HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A PATIENT/FAMILY CENTERED NURSING CARE STUDY ON

ACUTE GASTRITIS

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

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PREFACE

Nursing has had a significant effect on people's lives, as rapid changes continue to transform the profession of nursing and health care system. According to the Henderson (1960), the unique function of the nurse, is to assist the individual either sick or well in the performance of those activities contributing to health or its recovery or peaceful death that he or she would have performed unaided if he or she has the necessary strength, will or knowledge. It is a profession that uses specialized knowledge and skills to promote wellness and to provide care for people in both health and illness in a variety of practices setting. Many people believed that nursing started with Florence Nightingale, however nursing itself dates back to the beginning of motherhood when nurses were traditionally females. The history of nursing has its origin in the care of infants and children, so all mothers were nurses. The word nursing derives its meaning form the Latin word "nutricus" which means to nourish.

The nursing profession has evolved from the rendering of care to a client in relation to just a disease and following orders from a physician to a comprehensive method of taking individualized care of an individual considering all aspects of the individual's life. It now includes support given to the client/family emotionally, socially and spiritually.

The patient and family care study are means by which final year students are assessed for the award of Registered General Nursing Certificate by the Nursing and Midwifery council of Ghana. The study helps the student nurse combine classroom knowledge and clinical experience in rendering nursing care to a client from time of admission to the time of discharge and also includes the continuity of care and rehabilitation.

Care study is therefore written using the nursing process approach and offers the student the opportunity to do a lot of research into the causes, clinical features, diagnosis, complications, treatment and the prevention of various diseases. This means that before the student passes out

successfully to become a registered nurse, the nursing care study would have successfully equipped the student with the knowledge and set of skills necessary to render care to an individual. Patient and family initials were used instead of full names to ensure confidentiality.

Finally, it gives the student the opportunity to interact with the client/family at the ward, in their home during home visit and the community at large.

ACKNOWLEDGEMENT

The writing of this patient and family care study would not have been successful without the help of some individuals and groups. I therefore find it necessary to show my sincere gratitude to them for their contribution in many ways

My first sincerest gratitude goes to the Almighty God for the immense strength and determination offered me to successfully carry out this study.

I am indebted to my entire family for their moral and financial support given me throughout the period of this study.

I also extend my thanks to my patient, Madam S.M. and her family for allowing me use them for my patient and family care study. I appreciate their co-operation throughout the period of hospitalization.

My next gratitude goes to my supervisors of Holy Family Nursing and Midwifery Training College, Berekum especially Mrs Rita Gyamfi and Master Ibrahim Alhassan who carefully guided me throughout this script, I cannot imagine my gratitude for their patience.

Furthermore, I am equally grateful to the nurse in-charge as well as the entire staff of the Female medical ward of Sunyani Municipal Hospital, for their contribution towards this work, may God bless you all for your guidance and support.

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May God richly bless you all.

INTRODUCTION

The patient and family care study is a study conducted on patient/family using the nursing process to nurse the patient and family as an individual, taking into account all the needs of the patient needed to arrive at a desired outcome. It also takes into account patient's psychological and social needs in planning the care.

The detailed account of nursing care rendered to Madam S.M. a 35-year-old woman who comes from Bodi in the Western region, her family and community through interaction and nursing process forms the patient/family care study.

For confidential reasons the initials S.M. has been used to represent patient's name.

A planned admission of the patient to the female's ward by Dr. J.G.A was on 25th November, 2022 at 9:30pm after being detained at the emergency unit. Patient was diagnosed of Acute Gastritis. I interacted with her the very day she was admitted. She spent five days at the hospital and throughout her stay in the hospital, she had treatment and care geared towards complete recovery.

Throughout the period of hospitalization, she was managed on the following drugs:

- IV Paracetamol 1gram stat
- IV Normal Saline 500mls
- IV Ringers Lactate 2litres
- IV Omeprazole 80mg stat then 40mg bd x 2 days
- IV Ciprofloxacin 400mg bd x 24 hours
- Tab tramadol 500mg bd x 7 days
- Nugel O 15mls tds x 7days

The laboratory investigation ordered for Madam S.M. were as follows:

1. Full Blood Count (FBC)
2. Helicobacter Pyloric test

With proper care and attention, she got well and was discharged on 29th November, 2022, without any complication. After she was discharged, I made three follow up visits until I handed her over to the community health center on 18th December,2022. This script is written, organized and compiled into six (6) chapters for easy reading and understanding.

Chapter one deals with the assessment of patient and family. It includes patient's particulars, family medical and socio-economic history, lifestyle and hobbies, past and present medical history. Others are admission of patient, patient concept of illness, literature review as well as data validation.

Chapter two is concerned with the analysis of data collected from patient and comparing this data with standards. This chapter also involves the identification of patient and family strengths, their health problems and formulating nursing diagnosis for them.

The third chapter is mainly about planning the care for patient and family where a nursing care plan was drawn and used in the management of the patient.

Chapter four is concerned with the implementation of patient and family care plan. The summary of actual nursing care, preparation of patient for discharge and follow-up visits are involved.

The fifth chapter deals with the evaluation of care rendered to patient and family. It involves the statement of evaluation, amendment of nursing care plans for partially met or unmet objectives and the termination of care.

The last chapter, which happens to be chapter six is the summary and conclusive of the care rendered to the patient

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment is a systematic process which involves the collection of data from the patient, family, friends, community members, patient's folder and other members of the health team, in with the significant information about the patient, family and locality in which they live is obtained. Assessment is the first phase of the nursing process according to the North American Nursing Diagnosis Association (NANDA-I) (2022), which provides the starting point for determining nursing diagnoses. The purpose for assessment is to help the nurse to know the actual and potential health problems of the patient which will enable the nurse to plan his or her nursing care. What the patient tells the nurse during this stage forms the subjective data whiles what the nurse observes from the patient physically forms the objective data. Data in this case study was gathered from my patient through observations, interview and the four techniques in physical assessment (thus inspection, palpation, percussion and auscultation). This data can be reviewed from past information provided by the patient/family or found within the patient chart. The first step of the nursing process is the assessment of the patient/family during the admission process. Assessment covers the patient's particulars, family medical/surgical history, family socio-economic history, patient's developmental history, patient's lifestyle and hobbies, patient past medical/surgical history and present medical/surgical history of the patient, literature review and validation of data.

1.1 Patient's Particulars

A patient according to the oxford dictionary is a person receiving medical or surgical treatment especially in the hospital.

Particulars is defined as an individual fact or detail regarding an information (Marriam-Webster, 2022, March 19)

Madam S.M. is the subject for the care study, she is thirty-five (35) years old woman. She is married to Mr. K.M. Madam S.M. was born to Mr E.A. and Mrs T.A. through spontaneous vaginal delivery at Bodi clinic in the Western region. She is the sixth child of eight siblings. Madam S.M. comes from Bodi in the Western region but stays at Abesim in the Bono region. Madam S.M. is a trader that deals in the selling of snails which her mom helps her with by transporting the snails from Bodi to Sunyani for her to sell. She also sells bread and water at her house on days she does not go to the market. Madam S.M. has 2 children with her husband who are both boys. Madam S.M.'s husband is outside the country so she lives in a rented room with her two boys. Madam S.M. is a Christian who worship with the Deeper Life church in Sunyani. She has a dark brown complexion, measures 1.7m tall and weighs 65kg. Madam S.M. started her education from crèche up to J.H.S where she dropped out of school due to personal issues. She completed her J.H.S at Roman school in Bodi. Twi and Sefwi are the language she's costumed to. Even with her low level of education she was well informed about her condition and always complied with treatment. She is registered under the National Health Insurance Scheme (NHIS). Madam S.M has no physical disabilities or impairments. Her sister Madam E.A. is her next of kin.

1.2 Family Medical history

This is information gained from patient concerning the patient's past and present medical information and that of any illness or disease attributed in the patient's family line.

Observing Madam S.M. during her period of hospitalization and my paid home visit she had no risk of developing other diseases. She is a very clean person and performs personal hygiene accurately. She also eats good diet. Both the parents of Madam S.M. are alive and

healthy working on their farms. She recently lost her grandmother from natural cause of death (old age) and both her grandparents from her dad's side are deceased but her grandfather from her mom's side is still alive and healthy. She mentioned no known chronic illness in the family except her elder brother who suffers from Peptic Ulcer Disease and further stated that all her family members are mentally healthy and stable. She mentioned no diseases like hypertension or diabetes in the family.

Madam S.M. has been hospitalized on several occasions from minor illness like malaria and acute abdominal pains. She said she mostly uses over the counter drugs to treat sudden abdominal pains and has no known allergy to any medication or food.

1.3Family Socio-Economic History

According to Bickey and Szilagyi (2015), family socio-economic history deals with the social background and economic status of the patient and her family. Socio-economic history is information gained about a particular family by a nurse or a physician by asking specific questions either from the patient or important people who can give credible information with the aim of obtaining information useful in formulating diagnosis and providing medical care to the patient.

According to the information collected, Madam S.M. moved from Bodi her hometown to Sunyani after she got married. She lives with her sister who also moved to Sunyani after being married. Both her parents and last child of her siblings are still living in their hometown. The rest of her siblings are working in different places to make ends meet themselves. The patient's family belongs to the middle-class group of the society. Madam S.M. main source of income is from the sales work she does but she also receives support from her husband who is a businessman outside the country. Out of the support from her husband, she uses to pay her medical bills and cater for herself and her two boys. The family

of Madam S.M. are not known to engage in any form of alcoholism, smoking or notorious activities. They are all responsible persons and help each other in times of need. Madam S.M. barely has any interaction with her friends in the community except those she attends church with. From my interaction with her she had no problem financially as she was willing to go ahead with every treatment and test, she was supposed to have.

1.4 Patient's Developmental History

According to Macmillan English Dictionary, Growth is the progressive development of a living thing, especially the process by which the body reaches its point of complete physical development. Also, Development is a progressive increase in intelligence, conscious thought, and problem-solving ability that begins in infancy. Maturation is the stage or process of attaining maximal development; attainment of maximal intellectual and emotional development. Puberty is a stage of development when a child changes physically into an adult.

