

**HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE**

**BEREKUM**

**A PATIENT/FAMILY CENTERED NURSING CARE STUDY ON**

**GASTROENTERITIS**

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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**

The patient /family care study is a project work carried out by the final year student as a partial fulfilment for the award of Diploma Certificate in Nursing by the Nurse's and Midwives Council of Ghana.

The significance of the study is to help the student nurse exhibit the skills and knowledge acquired from his or her training from the classroom into practice. The care also helps the student nurse to acquire more knowledge on the signs and symptom, diagnosis, causes and management of the specific disease condition studied by the student.

The care study therefore helps the student nurse have the opportunity to initiate and implement patient care. It is in this vein that the nursing processes which include assessment, analysis, diagnosis, planning, implementation and evaluation is employed.

## **ACKNOWLEDGEMENT**

My foremost thanks go to the Almighty God for giving me the wisdom and direction to bring this work to a successful end.

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## INTRODUCTION

This patient and family care study is about Mr. A.K.E a 26year old man who was admitted to the males' ward of SDA hospital Suyani through Out-Patients' Department on the 11th November, 2022 at 2:00pm by physician on duty who upon various investigation was diagnosed of gastroenteritis. For the purpose of protecting my patient's identity, hence promoting confidentiality, I would like to refer to him as Mr. A.K.E throughout my write up.

My interactions began the day of admission. Patient walked to the ward with his mother and accompanied nurse from the Out-Patients' Department in a conscious state. They were warmly welcome and patient's OPD card was collected from accompanying nurse. Patient's name and other particulars were confirmed. Assessment on patient revealed that he is experiencing dizziness, vomiting, diarrhoea, abdominal pain, loss of appetite, general body weakness. Patient was made comfortable in bed and reassured patient and family to allay fear and anxiety. A care plan was drawn for him throughout his stay on the ward.

Various investigations were requested and done. He was managed on drug medically with the appropriate nursing and medical management, the support and cooperation of Mr. A.K.E and his family. He was discharged home on 14th November, 2022 in a satisfactory state.

Care for patients and family lasted for four days including a three-home visits (12th, 18th, and 29th November 2022 for the first, second and third home visit respectively). Its purpose was to assess patient's home environment and practices in order to know whether these contribute to his condition or illness.

The nursing process was employed hence the script has been divided into five chapters and they are organized as follows;

Chapter one dealt with assessment of client and family comprising client particulars, family medical/surgical history, socio-economic history, patient's developmental history, lifestyle and hobbies, past and present medical history, admission of client, her concept of illness, literature review and validation of data. Chapter two deals with analysis of data including comparisons of data with standard, diagnosis investigation, causes of patient's condition, medical treatment given to patient, patient's complications, patient/family problem, patient's and family strength, busting diagnosis.

Planning of patients and family care, Nursing objective/outcome criteria, and Nursing care plan for the patient/family forms chapter three.

Chapter four entails implementation of actual nursing care, summary of actual nursing care, home visits, preparation of patient/family for discharge and chapter five finally deals with evaluation of care, amendment of nursing care plan for partially met or unmet outcome criteria, termination of care, summary and conclusion of the study.

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# CHAPTER ONE

## ASSESSMENT OF PATIENT AND FAMILY

### 1.0 Introduction

Assessment is the first stage of the nursing process. It is the process that enables the nurse to identify the patient's needs and problems. It is fundamental to all procedures that a patient or family may undergo. It is an ongoing process repeated at regular intervals depending on the patient/family condition. Assessment of patient/family entails gathering information from the patient, the family and their environment through interviews, observation, laboratory investigations of health problems so as to render a holistic nursing care to solve them. The assessment covers the patient's particulars, family medical/surgical history, family socio-economic history, patient's developmental history, patient's lifestyle and hobbies, patient's past medical/surgical history, the present medical/surgical history of the patient, admission process of the patient and family, patient/family's concept of his/her illness, literature review on the condition and validation of data.

### 1.1 Patient's Particulars

Mr. A.K.E is a 26years old man who was born on 20<sup>th</sup> May,1996 at Suyani to Mr. A.A and Mrs. A.C. He is a Ghanaian and currently lives at Suyani-Odumasi in the Bono Region of Ghana. Patient's folder revealed a height of 1.7 meters and weight of 50 kilogram. He is the first born of to his parents. The patient is an Akan by tribe and a Christian by religion who worships with SDA church in Suyani. He speaks Asante Twi, English and Fantra language. He is not married. His next of kin is Mr. A.E his brother.

### **1.2 Family's Medical/Surgical History**

My interactions with Mr. A.K.E and his family revealed that, there is a familial or genetic disease which is hypertension, in their family. Also, he mentioned that they do suffer minor ailments like common cold, headache, abdominal pain but they usually buy drugs from chemical stores to treat themselves. He mentioned paracetamol, and amoxicillin as some of the drugs they usually buy. Currently Mr. A.K.E grandparents, parents and his siblings are not sick or injured, they are all in good health. The family does not have any known allergies.

### **1.3 Family's Socio-Economic History**

The patient stated that most of his family members are involved in trading and depend on it for their daily bread. Mr. A.A the father, mentioned that they are able to support the family with their needs. Mr. A.A said that he will be able to pay the hospital bill of his son since National Health Insurance Scheme (NHIS) covers part of the bill.

### **1.4 Patient's Developmental History**

According to my patient, he was delivered in the hospital through spontaneous vaginal delivery supervised by a qualified midwife after the mother had gone through a period of nine months pregnancy successfully without any sickness. He said he received some immunization during childhood but he is not sure whether he received all the immunizations which include Diphtheria Pertussis-tetanus (DPT), Whooping Cough, Measles and Poliomyelitis but has scar visible on his right upper arm as evidence for BCG vaccine. He said he did not suffer from any childhood disease. According to my patient, he passed through all the developmental milestone crawled at age eight months and walked at age one. He also said he was breastfed for two years but not exclusively. He said this was confided to him by his mother. He started schooling at age 3 from kindergarten to J.H.S at Adventist preparatory school at Juaboso and also, attended Juaboso Snr High School. He

is now a student of Yamfo College of Health. My patient said he experience his secondary characteristics at age 16. (broad chest, growing of pubic hairs and enlargement of larynx (Adam's apple). He is at the sixth stage of development among the eight stages according to Erik Erikson's psychoanalytical theory of development. He is at the stage of Intimacy versus Isolation which talks about young adults (18-29) years who to need to form intimate, loving relationship with other people. Success leads to strong relationships while failure results in loneliness and isolation.

### **1.5 Patient's Lifestyle/Hobbies**

Mr. A.K.E usually goes to bed around 10pm and wakes up around 4:30am every day except weekends. He always pray before and after bed. He always pays heed to all personal hygienic needs such as brushing his teeth with pepsodent paste, emptying his bowel in the morning and bathing with cold water and geisha soap. He repeats this routine before he returns to bed in the evening. He always has three meals a day. He, most at times takes porridge with bread as his breakfast, jollof rice with chicken for lunch and takes his favorite food, fufu and light soup as supper.

He likes listening to music and sports and argues along with friends on his leisure time. He is not involved in smoking but drinks one bottle of alcoholic beverages occasionally.

### **1.6 Patient's Past Medical/Surgical History**

Mr. A.K.E mentioned that, he has been admitted into the hospital for more than three times since he grew up. However, for all these admissions to the hospital he was sometimes diagnosis of malaria, typhoid fever and gastroenteritis. He has no known allergy and has never undergone surgery before but suffers minor ailments such as headache, general body weakness and stomach ache of which he treats with over the counter drugs.

