HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT/FAMILY CARE STUDY ON GASTRITIS

ADDO-TWUM BELINDA

4120190007

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

AUGUST 2022

PREFACE

Under the influence of Florence Nightingale, the nursing profession began to change rapidly. Through the use of nursing process, nursing has been modified to a holistic care by means of new techniques used in the profession. Nursing has changed from only caring for the sick to include taking of medical history and conducting head-to-toe examination through the use of nursing process which was initially the duty of the medical doctor.

Patient/family care study is a report written about the care rendered to patient/family with the help of nursing process within a specific period of time. It explores nursing care rendered from the time of encounter on the ward till discharge through home visit till care is terminated. It gives an in-depth knowledge to the student nurse and on the nursing process which serves to provide a systemic methodology of nursing practice.

The Patient/Family Care Study involves a record nursing care, documenting the problems of a client and how they are dealt with by the nurse in the course of finding solution to the problems. It provides a systemic way of collecting data, analyzing information and reporting the results of nursing care.

The study again, is an academic exercise that forms part of the requirement for an award of professional license by the Nursing and Midwifery Council of Ghana to practice as a Registered General Nurse.

Owing to the comprehensive care plan given, the student nurse becomes equipped with information on the patient's condition and becomes familiar with the use of the nursing process as a basis for practice thereby encouraging evidence-based nursing care. It involves initials to ensure confidentiality.

ACKNOWLEDGEMENT

All praise and thanks be to God. This study would not have been possible without the help of the Almighty God, who granted me strength, wisdom and knowledge in spite of all challenges to commence and conclude this care study successfully.

A special thanks goes to Mr. Y.W. and his family for their cooperation. Without their consent, this study would never have been successful.

I am also thankful to all the doctors and nurses of Dormaa-East District Hospital, Wamfie, especially to the Medical-Emergency ward. They ensured continuity of care for my patient and gave me support for this study.

My appreciation also goes to my supervising tutors Mr. Obeng Eric and Mr. Tuffour Kwame. Their persistent guidance has ensured the successful completion of this study.

Warmest gratitude is reserved for my mother Beatrice Adoma who has ensured my coming this far, I can’t thank you enough.

I am grateful to my family and colleagues of the noble profession and all whose criticisms and encouragement helped me to finish this study.

Finally, I acknowledge and thank all authors and publishers whose works have been used as references in this care study. Danke!

INTRODUCTION

This study was carried out on Mr. Y.W., a 51-year-old man who was admitted at the Medical-Emergency ward of Dormaa-East District Hospital, Wamfie with the diagnosis of Gastritis on the 5th November, 2021. To render a holistic care, per assessment some problems were identified and managed on daily basis. The following was his base-line data;

1. Temperature - 36.8 degree Celsius (^{0}C)
2. Pulse - 88 beat per minute (bpm)
3. Respiration - 18 cycle per minute (cpm)
4. Blood pressure - 150/89 millimeters per mercury (mmHg)
5. Weight - 61 kilograms
6. Oxygen saturation - 97%

He as then given the following drugs;

1. Intravenous metoclopramide 10mg three times daily x 24 hours.
2. Intravenous omeprazole 80mg stat
3. Intravenous fluid Ringers Lactate 1litre x 24 hours
4. Omeprazole capsule 20mg twice daily x 7 days
5. Syrup sucralfate 15mls three times daily x 7 days
6. Buscopan tablet 20mg three times daily x 7 days

Three home visits were made to the patient's home to assess him and his environment for continuity of care. Patient was discharged on 8th November, 2021, since he was fully recovered. Mr. Y.W. was chosen in order to help me gain much knowledge on the condition. Care was finally terminated on 23rd November, 2021.

This study is in six chapters;

Chapter 1: Assessment of patient/family

Chapter 2: Analysis of data

Chapter 3: Planning care for patient/family

Chapter 4: Implementation of patient/family care plan

Chapter 5: Evaluation of care rendered to patient/family

Chapter 6: Summary and conclusion

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment is the systematic collection of data to determine the patient's health status and any actual or potential health problems, (Smeltzer, Bare, Hinkle, & Cheever, 2014). Assessment is the initial phase of the nursing process. The goal of the patient and family assessment is to determine the health needs of a patient and family to help plan an individualistic care for the patient. The data can be collected directly from the patient, relatives, and friends and significant others. Assessment can take different forms such as observation, interviewing, physical examinations, diagnostic investigations, etc.

1.1 Patient's Particulars

Patient particulars are the facts or details about patients which are written down and kept on record, (Mish 2016). Mr. Y.W. is a 51-year-old man, born on 1st July,1970 at Naamon in the Upper East region, where he hails from. He is dark in complexion, about 1.7m tall and weighs 61kilograms on admission. He speaks Frafra, Twi and French. He stays at Begyewe (Wamanafo). He is married to Mrs. R.W. with five children. He has eight siblings who are alive and healthy. Mr. Y.W. is illiterate with no educational background. He has no physical disabilities. He is a farmer and worships with Assemblies of God Church at Habitat in Wamfie. Mr. E.W. his eldest son, who is now in Cote d'ivoire is his next of kin. His parents are Mr. A.W. and Mrs. T.W.

1.2 Family's Medical History

Mr. Y.W. indicated that, there is no known hereditary diseases like asthma, epilepsy, hypertension in his family. He also stated that any time a member of his family experiences symptoms like headache, fever, chills or stomach pains, they resorted to either over-the-counter drugs or herbal preparations. However, if symptoms persist, they seek for medical attention from Dorma-East District Hospital (D.E.D.H). Mr. Y.W. also revealed that his parents are

deceased. His father died of old age whereas his mother died of gastritis. He also disclosed that he has no known allergy but anytime he eats okro or cocoyam, he suffers from stomach ache.

1.3 Family's Socio-Economic History

Mr. Y.W. stated that he sometimes gets financial support from his extended family and wife. Members of his family are also registered with the National Health Insurance Scheme, which is their main sources of medical financing. Mr. Y.W. can afford his basic needs of foods, shelter, and security. Patient and family conform to traditions and taboos governing his extended family, like not harming a lion or a tortoise because he said that the aforementioned animals helped his great-great grandparents. He also stated that he has a good interpersonal relationship with his neighbours and takes part in virtually all community and religious activities in his church.

1.4 Patient's Developmental History

Oxford dictionary (2012) defines development as the steady growth of something so that it becomes more advanced and stronger. Weller (2019) also defines growth as the progressive development of a living thing. Mr. Y.W. revealed that, his mother delivered spontaneously per vagina with the help of a traditional birth attendant at Naamon in the Upper East Region. He was born with no birth defects and was later immunized against the vaccine preventable diseases. Mr. Y.W. was breastfed for three (3) months after which complementary foods such as cereal porridge were introduced. He went through a normal developmental milestone smiling at familiar faces between the first and third month and sitting with support at the seventh month, crawling at ninth month and walking at the first eighteenth month. He developed secondary sexual characteristics at age fifteen (15). He got married at the age of 29 to Mrs. R.W. with five (5) children;(two girls and three boys). According to Erik Erickson's psychosocial development theory (Cherry, 2021) which includes eight stages, patient is now in the middle age group where there is conflict between generativity versus stagnation (40-65 years). During this stage, adults have the urge to contribute to the next generation. Generativity involves

sharing, teaching, mentoring and contributing to the growth of others. Failure to do this at the said age reflects a sense of stagnation. I am convinced that patient is in the generativity dimension of Erikson's development because the success of his family is his utmost priority.

1.5 Patient's Lifestyle and Hobbies

Mr. Y.W. wakes up at 6:00am and observes his morning devotion. He then attends to his personal care; brushes his teeth, washes his face, empties his bowl and voids and takes his bath. Although he sometimes skips breakfast, he usually loves to take porridge for breakfast. Mr. Y.W. likes akpele with 'ayoyo' soup. Mr. Y.W. and his family normally eat three times daily. Patient accounted that he used to drink excess alcohol but he no longer does. He goes to the farm to work and sometimes go for funerals on Saturdays. He goes to bed around 9pm daily. On Sunday he goes to church with his family and when they close, he gets home to rest. He is an outspoken person and verbalizes his emotions. He uses eye contact and gestures to display his dissatisfaction whenever his children go wrong. He is caring, very disciplined and an extrovert. What he likes most is telling the truth and what he dislikes is telling lies. He is a responsible father and a husband.

1.6 Patient's Past Medical History

Mr. Y.W. was admitted to the Dormaa-East District Hospital in 2020 on account of malaria. He said he underwent an umbilical herniorrhaphy. He has ever suffered minor injuries during his youthful days due to oversight and treated them with herbal medicines at home. He does not have any childhood disease. He uses over-the-counter drugs such as paracetamol, when he experiences symptoms like headaches and abdominal pains. He has no known allergies. Mr. Y.W. stopped going for medical check-ups due to high medical cost.

1.7 Patient's Present Medical History

Mr. Y.W. was perfectly fine until Thursday 4th November, 2021 in the evening, Mr. Y.W. begun to experience, abdominal pain, and general body weakness, anorexia, dizziness, and fever. He decided to come to the hospital along with his wife and their 1-year-old daughter the

next day. He was brought to the Medical-Emergency ward with the stated symptoms. He was seen by Dr. Stephen Gyasi and diagnosed of Gastritis, and plan was to admit to the Medical-Emergency ward for further management.