The patient developmental history was given by Madam S.M. herself. She said her mother had nine-month full term pregnancy with no pregnancy-related problems and she had a spontaneous vaginal delivery at the Bodi clinic by a midwife, without any complication to the mother or child after delivery. Patient was immunized against childhood vaccine preventable diseases such as poliomyelitis, diphtheria, whooping cough yellow fever, measles, tetanus etc. She was weighed occasionally. She was introduced to supplementary feed after several months of exclusive breastfeeding. She was weaned after 6 months of breastfeeding. Madam S.M. went through childhood development successfully. She started schooling at the age of four and her female secondary sexual characteristics which includes; development of pubic hairs, enlargement of breast, widening of hips etc. at the age of fifteen. Madam S.M. had a vision of becoming a nurse as a child but due to financial constraints she has not been able to

continue school after her junior high education. According to Eric Erikson theory of human development, his psychosocial characteristics dilemma for the age group within which my patient falls (18 – 40) is Intimacy versus Isolation. According to him this is the period of early adulthood when people are exploring close personal relationships. Erikson believes it was vital that people develop close, committed relationships with other people. Those who are successful at this step will develop relationship that are committed and secure. Erikson described intimate relationships as those characterized by closeness, honesty and love. Success of this leads to strong relationship while failure results in loneliness and isolation. With this my patient has successfully accomplished this task. She has built a strong relationship with his family and friends at home and she is even a happily married woman despite her husband being away from her most of the time. She also has a close relationship with her siblings whom she depends on for advice and support in times of hardship. This was proven during her admission when her sister took very good care of her and always running **e**rrand**s** for her and was ready to assist the nurses and doctors on the recovery of her sister. She also received call from her husband and family daily to check up on her progress. Few of her friends from church also to visit her. Hence, she has been able to accomplish this stage of developmental milestone successfully. Madam S.M. did not speak much about her educational background. She spoke of having a little bit of difficulty in her studies when she was in school. She later dropped out of school after completing her Basic Education Certificate Examination due to reasons she did not want to disclose. As at now she had not undertaken any educational programme and only focuses on her trading business and raising her children.

1.5 Obstetric History

Madam S.M. has had two safe pregnancies with no post complication or abortions. She had her children through safe vaginal delivery. She has two boys who are all alive and healthy. Madam S.M. experienced her first menarche at the age of 13. She complained of having the normal menstrual cramps on each flow of the month which subsides after a day or two. From her belief at church, she has not used any contraceptives before and consider it a sin.

1.6 Patient's Lifestyle/hobbies

According to oxford dictionary for advanced learners, lifestyle refers to the pattern of daily living that an individual develops. It also totals the likes and dislikes of an individual. Hobbies are the activities an individual enjoy doing in one's spare time.

Madam S.M. goes to bed around 10:00pm after having her evening devotion with her children. She gets up at 4:00am and says her morning prayers and does devotion for about 30 minutes. She brushes her teeth with toothbrush and toothpaste twice daily. She puts water on fire for her kids and does some cleaning in the house and later sweeps the house compound. She empties her bowel twice daily and whenever she feels the edge to do so. Afterwards she takes her bath and she wakes her kids up and prepares them for school. She sends them to school around 7:00am and comes back to the house to continue her house work. Madam S.M. said on days she has snails to sell she goes to the market after sending the children to school and on days she does not have she stays home and sell her bread and water. Despite her knowledge on having stomach ulcer Madam S.M. says she does not have her meals on time. She takes her breakfast late in the morning and sometimes skips lunch due to her work. The food Madam S.M. likes best is ampesi with palaver sauce or garden egg stew. She normally eats twice a day. She is not a fun of taking alcohol or any hard drug and desist her children from it too. On Saturdays she does her washing and some general cleaning around the house

with her children. Later in the day she sends her children to choir practice at their church. Madam S.M. explains to me she joins no society at church neither does she partake in active activity at her church. She said she normally uses her leisure time to read her bible and listen to hymns. On Sundays she goes to church at 8:00am with her children and close at 1:00pm after which she comes home and prepares for the next weekdays. She does some ironing and helps her children with their homework. I observed Madam S.M. was a calm person and did not like to socialize much with her friends as she was always home with her children. She does video calls with husband almost all the time which gave me the opportunity to greet him on several occasions.

1.7 Patient's Past Medical History

Past medical history is a record of past medical problems and treatments that a person has had (Marriam-Webster, 2022). Madam S.M. never had whooping cough, poliomyelitis, measles, tetanus, TB, diphtheria as a child and has no known allergies to medication, animals or insects. Madam S.M. has had stomach ulcer for some time now. She has been admitted at the hospital on several occasions when she experiences severe abdominal pains or has diarrhoea and sometimes malaria. Apart from that she has not had any serious ailment. Madam S.M. has no history of any surgical intervention and no underlying condition.

1.8 Patient's Present Medical/Surgical History

The history of the present illness or problem includes such information as the date and manner (sudden or gradual) in which the problems occurred, the setting in which the problem occurred and the course of the illness including self-treatments, specific symptoms are also described in detail. (Hinkle & Cheever, 2018)

According to Madam S.M. she was well until she started experiencing abdominal pains on 24th November 2022 at 5:00pm. She said the pains started shortly after eating rice with

vegetable sauce she had bought later in the day. Patient took some pain-relieving medication and antacid for the pain but symptoms was still progressing. Patient started having diarrhoea on 25th November 2022, Friday morning accompanied with vomiting. She complained of visiting the toilet for about 10 times that day. Symptoms later was accompanied with headache and fever and said the pain was centred on the epigastric region. She was brought in to the Accident and emergency ward at the Sunyani Municipal hospital around 7:00pm in the evening where she was seen by a prescriber where tests were ordered to be done on the patient and diagnosed of acute gastritis leading to her admission at the female's ward on the same day.

1.9 Admission of Patient

Madam S.M. was admitted on the 25th November 2022 at 9:30pm through the accident and emergency unit to the female ward at the Sunyani Municipal Hospital, with the diagnosis of Acute Gastritis. She came in weak but conscious accompanied by her sister and some nurses. On arrival, patient was welcomed and made comfortable in a chair for vital signs to be checked. The patient hospital card was collected and her admission was confirmed on the computer. She was made comfortable in an admission bed later on and her sister was offered a seat close to the nurse's station. Patient's name was identified and confirmed. At the bedside, patient was introduced to nearby patients. Her vital signs were checked and recorded as follows;

Temperature – 37.9^0c

Pulse – 81 beat per minutes (bpm)

Blood Pressure – 130/108mm/hg

Respiration – 28 cycle per minutes (cpm)

Physical examination on the patient was done from head to toe and patient was in a good body alignment. At the time of admission, assessment revealed abdominal pain (epigastric region) with no palpable mass, high body temperature and general body weakness.

Patient looked anxious. She was reassured to put her thought and anxiety to rest and assured of good quality healthcare. The hospital policies of visiting and bill payment were discussed with the patient and her sister. The patient's sister was given a thorough orientation at the ward and the ward annexes that is the washroom for patients in the ward, nurses station, dustbin to be used by the patients only and shown her bedside table where she can arrange her things to feel comfortable.

An IV line was accessed on her right arm and secured with a plaster. She was to be managed on the following drugs:

- IV Paracetamol 1gram stat
- IV Normal Saline 500mls
- IV Ringers Lactate 2litres
- IV Omeprazole 80mg stat then 40mg bd x 2 days
- IV Ciprofloxacin 400mg bd x 24 hours
- Tab tramadol 500mg bd x 7 days
- Nugel O 15mls tds x 7days

The laboratory investigation ordered for Madam S.M. was as follows

3. Full Blood Count (FBC)
4. Helicobacter Pyloric test

Due to high body temperature, patient was asked to remove extra clothing, she was served cold drinks and intravenous Paracetamol 1g was set up.

I introduced myself to the patient as a final year nursing student at the Holy Family Nursing and Midwifery Training College, Berekum who wants to take her and her family for my care study. Madam S.M. and her family were told that the care study is a requirement for the award of a Diploma in Registered General Nursing by the Nursing and Midwifery council of Ghana. I explained to them that at least three official home visits will be made, after clearly explaining that every information obtained will be treated with outmost confidentiality, I asked for permission to use her and her family for my care study and they agreed. Discharged planning was initiated with the relatives thus they will continue the care at home once she is well. Patient was given a brief education on her condition and why she was manifesting the signs and symptoms associated with her condition and what she should expect from the medical team as part of her treatment regimen and was also assured of competent nursing care. Acute gastritis had recently been reported on several occasions at the hospital, so I wanted to use this opportunity to find the possible causes and give education to Madam S.M. and her family to prevent the condition from occurring again.

1.10 Patient's Concept of the Condition

Madam S.M. did not attribute her illness to any supernatural powers because she said illness can occur at any point in time in an individual's life. She also said it might be due to the rice and vegetable sauce she took that day and her usual intake of caffeinated beverages after explaining some of the risk factor to her. She had no fears concerning her illness as she knew taking of her medication and following set treatment plan would make her well soon.

1.11 Literature Review

This section deals with documented information about the condition of Madam S.M. literature review of a condition gives a detailed insight into the condition. It talks about the

established and laid down facts about the disease condition, which aids in the medical and nursing diagnosis and the appropriate management for that particular disease.

Anatomy and Physiology of Stomach

The stomach is a J-shaped enlargement of the GI tract directly inferior to the diaphragm in the abdomen. (Tortora & Derrickson, 2009) The stomach connects the oesophagus and to the duodenum, the first part of the small intestine. Because a meal can be eaten much more quickly than the intestine can digest and absorb it, one of the functions of the stomach is to serve as mixing chamber and holding reservoir. At appropriate intervals after food is ingested and, the stomach forces a small quantity of the digested food into the duodenum. The stomach has four main regions: the cardia, fundus, body and pyloric part.

The cardia surrounds the opening of the oesophagus into the stomach. The rounded portion superior to and to the left of the cardia is the fundus. Inferior to the fundus is the large central portion of the stomach, the body. The pyloric part is divisible into three regions. The first region, the pyloric antrum connects to the body of the stomach. The second region, the pyloric canal leads to the third region, the pylorus, which connects with duodenum. When the stomach is empty, the mucosa lies in large folds, or rugae, that can be seen with unaided eye. The pylorus communicates with the duodenum of the small intestine via a smooth muscle sphincter called the pyloric sphincter. The concave medial border of the stomach is called the Lesser curvature; the convex lateral border is called the greater curvature.

Functions of the stomach

1. Mixes saliva, food and gastric juice to form chyme
2. Serves as reservoir for food before release into small intestine

3. Secretes gastric juice which contains HCL (kill bacteria and denatures proteins), pepsin (begins the digestion of proteins) intrinsic factors (aids in absorption of vitamin b_{12}) and gastric lipase (aids digestion of triglycerides)
4. Secretes gastrin into blood

Definition

Introduction

According to Feldman M., et al (2018)., Gastritis is a general term for a group of conditions with one thing in common: Inflammation of the lining of the stomach. The inflammation of the gastric mucosa is most often as the result of infection with the same bacterium that causes most stomach ulcers or the regular use of certain pain relievers. Drinking too much alcohol also can contribute to gastritis.

1. Gastritis is the inflammation, irritation, or erosion of the lining of the stomach.

2. Gastritis is an inflammation of the gastric mucosa, is one of the most common problems affecting the stomach.

Types

There are two types of gastritis;

Acute Gastritis

Chronic Gastritis

Acute Gastritis

Gastritis is an inflammation of the gastric or stomach mucosa (Hinkle & Cheever, 2018). It usually comes on suddenly and causes severe or nagging pain. It may be caused by so many factors including; injury, bacterial infection, viral infection, drugs and many others. There are

varying degrees of severity. Mild cases can be asymptomatic or may present with nausea and vomiting associated with inflammatory changes of the gastric mucosa. Erosions can also occur, which are characterised by tissue loss affecting the superficial layers of the gastric mucosa. In more serious cases, there are multiple erosions, which may result in life threatening haemorrhage causing hematemesis (the presence of blood in the vomit) and melena (the presence of blood in the faeces) (Grant, Waugh, & Wilson, 2018)

CHRONIC GASTRITIS

Chronic gastritis is a long-term condition in which mucus lined layer of the stomach also known as the gastric mucosa, is inflamed or irritated over a longer period of time.