### **1.7 Patient's Present Medical/Surgical History**

Patient said he was going about his daily activities until on the 11th November, 2022 about 5:00am when he started experiencing the following signs and symptoms; passing out loose stools, vomiting, loss of appetite, high body temperature and abdominal pain. He came to the SDA Hospital-Suyani and he was attended to at the Out Patient Department. The following laboratory investigations were ordered for him; full blood count, blood for malaria parasite and routine stool examination. He was then put on the medications; Metronidazole Injection, Intravenous Ciprofloxacin, Ringers lactate Solution and IV Paracetamol. He was then admitted to the male's ward for further management.

### **1.8 Admission of the Patient**

On 11<sup>th</sup> November, 2022 at about 11:00am, Mr. A.K.E with his mother accompanied by a nurse walked into the Male's Ward for admission. He was seen and admitted by PA Alhassan with the diagnosis of Gastroenteritis. I introduced myself, and the other staffs on duty to his relative. The nurse handed over his folder to me, I confirmed the particulars in the folder with those his relative told me. He was placed in a well prepared simple unoccupied bed. I assisted them in arranging his personal items. I orientated his family to the ward and its annexes and I introduced the other patients in the same room to his family. On admission, Mr. A.K.E complained that he has been vomiting, passing loose stools (bloody and mucoid- 4 times), inability to sleep, cannot eat well, fatigue, high body temperature and abdominal pain. He looked weak, moderately dehydrated and very sick

Vital signs checked on admission were;

Temperature	38.6°C
Weight	50kg
Pulse	100bpm
Respiration	25cpm
Blood Pressure	90/40mmHg
RBS	8.0mmol/L

I then entered the information into the admission and discharge book and the daily ward state

The following treatment plans were written in her folder:

1. Ringers lactate Solution, 500ml, 3L, daily x1
2. Metronidazole Injection 5mg/ml in 100ml, 500mg, tid x 1
3. Intravenous Ciprofloxacin 2mg/ml in 100ml, 400mg, bd x 1
4. IV Paracetamol 1G tid x 24hours

Laboratory investigations ordered by the doctor included:

1. Full blood count (Hemoglobin, white blood cell count).
2. Routine Stool Examination.
3. Blood for malaria parasites.

A thorough physical examination was conducted.

Head and face- Hair was black and normal, no cracks at the corners of the lips.

Eyes and Ears- symmetrical, no discharge, no abnormality seen.

Skin- warm to touch, reduced skin turgor. No abnormality seen on the skin.

Respiratory function: clear, no abnormality detected, Abdomen: there were bowel sounds; abdomen was soft and generalized tenderness on palpation.

Musculoskeletal function: muscle tone was intact, active and resistant.

Neurological: He was moody and dull due to ill health.

Generally, he was normal. Mr. A.K.E. had no known allergies. An intravenous cannula was set for patient and blood sample taken to laboratory for laboratory investigations. His due medications were administered as prescribed. Patient was made comfortable in bed and Madam A.C. was reassured that he was in good hands and both doctors and nurses will do their best to the recovery of her son Mr. A.K.E. I introduced myself as a final year student of the Holy Family Nursing and Midwifery Training College, Berekum. I made them aware of my desire to take Mr. A.K.E and his family as the patient/family for a care study to enable me render to his individualized comprehensive nursing care until he is discharged home and even follow him after discharge for some time until he has fully recovered. I made it known to them that it was a requirement by the Nursing and Midwifery Council in partial fulfillment towards the award of license in Registered General Nursing in Ghana and they agreed to my request and promised to cooperate in the care of Mr. A.K.E. A care plan was quickly drawn to care for patient and family. A nursing care plan was

drawn based on patients' problems in order to help give individualized care to them. The actual care rendered is discussed in chapter four.

### **1.9 Patient's Concept of Illness**

Patient had little knowledge about his illness and so understands some specific causes of his illness. Patient was however quick to recognize the signs and symptoms of ill health such as vomiting, diarrhoea and fever. He was looking forward to recover speedily. He believed that his illness could be treated by modern medicines and was much specific about the need for orthodox medicine.

### **1.10 Literature Review on Gastroenteritis**

Review of Anatomy and Physiology of the Gastro-Intestinal Tract (GIT)

The GI tract is a pathway 7 to 7.9 meters (23 to 26 feet) in length that extends from the mouth to the esophagus, stomach, small and large intestines, and rectum, to the terminal structure, the anus (Hinkle & Cheever, 2018)

#### **The Oesophagus**

According to Tortora and Derrickson (2009), once food has been chewed and mixed with saliva in the mouth, it is swallowed and passes down the oesophagus. The oesophagus has a stratified squamous epithelial lining which protects the oesophagus from trauma; the sub mucosa has goblet cells which secretes mucus to aid in the smooth passage of food down the oesophagus. The lumen of the oesophagus is surrounded by layers of muscle - voluntary in the top third, progressing to involuntary in the bottom third and food is propelled into the stomach by waves of peristalsis.

#### **The Stomach**

The stomach is situated in the left upper portion of the abdomen under the left lobe of the liver and the diaphragm, overlaying most of the pancreas. A hollow muscular organ with a

capacity of approximately 1,500 ml, which stores food during eating, secretes digestive fluids and propels food or chyme, into the small intestine (Hinkle & Cheever, 2018). The stomach is a 'j'-shaped organ, with two openings- the esophageal and the duodenal- and four regions- the cardia, fundus, body and pylorus. Each region performs different functions; the fundus collects digestive gases, the body secretes pepsinogen and hydrochloric acid, and the pylorus is responsible for mucus, gastrin and pepsinogen secretion (Tortora & Derrickson, 2009). According to Wagh and Grant (2014), The stomach is continuous with the oesophagus at the cardiac sphincter and with the duodenum at the pyloric sphincter. It has two curvatures; the lesser curvature and the greater curvature. When the stomach is empty, the mucosa appears wrinkled or folded. These folds are called rugae.

### **Functions of the Stomach**

As specified in Tortora and Derrickson (2009) the stomach performs the following functions:

1. Mixes saliva, food, and gastric juice to form chyme.
2. Serves as a reservoir for food before release into small intestine.
3. Secretes gastric juice, which contains HCl (kills bacteria and denatures protein), pepsin (begins the digestion of proteins), intrinsic factor (aids absorption of vitamin B12), and gastric lipase (aids digestion of triglycerides).
4. Secretes gastrin into blood.

**N.B:** Different areas of the stomach contain different types of cells which secrete compounds to aid digestion. The main types involved are:

1. Parietal cells which secrete hydrochloric acid.
2. Chief cells which secrete pepsin.

3. Entero-endocrine cells which secrete regulatory hormones (Tortora & Derrickson, 2009).

### **The Small Intestine**

According to Wagh and Grant (2014), the small intestine is the site where most of the chemical and mechanical digestion is carried out, and where virtually all of the absorption of useful materials is carried out. The whole of the small intestine is lined with an absorptive mucosal type, with certain modifications for each section. The intestine also has a smooth muscle wall with two layers of muscle rhythmic contractions force products of digestion through the intestine (peristalsis).

### **The Duodenum**

It forms a 'C' shape around the head of the pancreas. Its main function is to neutralize the acidic gastric contents called 'chyme' and to initiate further digestion; Brunner's glands in the submucosa secrete alkaline mucus which neutralizes the chyme and protects the surface of the duodenum (Wagh & Grant, 2014).