1.8 Admission of Patient

On 5th November, 2021 at about 8:10am, Mr. Y.W. was brought into the Dormaa-Eat District hospital's Medical-Emergency ward per ambulatory accompanied by his wife and little child. They were welcomed and offered a seat. Patient's name was confirmed and was immediately admitted into a prepared admission bed. Patient and his family were reassured of competent care. A tray was set for intravenous line which was successfully inserted and secured. Patient's complains on admission included abdominal pain, anorexia, vomiting, headache, and dizziness. On admission his vital signs were checked and recorded as follows:

1. Temperature - 36.8 degree Celsius (^{0}C)
2. Pulse - 88 beat per minute (bpm)
3. Respiration - 18 cycle per minute (cpm)
4. Blood pressure - 150/89 millimeters per mercury (mmHg)
5. Weight - 61 kilograms
6. Oxygen saturation - 97%

Patient and family were orientated to the ward and its annexes. Visiting hours and other ward protocols were also explained to them. Patient's details were written in the admission and discharge book as well as daily ward state, relatives were informed of items patient would need on admission including his clothes and toiletries. Patient and family were educated on the causes, signs and symptoms, prevention and complication of the disease condition. They were allowed to ask questions in relation to the education given and answers were provided to their understanding. Questions asked by patient and family were answered. All the nursing activities rendered were recorded in the nurses' notes. Laboratory investigations requested include:

1. Full blood count

2. Widal test
3. Rapid diagnostic test

Patient was to be managed on the following treatments;

1. Intravenous fluid Ringers Lactate 1litres over 24 hours
2. Intravenous omeprazole 80mg stat
3. Intravenous metoclopramide 10mg three times daily over 24 hours

The above prescribed drugs were administered and recorded immediately. He was assured of the fact that his hospitalization was temporal and that he would be discharged once he gets better. Mr. Y.W.'s condition on admission was fair.

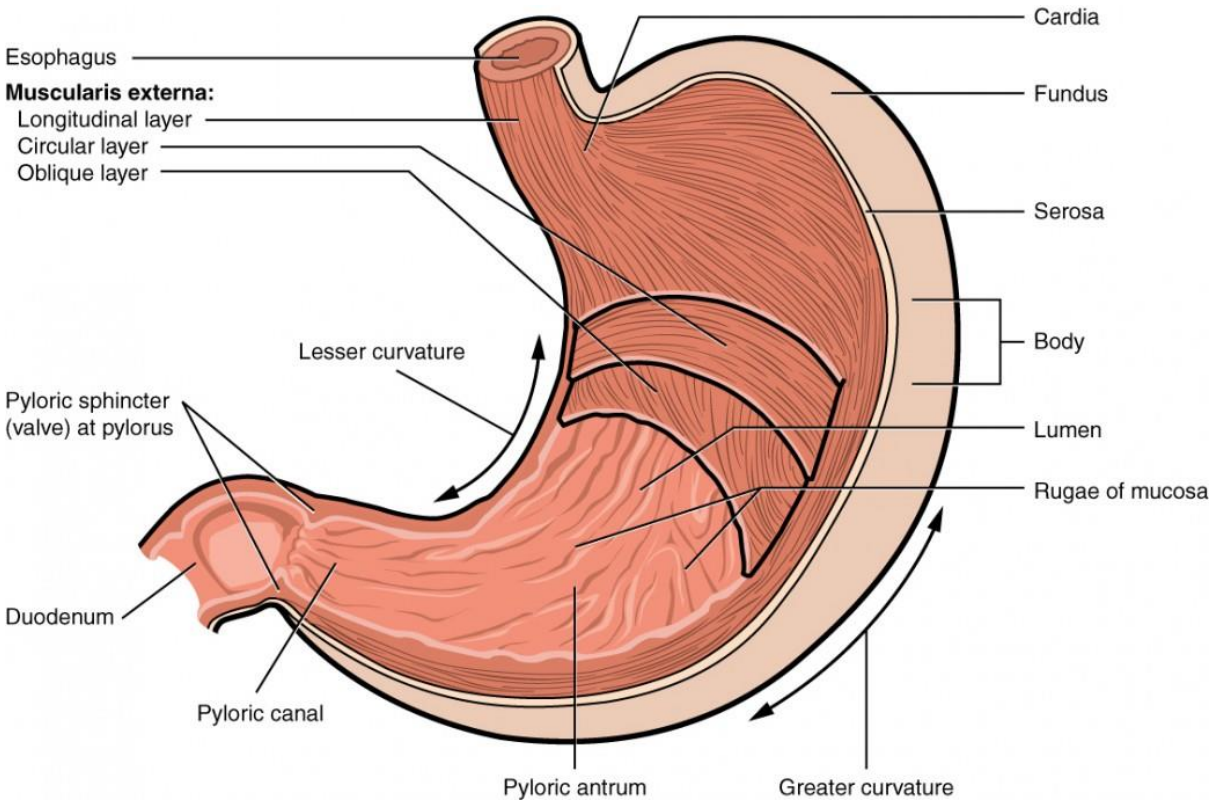
1.9 Patient's Concept of Illness

Mr. Y.W. had little knowledge about his condition. He speculated that Gastritis may be due to dietary factors. He believed that anyone can develop gastritis and that it is not caused by any spiritual force. He expressed confidence in the health care team and was convinced that he would fully recover.

1.10 Literature Review

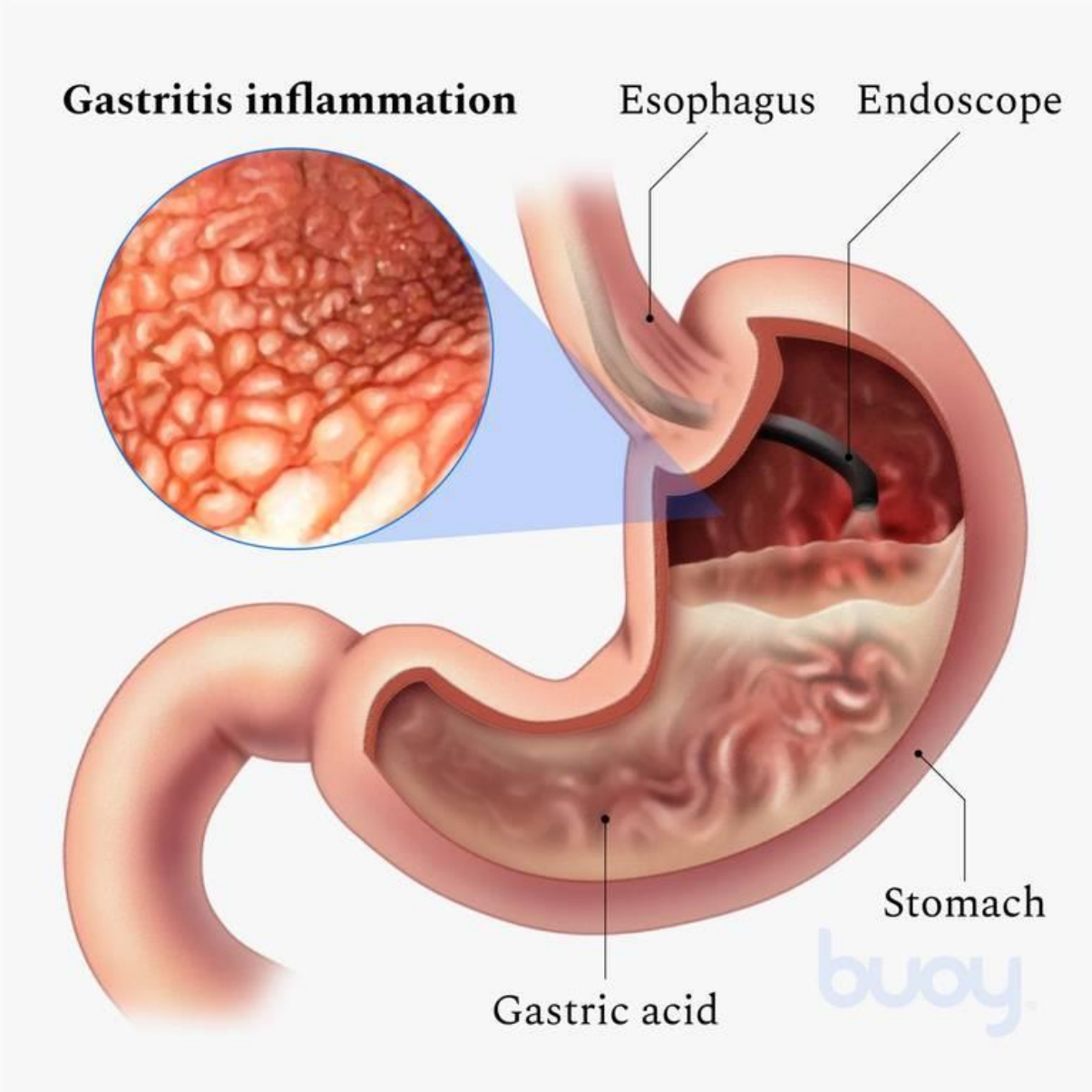
Anatomy of the Stomach

Smeltzer, Bare, Hinkle and Cheever (2012), defined stomach to be a J dilated portion of the alimentary tract situated in the epigastric, umbilical and left hypochondriac regions of the abdominal cavity. It has two curvatures; the lesser curvature is short; it lies on the posterior surface of the stomach and is the downward continuation of the posterior wall of the esophagus. Just below the pyloric sphincter, it curves upward to complete the J shape. The anterior region angles acutely upwards, curves downwards forming the greater curvature and then slightly upward, the pyloric sphincter. The stomach has three divisions; the antrum, the fundus and the body.