This is a condition characterized by prolonged inflammation of the stomach lining (Hinkle & Cheever, 2018). Chronic gastritis usually gets better with treatment, but may need ongoing monitoring.

Epidemiology

Epidemiologic studies reflect widespread of the incidence of gastritis. In the United States, it accounts for approximately 1.8-2.1 million visits to doctors' offices each year

According to El-Nakeep (2023), gastritis affects all age group however the condition is especially common in people older than 60 years.

Pathophysiology

According to El-Nakeep (2023), acute gastritis has a number of causes, including certain drugs; alcohol; bile; ischemia; bacterial, viral, and fungal infections; acute stress (shock); radiation; allergy and food poisoning; and direct trauma. The common mechanism of injury is an imbalance between the aggressive and the defensive factors that maintain the integrity of the gastric lining (mucosa).

Acute erosive gastritis can result from exposure to a variety of agents or factors. This is referred to as reactive gastritis. These agents/factors include nonsteroidal anti-inflammatory drugs (NSAIDs), alcohol, cocaine, stress, radiation, bile reflux, and ischemia. The gastric mucosa exhibits haemorrhages, erosions, and ulcers. NSAIDs, such as aspirin, ibuprofen, and naproxen, are the most common agents associated with acute erosive gastritis. This results from both oral and systemic administration of these agents, either in therapeutic or supratherapeutic doses.

Because of gravity, the inciting agents lie on the greater curvature of the stomach. This partly explains the development of acute gastritis distally over or near the greater curvature of the stomach in the case of orally administered NSAIDs. However, the major mechanism of injury is the reduction in prostaglandin synthesis. Prostaglandins are chemicals responsible for maintaining the mechanisms that result in the protection of the mucosa from the injurious effects of gastric acid. Long-term effects of such ingestions can include fibrosis and stricture formation.

Causes of Acute gastritis

The causes of acute gastritis as described by Hinkle and Cheever, (2018) include;

1. Excessive intake of caffeinated beverages
2. Ingestion of contaminated food or high seasoned food.
3. Excessive alcohol intake
4. Bile reflux
5. Radiation therapy
6. Strong acids or alkali ingestion
7. Autoimmune disease like pernicious anaemia

8. Over use of certain medications like NSAIDs

Clinical Manifestation.

According to the Hinkle and Cheever, (2018) after exposure to the offending substances the patient with Gastritis typically reports a rapid onset of the following signs and symptoms as;

1. Epigastric pain

2. Vomiting

3. Headache

4. Anorexia

5. Nausea.

6. Malaena

7. Heart burns after eating

8. Hematemesis

9. Hiccupping

Other patients remain asymptomatic, the symptoms if present last from few hours to some days.

The patient with chronic gastritis may present similar symptoms as acute gastritis or may have;

1. Belching
2. A sour taste in the mouth

3. Malabsorption of vitamin b12 caused by production of antibodies that interferes with the binding of vitamin b12 to intrinsic factors.
4. Anaemia
5. hypochlorhydria

Assessment and Diagnostic Findings

According to Hinkle and Cheever, (2018), gastritis is sometimes with hypochlorhydria (low level of hydrochloric acid) or with hyperchlorhydria (high level of hydrochloric acid). Diagnosis can be determined by;

1. Clinical history

2. Serologic testing for antibodies to helicobacter Pylori

3. Hemoglobin analysis i.e., hypochlorhydria, hyperchlorhydria.

4. Endoscopy of the gastric mucosa (gastroscopy)

Treatment /Management

According to Grant (2019), the aims of treating gastritis are as follows:

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

Medical Management.

According to Hinkle and Cheever, (2018) states the medical treatment to be given to a person with Acute gastritis are;

1. Proton pump inhibitors such as omeprazole
2. Antibiotics to treat underlying infection.
3. Intravenous fluids to restore lost fluid
4. Analgesics is given to relief patient of pain
5. Anti-emetics to stop the vomiting
6. Antacids to neutralize stomach acid content.

Nursing management

The nursing management of acute gastritis as described by Hinkle and Cheever, (2018) are as follows;

a. Psychological

- There is the need for continuous reassurance of patient and relative about readiness of health care team to help in the treatment of the patient and effectiveness of available medication.

-Educate the patient on the condition that is the causes, signs and symptoms, and medication that would be given to return patient's comfort.

- Allow patient and relatives to ask questions freely and answer tactfully to relieve anxiety.

b. Relieving pain

1. Instruct patient to avoid foods and beverages that may irritate the gastric mucosa to relieve pain and instruct the patient about correct use of medications to prevent chronic gastritis.
2. Assess patient's level of pain and the extent of comfort attained from the use of medications and avoidance of irritating substances.

c. Rest and sleep

1. All nursing procedures to be carried out should be done in calm manner with little or no disturbances to the patient.
2. Bed should be made free from creases and crumbs.
3. Ensure good ventilation by opening all windows
4. Visitors should be allowed only during visiting hours.

d. Observation and monitoring

1. The vital signs should be checked four hourly that is pulse, respiration, temperature and blood pressure, recorded and any deviation reported.

2. Monitor intake and output and record especially when vomiting or diarrhoea persists.

3. Observe patient for therapeutic or adverse effects of administered medication and improvement in condition.

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

e. Diet and Fluid

1. Patient should not take diet / food that is very hot or cold to prevent further inflammation of the mucous membrane.
2. Discourage caffeinated beverages to decrease gastric activity, alcohol and cigarette smoking to enhance neutralization of gastric acid
3. Give enough fluid and roughage to prevent constipation.
4. Infuse intravenous fluids if prescribed and monitor intake and output
5. Adequate fluid and roughage should be given to prevent constipation.

6. Adequate fluid intake should be encouraging to avoid dehydration about 3 to 4 litres daily can be given.
7. Food should be served in bits and attractively as well.

f. Personal Hygiene

1. Patient hygiene should be improved and maintained, mouth care to improve appetite when patient vomits.
2. Patient should bath twice a day to improve her comfort
3. The lips should be kept moist with Vaseline
4. Patients clothing should be changed regularly

g. Psychotherapy

Patient normally react with anxiety if there are abdominal pains. The nurse should allow them to express their fear and then the nurse explain the treatment regimen. The nurses should also reassure patient and relative.

h. Elimination

1. Ensure fluid intake of about 3-4 litre a day. Encourage client for adequate intake of roughage and fruits to promote bowel movement.
2. Monitor patient's bowel movement and assess patient for any abnormality.

i. Health Education

1. Assess patient's knowledge about gastritis.
2. Educate patient as well as relatives on the causes, signs and symptoms and prevention of the condition.
3. Educate patient on avoidance of alcohol, smoking and fatigue.
4. Educate patient on the need for follow up care.

5. Educate patient on the need to avoid very hot or cold food and food that are very spicy.
6. Explain the need for rest, taking a balance diet, sleeping in a well-ventilated room, taking in a lot of water and taking of prescribed drugs even when the signs and symptoms have stopped to the patient or relatives

Prevention

Certain simple points can be followed to reduce the risk of developing gastritis, (Hinkle & Cheever, 2018),. These include;

1. Wash your hands with soap and water regularly and before meals. This can reduce the risk of being infected with helicobacter pylori
2. Cook food thoroughly to reduce risk of infection.
3. Avoid alcohol or limit your alcohol intake.
4. Avoid NSAIDs and use of over the counter drugs. Consume NSAIDs with food and water to avoid symptoms.

Complication

Hinkle and Cheever, (2018), outlined the following as the complications of acute gastritis;

1. Chronic gastritis: This is a common complication of acute gastritis which results after repeated episodes of acute gastritis, where the stomach lining is damaged long term, often due to infection by H. pylori.
2. Anaemia: If left untreated, acute gastritis can cause serious problems like anaemia that is when H. pylori causes gastritis or stomach ulcers erodes the gastric epithelium leading to loss of parietal cells which produces the intrinsic factors (sores in your stomach) there is bleeding thereby lowering your red blood counts causing anaemia.

3. Pyloric stenosis: This occurs when the is repeated inflammation of the pylorus from the gastritis leading to scar formation that causes narrowing of the opening. Food is then blocked from entering the small intestine. It occurs more often in males.
4. Malignant changes of gastric mucosa: When left untreated, gastritis may lead to stomach ulcers and bleeding. Rarely, some forms of chronic gastritis may increase your risk of stomach cancer, especially if there is extensive thinning of the stomach lining and changes in the mucosa cells.
5. Haemorrhage or bleeding from an erosion or ulcer: Bleeding occurs in chronic gastritis when there is h. pylori infection which causes a sore that erodes into the stomach mucosa.

1.12 Validation of Data

This is the cross-check data obtained from the patient and its free from biases, misconception and errors as much as possible. All data collected from the patient was confirmed by patient's reliable family, textbooks and health team which includes medical doctors, nurses, laboratory investigation and valid medical records. This shows that the data was free from bias and misinterpretations as data was compared with that of literature review. It was however proven that Madam S.M. had developed Acute Gastritis.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

According to Leyland (2022), analysis is the detailed study or examination of something in order to understand more about it. Analysis of data is the second phase in the nursing process. Analysis in the nursing process is the breakdown of relevant information into simply component which helps in decision making to ensure individualized nursing care. During the data gathering phase, nurses obtain a great deal of information about their patient. This chapter also deals with the patient and family strength, their problems and the interpretation of the data collected during assessment of the patient. The data is then grouped so that problems can be identified and their cause discerned.

2.1 Comparison of Data with Standards

Data collected on and from patient were compared with those of the literature review in terms of diagnostic investigation, causes, signs and symptoms, treatment and complications. This was done to identify any deviation from normal.

A. Diagnostic Investigation

Diagnostic investigations are various examinations conducted on the patient to find any deviations from normal.

1. Full Blood Count (FBC)
2. Helicobacter Pylori test

Table 1: Comparison of Investigations Requested for Patient with Literature Review

Investigation from literature review	**Patient investigation ordered**
Clinical history	Assessed
Helicobacter pylori test	Requested
Blood test	Requested
Endoscopy	Not requested

Information from the above table indicates that only two of the investigation prescribed by the literature review were ordered for the patient, endoscopy was not requested because the diagnosis was concluded from the history taken.

Table 2: diagnostic Investigation done for madam S.M.