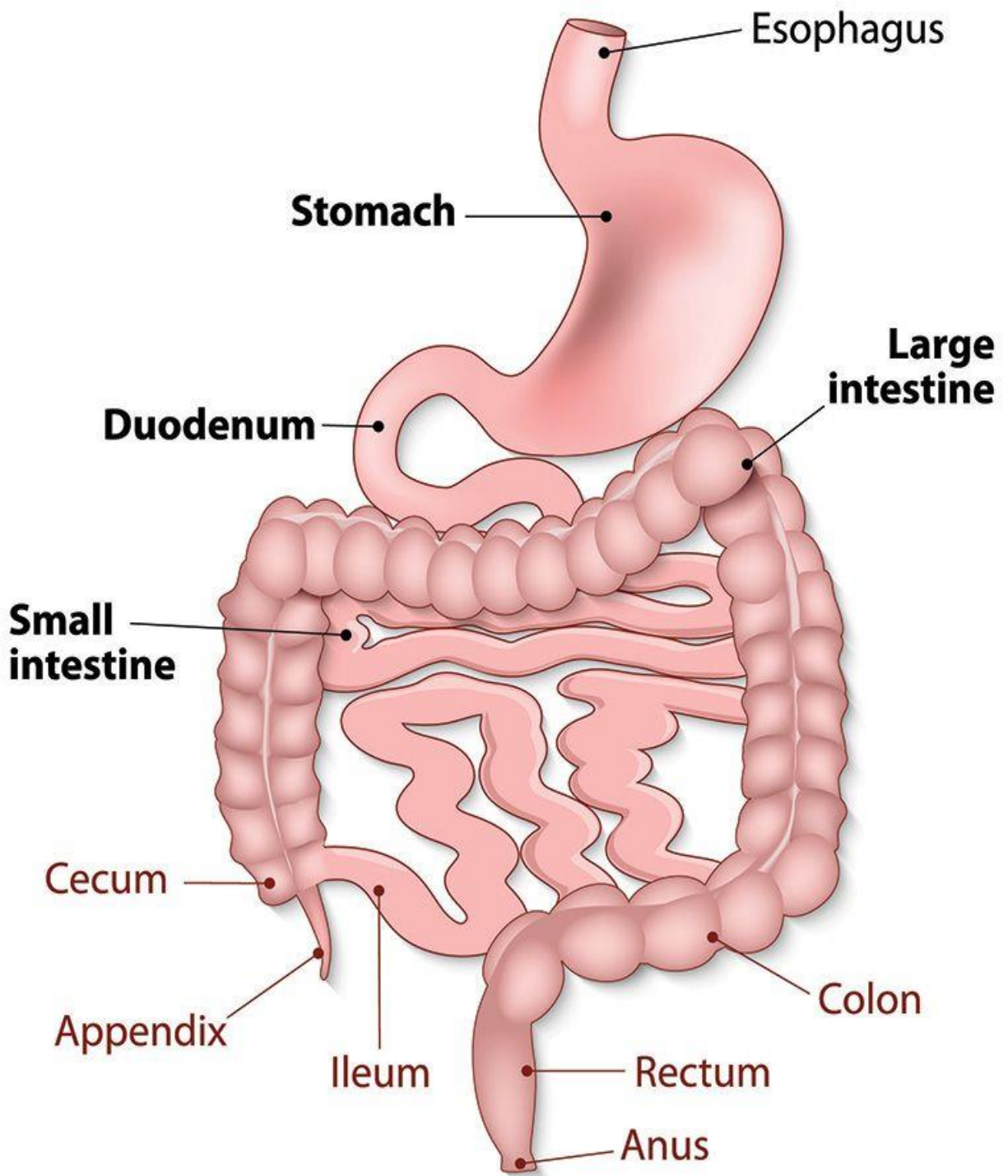


Figure 1: Diagram of Gastrointestinal Tract

(Fremont, 2019).

## **Definition**

Gastroenteritis is an inflammation of the lining of the stomach and intestines. The inflammation usually leads to the destruction of the superficial cells. The condition is marked by sudden episodes of epigastric pains, vomiting, abdominal pains, fever and diarrhoea.

## **Incidence**

Gastroenteritis is a condition which affects all age groups, sex, nationality or race. It is distributed worldwide but is more common in western countries like United States, Canada then in Asia, Africa and South America. The condition is a common cause of death in areas where people are crowded together and sanitation is poor. The incidence peaks between 15 and 30 years of age because of poor eating habit and lifestyle. It also affects patients with diseases such as human immune deficiency virus and acquired immune deficiency syndrome due to their lower immunity.

## **Aetiology / Causes**

Gastroenteritis can be caused by either of the following;

1. Bacteria; examples staphylococcus aureus, salmonella species and escherrichia coli.
2. Parasites; examples round worm, ascaris, enterobins and trichinellasprialis.
3. Viruses; examples influenza virus, adenovirus and rotavirus.
4. Chemical irritants; example excessive alcohol intake, caffeine, cigarette and spicy foods.
5. Radiation therapy (used in cancer treatment or X-ray)
6. It can also be due to secondary infections such as malaria.
7. Surgical conditions/operations following conditions such as short bowel syndrome.
8. Prolonged use of Non- Steroidal Anti-inflammatory Drugs (NSAIDS) examples aspirin and ibuprofen.

## **Mode of Transmission**

It is transmitted mainly through the fecal-oral route. The causative organism gets into the gastrointestinal tract when there is improper washing of hands before eating, after personal contact with an infected or contaminated person or materials and by eating or drinking contaminated food and water.

## **Incubation Period**

It is between 12 hours to 10 days.

## **Types of Gastroenteritis**

Gastroenteritis can be classified into three main types namely:

1. Acute gastroenteritis
2. Chronic gastroenteritis
3. Toxic gastroenteritis

## **Acute Gastroenteritis**

This is a sudden inflammation of the lining of the stomach and the intestine due to an acute illness especially when the patient has had a major traumatic injury like burns or severe infections. The ingestion of irritating food such as pepper can also cause acute gastroenteritis. Excessive intake of alcohol and hypersensitivity of some foods can be a cause. It can also be due to secondary infections such as malaria. Acute gastroenteritis is often characteristics by severe epigastric pain, severe abdominal cramps and diarrhoea.

### **Chronic Gastroenteritis**

This is a prolonged and repeated irritation of the mucosal lining of the stomach as well as the small intestines. It is commonly caused by intestinal infections such as helicobacter pylori and salmonella. Also, irritating substances such as drugs, alcohol, cigarette or reflux of intestinal contents into the stomach can cause chronic gastroenteritis. Other microorganisms such as fungi and virus can also be a cause. It is usually characterized by symptoms such as anorexia, discomfort, flatulence, belching, nausea and vomiting.

### **Toxic Gastroenteritis**

Toxic gastroenteritis occurs as a result of ingestion of irritating corrosive substances that can counteract with the protective functioning of the gastroenteritis tract, ingestion of poison like mercury, lead, DDT and ammonia. Also, drugs such as NSAIDS, cytotoxic agents and corticosteroids when taken in large doses can cause toxic gastroenteritis. Endotoxins released by the infectious bacteria such as Escherichia coli can be a cause. It is characterized by severe abdominal distress, nausea, and vomiting, pain after eating, diarrhoea, dyspepsia and general malaise.