Gastritis

Gastritis is an inflammatory disease affecting the mucosal surface of the stomach, which may be acute or chronic. It is also an inflammatory disorder of the stomach lining. Gastritis may be acute, lasting several hours to few days, or chronic, resulting from repeated exposure to irritating agent or recurring episode of acute gastritis. Acute gastritis is often caused by dietary indiscretion, thus eating too highly seasoned foods, over use of aspirin and other NSAIDs, excessive alcohol intake, among others. Chronic gastritis may be caused by benign or malignant ulcers of the stomach or by the bacteria Helicobacter pylori. (Smeltzer, Bare, Hinkle, & Cheever, 2012)



Inflamed stomach lining

Pathophysiology

In gastritis, the gastric mucous membrane becomes edematous and hyperemic (congested with fluid and blood) and undergoes superficial erosion. It secretes scanty amount of gastric juice containing very little acid but much mucous. Superficial ulcerations may occur and can lead to hemorrhage. (Smeltzer, Bare, Hinkle, & Cheever, 2012)

Types of gastritis

Acute and chronic gastritis are the types of gastritis that can be identified.

Acute gastritis is often caused by dietary indiscretion, the person eats food that is irritating or too highly seasoned or contaminated with diseases causing microorganism. Other causes of acute gastritis include over use of aspirin and other non-steroidal anti-inflammatory drugs, excessive alcohol intake, bile reflux and radiation therapy. A more severe form of acute gastritis is caused by the ingestion of strong acid or alkali, which may cause the mucosa to become gangrenous or to perforate. Scarring can occur resulting in pyloric stenosis or obstruction. Acute gastritis also may develop in acute illness, especially when the patient had major traumatic injuries, burns, severe infection, gastritis maybe the first sign of acute systemic infections.

Chronic gastritis and prolong inflammation of the stomach may be caused by either benign or malignant ulcers of the stomach or by the bacterial Helicobacter pylori. Chronic gastritis is sometimes associated with autoimmune diseases such as pernicious anaemia. Dietary factors such as caffeine; the use of medications especially NSAIDS; alcohol, smoking, or reflux of intestinal contents into the stomach. (Smeltzer, Bare, Hinkle, & Cheever, 2012)

Incidence

Gastritis occurs in all manner of people irrespective of age or gender

Causes Of Gastritis

Medications: certain medications such aspirin; non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen.

Medical and surgical conditions;

1. Physical stress in people who are critically ill or injured.
2. After medical procedure such as endoscopy, in which a specialist looks into the stomach with a small lighted tube.
3. After an operation to remove parts of the stomach.
4. Autoimmune diseases and pernicious anaemia.
5. Chronic vomiting

Infections

1. Bacterial infections; Helicobacter pylori infection is the most common.
2. Parasites and worms.

Excess intake of alcohol.

Clinical manifestation

Patients with gastritis may have;

1. Abdominal discomfort.
2. Headache.
3. Nausea.
4. Vomiting.
5. Hiccups.
6. Fever.
7. Anorexia.

Diagnostic Investigations

Diagnosis can be done by;

1. Endoscopy.
2. Clinical features.
3. Upper G-I x-ray studies.
4. Histological examination of tissue specimen obtained by biopsy.
5. Serologic testing for antibodies against the H. pylori antigen.

Medical management

1. The gastric mucosa is capable of repairing itself after some time. The patient may recover in about a day although the appetite may be diminished for additional two or three days.
2. Gastritis is also managed by instructing the patient to refrain from alcohol and food until symptoms subside. Thereafter, the patient can take nourishment by mouth, a non-irritating diet is recommended.
3. If gastritis is caused by ingestions of strong acids or alkalis, treatment consist of diluting and neutralizing the offending agent with antacids such as aluminum hydroxide.
4. Analgesics and sedatives are administered as well.
5. In chronic gastritis, patient's diet is modified, rest and sleep are also promoted.
6. Antibiotics e.g., Tetracycline are administered.
7. Proton pump inhibitors are given to block the action of acid secretion.
8. Antiemetics are given to prevent vomiting.

Nursing Management

Reassurance

Reassurance can be given to both patient and family by telling them that they are in the hands of qualified and competent staff and that effort are being made to ensure client's recovery. This helps to relax both client and family from anxiety. Whiles reassuring, rapport is also built to gain their cooperation in care and treatment being provided for the client. Both client and family should be allowed and encouraged to ask questions to help them understand things about the condition. In order to gain patient's cooperation and confidence, explain every procedure to be performed to the patient. Introduce client to other clients who had the same condition and with treatment they have undergone successfully. This will help to allay client's fears and anxiety and gain his cooperation.

Rest And Sleep

Adequate rest and sleep enhance recovery and therefore necessary for the client. It relaxes the body and reduces stress on the affected body part as well as promotes good health. Patient's bed should be made comfortable free from creases and cramps. All dirty and soiled linen should be changed to promote rest and sleep and prevent pressure sores. For good ventilation, nearby windows should be opened to facilitate rest and sleep. Restrict visitors to minimize disturbance and television volume low to help induce sleep and relaxation. Warm bath and drinks can be done and given to promote sleep.

Position

Patient should be encouraged to lie in a position best for him due to pains they normally feel. Enough pillows should be provided for support. The best position is the lateral position.

Diet

Patient must take at least 6 or more small meals in a day at regular intervals. The diet should be blunt spice free and paper free. Patient should be advice to take his time when eating and the food should not be too hot or cold. Advice patient to avoid alcohol and cigarette smoking and food containing acid should be advised against.

Reducing Anxiety

Often supportive therapy to the patient and family during treatment should be undertaking. Patient may feel anxious about pain and the treatment modalities use a calm approach to assess the patient and to answer all questions as completely as possible. In explaining procedure, do it according to the patient's level of understanding.

Observation

Monitor and record vital signs which include; temperature, pulse, respiration, and blood pressure four-hourly. If client is on intravenous fluid, regulate the flow rate as prescribed. The site of incision should be observed for swollen and leakages. Accurate input and output charts should be monitored in order to know the amount of fluid that client takes and excretes. This helps to determine whether client is dehydrated or otherwise.

Personal Hygiene

Assist client to carry out personal hygiene practices like bathing at least twice daily. This promotes circulation to prevent and eliminate offensive odour from client's body. It also enhances the nurse in offering informal education on personal hygiene like bathing. Patient is assisted in care of the mouth with toothpaste, brush and clean water for cleansing or normal

saline can be used. This helps to prevent oral infections such as halitosis, gingivitis and stomatitis.

Exercise

Exercise depends on the patient's condition. Passive exercises should be encouraged. This is done to improve blood circulation, prevent joint stiffness, and enhance general wellbeing.

Active exercise should be encouraged when client's condition improves by walking around the ward. This helps to prevent constipation and pressure sores.

Education

Client is nursed in a comfortable position while the nurse sits comfortably besides the patient. Establish good rapport with patient and relatives giving them seats in a quiet and comfortable environment. Ask about the knowledge they have on the condition to serve as a baseline and build on it. During the education, let them know what the condition of the client means. Educate client to continue taking his drugs as prescribed, its dosage, the right time and route. Advice should be given to the client to avoid eating food that is too hot or cold, foods with caffeine, spicy foods, peppery foods, alcohol, cigarette smoking etc. the client and his or her family must be told of the review dates and how importance it is for them to come for reviews as stipulated.

Pain Management

It is always important to reassure the patient that the pain he is feeling will go through nursing care. Therapeutic massage should be given and also encourage deep breathing exercises to relieve the pain. Psychologically, deep breathing helps the client to feel that through breathing more blood will be sent to the site of pain to relief him of the pain.

Diversional therapies like reading of story books to the patient or giving him a story book; singing a music which is cool should be promoted. The patient's bed should be made

comfortable for him or her with no creases or cramps. Warm beverages should be served. Prescribed analgesics should be administered.

Complications

1. Gastric perforation.
2. Anaemia.
3. Peptic ulcer.

1.11 Validation

American Psychological Association (2020) defines validation as the process of establishing the truth or legal efficacy of something. Information gathered from the patient's family was compared with that of the patient. This was done to prevent misinformation and mistakes. The symptoms exhibited and the literature reviewed as well as the laboratory investigation carried out confirmed that Mr. Y.W. was suffering from Gastritis.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Wester (2019) defines analysis of data as the comprehensive examination of anything complex in order to find out its nature or to determine its essential features. Analysis of the data was done through comparative analysis of the various data collected and comparing them to the known standards. This was done so that meaningful inferences could be drawn from the data gathered about the patient. Following this, accurate and appropriate nursing interventions could be planned and administered to the patient.