Date	Specimen	Investigation	Results	Normal Valves	Interpretations	Remarks
25/11/2022	Blood	**FULL BLOOD COUNT** Haemoglobin level estimation	11.9g/dl	Female: 11 -16g/dl Male 14 – 18g/dl	Within normal	Patient is not anaemic
		White blood cells count	12.8 x [$10^{\wedge 3}$/µl]	4.0-11.0 [$10^{\wedge 3}$/µl]	Above normal ranges indicates the presence of an infection	Patient has an infection. Antibiotics was given.
		Lymphocyte count	34.1%	25 – 40%	Within normal range	No treatment given
		Monocyte count	5.6%	3 – 7%	Within normal range	No treatment given
		Granulocyte count	55%	50% - 70%	Within normal range	No treatment given

		Platelets count	266x10^3g/dl	150 – 450x10^3g/dl	Within normal range	No treatment given
25/11/20 22	Blood	Helicobacter Pylori test	Negative	Negative	This confirms patient does not have h pylori infection	No treatment was given

B. Causes of Patient's Illness

With reference to the literature review and from the information gathered, Madam S.M.'s condition was caused from ingestion of contaminated food and high seasoned food and prolonged intake of caffeinated beverages.

TABLE 3: Comparison of Clinical Features of Patient's to that of literature review presentation

Clinical Features According to the Literature Review	**Clinical Features Exhibited by Patient**
Severe epigastric pains	Patient complained of severe abdominal pain
Vomiting	Patient experienced vomiting
Headache	Patient complained of headache
Anorexia	Patient experienced anorexia
Nausea	Patient experienced nausea
Malaena	Not presented by patient
Heartburns after eating	Patient did not experienced heartburns
Hematemesis	Patient did not experience hematemesis
Hiccupping	Patient did not experience hiccup
Diarrhoea	Patient did experience diarrhoea

Fever	Patient's temperature was above normal range (37.9)

With reference to the table above, patient experienced most of the clinical manifestations in the literature review indicating that her diagnosis that is Acute gastritis was rightly proven.

C. Medical treatment given to patient

According to Macmillan English dictionary for advanced learners, treatment is something that health care providers do for their patients to control a health problem, lessen its symptom or clear it up. Treatment can include medicine therapy surgery or other approaches. The medical treatment given to Madam S.M. were as follows

- IV Paracetamol 1gram stat
- IV Normal Saline 500mls
- IV Ringers Lactate 2litres
- IV Omeprazole 80mg stat then 40mg bd x 2days
- IV Ciprofloxacin 400mg bd x 24 hours
- Tab tramadol 500mg tds x 7days
- Nugel O 15mls tds x 7 days

TABLE 4: Comparison of Drugs Given to Madam S.M. to that in the Literature Review

Drugs In Literature Review	**Drugs Given to The Patient**
Proton pump inhibitors; e.g., Omeprazole, Lansoprazole	Intravenous Omeprazole 80mg stat, then 40mg bd ×48hours was given.
Antibiotics; e.g., Metronidazole, Cefuroxime, Ceftriaxone	• Intravenous ciprofloxacin 400mg bd x24hour was given
Intravenous fluids ; e.g., Normal saline, Ringer's lactate, Dextrose saline	• Normal saline 500mls was given • Ringer's lactate 500mls was given
Analgesics to relief pain and antipyretic. e.g., Tramadol and paracetamol	Tab Tramadol 50mg tds×7days was given IV paracetamol 1g
Anti-emetics to stop vomiting	No anti-emetics was given to patient
Antacids to neutralize stomach acid content; e.g., Magacid, Nugel	Suspension Nugel O 15mls tds×7days

From comparison in the table 4, there is clear indication that treatment given was in line with the standard treatment for the condition and contributed to her recovery

Table 5: Shows the details of the pharmacology of drugs administered to Madam S.M. during hospitalization

Date	**Drug**	**Standard dosage/route administration**	**Dosage/ route given to patient**	**Classification**	**Desired effect**	**Actual effect observed**	**Side effect/remarks**
25/11/22	Intravenous Ciprofloxacin	**Adult dosage:** 400mg every 12hours **Children**: 10mg every 24hours **Can be given**: Intravenous OR oral	Ciprofloxacin IV **Dosage**: 400mg bd x 24 hours **Route:** Intravenous	Quinolone Antibiotics	Acts on the bacterial DNA gyrase. Ciprofloxacin targets the alpha subunits of the DNA gyrase preventing it from supercoiling the bacterial DNA	Patient infection was treated	Diarrhoea, Nausea, dizziness, light headedness, headache and insomnia may occur None of the above side effect

					which prevents DNA replication thus stopping the growth of the bacteria		was observed on patient.
25/11/22	Intravenous Omeprazole	The dosage depends on the severity of the condition. **Adult dose**; 37.6 to 50mg. **Children dose** (1-16) 0.2 to 3.5	Intravenous omeprazole 80mg as a stat dose then 40mg bd for 2 days x 24 hour **Route:** Intravenous	Proton pump inhibitor	Inhibit gastric acid by blocking the hydrogen potassium adenosine triphosphate enzyme system at the gastric parietal cells.	Patient was relieved of abdominal pain.	Nausea, Vomiting, flatulence, headache. None occurred.

		Duration; 20:30 minutes. Can be given orally and intravenous,					

Date	**Drug**	**Standard dosage/route of administration**	**Dosage/route given to patient**	**Classification**	**Desired effect**	**Actual effect observed**	**Side effect/remarks**
25/11/2022	Intravenous Normal Saline	Dosage is variable depending on the person's fluid or electrolyte requirement and age. It is given intravenously	Intravenous normal saline 2 litres x 24 hours Route: intravenous	Crystalloid	To provide energy prevents hypoglycaemia and to maintain fluid and electrolyte balance	Patient's electrolyte balance was maintained and there were no signs of dehydration.	Oedema, aggravation of heart failure and hyperthermia. None was observed

26/11/2022	Syrup Nugel O	**Adult dose;** 10 – 20ml three times daily between meals and at bedtime **Children dose;** (5-12 years) 5-10ml.	Suspension mixed magnesium Trisilicate 15mls tds for 7 days **Route:** oral	Antacid	For the neutralization of hydrochloric acid secreted by gastric parietal cells	Symptomatic relief of gastritis was achieved	Mild diarrhoea, stomach cramps, belching were not observed.

Date	**Drug**	**Standard dosage/route administration**	**Dosage/route given to patient**	**Classification**	**Desired effect**	**Actual effect observation**	**Side effect/remarks**
25/11/2022	Ringer's lactate	Depends on patient condition and it's calculated by estimated fluid loss and presumed fluid deficit	Intravenous ringer's lactate 1litre x24 hours **Route:** intravenous	Crystalloids	To maintain fluid and electrolyte balance	Patient regained strength and fluid and electrolyte balance were maintained	Chest pain, abnormal heart rate, cough and itching None occurred
26/11/2022	Tablet Tramadol	**Adult dose;** 25mg, should not be more	Tab tramadol 500mg tds×7days	Opioid analgesics	It modulates the descending pain pathway within the	Madam S.M. was relived of pain	Nausea, Dry mouth, Constipation, Drowsiness

		than 400mg per day **Children dose;** not to be used in children younger than age 12 **Route:** intravenous or oral	**Route:** Oral		central nervous system through the binding of opioid receptors and the weak inhibition of the reuptake of norepinephrine and serotonin.		None occurred

Date	**Drug**	**Dosage/ route administration**	**Dosage / route given to patient**	**Classification**	**Desired effect**	**Actual effect observed**	**Side effect / remarks**
25/11/2022	Paracetamol	**Dosage;** **Adult dosage;** 500mg – 1g **Children** dosage; syrup 250mg in 5mls Tablet 250mg - 500mg **Route:** Orally or intravenous	Intravenous paracetamol 1g was given to patient **Route:** intravenous	Non opioid and antipyretic agent	Paracetamol is a weak inhibitor of prostaglandin synthesis in COX-1 and COX-2. It exerts central action which ultimately lead to the alleviation of pain symptom and relieve of fever thus acting as antipyretic	Patients high body temperature reduced to normal range.	Flushing, low blood pressure and tachycardia Non occurred in patient.

D. Patient's Complication

With reference to the complication listed in the literature review, Madam S.M. had no complication, due to prompt medical attention, accurate treatment and appropriate care.

2.3 Patient and family strength

Strength as defined as the ability of a muscle or a person to produce or resist a physical or psychological force, (Weller, 2014). This is explained as the ability of the client or her family to help or participate in the care for the achievement of set goals. Among many things that contributed to patient's speedy recovery were the strength of the patient and family. Below are the strengths identified from the patient and family throughout her period of hospitalization:

1. Patient could verbalize intensity and location of the pain
2. Patient allowed herself for tepid sponging
3. Patient could take in liberal fluids which protected her from dehydration
4. Patient and family were cooperative with the treatment plan
5. Patient could eat at least 5 spoons of rice and stew served
6. Patient and family were ready and willing to learn more about the disease condition.

2.4 Health Problem of patient and family

Problems is any health care conditions that requires medical, psychological, diagnostic therapeutic or educational intervention (Weller, 2014). It also refers in nursing to any unmet or partially met basic human need. The patient and family's problem means the difficulties they faced because of the disease condition. The following were the actual and potential health problems identified in the patient during the period of hospitalization;

1. Patient complained of abdominal pains (25/11/1022)
2. Patient had an increased body temperature (25/11/2022)

3. Patient complained of persistent passing of diarrhoea stools (25/11/2022)
4. Patient and family were anxious (25/11/2022)
5. Patient complained of loss of appetite as a result of anorexia (26/11/2022)
6. Patient and relatives had inadequate knowledge about the disease condition (26/11/2022)

2.5 Nursing Diagnosis

A nursing diagnosis according to North American Nursing Diagnosis Association (2022) is a clinical judgement concerning a human response to health condition process or vulnerability for the response by an individual, family, group, or community. It is a clear concise and definite statement of the patient health status that can be influenced by nursing interventions.

1. Acute abdominal pain (epigastric region) related to inflammation of gastric mucosa. (25/11/2022)
2. High body temperature (37.9^0c) related to gastric inflammatory process. (25/11/2022)
3. Risk for fluid and electrolyte volume deficit related to frequent diarrhoea stools. (25/11/2022)
4. Anxiety related to unknown outcome of disease condition as evidence by patient being quiet and having a gloomy look. (25/112022)
5. Nutritional imbalance less than body requirement related to loss of appetite. (26/11/2022)
6. Deficient knowledge related to inadequate information on acute gastritis, its causes and management. (26/11/2022)

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 Introduction

This is the third face of the nursing process. Planning is the act of prioritizing the patient's health problems in order to render optimal care to her. It involves the use of the nursing process which is a systematic method by which the nurse, patient and family work hand in hand to identify actual and potential health needs that should be managed through effective nursing care. Planning ensures continuity of care and directs the nurse as to what should be done first.