### **Pathophysiology**

Gastroenteritis arises when the microorganism capable of causing it enters the gastrointestinal tract through the ingestion of contaminated foods or when any of the possible causes are present; they cause irritations in the mucosal lining of the gastroentero tract. The body in its defense to the irritation invades the affected site with leucocytes and other inflammatory process.

Following this the gastric mucosa becomes edematous and hyperemic thereby undergoing superficial erosion. This results in the secretion of gastric juices containing acids with much mucus contents. This further leads to exhibition of symptoms such as abdominal distress accompanied

with nausea and vomiting, hiccupping and diarrhoea. Again, when the gastric irritating agents such as alcohol or NSAIDS and other toxins are ingested, they result in increased reflux of fluid into intestinal lumen which eventually leads to intestinal motility. The increased intestinal motility finally leads to diarrhoea and subsequent dehydration in severe cases.

### **Clinical Manifestation**

1. Headache
2. Elevated body temperature
3. Weight loss
4. Diarrhoea
5. Nausea and vomiting after eating
6. Weakness
7. Hiccup
8. Dehydration
9. Fatigue
10. Tachycardia
11. Elevated white blood cells
12. Restlessness
13. Weak rapid pulse
14. Blood stools with mucus and pus
15. Frequent diarrhoea stools which may be bloody
16. Cramping abdominal pain
17. Anorexia (loss of appetite)

## **Diagnostic Investigation**

Some of the laboratory investigations that can be carried out to diagnose gastroenteritis include the following;

1. Leukocyte count: Blood studies is done to confirm the presence of leukocyte that is, white blood cells in the blood. An increase in leukocytes especially neutrophils may indicate an infection and acute inflammation. The normal range in 4500-10,000 white blood cells per microlitre (MCL).
2. Stool cultures may be carried out to identify the presence of several microorganisms that can cause inflammatory bowel disease.
3. Routine stool examination.
4. Malaria test
5. Colonoscopy: This enables the complete visualization of the colon and taking of biopsy and pictures of the lesion and removal of polyps.
6. Erythrocyte count: Haemoglobin and haematocrit concentration is done and a decrease in the number of red blood cells and the amount of haemoglobin level may indicate the loss of blood or nutritional deficiency.
7. Sigmoidoscopy: A sigmoidoscope is used to examine the anal canal and the sigmoid colon.
8. Signs and symptoms exhibited by the client can be used to diagnose gastroenteritis.
9. Serum electrolytes estimation. Example potassium and sodium calcium.
10. Radiological techniques and fluoroscopy: This involve introducing contrast medium into the gastrointestinal tract which allows it to be examined radiologically.

## **Medical Management**

Gastroenteritis in its acute form must be treated as a medical emergency in order to prevent transmission to other patients if infective and to prevent the occurrence of complications. The management is based on the cause and signs and symptoms the patient exhibits.

A) If there is vomiting and diarrhoea drugs administered include,

1. Intravenous metronidazole
2. Intravenous ciprofloxacin
3. Intravenous hyoscine butylbromide

B) For dehydration, fluid and electrolyte imbalance, oral rehydration or intravenous fluid like normal saline and ringers lactate may be administered.

C) For infection control, antibiotics based on causative organism identified. It includes;

1. Chloramphenicol, ciprofloxacin and amoxicillin
2. Metronidazole 500mg every 8 hours in adult and 75mg every 8 hours in children.
3. Tetracycline, co-trimazole, administer antidote if the cause is as a result of poison.

## **Nursing Management**

The aim of nursing management is to help patient overcome anxiety, maintain good nutrition, personal, hygiene, expedite recovery of patient and above all prevent complications.

## **Reassurance**

1. Introduce patient to other patient's with similar conditions who are recovering as well as other patients who have gone through same condition successfully and explain to patient the competency of health team who have handed similar condition successfully.

2. Give patient the opportunity to ask questions about his condition and answer appropriate to allay his anxiety and the patient and encourage family visits at the appropriate time.

### **Observation**

1. Monitor vital signs such as temperature, pulse, respiration and blood pressure four hourly and observe for adverse effects of drugs.
2. Monitor input and output and maintain input and output chart reporting any variations or deviations.
3. Take patient weight daily to assess dehydration status
4. Observe for signs of dehydration such as dry skin, sunken eyes, fever and dry mucus membrane.
5. Monitor for the rate of intravenous fluid and observe for signs and symptoms of circulatory overload such as dyspnea.
6. Monitor for signs of shock because of hypovolaemia such as low blood pressure, confusion and weakness.

### **Maintaining Adequate Nutrition**

1. Because of loss of appetite, oral hygiene should be employed before and after meals.
2. Food should be served in bits and at regular intervals.
3. Food should be served attractively and all nauseating objects such as bedpans and urinals should be away from patient's bedside.
4. Increase intake of fluids to replace fluid loss through vomiting and diarrhoea.
5. Serve food that contains all the needed nutrients such as protein and carbohydrate and vitamins

## **Rest and Sleep**

1. Position patient comfortably on bed
2. Bed should be clean, dry and free from creases and cramps.
3. Restrict visitors to ensure enough rest.
4. Provide a calm, quiet and conducive environment.
5. Ensure patient sleeps 6-8 hours uninterrupted.
6. Avoid unnecessary interruption by performing nursing activities together.
7. Administer prescribed analgesics.

## **Personal Hygiene**

1. Assist patient to bath twice daily .
2. Take good care of patient's mouth, hair, nails and pressure areas.
3. Ensure environmental and food hygiene
4. Change soiled linen frequently and patient's attire should be cleaned always.

## **Medication**

1. Administer all prescribed drugs appropriately.
2. Explain the rationale for drug administered to elicit compliance.
3. Educate patient on side effects of drugs.
4. The nurse should observe for adverse drug reactions.

## **Health Education**

1. Educate patient on the need to ensure good personal hygiene all the time.
2. Educate patient on the cause and predisposing factors of the condition
3. Educate patient to wash the hands with soap and water before and after eating.

4. Educate patient on food hygiene practice such as preparing and handling food under hygiene condition.
5. Patient and relative should be educated on the need for follow ups.

### **Complications**

1. Dehydration
2. Hypovolaemic shock
3. Septicaemia
4. Intestinal perforation
5. Renal failure
6. Ulcerative colitis
7. Gastrointestinal bleeding
8. Electrolyte imbalance

### **1.11 Validation of Data with Standards**

Information about patient's condition was collected from the patient and his relatives. Other information was also collected from patient's laboratory investigation results. This information, both the subjective and objective data when compared were not different from each other. The data collected were free from errors and biases and therefore valid.

## **CHAPTER TWO**

### **ANALYSIS OF DATA**

#### **2.0 Introduction**

Analysis of data is a systematic examination and evaluation of data or information, by breaking it into its component parts to uncover their interrelationship, thus providing basis for problem solving and decision making (Weller, 2018).

This chapter forms the second phase of the patient/family care study. It entails comparing the results of the investigation carried out with standards in the literature review. It also involves comparing the causes, clinical manifestations, treatments and complications of the patient's condition (gastroenteritis) with those stated in textbooks.

It gives the pharmacology of drugs prescribed by the medical officer for Mr. A.K.E. This chapter also captures the patient/family strengths, the health problems identified and nursing diagnoses formulated for given care to Mr. A.K.E.