2.1 Comparison of Data with Standard

The following data were compared with the standard of literature view;

1. Diagnostic investigation.
2. Causes.
3. Clinical features.
4. Treatment.
5. Complications.

Diagnostic Investigation

This includes procedure performed on a patient to confirm, find out causative organism and possible treatment. The following investigation were ordered and carried out on Mr. Y.W

1. Full blood count (FBC).
2. Widal test.
3. Rapid diagnostic test (RDT).

Table 1: Diagnostic Investigation Compared with Literature Review

Diagnostic Tests in Literature Review	Diagnostic Tests Done on Mr. Y.W.
1. Endoscopy	Endoscopy was not carried out on patient
2. Clinical features	Clinical features were assessed
3. Upper G.I. X-ray	X-ray was not carried out.
4. Biopsy of the gastric mucosa	Biopsy was not carried out.
5. Serologic testing for antibodies against the H. pylori antigen	Serologic testing was not done

Serologic testing for antibodies against the H. pylori antigen, histological examination of tissue specimen obtained by biopsy, upper GI x-ray, upper GI endoscopy were not done because the RDT was done to rule out the presence of malaria. Widal test was done to rule out typhoid.

Table 2: Diagnostic Investigation

DATE	SPECIMEN/BODY PART EXAMINED	INVESTIGATION	RESULT	NORMAL VALUES	INTERPRETATIONS	REMARKS
5/11/2021	Blood	Hemoglobin level estimation	15.2g/dL	Males:12-18g/dL Females: 11-16g/dL	Hemoglobin was within the normal range	No treatment given
		White blood cell count	$5.2x10^3$/L	Males $4.0-10.0x10^3$/L	White blood cell count was within normal range	No treatment given
		Hematocrit level	46.8%	Males:32-54% Female: 32-48%	Hematocrit level was within the normal range	No treatment given
		Platelets	$82\ x10^3$/L	$150-450x10^3$/L	Patient platelets count was within normal range	No treatment given
		Red blood cell count	$4.8x10^6$/L	Males:3.0-5.0 $x10^6$/L Females: 2.5-5.0 $x10^6$/L	Red blood cell count was within normal range.	No treatment given

Table 2: Diagnostic Investigation Continued

DATE	SPECIMEN/BODY PART EXAMINED	INVESTIGATION	RESULT	NORMAL VALUES	INTERPRETATIONS	REMARKS
5/11/2021	Blood	Widal test	ST/O-1:20 ST/H-1:20	Negative	Negative	No treatment given
		RDT	Negative	Negative	Patient does not have malaria	No treatment given however; patient was encouraged to take measures to prevent malaria

Causes of patient's illness

With reference to the literature review, causes of gastritis include; certain medications, alcohol, infections etc. Assessment revealed that Mr. Y.W.'s condition was as a result of excess alcohol intake.

Clinical Features

Table 3: Comparison of Clinical Features in the Literature review with that Exhibited by Patient

Clinical Features in Literature Review	**Clinical Features Exhibited by Patient**
1. Abdominal discomfort	Patient complained of severe abdominal pain
2. Headache	Patient complained of headache
3. Nausea	Patient experienced nausea
4. Hiccups	Patient did not experience hiccups
5. Anorexia	Patient complained of anorexia
6. Vomiting	Patient vomited 3 times on 5/11/2021
7. Fever	Patient had normal body temperature (36.8^0C)

Mr. Y.W presented most of the clinical features therefore, the diagnosis of Acute Gastritis was therefore precise.

Treatment;

Some specific treatment given to Mr. Y.W. include;

7. Intravenous metoclopramide 10mg three times daily x 24 hours.
8. Intravenous omeprazole 80mg stat
9. Intravenous fluid Ringers Lactate 1litre x 24 hours
10. Omeprazole capsule 20mg twice daily x 7 days
11. Syrup sucralfate 15mls three times daily x 7 days
12. Buscopan tablet 20mg three times daily x 7 days

Table 4: Comparison of Treatment Given to Mr. Y.W. to that of the Literature Review

Drugs In Literature Review	**Drugs Given to Patient**
Antacids	Antacids were not prescribed
Analgesics and sedatives	No analgesics and sedatives were prescribed
Antibiotics	Antibiotics were not prescribed
Proton pump inhibitors	IV omeprazole 80 stat, Caps. Omeprazole 20mg bd x 7 was administered
Antiemetics	IV metoclopramide 10mg tds x24 was prescribed

Mr. Y.W. was given most of the drugs mentioned in the literature review and it concludes that he was given the right medication. However, syrup sucralfate was prescribed because of its mucosal protective ability as well as Buscopan to relief abdominal pain through its antispasmodic effect.

Table 5: Pharmacology of Drugs Administered to Mr. Y.W.

Date	Drugs	Standard dosage and route of administration	Dosage and route of administered	Classification	Desired effect	Actual action observed	Side effects	Comment
5/11/21	Metoclopramide	**Dose:** **Adult-** 10mg, 8 hourly **Child-** 2.5mg x 3 times daily **Route:** IV, IM, PO	**Dose:** 10mg tds x 24 hours **Route:** IV	Antiemetics	Relief of nausea and vomiting	Patient's nausea and vomiting was relieved	Drowsiness, restlessness, confusion.	None of the side effects was observed
5/11/21	Ringer Lactate (R/L)	**Dose:** Depends on the age and the clinical condition of the patient **Route:** IV only	**Dose:** 1litre x 24 hours **Route:** IV	Isotonic IV fluid	Corrects fluid electrolyte imbalance	Patient's fluid and electrolytes status was maintained	Sweating, weight gain, micturition	None of these side effects was observed.

Table 5: Pharmacology of Drugs Administered to Mr. Y.W. Continued

Date	Drugs	Standard dosage and route of administration	Dosage and route of administered	Classification	Desired effect	Actual action observed	Side effects	Comment
5/11/21 6/11/21	Omeprazole Caps Omeprazole	**Dose:** **Adult:** 40mg, 12 hourly (bd) **Child:** 20mg, bd **Route:** IV **Dose:** **Adult-** 20mg bd **Children-** 10mg bd **Route:** Oral	**Dose:** 80mg stat **Route:** IV **Dose**: 20mg bd x 7 **Route**: Oral	Proton pump inhibitor	Decreases the production of gastric acid; decreasing abdominal pain	Patient's stomach pain was decreased	Headache, flatulence, dizziness.	Patient experienced excess flatulence No other side effects were observed

Table 5: Pharmacology of Drugs Administered to Mr. Y.W. Continued

Date	Drugs	Standard dosage and route of administration	Dosage and route of administered	Classification	Desired effect	Actual action observed	Side effects	Comment
6/11/21	Syrup sucralfate	**Dose:** Depends on the age of the patient **Route**: Oral.	**Dose:**15mls tid x 7 **Route**: Oral	GI Protectants	Protects damaged ulcer tissues against acid.	Patient's abdominal pain was relieved	Itching, nausea	None of the side effects was observed
	Buscopan	**Dose**: 10mg, 20mg/ml **Route:** Oral, IV	**Dose:** 20mg tds x 7 **Route:** Oral	Antispasmodic	Reduces abdominal muscle spasm relieving abdominal pain	Patient was relieved of pain	Skin rashes, dizziness, micturition	Patient complained of dizziness; however, no treatment was given

Complications.

On account of efficient nursing and medical care and with reference to the complications stated under the literature review, patient did not develop any complication throughout the period of our interaction.

2.2 Patient/Family Strengths

This involves the activities the patient can do and what the family can perform in the achievement of health goals set for early recovery. Interactions with the patient and observations made led to the identification of the following strength;

1. Patient could describe and point to the location of pain.
2. Patient could describe the frequency and colour of vomitus.
3. Patient could eat seven tablespoonsful of food served.
4. Patient could verbalize the intensity of the headache.
5. Patient could verbalize the feeling of dizziness.
6. Patient and family could state some causes and clinical manifestations of gastritis.

2.3 Patient / Family Problems

These are conditions that affect the patient physically, mentally and socially which could hinder recovery if special attention is not given to the patient. The following health related problems were identified;

1. (5/11/2021) Patient complained of abdominal pain.
2. (5/11/2021) Patient experienced vomiting.
3. (5/11/2021) Patient complained of loss of appetite.

4. (6/11/2021) Patient complained of headache.
5. (7/11/2021) Patient complained of dizziness.
6. (7/11/2021) Patient and family had less knowledge about gastritis.

2.4 Nursing Diagnosis

This is the component of nursing care which involves formulating diagnosis from patient potentiated actual health problems which were gathered during admission. After patient assessment these diagnoses were made based on the health problems;

1. (5/11/2021) Impaired body comfort (abdominal pain) related to irritation of mucosal lining of stomach.
2. (5/11/2021) Vomiting related to gastric mucosal irritation.
3. (5/11/2021) Anorexia related to inflammatory process of the stomach mucosa.
4. (6/11/2021) Impaired body comfort (headache) related to decreased blood supply to the brain.
5. (6/11/2021) Risk for injury as evidenced by dizziness.
6. (7/11/2021) Knowledge deficit (patient and family) related to complexity of information on gastritis.