3.1 Patient/ Family Care Objective/Outcome Criteria

1. Patient would be relieved of pain within 24hours as evidenced by
    a. Patient verbalizing that she does not feel any pain
    b. Nurse visualizing patient wearing a cheerful facial expression.
2. Patient's body temperature would return to the normal range (36.2 – 37.2) within 4 hours as evidenced by
    a. Patient body temperature dropping to the normal range (36.2 – 37.2)
    b. Nurse recording normal body temperature values of patient's body temperature
3. Patient would maintain a normal fluid and electrolyte balance within the period of admission as evidenced by
    a. The patient verbalizing that she has a normal bowel movement
    b. Nurse observing Patient having a normal skin turgor
4. Patient and family would be free of anxiety in 24hours as evidenced by
    a. Patient and family verbalizing that they are no more anxious
    b. Nurse observing the patient interacting with other patient and putting on a cheerful facial expression

5. Patient nutritional status would improve within 72hours as evidenced by
    a. Patient verbalizing, she has an improved appetite
    b. Nurse observing patient eat more than half of meal served

6. Patient and relatives would gain adequate knowledge on the causes, signs and symptoms and prevention of acute gastritis within 3 hours as evidenced by:
    a. Patient and relatives being able to talk more about the condition including its causes, signs and symptom and prevention of the condition
    b. Nurse observing client being able to answer questions correctly concerning the condition

Table 5: Nursing Care Plan for Madam S.M. and Family

Date/ Time	**Nursing Diagnosis**	**Objective/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Sign**
25/11/2022 9:40pm	Acute abdominal pain (epigastric region) related to inflammation of gastric mucosa	Patient would be relieved of pain within 24hours as evidenced by a. patient verbalizing that he does not feel any pain	1. Reassure patient of competent nursing care 2. Assess the level of pain by using the pain rate scale (0-10) 3. Monitor factors that worsens or relieve patient's pain	1. Patient was reassured of competent nursing care. 2.Patient's level of pain was assessed to know the severity of the pain. 3. Factors that worsens and relieved patient's pain were checked to know the cause of the pain.	26/11/2022 9:40pm	Goal fully met as patient verbalized a reduction in pain and nurse observed the patient has a cheerful facial expression.	M.A. K. A

		b. Nurse visualizing patient wearing a cheerful facial expression	4. Assist patient into a comfortable position in bed 5. Educate patient to avoid intake of spicy diet 6. Administer prescribed medication	4.Patient was assisted into a left lateral position in bed 5. Patient was encouraged to avoid spicy diet to prevent further injuries. 6. Prescribed medication (iv omeprazole, tablet tramadol) were administered to patient.			

Table 5: Nursing Care Plan for Madam S.M. and Family

Date and Time	**Nursing Diagnosis**	**Nursing Objectives/Outcome criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/Time**	**Evaluation**	**Sign**
25/11/2022 9:50pm	High body temperature related to gastric inflammation process (37.9)	Patient body temperature will fall to normal range within 4 hours as evidenced by; 1.patient not feeling feverish 2. nurse recording normal values on	1. Reassure patient. 2.Tepid sponge patient. 3. Open windows to ensure good ventilation.	1.Patient was reassured 2. Madam S.M. was tepid sponged 1hourly. Body temperature dropped to 36.7. 3. Near windows were opened to allow for good ventilation.	26/11/2022 1:50am	Goal fully met, as patient's body temperature was normal and patient was not feverish and nurse recorded 36.7 as patient	M.A.K.A.

		patient body temperature	4. Serve cold drinks to patient. 5. Take of extra clothing. 6. Serve prescribed medication to patient	4. Cold drinks were given to patient to cool temperature. 5. Madam S.M. extra clothing was removed to allow for good ventilation. 6. Antipyretic medication was administered to patient (tab paracetamol).		body temperature.	

Table 5: Nursing Care Plan for Madam S.M. and Family

Date and Time	**Nursing Diagnosis**	**Nursing Objectives/Outcome criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/Time**	**Evaluation**	**Sign**
25/11/2022 10:00pm	Risk for fluid and electrolyte volume deficit related to diarrhoea	Patient would maintain a normal fluid and electrolyte balance within the period of admission as evidenced by: a. Patient verbalizing that she has normal movement of bowel	1.Reassure patient of competent care. 2.Evaluate the pattern of defecation and stool consistency 3.Weigh patient daily	1.Patient was reassured that her condition will get better soon due to competent care. 2.Patient's bowel movement pattern was evaluated and recorded daily 3.Patient was weighed daily with no significant changes detected.	29/11/2022 11:00am	Goal fully met, as patient maintained an elastic skin turgor and nurse observed that patient had a	M.A.K.A

		b. Nurse observing patient having a normal skin turgor	4.Evaluate for signs of dehydration. 5.Monitor fluid intake and output daily 6.Monitor vital signs at regular intervals. 7.Encourage patient to take in more copious fluids. 8.Administer prescribed intravenous fluids.	4.Patient was evaluated for signs of dehydration by observing skin turgor and observe for thirst, dizziness and symptoms of shock. 5.Patient was put on strict intake and output monitoring chart daily. 6.Vital signs were checked and recorded every 4hours. 7.Patient was encouraged to take in copious fluids at regular intervals 8.Prescribed intravenous fluid (ringer lactate and normal saline) were administered.		normal skin turgor.	

Table 5: Nursing Care Plan for Madam S.M. and Family

Date and Time	Nursing Diagnosis	Nursing Objectives/Outcome criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
25/11/2022 10:30 pm	Anxiety related to unknown outcome of disease condition as evidence by patient being quiet with a gloomy look.	Madam S.M. and relatives would be free of anxiety within 24 hours as evidenced by; 1. A.V verbalizing that she is no more anxious. 2. Nurse observing that patient interacting with other patient and	1. Reassure the patient and family to alley anxiety. 2.Orientate patient to the ward environment and equipment. 3.Educate patient on disease condition	1. Patient and family were reassured to alley anxiety and fears. 2.Patient was orientated to the ward environment and equipment. 3.Patient was educated on the causes, clinical manifestations, diagnosis and treatment of peptic ulcer disease, starting from the known to the unknown.	26/11/2022 10:30pm	Goal fully met as patient verbalizing that she is no longer anxious and nurse observe patient calm in bed with	M.A.K.A

		putting on a cheerful facial expression.	4.Encourage patient to ask questions for clarifications 5. Maintain a quiet environment such as noise which can cause irritation. 6. Introduce patient to patients who have undergone similar treatment.	4.Patient was encouraged to ask questions for clarifications. 5. A quiet environment was maintained to avoid irritation. 6. Patient was introduced to patient who have undergone same treatment to serve as motivation.		a relaxed facial expression.	

			7.Encourage the use of diversional therapy.	7.Diversional therapy like music was introduced to divert him from being anxious.			

Table 5: Nursing Care Plan for Madam S.M. and Family

Date and Time	**Nursing Diagnosis**	**Nursing Objectives/Outcome criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/Time**	**Evaluation**	**Sign**
26/11/2022 9:00am	Nutritional imbalance (less than body requirement) related to loss of appetite.	Patient's nutritional status would improve within 72hours as evidenced by a. patient verbalizing, she has an improved appetite. b. nurse observing patient can eat	1. Assess for signs and symptoms of malnutrition. 2.Plan menu with patient to stimulate appetite.	1. Signs and symptoms of malnutrition such as weakness were assessed. 2.Menu was planned with patient and dietician to stimulate appetite. Patient gave his preferred food which were modified.	29/11/2022 9:00am	Goal fully met as nurse observe patient eat More than half of food served and patient verbalizing she could eat well.	M.A.K.A

		half of food served.	3.Encourage the intake of non-irritating fruits such banana and pawpaw 4. Remove all nauseating items from patient's bedside. 5.Serve small frequent meal 6.Encourage copious fluid intake.	3.Intake of non-irritating fruits such banana and pawpaw was encouraged. 4. All nauseating items such vomitus bowl and sputum mug were removed from patient's site to prevent nausea when eating. 5. Foods were attractively served. 6. Patient was encouraged to take in more copious fluids.			

			7. Encourage patient to practice oral hygiene twice daily.	7. Patient was encouraged to perform oral hygiene twice a day to prevent loss of appetite.			

Date and time	Nursing diagnosis	Nursing objectives/outcome criteria	Nursing orders	Nursing Intervention	Date / Time	Evaluation	Sign
26/11/2022 10:30am	Deficient knowledge related to inadequate information on acute gastritis, its causes and management.	Patient and relatives would gain adequate knowledge on the causes signs and symptoms and prevention of acute gastritis within 3 hours as evidenced by: a. Patient and relatives being able to tell more about the condition including causes, signs and symptoms and	1. Reassure the patient and relatives. 2. Assess patient and relative's knowledge on the condition 3. Educate patient and relatives on the condition.	1. Patient and relatives were reassured that the education will be in simple terms for their understanding. 2. Patient and relative were asked questions about the condition to assess their knowledge of it. 3. Patient and relatives were educated on acute gastritis, its causes, signs and symptoms and management regimen.	26/11/2022 1:30pm	The goal was fully met as; The patient and relatives being able to tell more about the condition including its causes, signs and symptoms and prevention of	M.A.K.A.

		prevention of the condition. b.The nurse asking patient and relatives questions about the condition and they answering them correctly.	4. Allow patient and relatives to ask questions and express their concerns and answer them tactfully 5. Ask patient and relatives feedback 6. thank patient and relatives for their attentiveness and cooperation	4. Patient and relatives were allowed to asked questions of which they answered tactfully and their concerned were addressed. 5. Patient and relative were asked for feedback and they were able to explain the condition, it causes and treatment. 6. They were thanked for their attentiveness and cooperation.		the condition. Nurse also observing patient being able to answer questions correctly concerning the condition.	

CHAPTER FOUR

IMPLEMENTING PATIENT/FAMILY CARE PLAN

4.0 Introduction

Implementation of patient's and family care plan is the fourth stage of the nursing process. Implementation is the giving of care in relation to defined nursing intervention and goals (Weller, 2014). It refers to the administration of the nursing orders necessary to fulfil the goals and objectives drawn out on patient and family care plan. It is aimed at alleviating all the identified health problems that the patient/family presented from day of admission to day of discharge and it includes all the nursing care that are initiated and carried out to enhance early recovery without complications. During implementation the nursing care plan is tested for effectiveness and accuracy. Data gathering continues and plan may change on the basis of new information obtained. The implementation phase concludes with recording of the activities performed and the patient response to the treatment given.

4.1 Summary of Actual Nursing Care Rendered to the Patient and Family

Nursing care rendered to Madam S.M. started from the day of admission which was 25/11/2022 and continued till she was discharged on 29/11/202 and ended on 18th December, 2022 when care was terminated and she was handed over to the community nurse.