#### **2.1 Comparison of Data with Standards**

##### **A. Diagnostic Investigations/Test**

The following diagnostic test were carried out on client;

1. Full blood count (haemoglobin, white blood cell count).
2. Routine Stool Examination.
3. Blood for malaria parasites.

**Table 1: Diagnostic tests/investigation in literature review compared with those carried out on patient.**

Diagnostic tests carried out in literature review	Diagnostic tests carried out on client
1. Patient history	1. History was taken
2. Serum electrolytes	2. Serum electrolytes was not done
3. Complete blood count	3. Complete blood count was done
4. Blood urea nitrogen	4. BUN was not done
5. Blood culture	5. Blood culture was not done
6. Rotazyme	6. Rotazyme was not done
7. Stool culture	7. Stool culture was not done
8. Malaria test	8. Malaria test was done
9. Routine Stool Examination	9. Routine Stool Examination was done

With reference to table 1, serum electrolytes, blood urea nitrogen, blood culture, rotazyme and stool culture were not carried out because the diagnosis was confirmed by patient history, routine stool examination and complete blood count. Malaria test also assisted in ruling out the possibility of the patient having malaria.

**Table 2: Results of Diagnostic Investigations/Tests Compared With Standards**

Date	Specimen	Investigation	Result	Normal Value	Interpretation	Remarks
11/11/22	Blood sample	Haemoglobin (HB) level	13.2g/dl.	13-18 (male) 11-15 (female)	Normal value	No treatment was given
11/11/22	Blood sample	White blood cell count.	$5.93 \times 10^3 / \mu\text{L}$	$4.0-10 \times 10^3 / \mu\text{L}$	Normal value Absence of infection in the blood.	No treatment was given
11/11/22	Stool	Routine Stool Examination.	Loose bloody stool	Brown Semi-solid stool	Diarrhoea and bloody stool was caused by bacterial.	Intravenous Ciprofloxacin 2mg/ml in 100ml, 400mg, bd x 1, Metronidazole Injection 5mg/ml in 100ml, 500mg x 1 were given.
11/11/22	Blood sample	Blood film for malaria parasites (MP's)	1538p/Ml	No malarial parasite	Malaria parasite present	Intravenous Artesunate 124mg

## B. The cause of patient's illness

With reference to the causes of gastroenteritis stated in the literature review, my client illness was a secondary infection from malaria.

## C. Clinical Manifestation

Table 3 below shows the Clinical Manifestation of Patient as Compared to Literature Review.

**Table 3: Comparison of Clinical Manifestation with Literature Review.**

Clinical Features in Literature Review	Clinical Features Exhibited By Patient
Nausea and vomiting	Patient experienced nausea and vomiting.
Fever	Patient experienced fever as a result of the infection (38.6 <sup>0</sup> C)
Loss of appetite	Patient experienced loss of appetite
Abdominal pain	Patient experienced abdominal pain
Headaches	Patient did not experience headaches
Diarrhoea	Patient experienced diarrhea
Heartburn	Patient did not experienced heartburn
Abdominal cramps	Patient experienced abdominal cramps
Bloody stools	Patient experienced bloody stools

Oedema	Patient did not experience oedema
Weight loss	Patient experienced weight loss (50kg)
Sunken eyeballs	Patient did not experience sunken eyeballs
Angular stomatitis	Patient did not experience angular stomatitis
Hepatomegaly	Patient did not experience hepatomegaly
Abdominal distension	Patient did not experience abdominal distension
Abdominal flatulence	Patient did not experience abdominal flatulence
Insomnia	Patient had insomnia
Lethargy/irritability	Patient experienced lethargy/irritability
Fatigue	Patient experienced fatigue
Reduced skin turgor	Patient had no reduced skin turgor

From the table above, it is evident that my patient had gastroenteritis because he exhibited most of the clinical features such as: nausea and vomiting, lethargy, loss of appetite, diarrhoea, bloody stools, abdominal cramps, abdominal pain, fatigue, weight loss and fever.

The following medical treatments were given;

1. Ringers lactate Solution, 500ml, 3L, daily x1
2. Metronidazole Injection 5mg/ml in 100ml, 500mg, tid x 1
3. Intravenous Ciprofloxacin 2mg/ml in 100ml, 400mg, bd x 1
4. IV Paracetamol 1G tid x 24hours

**Table 4: Shows Pharmacology of Drugs Given To Mr.A.K.E**

Date	Drug	Dosage/Route of Administration	Classification	Desired Effect	Actual Action Observed	Side Effects/Remarks
11/11/22	Ringers lactate	3liters over 24 hours; Intravenously	Electrolyte and fluid balance	To restore fluids and electrolytes balance and expand plasma volume	Patient was well hydrated. The patient skin turgor improved	Fluid overload, example pulmonary edema.  No side effect was observed
11/11/22	Metronidazole	5mg/ml in 100ml, 500mg, tid x 1; Intravenously	Antibacterial, antiprotozoal	Disrupts DNA, inhibiting nucleic acid synthesis.	Patient did not show any sign of infection.	Anorexia, dry mouth, diarrhoea, constipation, dizziness. None of the above effect was observed

11/11/22	Ciprofloxacin	Intravenous 2mg/ml in 100ml, 400mg, bd x 1;  Intravenously	Antibiotic (Fluoroquinolone)	Treatment of susceptible infection due to; campylobacter, salmonella, Shigella.	Patient's infection resolved.	Nauseas and vomiting, constipation, rash, flatulence. Headache, abdominal pain.  No side effect was observed on patient.
11/11/22	Paracetamol	1G tid x 24hours;  Intravenously	Analgesic, antipyretic	Treatment of pain and fever	Patient's pain and fever subsided	Flushing, Headache, dizziness, nausea, vomiting. No side effect was observed on patient.

## **D. Complications**

With regards to the complications outlined under the literature review, Mr. A.K.E did not develop any of the complications. This can be attributed to the fact that; he was brought early to the hospital and hence early treatment was initiated and led to his early recovery.

### **2.2 Patient/Family's Strengths**

Through interaction and observation of Mr.A.K.E and his relatives, it was revealed that, they had several strengths which in diverse ways contributed to the patient's quick recovery. These strengths include;

1. Patient was able to assume a position to decrease abdominal pain.
2. Patient was able to clean the mouth with water after vomiting.
3. Patient was able to inform the nurse whenever he experiences warmness of the body indicating high body temperature.
4. Patient was able to tell the frequency and colour of stool.
5. Patient was able to eat one-third of food served.
6. Patient and family were cooperative despite their anxiousness.
7. Patient could tolerate activities of daily living if assisted example bathing, walking etc

### **2.3 Patient /Family Health Problems**

Health problem is a state in which people are unable to function normally and without pain Health is also a state of complete physical, mental and social wellbeing and not merely the absence of diseases or infirmity, according to W.H.O, (1948).

Through assessment, observation as well as the complaints made by patient, the following health problems were identified;

1. Patient complained of abdominal pain (11/11/22).
2. Patient complained of nausea and vomiting (11/11/22).
3. Patient had high body temperature (Pyrexia, 38.6°C), (11/11/22).
4. Patient had diarrhoea (11/11/22).
5. Patient complains of loss of appetite (11/11/22).
6. Patient and family were anxious (11/11/22).
7. Patient looked very weak (11/11/22).

#### **2.4 Nursing Diagnosis**

According to NANDA International, nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group, or community.

1. Alteration in body comfort related to abdominal pain (11/11/22).
2. High risk of fluid and electrolyte imbalance (less than body requirement) related to nausea and vomiting (11/11/22).
3. Thermoregulation imbalance (Pyrexia 38.6°C) related to inflammation process (11/11/22).
4. Risk for fluid volume deficit (dehydration) related to diarrhoea (11/11/22).
5. High risk of nutritional imbalanced (less than body requirement) related to low dietary intake (11/11/22).