CHAPTER THREE

PLANNING CARE FOR PATIENT AND FAMILY

3.0 Introduction

Planning is the third stage of the nursing process. Weller (2019), defines planning as the process in which the nurse and the patient consider the goals to achieve in meeting the patient's potential problems and draw an individual care plan. Planning care ensures continuity of care and prioritizing patient's problems in order to render optimum care.

3.1 Patient/Family Care Objectives

1. Patient would be relieved of abdominal pain within 24 hours as evidenced by;

    a. Patient verbalizing reduction in pain.

    b. Nurse observing patient having a relaxed facial expression. .

2. Patient would be relieved of vomiting within 24 hours as evidenced by;

    a. Patient reporting a relief of vomiting.

    b. Nurse observing a reduction in the frequency of vomiting.

3. Patient would regain his normal nutritional pattern within 24 hours as evidenced by;

    a. Patient verbalizing that he has regained his appetite.

    b. Nurse observing patient eat at least two-thirds ($^2/_3$) of a plate of food served.

4. Patient would be relieved of headache within 24 hours as evidenced by;

    a. Patient verbalizing a relief of headache.

    b. Patient rating headache as 2 or less on the numerical pain rating scale.

5. Patient would be relieved of dizziness within 24 hours as evidenced by;

a. Patient verbalizing the absence of dizziness

b. Nursing observing patient perform his daily activities with minimal assistance.

6. Patient and family would gain adequate knowledge about gastritis within 4 hours as evidenced by;

a. Patient's family practicing knowledge gained on the management of gastritis.

b. Nurse obtaining positive answers from patient and family on questions asked about gastritis.

Table 6: Patient/Family Care Plan

Date and time	Nursing diagnosis	Objectives/Outcome criteria	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
5/1152021 at 8:30am	Impaired body comfort (abdominal pain) related to irritation of mucosa lining of stomach.	1. Patient would be relieved of abdominal pain within 24 hours as evidenced by; a. Patient verbalizing reduction in pain. b. Nurse observing patient having a relaxed facial expression.	1. Reassure patient. 2. Assess patient for onset, duration, intensity and frequency of the pain. 3. Nurse patient in a position that is comfortable to him.	1. Patient was reassured that he would be relieved of the pain by available interventions. 2. Patient was assessed for onset, duration, intensity and frequency to know the intensity of the pain. 3. Patient was put in a prone position to minimize the pain.	6/11/2021 at 8:30am	Goal fully met as patient verbalized reduction in pain intensity and on observation, patient had a relaxed facial expression.	B.A.T.

Table 6: Patient/Family Care Plan Continued

Date and time	Nursing diagnosis	Objectives/Outcome criteria	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
			4. Reduce noise in the ward and restrict visitors. 5. Encourage patient to take sips of water at frequent intervals.	4. Noise making was reduced by reducing the volume of ward T.V. and visitors were restricted for maximum rest to reduce pain. 5. Patient was encouraged to take sips of water at frequent intervals to dilute the hydrochloric acid in the stomach.			

Table 6: Patient/Family Care Plan continued

Date and time	Nursing orders	Objectives/Outcomes	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
			6. Serve prescribe medication.	6. Omeprazole 20mg was administered to reduce gastric acid production; decreasing abdominal pain.			

Table 6: Patient/Family Care Plan continued

Date and time	Nursing diagnosis	Objectives/Outcome criteria	Nursing orders	Nursing interventions	Date and time	Evaluation	Sign.
5/11/2021 at 8:40am	Vomiting related to gastric mucosal irritation.	Patient would be relieved of vomiting within 24 hours as evidenced by; a. Patient reporting a relief of vomiting. b. Nurse observing a reduction in the frequency of vomiting.	1. Assess frequency and quality of vomitus. 2. Assist patient to perform oral hygiene. 3. Eliminate strong odours from the surrounding.	1. Pattern and quality of vomitus was assessed. Patient vomited described vomitus as brownish in colour. 2. Patient was assisted to attend to his oral hygiene. 3. Urine pales and soiled linens were eliminated from the surrounding to reduce the induction of vomiting.	6/11/2021 at 8:40am	Goal fully met as patient reported a relief of vomiting and nurse observed the absence of vomiting.	B.A.T.

Table 6: Patient/Family Care Plan continued

Date and time	Nursing diagnosis	Objectives/Outcome criteria	Nursing orders	Nursing interventions	Date and time	Evaluation	Sign.
			4. Give frequent, small amounts of foods that appeal to the patient. 5. Assess for signs of dehydration. 6. Administer prescribed antiemetics.	4. Patient was encouraged to take in sips of fruit juice as tolerated. 5. Patient's skin and mucous membranes were assessed for dryness. 6. I.V. metoclopramide 10mg was administered.			

Table 6: Patient/Family Care Plan continued

Date and time	Nursing diagnosis	Objective/Outcome criteria	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
5/11/2021 at 8:50am	Anorexia related to inflammatory process of the stomach mucosa.	Patient would regain his normal nutritional pattern within 24 hours as evidenced by; a. Patient verbalizing that he has regained his appetite. b. Nurse observing patient eat at least two-thirds ($^2/_3$) of plate of the food served.	1. Reassure patient. 2. Assist patient to perform oral hygiene before and after meal. 3. Weigh patient daily. 4. Serve meal attractively.	1. Patient was reassured that possible measures would be taken to restore his appetite. 2. Patient was assisted to perform oral hygiene before and after meal to improve his appetite. 3. Patient was weighed and recorded. 4. Meals were served attractively to improve appetite.	6/11/2021 at 8:50am.	Goal fully met as patient verbalized that he has regained his appetite and an observation of patient eating two-thirds ($^2/_3$) of a plate of food served was made.	B.A.T.

Table 6: Patient/Family Care Plan continued

Date and time	Nursing diagnosis	Objective/Outcome criteria	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
			5. Serve patient's preferred meal. 6. Serve prescribed medication.	5. Patient's preferred meal was served. 6. IV metoclopramide 10mg had been administered.			

Table 6: Patient/Family Care Plan continued

Date and time	Nursing diagnosis	Objective/Outcome criteria	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
6/11/2021 at 9:10am	Alteration in comfort (headache) related to decreased blood supply to the brain	Patient would be relieved of headache within 24 hours as evidenced by; a. Patient verbalizing that he is relieved of headache. b. Patient rating headache as 2 or below on the numerical pain rating scale.	1. Assess vital signs. 2. Assess patient for onset, duration, intensity and frequency of the pain. 3. Assist patient to be in the most comfortable position. 4. Restrict visitors.	1. Vital signs were checked and recorded. 2. Patient was assessed for the onset, duration, intensity and frequency of the headache. 3. Patient was put in a supine position to minimize headache. 4. Visitors were restricted to enhance rest and sleep.	7/11/2021 at 9:10am	Goal fully met as patient verbalized a relief of headache and rated headache as 1 on the numerical pain rating scale.	B.A.T.

Table 6: Patient/Family Care Plan continued

Date and time	Nursing diagnosis	Objective/Outcome criteria	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
			5. Apply compress on forehead every 30 minutes. 6. Engage patient in diversional therapy.	5.Cold compress was applied to patient's forehead to relieve headache. 6.Patient was encouraged to watch television as a diversional therapy.			

Table 6: Patient/Family Care Plan continued

Date and time	Nursing diagnosis	Objective/Outcome criteria	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
6/11/2021 at 10:00am	Risk for injury as evidenced by dizziness.	Patient would be relieved of dizziness within 24 hours as evidenced by; a. Patient verbalizing the absence of dizziness. b. Nurse observing patient perform his daily activities with minimal assistance.	1. Reassure patient and family. 2. Assess vital signs. 3. Ensure bed rest. 4. Put patient on bed with side rails. 5. Place frequently used items within patients reach.	1. Patient and family were reassured of competent nursing care. 2. Vital signs were checked and recorded. 3. Bedrest was ensured. 4. Patient was put on bed with side rails to prevent falls. 5. Patient's frequently used items were within easy reach to prevent falls.	7/11/2021 at 10:00am	Goal fully met as patient verbalized the absence of dizziness and nurse observed patient performing his daily activities with minimal assistance.	B.A.T.

Table 6: Patient/Family Care Plan continued

Date and time	Nursing diagnosis	Objective/Outcome criteria	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
			6. Encourage patient to ask for assistance.	6. Patient was encouraged to ask for assistance to reduce frequent movement.			