Nursing care was aimed at ensuring comfort of the patient and to promote his recovery by making him free from all symptoms with no complications. The nursing care plan is organized on daily basis as follows;

First Day of Admission (25th November 2022)

Madam S.M. was admitted on the 25th November 2022 at 9:30pm through the accident and emergency unit to the female ward at the Sunyani Municipal Hospital, with the diagnosis of

Acute Gastritis. She came in weak but conscious accompanied by her sister and nurses. On arrival, patient was welcomed and made comfortable in a chair for vital signs to be checked. The patient hospital card was collected and her admission was confirmed on the computer. She was made comfortable in an admission bed later on and her sister was offered a seat close to the nurse's station. Patient's name was identified and confirmed. At the bedside, patient was introduced to nearby patients. Her vital signs were checked and recorded as follows;

Temperature – 37.9^0c

Pulse – 81 beat per minutes (bpm)

Blood Pressure – 130/108mm/hg

Respiration – 28 cycle per minutes (cpm)

Physical examination on the patient was observed from head to toe and patient was in a good body alignment. At the time of admission, assessment reviewed abdominal pain (epigastric region) with no palpable mass, high body temperature and general body weakness.

Patient looked anxious. She has reassured to put her thought and anxiety to rest and assured of good quality healthcare. The hospital policies of visiting and bill payment were discussed with the patient and her sister. The patient's sister was given a thorough orientation at the ward and the ward annexes that is the washroom for patients in the ward, nurses station, dustbin to be used by the patients only and shown her bedside table where she can arrange her things to feel comfortable.

An IV line was accessed on her right arm and secured with a plaster. She was to be managed on the following drugs:

- IV Paracetamol 1gram stat
- IV Normal Saline 500mls

- IV Ringers Lactate 2litres
- IV Omeprazole 80mg stat then 40mg bd x 2 days
- IV Ciprofloxacin 400mg bd x 24 hours
- Tab tramadol 500mg bd x 7 days
- Nugel O 15mls tds x 7days

The laboratory investigation ordered for Madam S.M. was as follows

5. Full Blood Count (FBC)
6. Helicobacter Pyloric test

Due to high body temperature, patient was asked to remove extra clothing, she was served cold drinks and intravenous Paracetamol 1g was set up.

I introduced myself to the patient as a final year nursing student at the Holy Family Nursing and Midwifery Training College, Berekum who wants to take her and her family for my care study. Madam S.M. and her family were told that the care study is a requirement for the award of a Diploma in Registered General Nursing by the Nursing and Midwifery council of Ghana. I explained to them that at least three official home visit will be made, after clearly explaining that every information obtained will be treated with outmost confidentiality, I asked for permission to use her and her family for my care study and they agreed. Discharged planning was initiated with the relatives thus they will continue the care at home once she is well. Patient was given a brief education on her condition and why she was manifesting the signs and symptoms associated with her condition and what she should expect from the medical team as part of her treatment regimen and was also assured of competent nursing care. Acute gastritis has recently been reported been reported on several occasions at the hospital, so I wanted to use this opportunity to find the possible causes and give education to Madam S.M. and her family to prevent the condition from occurring again.

On admission at 9:40 patient complained of abdominal pain (epigastric region) hence a nursing diagnosis of acute abdominal pain (epigastric region) related to inflammation and hypersecretion of hydrochloric acid (HCL) was formulated. An objective was set to relieve patient of abdominal pain within 24hours. The following nursing intervention were then implemented; Patient's level of pain was assessed to know the severity of the pain, factors that worsens and relieved patient's pain were checked to know the cause of the pain, patient was assisted into a left lateral position in bed, patient was encouraged to avoid spicy diet to prevent further injuries, prescribed medication (iv omeprazole, tablet tramadol) were administered to patient, patient was reassured of competent nursing care.

At 9:50pm, patient had a high body temperature so a nursing diagnosis of high body temperature related to gastric inflammation process was formulated hence, an objective was set to restore patient's body temperature to normal range (36.2-37.2^{0}c) within 4 hours. The following intervention were implemented; Patient was reassured. Madam S.M. was tepid sponged 1hourly. Body temperature dropped to 36.7. Near windows were opened to allow for good ventilation. Cold drinks were given to patient to cool temperature. Madam S.M. extra clothing was removed to allow for good ventilation. Antipyretic medication was administered to patient (tab paracetamol).

At 10:00pm, patient complained of persistent passing of diarrhoea stools. Therefore, a nursing diagnosis of risk for fluid and electrolyte imbalance related to diarrhoea was formulated. An objective was set to maintain a balance fluid and electrolyte for the patient within the period of admission. The following interventions were implemented; Patient was reassured that her condition will get better soon due to competent care. Patient's bowel movement pattern was evaluated and recorded daily. Patient was weighed daily with no significant changes detected. Patient was evaluated for signs of dehydration by observing skin turgor and observe for thirst, dizziness and symptoms of shock. Patient was put on strict intake and output monitoring chart

daily. Vital signs were checked and recorded every 4hours. Patient was encouraged to take in copious fluids at regular intervals. Prescribed intravenous fluid (ringer lactate and normal saline) were administered.

At 10:30pm patient and family were very anxious due to unknown outcome of disease. An objective was set to relieve patient and family of anxiety within 24 hours. The following nursing intervention were then implemented; Patient and family were reassured to alley anxiety and fears. Patient was orientated to the ward environment and equipment. Patient was educated on the causes, clinical manifestations, diagnosis and treatment of peptic ulcer disease, starting from the known to the unknown. Patient was encouraged to ask questions for clarifications. A quiet environment was maintained to avoid irritation. Patient was introduced to patient who have undergone same treatment to serve as motivation. Diversional therapy like music was introduced to divert him from being anxious.

Madam S.M. was given warm milo and bread to eat even though she insisted on not having the appetite and slept around 11:30pm.

Second day of Admission 26/11/2022

On 26th November, 2022 at 1:50am, evaluation of the set objective on 25th November, 2022 at 8:00pm to reduce patient body temperature within normal range (36.2^0c – 37.2^0c) within 4 hours was done and goal was fully met as evidenced by patient's temperature falling within the normal range and patient was no longer feverish and nurse recorded 36.7^0c as patient's body temperature.

Madam S.M. woke up at 6:00am and took an unassisted bath. She brushed her teeth with a toothpaste and toothbrush. Her bed was laid and her locker cleaned in the morning, patient slept well after her prescribed medication was given to her of which Madam S.M. confirmed. She was reviewed by doctors and requested to continue with the treatment.

At 9:00am patient complained of loss of appetite hence a diagnosis of nutritional imbalance less than body requirement related to loss of appetite (anorexia) was formulated. An objective was set for patient to be able to attain and maintain adequate nutrition within 72 hours. The following intervention were implemented; Signs and symptoms of malnutrition such as weakness were assessed. Menu was planned with patient and dietician to stimulate appetite. Patient gave his preferred food which were modified. Intake of non-irritating fruits such banana and pawpaw was encouraged. All nauseating items such vomitus bowl and sputum mug were removed from patient's site to prevent nausea when eating. Foods were attractively served. Patient was encouraged to take in more copious fluids. Patient was encouraged to perform oral hygiene twice a day to prevent loss of appetite.

She was reviewed by doctors that morning at 10:00am and the plan was that patient should continue with the treatment.

At 10am vital signs were checked and recorded as follows:

Blood pressure (Bp): 110/70mmHg

Respiration (R): 21 cpm

Pulse rate (P): 80 bpm

Temperature (T): 36.7 °C

At 10:30am, it was assessed that patient had little knowledge of her condition, hence the nursing diagnosis of deficient knowledge related to inadequate information on acute gastritis, its causes and management was formulated. An objective was set for patient and family to gain adequate knowledge on the causes, signs and symptoms and prevention of acute gastritis within 3 hours. The following interventions were implemented; Patient and relatives were reassured that the education will be in simple terms for their understanding. Patient and relative were

asked questions about the condition to assess their knowledge of it. Patient and relatives were educated on acute gastritis, its causes, signs and symptoms and management regimen. Patient and relatives were allowed to asked questions of which they answered tactfully and their concern were addressed. Patient and relative were ask for feedback and they were able to explain the condition, it causes and treatment. They were thanked for their attentiveness and cooperate

At 1:30pm, evaluation of the set objective to help patient and family gain knowledge on acute gastritis that is the causes, signs and symptoms and prevention of it within her period of hospitalization was done and goal was fully met as evidenced by patient and family being able to talk more about the condition including its causes, signs and symptom and prevention of acute gastritis.

Madam S.M. took her afternoon medication at 2pm and vital signs were checked and recorded.

Madam S.M. took banku and okro stew at 3pm. She was then given banana and apple as desert. She took her rest around 4:00pm. At 4:30pm she had some visitors but since she was resting, they were not allowed to disturb her.

Vital signs were also checked and recorded at 6:15pm, drugs were served as prescribed. She then had supper at 6:30pm. I congratulated her after eating. Patient was reassured and she took a Milo drink at 7:30pm. Since she had already taken her bath, she brushed her teeth and a conducive environment was created for her to induce sleep.

At 9:40pm, evaluation of set objectives on 25th November, 2022 to regain patient body comfort was done and goal was fully met as patient verbalized reduction in pain in the abdomen and nurse observed patient had a cheerful facial expression.

At 10:00pm, vital signs were cheeked and recorded.

At 10:30pm, evaluation of set objectives on 25th November,2022 to relieve patient and family of anxiety was fully met as patient verbalized that she is no longer anxious and nurse observe patient calm in bed with a relaxed facial expression.

Patient slept around 10:40pm.

Third day of admission 27/11/2022

On the third day of her admission, her condition was starting to improve. Madam S.M. took her bath and had oats and bread as breakfast. Her bed linen was straightened afterwards. She was reassured that she will be well in some few days.

At 10am her Vital signs were checked and recorded as follows:

Blood pressure (Bp): 110 / 70mmHg

Respiration (R): 20 cpm

Pulse rate (P): 82 bpm

Temperature (T): 36.1 °C

During Doctors rounds, patient was reviewed and asked to continue her drug regimen.

At 1:10pm I discussed with her sister about my home visit the next day as I had already established a trusting relationship with the patient and her sister.

Vital signs were checked and recorded at 2:00pm. Patient was also served prescribed medication in the afternoon. Madam S.M. was able to eat most of her afternoon meal as compared to the previous day. She was encouraged to take a nap after eating.

At 6:00pm vital signs were checked and recorded as shown in the appendix

At 10:00pm, vital signs were checked and recorded. Patient was made comfortable in bed and she slept around 10:30pm.

Fourth day of admission 28/11/2022

Madam S.M. woke up around 6am and took her bath. Madam S.M.'s general condition was satisfactory and she was eager to be discharged because she missed her boys at home. She took Hausa kooko and koose for breakfast. At 10am her vital signs were checked and recorded as follows;

Blood Pressure (BP): 105/68 mmHg

Respiration (R): 20 cpm

Pulse rate (P): 76 bpm

Temperature (T): 36.7 °C

During Doctors rounds, the medical officer informed Madam S.M. of her possible discharge the next day. Patient made no complaint that day. I went on a home visit on this same day around 12:30pm and returned around 2:00pm**.**

At 2:00pm, her vital signs were checked and recorded as shown in the appendix.

