTIVE TO HELP PERFORM SELF – CARE ACTIVITIES WITHOUT ASSISTANCE WITHIN 48 HOURS WAS DONE AND GOAL WAS FULLY MET AS PATIENT WAS ABLE TO PERFORM ACTIVITIES OF DAILY LIVING WITHOUT ASSISTANCE AND NURSE OBSERVED PATIENT PERFORMING ACTIVITIES OF DAILY LIVING WITHOUT ASSISTANCE.

6. PATIENT GAINED ADEQUATE KNOWLEDGE ON GASTRITIS

ON 16TH NOVEMBER, 2021 AT 8:00AM, I HAD A CHAT WITH PATIENT ABOUT HIS CONDITION (GASTRITIS) AND REALIZED HE HAD LITTLE KNOWLEDGE ABOUT THE CONDITION HE PRESENTED WITH AT THE HOSPITAL. HE SHOWED INTEREST IN BEING A LEARNER TO KNOW MORE ABOUT HIS CONDITION, BASED ON THAT, THE NURSING DIAGNOSIS OF DEFICIENT KNOWLEDGE RELATED TO LITTLE KNOWLEDGE ABOUT THE CONDITION, PROCEDURE AND TREATMENT OF GASTRITIS WAS FORMULATED. AN OBJECTIVE WAS SET TO

ENABLE PATIENT DEMONSTRATE UNDERSTANDING OF THE CONDITION (GASTRITIS) WITHIN 12HOURS. THE NURSING ACTIONS THAT WERE EXECUTED INCLUDE THE FOLLOWING: ASSESSMENT ON THE MOTIVATION AND WILLINGNESS OF THE PATIENT AND RELATIVES TO LEARN WAS DONE, A CONDUCIVE LEARNING ENVIRONMENT WAS ENSURED, A GOOD INTERPERSONAL RELATIONSHIP WITH PATIENT AND RELATIVES WAS ESTABLISHED, THE PATIENT WAS QUESTIONED REGARDING PREVIOUS EXPERIENCE AND HEALTH TEACHING, EXISTING MISCONCEPTIONS REGARDING MATERIAL TO BE TAUGHT WERE IDENTIFIED, PATIENT AND RELATIVES WERE EDUCATED ON THE CONDITION IN THE LANGUAGE THEY CAN UNDERSTAND WELL, THUS IN 'TWI', AND FINALLY, PATIENT AND RELATIVES WERE ALLOWED TO ASK ANY QUESTION TO CLEAR DOUBTS AND TACTFUL ANSWERS WERE PROVIDED.

ON THE SAME DAY AT 8:00PM EVALUATION OF THE SET OBJECTIVE TO HELP PATIENTS AND RELATIVES GAIN ADEQUATE KNOWLEDGE ON GASTRITIS AT 8:00AM WAS DONE AND GOAL WAS FULLY MET AS PATIENT AND RELATIVES BEING ABLE TO PROVIDE CORRECT ANSWERS TO QUESTIONS THEY ARE ASKED REGARDING THE FEATURES, MANAGEMENT AND CARE OF GASTRITIS AND NURSE OBSERVED PATIENT AND RELATIVES PRACTICE WHAT WAS TAUGHT.

5.2 AMENDMENT OF NURSING CARE PLAN

THE OBJECTIVES AND GOALS THAT WERE SET DURING THE NURSING CARE OF MR. A.B. WERE FULLY MET HENCE NO AMENDMENTS WERE MADE.

5.3 TERMINATION OF CARE

THIS IS THE TIME IN WHICH THE NURSE BRINGS TO AN END THE THERAPEUTIC TREATMENT AND NURSING CARE WITH THE PATIENT AND FAMILY. EVERY NURSE-PATIENT RELATIONSHIP AT THE HOSPITAL NEEDS TO BE TERMINATED. HOWEVER, THIS IS A VERY DIFFICULT STEP TO TAKE AFTER A GOOD RAPPOROT HAS BEEN ESTABLISHED. BECAUSE OF THIS, THE REALITY OF TERMINATION OF CARE HAS TO BE MADE KNOWN TO BOTH PATIENT AND FAMILY FROM THE DAY OF ADMISSION. PATIENT AND FAMILY WERE GIVEN A GRADUAL PSYCHOLOGICAL PREPARATION; THEY WERE TOLD THAT, OUR RELATIONSHIP WAS A THERAPEUTIC ONE AND WAS TEMPORAL, WHICH WOULD LAST FOR A REASONABLE PERIOD. WHEN MR. A.B. WAS REVIEWED BY THE DOCTOR, HE WAS DECLARED FIT AND LOOKED VERY HEALTHY WITH NO COMPLAINS. DURING MY VISIT TO HIS HOME ESPECIALLY THE THIRD TIME, I OBSERVED THAT HIS GENERAL CONDITION WAS ENCOURAGING AND THEREFORE TERMINATED MY CARE WITH HIM ON 12TH DECEMBER, 2021 BY FINALLY ADVISING HIM ON EATING BALANCED MEALS AND HAVING ENOUGH REST AND OFFICIALLY HANDED OVER TO A COMMUNITY HEALTH NURSE AT SAVIOR CLINIC. I THANKED MR. A.B. AND HIS FAMILY FOR THEIR COOPERATION.