Table 6: Patient/Family Care Plan continued

Date and time	Nursing orders	Objectives/Outcomes	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
7/11/2021 at 10:15am	Knowledge deficit (patient and family) related to complexity of information on gastritis.	Patient and family would gain adequate knowledge about the causes, signs and symptoms and prevention of gastritis within 4 hours as evidenced by; a. Patient's family practicing knowledge gained on the management of gastritis. b. Nurse obtaining positive answers from patient and family on questions asked about gastritis.	1. Reassure patient and family. 2. Provide a conducive environment for the education. 3. Educate patient on gastritis.	1. Patient and family were reassured that the education to be delivered will be in simple terms. 2. Volume of ward T.V. was reduced to minimize noise and nearby windows were opened to ensure adequate ventilation. 3. Patient and family were educated on causes, symptoms and prevention gastritis.	8/11/2021 at 10:15am	Goal was fully met as family practiced knowledge gained on the management of gastritis and provided positive answers to questions asked on gastritis.	B.A.T.

Table 6: Patient/Family Care Plan continued

Date and time	Nursing orders	Objectives/Outcomes	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign.
			4. Allow patient and family to ask questions. 5. Answer questions tactfully. 6. Thank patient and family for their cooperation.	4. Patient and family were allowed to ask questions. 5. Their questions were answered tactfully. 6. Patient and family were praised for their cooperation.			

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

Weller (2019) defined implementation to be the process by which the nurse and the patient put into practice the planned care. Implementation is the fourth stage of the nursing process and it deals with the actual nursing care rendered to the patient and family from the day of admission to the day of discharge. The patient and relatives are encouraged to participate by playing their role in patient's recovery.

4.1 Summary of the Actual Nursing Care

The nursing care rendered to Mr. Y.W. started on 5th November, 2021 and continued till 23rd November, 2021.The aim of the care was to meet the patient's health needs. The details of the actual nursing care are as follows:

First Day on Admission (5th November, 2021)

On 5th November, 2021 at 8:10am, patient was brought into the ward per ambulatory with assistance in a conscious state. Patient was accompanied by his wife and little child. On arrival, patient and relatives were welcomed and offered a seat. Patient complained of abdominal pain, vomiting and anorexia. Per observation, patient appeared weak but fairly stable. Vital signs were checked and recorded as;

1. Temperature - 36.8^0C
2. Pulse - 88bpm
3. Respiration -18cpm
4. Blood pressure - 150/89mmHg.

Patient weighed 61kg and his oxygen saturation was 97%. Patient was to be managed on;

1. I.V. R/L 1L X 24 hours

2. I.V. omeprazole 80mg stat
3. I.V. metoclopramide 10mg tid X 24 hours

Patient and family were reassured of competent nursing care. I.V. line was secured. Blood sample was sent to the laboratory for the following investigations;

1. Full blood count
2. Widal test
3. Rapid diagnostic test

Orientation was done and patient was made comfortable in bed. His particulars were recorded in the daily ward state and the admission and discharge book.

At 8:30am, based on patient's complains of abdominal pains, a nursing diagnosis of Impaired body comfort (abdominal pain) related to irritation of mucosal lining of stomach was made with an objective to relief patient of abdominal pain within 24 hours. The following nursing interventions were carried out; Patient was reassured that he would be relieved of the pain by available interventions, patient was assessed for onset, duration, intensity and frequency to know the intensity of the pain, patient was put in a prone position to minimize the pain, noise making was reduced by reducing the volume of ward T.V. and visitors were restricted for maximum rest to reduce pain, patient was encouraged to take sips of water at frequent intervals to dilute the hydrochloric acid in the stomach and I.V. omeprazole 20mg was administered to reduce gastric acid production; decreasing abdominal pain.

At 8:40am, a nursing diagnosis of vomiting related to gastric mucosal irritation was formulated. An objective was set to relief patient of vomiting within 24 hours. Nursing action executed include; pattern and quality of vomitus was assessed, patient described vomitus as brownish in colour, patient was assisted to attend to his oral hygiene, urine pales and soiled

linens were eliminated from the surrounding to reduce the induction of vomiting, patient was encouraged to take in sips of fruit juice as tolerated, patient's skin and mucous membranes were assessed for dryness and I.V. metoclopramide 10mg was administered.

At 8:50am, a nursing diagnosis of anorexia related to inflammatory process of the stomach mucosa was made. An objective was set to help patient regain his normal nutritional pattern within 24 hours. The following nursing interventions were implemented; patient was reassured that possible measures would be taken to restore his appetite, patient was assisted to perform oral hygiene before and after meal to improve his appetite, patient was weighed and recorded, meals were served attractively to improve appetite, patient's preferred meal was served and I.V. metoclopramide 10mg had been administered at 8:40am.

At 1:40pm, patient was served with rice and stew. His vital signs were checked and recorded as shown in appendix at 2:00pm. Mr. Y.W. was assisted to perform oral hygiene. He was asked to take some rest, since his medication was not due to be administered.

His second dose of I.V. metoclopramide 10mg was administered at 4:40pm. Patient was encouraged to take a stroll outside the ward. He later came to rest in bed. All the activities carried out on this day were documented.

Second day on admission (6th November, 2021)

Mr. Y.W. woke up around 5:30 am and was assisted to perform his personal hygiene and caring for his mouth. His bed was made comfortable by changing dirty and soiled linens and made free from creases and crumps. Patient was given oat and a slice of bread. He was able to eat more than half of the food served to him and said the intensity of abdominal pain had reduced. Patient and family were told that his condition will be better if he follows his treatment regimen correctly. A calm and serene environment was maintained while interacting with patient to

allay anxiety. Patient's vital signs were checked and all due medications were served and recorded without any adverse effects, this was documented in the nurses' note.

At 8:30am, the objective set on 5/11/2011 to relief patient of abdominal pain within 24 hours was evaluated and goal was fully met as patient verbalized reduction in pain intensity and on observation, patient had a relaxed facial expression.

At 8:40am, the objective that was set on 5/11/2021 to relief patient of vomiting within 24 hours was evaluated and goal was fully met at as patient reported a relief of vomiting and nurse observed the absence of vomiting.

At 8:50am, the objective set on 5/11/2021 to help patient regain his normal nutritional pattern within 24 hours was evaluated and goal was fully met as patient verbalized that he has regained his appetite and an observation of patient eating two-thirds ($^2/_3$) of a plate of food served was made.

At 9:10am, patient complained of headache. Nursing diagnosis was formulated as alteration in comfort (headache) related to decreased blood supply to the brain. A goal was set to relief patient of headache within 24 hours and interventions carried out include; vital signs were checked and recorded, patient was assessed for the onset, duration, intensity and frequency of the headache, patient was put in a supine position to minimize headache, visitors were restricted to enhance rest and sleep, cold compress was applied to patient's forehead to relieve headache and patient was encouraged to watch television as a diversional therapy.

At 9:30am, patient was reviewed and plan was to continue treatment. The following medications were added;

1. Omeprazole capsule 20mg twice daily x 7 days
2. Syrup sucralfate 15mls three times daily x 7 days
3. Buscopan tablet 20mg three times daily x 7 days.

At 10:00am, upon interaction with patient, he revealed that he was feeling dizzy. A nursing diagnosis of risk for injury as evidenced by dizziness and an objective set to relief patient of dizziness within 24 hours. Nursing interventions executed include; patient and family were reassured of competent nursing care, vital signs were checked and recorded, bedrest was ensured, patient was put on bed with side rails to prevent falls, patient's frequently used items were within easy reach to prevent falls and patient was encouraged to ask for assistance to reduce frequent movement.

In the evening during supper, patient was served with yam and egg stew, and was able to eat the food served to him. He was assisted to have warm bath to feel fresh and clean, visitors were restricted on the ward to avoid interruptions in sleep, and noise were reduced on the ward to promote sleep. Windows and fans were opened to ensure adequate ventilation to induce sleep, warm drinks were served and bright light put off to enhance sleep after which he retired to bed and had a sound sleep without any interruptions. All the nursing activities rendered were recorded in the nurses' note. Vital signs checked and recorded as shown in the appendix.

Third day on admission (7th November, 2021)

On the third day on admission, patient woke up around 5:30am in the morning and he maintained his personal hygiene. His condition had improved considerably when the doctor came to review him and planned on a possible discharge the next day.

At 9:10am, the objective that was set on 6/11/2021 to relief of headache within 24 hours was evaluated and goal was fully met at as patient verbalized a relief of headache and rated headache as 1 on the numerical pain rating scale.

At 10:00am, the objective that was set on 6/11/2021 to relief patient of dizziness within 24 hours was evaluated and goal was fully met at as patient verbalized the absence of dizziness and nurse observed patient performing his daily activities with minimal assistance.

At 10:15am, patient and family were engaged in an interaction on gastritis and it was realized that patient and family had less knowledge about the condition. A nursing diagnosis of knowledge deficit (patient and family) related to complexity of information on gastritis was made and an objective was set to help patient and family gain adequate knowledge about the causes, signs and symptoms and prevention of gastritis within 4 hours. The following nursing interventions were implemented; patient and family were reassured that the education to be delivered will be in simple terms, volume of ward T.V. was reduced to minimize noise and nearby windows were opened to ensure adequate ventilation, patient and family were educated on causes, symptoms and prevention gastritis, patient and family were allowed to ask questions, their questions were answered tactfully and patient and family were praised for their cooperation. On this day, I visited the patient's home to assess their environment to identify health related problems.