6. Anxiety (patient and family) related to unknown outcome of condition and hospitalization (11/11/22).

7. Activity intolerance related to weakness and inability to stand (11/11/22).

## **CHAPTER THREE**

### **PLANNING FOR PATIENT/FAMILY CARE**

#### **3.0 Introduction**

Planning is the process of thinking about and organizing the activities required to achieve a desired goal (Anderson, 2009). This is the third component of the nursing process which involves setting objectives/outcome criteria that will help to solve the problems identified. It involves the use of the nursing care plan to set objectives for patient and family. The nursing care plan enables care to be continued and also interventions to be carried out to help the patient be relieved of his problems. It is based on the potential and actual problems identified.

#### **3.1 Objectives and outcome criteria for Patient/Family Care**

The following objectives were set for the patient and family care during the period of hospitalization to help solve their health problems identified.

1. 11/11/22, Patient will be relieved of abdominal pain within 1 hour as evidenced by:
  - a). Nurse visualizing that patient is not showing signs of abdominal pain.
  - b). Patient verbalizing that abdominal pain has subsided.
2. 11/11/22, Patient normal fluid volume and electrolyte balance will be restored within 72 hours as evidenced by:
  - a). Nurse observing patient has a normal skin turgor.
  - b). Patient verbalizing that he no longer feels nauseated and vomits no more.
3. 11/11/22, Patient's body temperature will be reduced to normal ( $36.2^{\circ}\text{C} - 37.2^{\circ}\text{C}$ ) within 24 hours as evidenced by:

a). Nurse recording that patient's temperature is within the normal range (36.2<sup>0</sup>C to 37.2<sup>0</sup>C).

b). Patient verbalizing that he no longer feels hot to touch.

4. 11/11/22, Patient will be relieved of diarrhoea within 48hours as evidenced by:

a). Patient verbalizing that he no longer passes watery stools.

b). Nurse observing patient has a normal skin turgor and a normal weight for his age.

5. 11/11/22, Patient will have good nutrition as required within 72 hours as evidenced by:

a). Patient verbalizing, he can eat well.

b). Nurse observing that patient consume at least two-thirds of meals served.

6. 11/11/22, Patient and his family will be relieved of anxiety within 24 hours as evidenced by:

a). Nurse observing that patient/family members' show relaxed facial expressions.

b). Patient and his family members verbalizing that they are no more anxious.

7. 11/11/22, Patient will be able to perform activities of daily living within 48hours as evidenced by:

a). Patient verbalizing that he can stand on his own without assistance.

b). Nurse observing that patient is able to perform some activities of daily living.

### **3.2 Nursing Care Plan**

This is the last step in the series of approaches used for presenting the patient's plan of nursing care. It enables the staff nurse to meet the needs of the patient and his family at a given time.

The nursing care plan consists of date and time, nursing diagnosis, objectives/outcome criteria, nursing orders/interventions and evaluation.

Table five (5) below shows the nursing care plan used to render care to Mr. A.K.E

**Table 5: Nursing Care Plan for Mr. A.K.E and Family**

<b>Date/ Time</b>	<b>Nursing Diagnosis</b>	<b>Objective/ Outcome Criteria</b>	<b>Nursing Orders</b>	<b>Nursing Intervention</b>	<b>Date/ Time</b>	<b>Evaluation Statement</b>	<b>Sign</b>
11/11/22  11:15am	Alteration in body comfort related to abdominal pain	Patient will be relieved of abdominal pain within 1hour as evidenced by:  a). Nurse visualizing that patient is not showing signs of abdominal pain like feels pain when abdomen is palpated.	1. Reassure patient that the pain would subside.  2. Assess the level of patient’s pain using the pain rating scale.  3. Ensure the use of diversional therapy to shift attention from pain.	1. Patient was reassured that the pain will subside in the course of treatment.  2. Patient’s level of pain was assessed using the pain rating scale of 0 to 10.  3. Patient was engaged in conversation to divert his attention from the pain.	11/11/22  12:15pm	Goal fully met as nurse visualizing that patient did not exhibit any sign of abdominal pain.	N.E

		<p>b). Patient verbalizing that abdominal pain have subsided.</p>	<p>4. Schedule nursing activities and limit the number of visitors.</p> <p>5. Nurse patient on a comfortable bed.</p> <p>6. Serve prescribed analgesic to relieve patient of his abdominal pain.</p>	<p>4. Nursing activities were scheduled. The number of visitors were restricted.</p> <p>5. Patient was nursed on a comfortable bed free from creases and cramps.</p> <p>6. 1g of IV paracetamol was served to relieve patient of his abdominal pain.</p>			
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**Table 5: Nursing Care Plan for Mr. A.K.E and Family Continued.**

<b>Date/ Time</b>	<b>Nursing Diagnosis</b>	<b>Objective/ Outcome Criteria</b>	<b>Nursing Orders</b>	<b>Nursing Intervention</b>	<b>Date/ Time</b>	<b>Evaluation Statement</b>	<b>Sign</b>
11/11/22  11:30am	High risk of fluid and electrolyte imbalanced (less than body requirement) related to nausea and vomiting	Patient normal fluid volume and electrolyte balance will be restored within 72 hours as evidenced by:  a). Nurse observing patient has a normal skin turgor.  b). Patient verbalizing that he no longer feels nauseated and vomits no more.	1. Reassure Patient and family of comprehensive nursing care.  2. Remove all nauseating items from the patient's bedside  3. Maintain Patient's oral hygiene.	1. Patient and family were reassured of comprehensive nursing care.  2. Nauseating items such as bedpan were emptied immediately after use.  3. Patient's oral hygiene was done twice daily.	14/11/22  11:30am	Goal fully met as;  Patient verbalizing that he no more feel nauseated and vomit again.	N.E

			<p>4. Monitor signs of dehydration such as sunken eyes and poor skin turgor.</p> <p>5. Encourage patient to take in oral fluids.</p> <p>6. Administer prescribed intravenous fluid.</p>	<p>4 Signs of dehydration such as sunken eyes and poor skin turgor were monitored.</p> <p>5. Patient was encouraged to take in oral fluids.</p> <p>6. Prescribed IV RL were administered</p>			
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**Table 5: Nursing Care Plan for Mr. A.K.E and Family Continued.**

<b>Date/ Time</b>	<b>Nursing Diagnosis</b>	<b>Objective/ Outcome Criteria</b>	<b>Nursing Orders</b>	<b>Nursing Intervention</b>	<b>Date/ Time</b>	<b>Evaluation Statement</b>	<b>Sign</b>
11/11/22  11:40am	Thermoregulation imbalance (Pyrexia 38.6 <sup>0</sup> C) related to inflammation process	Patient's body temperature will be reduced to normal (36.2 <sup>0</sup> C – 37.2 <sup>0</sup> C) within 24hours as evidenced by:  a). Nurse recording that patient's temperature is within the normal range (36.2 <sup>0</sup> C to 37.2 <sup>0</sup> C).	1. Reassure patient.  2. Serve cold oral fluids.  3. Tepid sponge patient.  4. Ensure enough ventilation by opening	1. Patient was reassured.  2. Cold water and don simon fruit juice were served.  3. Patient was tepid sponge to reduce temperature by 1 <sup>0</sup> C within 30 minutes.	12/11/22  11:40am	Goal was fully met as Patient's temperature reduced to normal and was normal to touch.	N.E