Madam S.M. took fufu and light soup as supper and was encouraged to take some fruits after. Vital signs were checked and recorded and her due medications were served.

At 10:00pm vital signs were checked and recorded. Patient was made comfortable in bed and slept around 10:30pm.

Fifth day of admission 29/11/2022

Madam S.M. woke up around 6am and took an unassisted bath. Her general condition was very good; she went about her task at the hospital with eagerness. Madam S.M. took warm milo with two slices of bread as her breakfast. Her vital signs were checked and recorded as follows;

Blood Pressure (BP): 120/70mmHg

Respiration (R): 21 cpm

Pulse rate (P): 78 bpm

Temperature (T): 36.2 °C

At 9:00am, evaluation of the set objective on 26th November,2022 to help patient attain and maintain adequate nutrition within 72 hours was done and goals was fully met as nurse observed patient eat more than half of the food served and patient verbalizing, she could eat well.

At 10am during the Doctors rounds, she was discharged by the medical officer and was scheduled for review on the 6th December 2022. She was to continue her medications in the house. I called her sister on phone to inform her of the discharge and she came to the hospital to settle their bills. I took her hospital card together with her insurance card to the accounts department for billing. I then went to the pharmacy to take her discharged medication. I discharged her in the admission and discharge book. Patient was educated to wash her hands with soap and water regularly and before meals. She was educated to cook food thoroughly to reduce risk of infection and avoid alcohol or limit her alcohol intake. She was also educated to avoid NSAIDs and the use of over-the-counter drugs and to consume NSAIDs with food and water to avoid symptoms.

At 11:00am, evaluation of set objective on 25th November,2022 to maintain patient's normal fluid and electrolyte balance within the period of hospitalization was done and goal was fully met as patient maintained an elastic skin turgor and nurse observed patient had a normal skin turgor.

I helped her pack her belongings into her bag. I removed her canula aseptically and later accompanied her and her sister into the taxi she had brought to take them home. I finally came back, removed the bed linens and went ahead to decontaminate the bedside and bed.

4.2 Preparation for Discharge

The preparation started on the first day of admission. Whiles on admission Madam S.M. and family were educated on the disease condition, its signs and symptoms, preventive measures and the complications of the disease. She was also educated on the need to avoid stress, long eating intervals and the need to eat a balanced diet. She was encouraged to cooperate with all staff during her care. She was made aware of her responsibilities and the role she had to play to aid her early recovery such as communicating effectively all her problems while on admission, taking her medications as they are served as well as abiding by all ward protocols. Patient educated to wash her hands with soap and water regularly and before meals. She was educated to cook food thoroughly to reduce risk of infection and avoid alcohol or limit her alcohol intake. She was also educated to avoid NSAIDs and the use of over-the-counter drugs and to consume NSAIDs with food and water to avoid symptoms.

Her recovery was quick due to the commitment of all nursing and medical staff on the ward who were always ready to deliver the best of care to Madam S.M. All nursing care activities were rendered duly.

4.3 Follow Up and Home Visit for Continuity of Care

Home visit is the visit that is made to the patient and family in their place of abode and the community in which they reside as a whole by a health worker. By doing this, one gets to assess the patient's home, identify health problems and helps to solve them. Home visit can be routine that is health team members may organize themselves and pay a visit to a particular area in a community and can also be selective in which one patient is selected by one member of a health team, studies that person and pays a visit to the patient to identify any health problem and supervises her for continuity of care after the patient has been discharged home. In my study

the selective type of home visit was used and it helped to evaluate the nursing care that was given to the patient and the continuity of care.

4.3.1 First home visit 28/11/2022

My first home visit to Madam S.M. house was made on 28th November 2022 at 12:30pm whiles patient was on admission. I had already informed patient that I had to visit her house whiles she was on admission to notify environmental hazards that poses risk on her condition and how to improve her health on her return to the house. Also, to verify information given by patient during admission and to check for nearest health centre in the patient's community.

I left the hospital after she gave me a thorough guide to her house located at abesim because I was unfamiliarised with the place. I boarded a taxi in town to abesim and alighted at regent hotel junction and took the route there as she told me. I made a few turns and finally met patient's sister on the way as she was coming to the hospital to see her sister. I greeted her and told her I was on my way to their home so we made a turn back and headed to their home. I realized I was on the right direction as the house described to me by the patient was not far from reach. It was a bricked rounded boy's quarters house divided into 8 parts and painted brown in colour. It had a big compound and it was well kept too. There was a poly tank connected to a borehole in the compound which was the patient's source of water. She opened the room of my patient for me to enter. I did a quick survey of the place. She had a small veranda in front of her room where she had packed her cooking utensils and a few stuffs. It was a close space so I encouraged them to open the windows more to allow for fresh her. I entered her room and saw things were arranged in order. There was a flat screen TV on right side of the wall and some couch was arranged in front of it. Her bed was suited on the opposite side of the room separated from the sitting room by a curtain. I was given water to drink and welcomed to the house. I stated my mission and explained why there was the need to visit them

whiles patient was on admission. I educated her on the need to feed patient regularly in bits and encourage her to serve patient with fruits as often as possible. I also told her to let patient finish her course of drugs when discharged. Patient slept under a mosquito net with her children and drank treated water from a pipe so no education was given on that. I later realized I had spent enough time there so I asked that we should take our leave and return to the hospital as the sister was already on her way there. We left the place around 1:40pm and arrived at the hospital around 2: 00pm.

4.3.2 Second home visit 3rd December 2022

I called Madam S.M. on the 2nd December 2022 (Friday) evening that I would be embarking on my second home visit the next day as it was my off day at the hospital. She was happy to hear that and told me I'm welcomed any time. I thanked her also for her cooperation and we ended our call. The purpose was to evaluate the education given during the first home visit as well as to find out how my client was coping with the treatment regimen after discharge. On the next morning I went to take a taxi in town to Abesim. Since I already knew the place, I didn't call her for directions again. I alighted at her junction and took the route forward. I got to the house around 9:00am and she was sitting in front of her house. she was surprised to see me as I didn't make a call that morning of my coming. She welcomed me warmly and gave me a seat beside her and offered me water. I noticed their compound was as neat as I first saw it on my first home visit and I praised her for that. I asked how she was doing and her response was quite impressive, she only complained of abdominal pain from time to time but stated it was not a sharp pain as before. I educated her to continue taking her drug regimen till it is finished. I also noticed the windows in her room was opened as I instructed on my first visit to allow for good ventilation. I asked about her children and she said she had just dropped them off at the church for music rehearsal and she was also done with her washing and was about to take some rest. I inquired of what she had eaten since her irregular eating pattern could have

been another factor that triggered her sudden illness. She said she had taken porridge that morning and prepared rice in case she got hungry again. I congratulated her on such a thoughtful diet plan and also educated her not to only eat when she is hungry but rather eat in bits and regularly to avoid another stomach upset or pain. Her sister had gone to the market so didn't get chance to greet her. We chatted for a while as she asked me questions on how to make her health better and I gave her the best knowledge I had and she understood me perfectly well. After sometime I asked for permission to leave and reminded her of her review date on 6th December 2022 and assured her I would be waiting to assist her with anything she might want. I then took my leave around 11:30am and Madam S.M. accompanied me to the road side to pick a taxi back home.

4.3.3 Day of Review 6th December 2022

I waited for Madam S.M. at the outpatient department till she arrived around 11:00am. We exchanged greeting and she handed me a pamphlet from church and asked me to read it. I then took her hospital card and opened her folder at the records department. We went to check her vitals and it recorded as follows;

Temperature (T) 36.5^{o}C

Blood pressure (BP) 118/70mmHg

Respiration (R) 22cpm

Pulse (P) 76bpm

After checking her vitals, we waited in line for about 30minutes before going to see the physician at consulting room 4. I accompanied her inside to see her general wellbeing. Upon Doctor's observation she was doing well. Madam S.M. made complains on her unusual stomach upset and the doctor said she should continue with her drug regimen and she would

prescribe another Nugel O for her to buy since she was done with the one given on admission. The doctor then stressed on the need to eat in bits and on time and to avoid spicy diet or intake of alcohol to prevent hypersecretion of hydrochloric acid HCL. She also stressed on the need to maintain a good personal hygiene such as washing hands before eating, covering of food when not in use and keeping her surroundings clean to prevent bacterial infections. She was to continue her old drugs and take new ones from the pharmacy. We thanked the doctor and took our leave. We went to the hospitals pharmacy to take the drug but we were told to purchase it at the greenlight pharmacy just beside the municipal hospital. We took the prescription and went there. They got us the drugs and my patient paid for it and we left the place. I reminded her of my last home visit before we parted ways.

4.3.4 Third home visit (18th December,2022)

The third home visit was on the 18th December,2022. The purpose of my visit was to terminate care and hand her over to a community health nurse which was discussed on the previous visit. I was warmly welcome on arrival. Patient looked very active and cheerful. I asked of her medication and found out that some of the drugs had already been completed. I congratulate her and encouraged her to continue with the rest of the medication. I stressed on the need to maintain personal and environmental hygiene and to visit the hospital whenever they are sick. I informed them that now that Madam S.M. is doing well there is the need to hand her over to a community nurse to continue the care. The community health nurse promised to continue the care and patient also expressed her willingness to cooperate with her. I told them that would be my last official visit because our resuming date was due and I would be returning to school very soon but promised to visit them anytime that I get a chance. We bid them goodbye after staying for some chat and took our leave around 2:00pm.

CHAPTER FIVE

EVALUATION OF CARE TOPATIENTAND FAMILY

5.0 Introduction

This is the fifth and final component of the nursing process. The chapter deals with evaluation of care rendered to the client and her family. It involves judging, appraising and identifying the degree to which the client goals have been met. It also includes the necessary amendments of care that were made in the course of the care and how the care was terminated.

Evaluation refers to the continuous process of comparing the progress of the patient regarding the treatment that was rendered to a patient with the objective criteria and the goals that were set for the patient. It also serves as a measurement of the appropriateness and efficiency and implementation of the care given to the patient. This helps to identify the state and manner of which the goals that were set for the patient in the nursing care was met.

5.1 Statement of Evaluation

This phase involves the reviewing of set objectives in accordance with the time from the day of admission to the day of discharge. Goals and objectives were fully met and so no amendment was made.

On admission, Madam S.M. looked weak and ill, with the diagnosis of acute gastritis. Six health problems were revealed after a conversation with Madam S.M. and her family and objectives were set to resolve them.

1. Patient was relieved of abdominal pain

Madam S.M.'s body comfort was altered due to pain felt in her abdomen (epigastric region) on 25th November 2022 at 9;40 pm hence, a nursing diagnosis of Acute abdominal pain (epigastric region) related to inflammation and hypersecretion of hydrochloric acid (HCL) was formulated. An objective was set to relieve patient of abdominal pain within 24hours. The following nursing intervention were then implemented; Patient's level of pain was assessed to know the severity of the pain, factors that worsens and relieved patient's pain were checked to know the cause of the pain, patient was assisted into a left lateral position in bed, patient was encouraged to avoid spicy diet to prevent further injuries, prescribed medication (iv omeprazole, tablet tramadol) were administered to patient, patient was reassured of competent nursing care.