In the evening during supper, patient was served with rice and kontomire stew, and was able to eat all the food served to him. He was assisted to have warm bath to feel fresh and clean, visitors were restricted on the ward to avoid interruptions in sleep, and noise were reduced on the ward to promote sleep. fans were switched on to ensure adequate ventilation to induce sleep, warm drinks were served and bright light put off to enhance sleep after which he retired to bed and he had a sound sleep without any interruptions. All the nursing activities rendered were recorded in the nurses' notes. His vital signs were checked and recorded as shown in the appendix.

Day of discharge (8th November, 2021)

Mr. Y.W.'s condition had improved remarkably. He looked strong, cheerful and felt better than the previous days of admission. He performed his daily routine activities. During ward rounds, it was noticed that patient's condition had improved such that he looked completely healthier and plan was to discharge patient. His vital signs were checked and recorded as shown in appendix.

At 10:15am, the objective that was set on 7/11/2021 to help patient and family gain adequate knowledge about the causes, signs and symptoms and prevention of gastritis within 4 hours was evaluated and goal was fully met at as family practiced knowledge gained on the management of gastritis and provided positive answers to questions asked on gastritis.

Discharge plan was made known to the patient and family. His due medications were served accordingly and recorded. Patient showed a sign of happiness upon hearing what the health team had said and was told to come for review on the 15th November, 2021. Patient and family were educated on the dosage, frequency, mechanism of action, side effects and storage of medications.

He was told on the need to adhere to therapeutic regimen despite resolution of symptoms and educated on the need to seek medical intervention promptly when drug adverse effect is noticed and also of any sudden attack. Education given on condition was reinforced, patient was as well encouraged to take nutritious diets at regular interval and to avoid intake of spicy foods, caffeinated and alcoholic beverages.

Patient and relatives helped pack all his belongings, his bill was assessed and as a member of the national health insurance scheme (NHIS), he had no difficulty in paying his bills. Patient name was entered in the admission and discharge book. Patient and family were reminded on

the date of review upon their departure home. Bed linen was discarded and bed was disinfected for subsequent admission.

4.2 Preparation of Patient/Family for Discharge and Rehabilitation.

The preparation for the discharge and rehabilitation of a patient and family started from the day of admission till the day of discharge. The aim of the care rendered to patient and family was to promote recovery for the patient and to the community as early as possible without any ill health. On the day of discharge, patient's bills were estimated and made known to his family to enable them settle the bills. Mr. Y.W. and family were given health education on the causes, signs and symptoms and prevention of the disease condition. He was advised to avoid starvation, intake of NSAIDs and alcohol. He was also entreated to take snacks in between meals and even when he is not feeling hungry to prevent gastric secretions from eroding the mucosal lining of the stomach. They were advised to regularly seek medical attention for any minor illness and desist from buying non–prescribed over the counter drugs which could be harmful to their health. Patient was advised on the importance of taking his medication as prescribed. Patient and family were education on the need for personal hygiene and good nutrition and reminded of the review date and the need to come for review on 15th November,

4.3 Follow-ups/Home visits/Continuity of Care.

Follow-up is the means of rendering health service to a patient in his or her home to ensure continuity of care. It also determines the health status of the patient following discharge and also to identify other problems and help find solutions to the identified problems. This involves visiting the patient home before and after discharge to have personal information on the condition of the house and its influence on the patient's health.

First home visit (7th November, 2021)

A visit was paid to Mr. Y.W.'s residence at Wamanafo on 7th November, 2021 at 12:30pm whiles he was still on admission, with the aim to detect factors relating to his surroundings which may have contributed to his condition or may serve as a limitation to the achievement of the best health by patient after discharge. The direction to their house was given earlier to me by the patient and wife. I had already informed him about the visit a day before and explained that it was to familiarize myself with their environment. I was cordially welcomed to the house. Mr. Y.W. and family currently stay at Wamanafo in the Bono region**.** They live in their own apartment with toilet, bath and a kitchen, well ventilated rooms roofed with aluminum roofing sheet. There was adequate supply of pipe water, electricity, and they dump their refuse at the community refuse dump. There was no health facility anywhere near their house.

Upon interaction with family, it was identified that Mr. Y.W. sometimes skips breakfast as he leaves for farm early in the morning. They were praised with their cleanliness and hospitality and were assured that Mr. Y.W. would be fine.

The family was educated on taking regular frequent meals, taking enough fluids, having enough rest and also to avoid the excessive use of over-the-counter drugs, especially with NSAIDs. Two under five children were in the house, I used the opportunity to check their road-to-health chat and it was noticed that they were fully immunized and their growth patterns were normal. Therefore, I educated their parents to continue their care. After various interactions with patient's family, permission was sought and another visit was arranged with them. The family was assured that, Mr. Y.W. was responding to treatment well and would soon be discharged home.

Second home visit (11th November, 2021).

The second home visit took place on 11/11/2021. The purpose of this visit was to assess how patient was recovering after discharge. On arrival, the family was happy to see me. I enquired about the patient's wellbeing which he answered in a positive way that all was well. He told me he does not feel abdominal pain, he could eat and the dizziness too is gone. This home visit was to ensure that patient and relatives adhere to health education given to them during the first home visit. Emphasis was made on the need to continue the treatment in the house, the need to visit the hospital immediately if any changes are noticed, the need to attend review on 15/11/2021 and the importance of preventing his disease from occurring in the future. Termination of care was also explained to them that, this care will be terminated during the next visit. Patient showed signs of happiness and appreciation. They thanked me for my good work and I also thanked them for their cooperation and bid them goodbye.

Review (15th November, 2021)

Mr. Y.W. came to the Dormaa-East District Hospital for review on 15th November, 2021 around 9am. He was assisted to retrieve his folder from the records. It was observed that his condition had greatly improved. His vital signs were checked and were within normal range thus,

1. Temperature: 36.6^{o}C
2. Respiration: 16cpm
3. Pulse: 84bpm
4. Blood pressure: 110/90mmHg.

The doctor confirmed his condition had improved; therefore, no other treatment was prescribed. He took off around 12:15pm.

Third home visit (23rd November, 2021)

Third home visit was made on 23/11/2021 with the aim of knowing patient's health status and to terminate care. When I arrived at their house, I was warmly welcomed by the family and was offered a seat. They were all very happy to see me again in their house and were very happy about Mr. Y.W.'s condition. He did not complain of any ill health. I explained to the family that Mr. Y.W.'s condition was good but he can report to the hospital if any problem arises. Patient and family were informed that care has been terminated and this is the last day of official visiting and they were congratulated for their cooperation through the study. I sought for permission and took leave of them

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT/FAMILY

5.0 Introduction

Evaluation is the last phase of nursing process and involves measuring how effective and well a goal is reached. Evaluation is defined by Weller (2019) as the act of examining something in order to judge its value, quality, importance, extent or condition. This phase enables the nurse to determine the patient's progress towards goal achievement as well as the effectiveness of the nursing care plan. When goals are not achieved, the nursing care plan is amended and appropriate measures are put in place to achieve the goal. This phase includes;

1. Statement of the evaluation.
2. Amendment of patient/family care for partially met and unmet goals.
3. Termination of care.

5.1 Statement of Evaluation

The care of Mr. Y.W. and family started on 5th November, 2021 at 8:10am as he was brought into the ward and diagnosed of Gastritis till 8th November, 2021, the day of discharge. Follow up visits were made and care was terminated on 23rd November, 2021. Below is the summary of interventions carried out and to what extent goals were achieved.

Mr. Y.W. was relieved of abdominal pain

On 5th November, 2021 at 8:30am, based on patient's complains of abdominal pains, a nursing diagnosis of Impaired body comfort (abdominal pain) related to irritation of mucosal lining of stomach was made with an objective to relief patient of abdominal pain within 24 hours. The following nursing interventions were carried out; Patient was reassured that he would be relieved of the pain by available interventions, patient was assessed for onset, duration, intensity and frequency to know the intensity of the pain, patient was put in a prone position to minimize the pain, noise making was reduced by reducing the volume of ward T.V. and visitors were restricted for maximum rest to reduce pain, patient was encouraged to

take sips of water at frequent intervals to dilute the hydrochloric acid in the stomach and I.V. omeprazole 20mg was administered to reduce gastric acid production; decreasing abdominal pain.

On 6th November, 2021 at 8:30am, the objective set on 5/11/2011 to relief patient of abdominal pain within 24 hours was evaluated and goal was fully met as patient verbalized reduction in pain intensity and nurse observed patient had a relaxed facial expression.

Patient was relieved of vomiting

On 5th November, 2021 at 8:40am, a nursing diagnosis of vomiting related to gastric mucosal irritation was formulated. An objective was set to relief patient of vomiting within 24 hours. Nursing action executed include; pattern and quality of vomitus was assessed, patient vomited once and described vomitus as brownish in colour, patient was assisted to attend to his oral hygiene, urine pales and soiled linens were eliminated from the surrounding to reduce the induction of vomiting, patient was encouraged to take in sips of fruit juice as tolerated, patient's skin and mucous membranes were assessed for dryness and I.V. metoclopramide 10mg was administered.

On 6th November, 2021 at 8:40am, the objective that was set on 5/11/2021 to relief patient of vomiting within 24 hours was evaluated and goal was fully met as patient reported a relief of vomiting and nurse observed absence of vomiting.