		<p>b). Patient verbalizing that he no more feels hot to touch.</p>	<p>windows and switching on the fans.</p> <p>5. Check and record temperature every 30 minutes until temperature subsides.</p> <p>6. Remove tight clothing for fresh air</p> <p>7. Serve prescribed antipyretic.</p>	<p>4. Windows were opened and the fans were switched on.</p> <p>5. Temperature was checked and recorded every 30 minutes until temperature subsided.</p> <p>6. Tight clothing was removed for fresh air</p> <p>7. 1g of IV paracetamol served.</p>			
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**Table 5: Nursing Care Plan for Mr. A.K.E. and Family Continued.**

<b>Date/ Time</b>	<b>Nursing Diagnosis</b>	<b>Objective/Outcome Criteria</b>	<b>Nursing Orders</b>	<b>Nursing Intervention</b>	<b>Date/ Time</b>	<b>Evaluation Statement</b>	<b>Sign</b>
11/11/22  12:00pm	Risk for fluid volume deficit (dehydration) related to diarrhoea	Patient will be relieved of diarrhoea within 48 hours as evidenced by:  a). Patient verbalizing that he no longer passes watery stools.  b). Nurse observing patient has a normal skin turgor and a normal weight for his age.	1. Reassure patient that diarrhoea will subside with time.  2. Assess patient's skin turgor and mucous membranes.  3. Encourage intake of oral fluids.	1. Patient was reassured that the diarrhoea will subside with time.  2. Patient's skin turgor and mucous membranes were assessed to rule out any deviations.  3. Oral fluids intake of about 2-3 litres a day	13/11/22  12:00pm	Goal fully met as the nurse observed a normal skin turgor and mucous membranes.	N.E

			<p>4. Monitor intake and output</p> <p>5. Check and record patient's vital signs.</p> <p>6. Serve prescribed intravenous fluids.</p> <p>7. Weigh patient daily.</p>	<p>was encouraged to maintain a normal fluid volume.</p> <p>4. A strict intake and output was monitored</p> <p>5. Vital signs were checked and recorded as and when the time was due.</p> <p>6. Intravenous RL was administered to cater for fluid deficit.</p> <p>7. Patient was weighed each morning.</p>		
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**Table 5: Nursing Care Plan for Mr. A.K.E and Family Continued.**

<b>Date/ Time</b>	<b>Nursing Diagnosis</b>	<b>Objective/ Outcome Criteria</b>	<b>Nursing Orders</b>	<b>Nursing Intervention</b>	<b>Date/ Time</b>	<b>Evaluation Statement</b>	<b>Sign</b>
11/11/22  12:20pm	High risk of nutritional imbalance (less than body requirement) related to low dietary intake.	Patient will have good nutrition as required within 72 hours as evidenced by:  a). Patient verbalizing, he can eat well.  b). Nurse observing that patient consume at least two-thirds of meal served.	1. Provide oral care before and after meals.  2. Serve patient preferred and favourite diet.  3. Remove nauseating objects like bed pans and urinals before food is served.	1. Patient's mouth was cleaned before and after meals.  2. Patient favourite meals were served.  3. Nauseating objects like bed pans and urinals were removed before food was served.	14/11/22  12:20pm	Goals fully met as evidenced by,  Patient verbalizing that he ate well.	N.E

			<p>4. Served food in bits, in an attractive manner and in frequent intervals.</p> <p>5. Served fruit juice to stimulate appetite.</p>	<p>4. Food was served in bits, attractively and in frequent intervals.</p> <p>5. Cold don simon fruit juice was served.</p>			
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**Table 5: Nursing Care Plan for Mr. A.K.E and Family Continued.**

<b>Date/ Time</b>	<b>Nursing Diagnosis</b>	<b>Objective/ Outcome Criteria</b>	<b>Nursing Orders</b>	<b>Nursing Intervention</b>	<b>Date/ Time</b>	<b>Evaluation Statement</b>	<b>Sign</b>
11/11/22  12:35pm	Anxiety (patient and family) related to unknown outcome of condition and hospitalization	Patient and his family will be relieved of anxiety within 24 hours as evidenced by:  a). Nurse observing that patient/family members' show relaxed facial expressions.  b). Patient and his family members verbalizing that they are no more anxious.	1. Reassure patient of competent nursing staffs and speedy recovery.  2. Introduce patient to other patients who have suffered from the disease and are	1. Patient was reassured that he was in the hands of competent nursing staff.  2. Patient was introduced to a man who has almost recovered from the	12/11/22  12:35pm	Goal was fully met as patient and his relatives verbalized that they were no more anxious.	N.E

			<p>recovering to share experience.</p> <p>3. Allow patient to ask questions and express his fears.</p> <p>4. Answer patient's questions in simple and clear terms.</p>	<p>same condition to share ideas.</p> <p>3. Time was spent with patient and he was allowed to ask questions and express his fears.</p> <p>4. Patient's concerns about disease condition were addressed appropriately.</p>			
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**Table 5: Nursing Care Plan for Mr. A.K.E and Family Continued.**

<b>Date/ Time</b>	<b>Nursing Diagnosis</b>	<b>Objective/ Outcome Criteria</b>	<b>Nursing Orders</b>	<b>Nursing Intervention</b>	<b>Date/ Time</b>	<b>Evaluation Statement</b>	<b>Sign</b>
11/11/22  12:50pm	Activity intolerance related to weakness and inability to stand	<p>Patient will be able to perform activities of daily living within 48 hours as evidenced by:</p> <p>a). Patient verbalizing that he can stand on his own without assistance.</p> <p>b). Nurse observing that patient is able to perform some activities of daily living.</p>	<p>1. Assess the level of intolerance.</p> <p>2. Assist patient in passive exercise.</p> <p>3. Provide complete bed rest and restrict visitors.</p>	<p>1. Patient’s level of activity intolerance was assessed.</p> <p>2. Patient was assisted to do passive exercises.</p> <p>3. Complete bed rest was ensured and visitors were restricted.</p>	13/11/22  12:50pm	Goal fully met as patient was able to perform some activities of daily living and can stand on his own when assisted.	N.E

			<p>4. Assist patient to assume a comfortable position.</p> <p>5. Monitor respiratory responses to activities.</p> <p>6. Encourage patient to eat at regular intervals to boost his energy.</p>	<p>4. Patient was assisted to assume semi-fowlers position.</p> <p>5. Respiratory response of patient activities was monitored.</p> <p>6. Patient was encouraged to eat his meals regularly.</p>			
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## **CHAPTER FOUR**

### **IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN**

#### **4.0 Introduction**

This chapter forms the fourth part of the patient/family care study. Implementation is the process by which the nurse and the patient put into practice the planned care (Weller, 2018). This chapter is concerned with the actual nursing care rendered to the patient and the family. It comprises of activities before and after discharge including preparation of patient and family for discharge and rehabilitation as well as follow-up or home visits for continuity of care.

#### **4.1 Summary of the Actual Nursing Care**

Mr. A.K.E was admitted to the male's ward of the SDA Hospital-Suyani on the 11th of November, 2022 at 11:00am with the diagnosis of Gastroenteritis. His vital signs were taken and recorded as shown in chapter one and also his drugs were collected and served as prescribed.

Specimen were taken and sent to the laboratory for investigations to be carried out and findings were documented. To render a holistic care to my patient, physical assessment was done on the day of admission and actual and potential health problems of the patient were identified and a comprehensive nursing care plan was drawn and implemented which led to the speedy recovery of my patient and subsequent discharge.