On 26th November 2022 at 9:40pm, evaluation of set objectives on 25th November, 2022 to regain patient body comfort was done and goal was fully met as patient verbalized reduction in pain in the abdomen and nurse observed patient has a cheerful facial expression.

2.Patient's body temperature fell to normal range

On 25th November,2022 patient had an elevated body temperature of 37.9^0c so at 9:50pm a nursing diagnosis of hyperthermia (37.9^0c) related to gastric inflammation process was formulated hence, an objective was set to restore patient's body temperature to normal range (36.2 to37.2^0c) within 4 hours. The following intervention were implemented; Patient was reassured. Madam S.M. was tepid sponged 1hourly. Body temperature dropped to 36.7. Near windows were opened to allow for good ventilation. Cold drinks were given to patient to cool temperature. Madam S.M. extra clothing was removed to allow for good ventilation. Antipyretic medication was administered to patient (tablet paracetamol).

On 26th November, 2022 at 1:50am, evaluation of the set objective on 25th November, 2022 at 8:00pm to reduce patient body temperature within normal range (36.2^0c – 37.2^0c) within 4 hours was done and goal was fully met as evidenced by patient's temperature falling within the normal range and patient was no longer feverish and nurse recorded 36.7^0c as patient's body temperature.

3. Patient maintained her fluid volume balance

Patient had a risk for fluid and electrolyte imbalance related to diarrhoea on 25th November, 2022 at 10:00pm. An objective was set to maintain a balance fluid and electrolyte for the patient within the period of admission. The following interventions were implemented; Patient was reassured that her condition will get better soon due to competent care. Patient's bowel movement pattern was evaluated and recorded daily. Patient was weighed daily with no significant changes detected. Patient was evaluated for signs of dehydration by observing skin turgor and observe for thirst, dizziness and symptoms of shock. Patient was put on strict intake and output monitoring chart daily. Vital signs were checked and recorded every 4hours. Patient was encouraged to take in copious fluids at regular intervals. Prescribed intravenous fluid (ringer lactate and normal saline) were administered.

On 29th November,2022 at 11:00am, evaluation of set objective on 25th November,2022 to maintain patient's a normal fluid and electrolyte balance within the period of hospitalization was done and goal was fully met as patient maintained an elastic skin turgor and nurse observed patient does not look pale.

4. Patient and family were relieved of anxiety

On admission day at 10:30pm patient and family were very anxious due to unknown outcome of disease. An objective was set to relieve patient and family of anxiety within 24 hours. The following nursing intervention were then implemented; Patient and family were reassured to

alley anxiety and fears. Patient was orientated to the ward environment and equipment. Patient was educated on the causes, clinical manifestations, diagnosis and treatment of gastritis, starting from the known to the unknown. Patient was encouraged to ask questions for clarifications. A quiet environment was maintained to avoid irritation. Patient was introduced to patient who have undergone same treatment to serve as motivation. Diversional therapy like music was introduced to divert him from being anxious.

On 26th November,2022 at 10:00pm, evaluation of set objectives on 25th November,2022 to relieve patient and family of anxiety was fully met as patient verbalizing that she is no longer anxious and nurse observe patient calm in bed with a relaxed facial expression.

5. **Patient attained and maintained a normal nutritional status**

On 26th November,2022 at 9:00am patient complained of loss of appetite hence a diagnosis of nutritional imbalance less than body requirement related to loss of appetite (anorexia) was formulated. An objective was set for patient to be able to attain and maintain adequate nutrition within 72 hours. The following intervention were implemented; Signs and symptoms of malnutrition such as weakness were assessed. Menu was planned with patient and dietician to stimulate appetite. Patient gave his preferred food which were modified. Intake of non-irritating fruits such banana and pawpaw was encouraged. All nauseating items such vomitus bowl and sputum mug were removed from patient's site to prevent nausea when eating. Foods were attractively served. Patient was encouraged to take in more copious fluids. Patient was encouraged to perform oral hygiene twice a day to prevent loss of appetite.

On 29th November,2022 at 9:00am, evaluation of the set objective on 26th November,2022 to help patient attain and maintain adequate nutrition within 72 hours was done and goal was fully met as nurse observed patient eat more than half of the food served and patient verbalizing, she could eat well.

6. **Patient and family gained enough knowledge on her condition.**

On 26th November,2022 at 10:30am, it was assessed that patient had little knowledge of her condition, hence the nursing diagnosis of deficient knowledge related to inadequate information on acute gastritis, its causes and management was formulated. An objective was set for patient and family to gain adequate knowledge on the causes, signs and symptoms and prevention of acute gastritis within 3 hours. The following interventions were implemented; Patient and relatives were reassured that the education will be in simple terms for their understanding. Patient and family were asked questions about the condition to assess their knowledge of it. Patient and relatives were educated on acute gastritis, its causes, signs and symptoms and management regimen. Patient and relatives were allowed to asked questions of which they answered tactfully and their concerned were addressed. Patient and relative were asked for feedback and they were able to explain the condition, it causes and treatment. They were thanked for their attentiveness and cooperation.

On 26th November,2022 at 1:30pm, evaluation of the set objective on 26th November, 2022 to help patient and family gain knowledge on acute gastritis that is the causes, signs and symptoms and prevention of it within 3 hours was done and goal was fully met as evidenced by patient and family being able to talk more about the condition including its causes, signs and symptom and prevention of acute gastritis.

5.2 Amendment of Nursing Care Plan for Partially Met and Unmet Outcome Criteria

With the support from other members of the health team and co-operation of the patient and family, all the set goals were fully achieved based on an individualized care plan. The care plan was not amended.

5.3 Termination of Care

Termination of care is a gradual process and it starts from the day of admission till the day of last home visit. This is done to enable client and family realize that they were temporary in the hospital and the disease condition that was taking its course would soon end. My last home visit to patient and family was on 18th December,2022. The reason of my visit was to determine whether her conditions had improved after review and to finally terminate care. The causes, signs and symptoms, treatment as well as prevention were explained to family. I also emphasized on the need to avoid over usage of over-the-counter drugs, avoid buying food from outside if necessary and eat a healthy diet and to maintain a good personal and environmental hygiene. I thanked Madam S.M. and her family for support and cooperation given me throughout the study. I informed them about the need to terminate care after assessing Madam S.M. and realizing that she was looking healthier and can go about her daily activities and work. It was explained that termination was only for academic purpose and that I would be available for any assistance needed. I finally handed over to a community health nurse in the area since there was no health facility in the area.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation, or compendium of previous stated fact or statements (Hornby, 2019). Conclusion is something that you decide when you have thought about all the information connected with the situation (Hornby, 2019).

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

6.1 Summary

Madam S.M. is the subject for the care study, she is thirty-five (35) years old woman. She is married to Mr. K.M. Madam S.M. was born to Mr E.A. and Mrs T.A.

Madam S.M. was admitted at the female medical ward through the Accidents and Emergency unit of Sunyani Municipal Hospital on 25th November,2022 at 9:30pm and was discharged on 29th November, 2022 but care given to patient continued till the last home visit. She was admitted with the diagnosis of acute gastritis thus a disease-causing abdominal discomfort. On admission, she presented with abdominal pains (epigastrium region), persistence passing of diarrhoea stools, a high body temperature and patient and family were anxious of unknown outcome of disease. Education was given to patient on acute gastritis and its management. Patient was relieved of abdominal pains and her body's normal temperature was attained in the shortest possible time. During Madam S.M.'s stay at the

ward, six health problems were identified. Objectives were set as well as nursing orders and intervention such as pain assessment, intravenous hydration, nutritional assessment, checking of vital signs, daily monitoring, providing emotional support, education of patient and family and many more. These goals set were fully met due to good nursing management, medical care and patient and family cooperation. Laboratory investigations were also conducted on patient to confirm her diagnosis. Education on personal and environmental hygiene and the need for proper nutrition was given. Patient was advised to adhere to all treatment regimens.

The laboratory investigation ordered for Madam S.M. was as follows

1. Full Blood Count (FBC)
2. Helicobacter Pyloric test

The following drugs were used in the treatment of the condition:

- IV Paracetamol 1gram stat
- IV Normal Saline 500mls
- IV Ringers Lactate 2litres
- IV Omeprazole 80mg stat then 40mg bd x 2days
- IV Ciprofloxacin 400mg bd x 24 hours
- Tab tramadol 500mg tds x 7days
- Nugel O 15mls tds x 7 days

Patient was discharged on 29th December, 2022 after a successful recovery.

On 6th December, 2022 patient reported for review as scheduled, it was to find out if patient was adhering to all education and advise given to improve his health and standard of living. Three home visits were made. The first one was when patient was on admission on 28th November, 2022, second home visit was on 3rd December, 2022 and the last was on 18th

December,2022. The care of Madam S.M. and her family were terminated on 18th December, 2022, during the third home visit when patient had fully recovered.

6.2 Conclusion/Recommendation

In conclusion, I have become more equipped with knowledge on how to care for a patient as an individual and Gastritis as a result of the care study. The literature review from different books has helped me a lot in understanding the disease condition (gastritis). Also, this study has helped me put theoretical studies in the lecture hall into practice.

I strongly recommend that the writing of the care study should be continued since it improves our communication and education skills. Generally, the study on the patient was a successful one. It was successful because of the early recovery and regaining of her strength. Through interactions with my patient and family, a lot has been learnt about the nursing process. In one way or the other; it has enabled me to apply the knowledge acquired in the course of my training to nurse my client.

It has widened my knowledge on the condition, both theoretically and practically. The patient and family have also benefited as they came to realize their health needs and were prepared to take the necessary measures to meet their health problems. I therefore accept the concept of patient and family care study to be used in order to equip the student nurse to work efficiently for a better nursing during and after training.

APPENDIX

Table 8: Vital Signs Chart of Madam S.M.

Date	**Time**	**Blood pressure**	**Respiration (cpm)**	**Pulse (bpm)**	**Temperature (^{0}c)**
25/11/2022	9:40pm	130/108	28	81	37.9
26/11/2022	6:00am	126/86	25	80	36.9
	10am	110/70	21	80	36.1
	2pm	112/70	22	78	36.2
	6pm	109/68	21	80	36.2
	10pm	110/70	22	75	36.0
27/11/2022	6am	110/78	24	80	35.4
	10am	110/70	20	82	36.1
	2pm	112/66	20	82	36.2
	6pm	112/70	18	70	36.2
	10pm	110/70	20	75	37.1
28/11/2022	6am	110/70	24	68	35.5
	10am	105/68	20	76	36.7
	2pm	120/60	20	70	36.0
	6pm	128/69	25	70	36.5
	10pm	125/68	20	78	37.0
29/11/2022	6am	120/70	18	65	35.4
	10am	120/70	21	78	36.2

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