Patient regained his normal nutritional pattern

On 5th November, 2021 at 8:50am, a nursing diagnosis of anorexia related to inflammatory process of the stomach mucosa was made. An objective was set to help patient regain his normal nutritional pattern within 24 hours. The following nursing interventions were implemented; patient was reassured that possible measures would be taken to restore his appetite, patient was assisted to perform oral hygiene before and after meal to improve his

appetite, patient was weighed and recorded, meals were served attractively to improve appetite, patient's preferred meal was served and I.V. metoclopramide 10mg had been administered at 8:40am.

On 6th November, 2021 at 8:50am, the objective set on 5/11/2021 to help patient regain his normal nutritional pattern within 24 hours was evaluated and goal was fully met as patient verbalized that he had regained his appetite and nurse observed patient eating two-thirds ($^2/_3$) of plate of meal served.

Patient was relived of headache

On 6th November, 2021 at 9:10am, patient complained of headache. Nursing diagnosis was formulated as alteration in comfort (headache) related to decreased blood supply to the brain. A goal was set to relief patient of headache within 24 hours and interventions carried out include; vital signs were checked and recorded, patient was assessed for the onset, duration, intensity and frequency of the headache, patient was put in a supine position to minimize headache, visitors were restricted to enhance rest and sleep, cold compress was applied to patient's forehead to relieve headache and patient was encouraged to watch television as a diversional therapy.

On 7th November, 2021 at 9:10am, the objective that was set on 6/11/2021 to relief of headache within 24 hours was evaluated and goal was fully met at as patient verbalized a relief of headache and rated headache as 1 on the numerical pain rating scale.

Patient was relieved of dizziness

On 6th November, 2021 at 10:00am, upon interaction with patient, he revealed that he was feeling dizzy. A nursing diagnosis of risk for injury as evidenced by dizziness and an objective set to relief patient of dizziness within 24 hours. Nursing interventions executed include; patient and family were reassured of competent nursing care, vital signs were

checked and recorded, bedrest was ensured, patient was put on bed with side rails to prevent falls, patient's frequently used items were within easy reach to prevent falls and patient was encouraged to ask for assistance to reduce frequent movement.

On 7th November, 2021 at 10:00am, the objective that was set on 6/11/2021 to relief patient of dizziness within 24 hours was evaluated and goal was fully met at as patient verbalized the absence of dizziness and nurse observed patient performing his daily activities with minimal assistance.

Patient and family gained adequate knowledge on gastritis.

On 7th November, 2021 at 10:15am, patient and family were engaged in an interaction on gastritis and it was realized that patient and family had less knowledge about the condition. A nursing diagnosis of knowledge deficit (patient and family) related to complexity of information on gastritis was made and an objective was set to help patient and family gain adequate knowledge about the causes, signs and symptoms and prevention of gastritis within 4 hours. The following nursing interventions were implemented; patient and family were reassured that the education to be delivered will be in simple terms, volume of ward T.V. was reduced to minimize noise and nearby windows were opened to ensure adequate ventilation, patient and family were educated on causes, symptoms and prevention gastritis, patient and family were allowed to ask questions, their questions were answered tactfully and patient and family were praised for their cooperation.

0n 8th November, 2021 at 10:15am, the objective that was set on 7/11/2021 to help patient and family gain adequate knowledge about the causes, signs and symptoms and prevention of gastritis within 4 hours was evaluated and goal was fully met as family practiced knowledge gained on the management of gastritis and provided positive answers to questions asked on gastritis.

5.2 Amendment of nursing care

Due to the quality care given with the help of patient and his family together with good medical care, all objectives set were fully met. Therefore, no amendment of care was done.

5.3 Termination of care

This marks the end of interaction between the nurse and patient. The interaction with the patient and family started on 5/11/2021 till the last home visit which was on 23/11/2021. It was made clear to patient and family that our interaction was therapeutic one which would last for only a short period of time. They were informed that I would not stay on the ward 24 hours with them so there will be the need for their co-operation with other nurses and medical staff on the ward.

They were educated on the maintenance of good personal hygiene, nutrition and conformity to treatment regimen, stress management as well as the need for follow up care. Finally, patient's care was terminated on 23/11/2021 and patient was handed over to his wife and other relatives to continue with care at home because there was no health facility in their community. Therefore, I told them that as Mr. Y.W. was fully recovered the care had officially come to an end. Termination did not have any bad effect on the patient and family, since they had been already prepared and educated. I praised them for their co-operation.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.1 Summary

Mr. Y.W., a 51-year-old man was admitted to the Medical-Emergency ward at Dormaaa-East District Hospital on 5th November, 2021, the day of admission. He was diagnosed of gastritis. He was taken through series of investigation which include;

1. Full blood count,
2. Widal test
3. Rapid diagnostic test for malaria.

The result of the investigation and signs and symptoms helped confirm his diagnosis. Patient presented health problems such as abdominal pain, headache, loss of appetite, dizziness and others.

Objectives were set and orders implemented, some of which included monitoring vital signs, reassuring patient and administration of medication.

Patient and family were educated on the causes, signs and symptoms, prevention and complication of gastritis. Also, they were advised to take drug regimen very important and accordingly. The following drugs were administered;

1. Intravenous metoclopramide 10mg three times daily x 24 hours.
2. Intravenous omeprazole 80mg stat
3. Intravenous fluid Ringers Lactate 1litre x 24 hours
4. Omeprazole capsule 20mg twice daily x 7 days
5. Syrup sucralfate 15mls three times daily x 7 days
6. Buscopan tablet 20mg three times daily x 7 days

Mr. Y.W. responded to treatment and condition improved.

Patient was nursed for four days from 5th November, 2021 to 8th November, 2021 and was discharged. He was due for review on 15th November, 2021. Follow-up and three home visits were made to assess the home situation and observe drug regimen. On 23rd November, 2021, patient/family care was finally terminated.

6.2 Conclusion

This study has really affirmed the need and importance of comprehensive nursing of the patient and their families. It has reinforced the need to practice the knowledge acquired during the three years training. It has broadened my knowledge on diseases of the stomach. It has also promoted a better understanding of the physiology of gastritis. Patient and family also benefited immensely from the interaction through the health education given. I therefore recommend that this remains as part of the academic program for the award diploma in General Nursing.

APPENDIX

Vital signs of Mr. Y.W.

Date	Time	Temperature (^{0} C)	Pulse (bpm)	Respiration (cpm)	Blood pressure (mmHg)
5/11/2021	8:10am	36.8	88	18	150/89
	2:00pm	36.9	74	16	130/89
	6:00pm	37.5	80	17	120/70
	10:00pm	36.2	89	18	120/60
6/11/2021	6:00am	37.3	72	17	110/60
	10:00am	36.9	70	16	120/60
	2:00pm	37.6	92	20	120/80
	6:00pm	37.5	85	19	100/90
	10:00pm	36.3	75	18	110/70
7/11/2021	6:00am	36.6	78	17	120/80
	10:00am	37.8	81	19	110/60
	2:00pm	36.7	72	16	120/70
	6:00pm	36.3	80	18	100/90
	10:00pm	37.1	79	17	120/60
8/11/2021	6:00am	36.9	74	16	120/90
	10:00am	37.2	72	16	100/70
	2:00pm	36.5	94	21	110/80

BIBLIOGRAPHY

Agbeko, M.E. (2011). *Pharmacology and Therapeutics.* (2nd ed.), Sunyani: Excel Print.

American Psychological Association. (2020). Retrieved from https://dictionary.apa.org

Barbara, F. W. (Ed.). (2019). *Bailliere's Nurses Dictionary for Nurses and Health Care Workers* (27th ed.). New York: Bailliere Tindal Elsevier.

B.N. (2014). *British National Formulary (BNF).* U.K.: London WC1H9, UK.

Hornby, A. S. (2012). *Oxford Advanced Learner's Dictionary of Current English* (7th ed.). Oxford: Oxford printing press.

Smeltzer, C. S., & Brenda, G. B. (2012). *Brunner and Suddath's Textbook of Medical-Surgical Nursing* (10th ed.). Philadelphia: Lippincott, Williams & Wilkins.

Suzanne, C. S., Brenda, G. B., Janice, L. H., & Kerry, H. C. (2014). *Brunner and Suddath's Textbook of Medical-Surgical Nursing* (12th ed.). London: Wolter's Kluwer/ Lippincott, Williams & Wilkins.

Others

Patient’s Folder: 956/20 (DEDH)

SIGNATORIES

The Student Nurse

Name: Belinda Addo-Twum

Signature: .....

Date: 05/10/2022

The Nurse In-Charge of the Medical-Emergency Ward (Dormaa-East District Hospital, Wamfie)

Name: Mrs. Abrokwa Precious

Signature: .....

Date: 05/10/2022

The supervisor (Holy Family Nursing and Midwifery Training College, Berekum)

Name: Mr. Obeng Eric

Signature: .....

Date: 05/10/2022

The principal (Holy Family Nursing and Midwifery Training College, Berekum)

Name: Monica Nkrumah

Signature: .....

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

Date: 06/10/2022