CHAPTER SIX

SUMMARY OF CARE RENDERED TO PATIENT AND FAMILY

6.0 SUMMARY

ON THE 14TH NOVEMBER, 2021 AT 12:00PM, PATIENT WAS RECEIVED INTO THE MALE WARD FROM THE ACCIDENT AND EMERGENCY UNIT OF DORMAA PRESBYTERIAN HOSPITAL. PATIENT WAS DIAGNOSED OF GASTRITIS. WITH THE USE OF NURSING PROCESS, THE PROBLEMS IDENTIFIED WERE

DEVELOPED INTO NURSING DIAGNOSIS WITH NURSING ORDERS WHICH WERE IMPLEMENTED TO HELP SOLVE THESE PROBLEMS AND PROMOTE RECOVERY.

USING THE NURSING CARE PLAN, EFFECTIVE NURSING CARE WAS CARRIED OUT ON THE PATIENT TO ENSURE FULL RECOVERY OF MR. A.B. AMONG THE CARE PROVIDED TO HIM WERE BED MAKING, MONITORING OF VITAL SIGNS (TEMPERATURE, PULSE, RESPIRATION, AND BLOOD PRESSURE), PROPER POSITIONING IN BED, ADMINISTRATION OF MEDICATION, AND PATIENT/FAMILY EDUCATION ON PERSONAL HYGIENE. HE WAS DISCHARGED ON 18TH NOVEMBER, 2021 WHEN HIS CONDITION HAD IMPROVED AND WAS DECLARED FIT TO GO HOME WITH NO COMPLAINS.

GOALS WERE FULLY MET DURING EVALUATION OF CARE. THREE HOME VISITS WERE PAID TO HIM TO ASSESS PROGRESS OF HIS CONDITION AT HOME. THE FIRST HOME VISIT WAS ON 15TH NOVEMBER, 2021, SECOND HOME VISIT WAS ON 23RD NOVEMBER, 2021 AND THIRD HOME VISIT WAS ON 25TH NOVEMBER, 2021. HE REPORTED TO THE HOSPITAL FOR REVIEW ON THE 25TH NOVEMBER, 2021. THERE WAS TERMINATION OF CARE ON 12TH DECEMBER, 2021.

6.1 CONCLUSION

THE PATIENT CARE STUDY HAS HELPED ME GAIN KNOWLEDGE ABOUT NURSING CARE RENDERED TO CLIENTS, THIS STUDY HAS ALSO HELPED ME TO KNOW HOW TO COLLECT RELEVANT INFORMATION FROM PATIENTS, IDENTIFY HEALTH PROBLEMS, ANALYZE AND FORMULATE A NURSING CARE PLAN USING THE NURSING PROCESS APPROACH. RECOMMENDATIONS OF PATIENT /FAMILY, MEDICAL TEAM, OPINIONS AND APPRAISAL OF THEIR CO-

OPERATION TOWARDS THE ACHIEVEMENT OF GOALS WHICH PROMOTED THE WELL-BEING OF PATIENT / FAMILY PHYSICALLY, PSYCHOSOCIALLY AND SPIRITUALLY.

THIS STUDY HAS ENABLED ME TO PUT INTO PRACTICE THE KNOWLEDGE ACQUIRED DURING MY THREE YEAR TRAINING IN THE INSTITUTION, IT HAS HELPED ME TO BE PREPARED TO NURSE CLIENTS EFFECTIVELY IN THE NEAR FUTURE REGARDLESS OF THEIR CONDITION WITH THE HELP OF NURSING PROCESS ADOPTED.

I THEREFORE RECOMMEND THAT THE PATIENT/FAMILY CASE STUDY SHOULD BE MAINTAINED AS A FACADE OF THE NURSE TRAINEE AND FULLY ESTABLISH IN THE COUNTRY HEALTH CARE DELIVERY SYSTEM TO AID IN THE IMPROVEMENT OF HEALTH FOR THE COUNTRY.

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APPENDIX

TABLE 7: VITAL SIGNS OF MR. A.B. THROUGHOUT THE PERIOD OF HOSPITALIZATION

DATE	TIME	TEMPERATURE (°C)	PULSE (BPM)	RESPIRATION (CPM)	BLOOD PRESSURE(MMHG)
14/11/21	12:00PM	37.8	68	18	110/70
	6:00PM	36.0	69	20	110/80
	10:00PM	35.7	70	22	130/70
15/11/21	6:00AM	36.3	57	19	130/80
	10:00AM	36.3	62	24	120/80
	2:00PM	36.4	65	18	130/70
	6:32PM	36.4	73	18	120/80
	10:38PM	36.0	80	20	120/60
16/11/21	6:00AM	35.3	73	18	130/90
	10:00AM	36.0	68	20	120/80
	2:00PM	35.9	94	27	120/70
	6:00PM	36.1	78	25	130/80

	9:55PM	36.5	81	20	120/70
17/11/21	6:00AM	35.2	73	18	120/80
	10:00AM	36.6	82	20	120/80
	2:00PM	36.5	92	22	120/80
	6:00PM	36.6	80	20	120/70
	10:00PM	35.7	84	21	100/60
18/11/21	6:00AM	35.2	73	18	120/80
	10:00AM	36.6	82	20	120/80

SIGNATORIES

NAME OF CANDIDATE: Alasidi Philomina

SIGNATURE..... *Alasidi Philomina*

DATE..... 05/10/2022

NAME OF WARD IN-CHARGE: Simon Adutwum

SIGNATURE..... *MA Prof (fm)*

DATE..... 05/10/2022

NAME OF SUPERVISOR: Mr. Ayamba Dramani

SIGNATURE..... *Mr. Ayamba Dramani*

DATE..... 05/10/2022

NAME OF PRINCIPAL: Monica Nkrumah

SIGNATURE..... *MA Prof (fm)*

DATE..... 06/10/2022

ACADEMIC CO-ORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
COLLEGE, BUKURU