**Day of Admission, 11<sup>th</sup> November, 2022.**

On 11<sup>th</sup> November, 2022 at about 11:00am, Mr. A.K.E with his mother walked into the Male's Ward for admission on account of Gastroenteritis. They were accompanied by a staff nurse. On arrival patient was fully conscious and well oriented to time and place. I welcomed them and offered them a seat at the nurse's station. It was a planned admission. I collected the patient particulars from the accompanying staff nurse. The patient's identity was verified by mentioning his name for him to respond. His particulars such as name, sex, age, and residential address were entered into the admission and discharge book and the daily ward state. He was made comfortable into an already prepared admission bed. Vital signs were checked and recorded accurately as follows:

Temperature	38.6 <sup>o</sup> C
Weight	50kg
Pulse	100bpm
Respiration	25cpm
Blood Pressure	90/40mmHg
RBS	8.0mmol/L

Physical examination on the patient was performed from head to toe and no abnormalities were seen. Assessment carried out on admission revealed that patient had a grimaced facial expression depicting presence of pain, he also complained that he has been vomiting, passing loose stools (bloody and mucoid- 4 times), inability to sleep, cannot eat well, fatigue and high body temperature. He looked weak, moderately dehydrated and very sick.

Patient and his relative were orientated to the ward and its environments and daily ward routines were adequately explained to them. Hospital policies regarding visiting periods and payment of bills was explained. Patient was also introduced to the other patients on the ward. The patient and his relative were very anxious and I took my time to prepare them psychologically by reassuring them of the readiness and competency of both the medical and nursing staff.

The following medications and IV fluids were prescribed for him;

1. Ringers lactate Solution, 500ml, 3L, daily x1
2. Metronidazole Injection 5mg/ml in 100ml, 500mg, tid x 1
3. Intravenous Ciprofloxacin 2mg/ml in 100ml, 400mg, bd x 1
4. IV Paracetamol 1G tid x 24hours

The following investigations were ordered:

1. Full blood count (Hemoglobin, white blood cell count).
2. Routine Stool Examination.
3. Blood for malaria parasites.

Patient had lost fluids and electrolytes through diarrhoea and vomiting so there was an IV in situ on arrival.

On admission patient complained of abdominal pain hence the nursing diagnosis Alteration in body comfort related to abdominal pain was formulated. An objective was set to help alleviate patient from abdominal pain within 1hours. The following interventions were implemented: Patient was reassured that the pain will subside in the course of treatment. Patient's level of pain was assessed using the pain rating scale of 0 to 10 and he chose 5.

Patient was engaged in conversation to divert his attention from the pain. Nursing activities was scheduled to limit the number of visitors. Patient was nursed on a comfortable bed free from creases and cramps.

1g of IV paracetamol was served to relieve patient of his abdominal pain. Evaluation of the set objective on 11<sup>th</sup> November, 2022 at 11:15am to relieve patient of abdominal pain within 1 hours was done; goal was fully met as patient verbalized, he is relieved of abdominal pain and nurse observed patient with a cheerful facial expression. At 11:30am, per patient complains, he was having nausea and vomiting hence the nursing diagnosis of High risk for fluid and electrolyte imbalance (less than body requirement) related to nausea and vomiting was formulated. An objective was set to help restore patient's fluid and electrolyte level within 72 hours. The following interventions were implemented: Patient and family were reassured of comprehensive nursing care. Nauseating items such as bedpan were emptied immediately after use. Patient's oral hygiene was done twice daily. Signs of dehydration such as sunken eyes and poor skin turgor were monitored. Patient was encouraged to take in oral fluids. Prescribed IV RL were administered. Goal was fully met as patient verbalized that he no more feels nauseated and vomit again.

At 11:40am, assessment on patient revealed that he had high fever (38.6 °C) hence the nursing diagnosis of Thermoregulation imbalance (Pyrexia 38.6°C) related to inflammation process. An objective was set to help reduce patient's body temperature. The following interventions were implemented: Patient was reassured. Cold don simon fruit juice was served. Patient was tepid sponge to reduce temperature by 1°C within 30 minutes. Windows were opened and the fans were switched on. Temperature was checked and recorded every 30 minutes until temperature subsided. 1G of IV paracetamol was served.

At 12:00pm, per patient complains, he was having diarrhoea hence the nursing diagnosis Risk for fluid volume deficit (dehydration) related to diarrhoea. The following interventions were implemented: Patient was reassured that the diarrhoea will subside with time. Patient's skin turgor and mucous membranes were assessed to rule out any deviations. Oral fluids intake of about 2-3 litres a day was encouraged to maintain a normal fluid volume.

Vital signs were checked and recorded as and when the time was due. Intravenous RL was administered to cater for fluid deficit. Patient was weighed each morning.

Patient also Patient complains of loss of appetite, Patient and family were anxious and Patient looked very weak. Care plan of all these problems were drawn for my patient as shown in chapter three.

At 5:30pm, patient took about one third of his supper which was rice and stew afterwards he was assisted to maintained his personal hygiene. At 6:00pm, his vital signs were checked and recorded as indicated in the appendix.

At 10:00pm, due medications were administered and his vital signs were checked and recorded.

Patient slept around 10:20pm.

Vital signs checked for the day ranged as follows:

Temperature	38.6-37.4 degree Celsius
Pulse	100-68 beats per minute
Respiration	21-25 cycle per minute
Blood pressure	120-90/40-90mmHg

## **Second Day of Admission, 12<sup>th</sup> November, 2022.**

On this day, patient woke up at 5:30am, I assisted him to take his bath and also maintained his oral hygiene.

His due medications were served at 6:00am and recorded. And also, vital signs checked and recorded as in the appendix.

The goal set on the 11<sup>th</sup> November, 2022 to enable patient maintain his normal body temperature that is 37.1°C within 24hours was fully met as evidenced by the nurse recording body temperature by checking with the thermometer and seeing temperature fell within the normal range 37.1°C.

The goal set on the 11<sup>th</sup> November, 2022 to enable patient and family relieved of anxiety within 24hours was fully met as evidenced by, Patient and family being in good mood, with a relaxed facial expression and they verbalized that, they were no more anxious.

He was encouraged to have rest and monitoring continue. He was served with jollof rice with fish as lunch. His due medications were served and vital signs checked and recorded at 2pm.

At 2:20pm, I made my first home visit to Suyani-Odumasi where my client lives whiles he was on admission.

His 6:00pm medications were served, vital signs checked and documented.

I handed him over to the night nurses at 8:00pm.

### **Third Day of Admission, 13<sup>th</sup> November, 2022**

Patient woke up around, 5:10am he performed his oral hygiene and also took his bath. His vital signs were checked and recorded as in the appendix

During morning rounds with the medical doctor, he ordered to continue current medications.

The goal set on the day of admission that patient will be able to perform daily activities was fully met as patient was able to perform oral hygiene and also bath without any assistance.

The goal that was set on the 11<sup>th</sup> November, 2022 to relieve patient of his diarrhoea within 48hours was fully met as evidenced by, patient verbalizing that diarrhoea has subsided.

I assisted Patient to have his lunch which was tomato stew with rice and fried chicken. Patient ate halve of the food served, his vital signs were checked and due medications served at 2:00pm, he slept for about 2 hours 30minutes.

He took his supper and he took his bath after eating. I then handed him over to the night nurses at 8:00pm.

### **Fourth Day of Admission, 14<sup>th</sup> November, 2022**

Patient woke up around at 5:40am, he performed his oral hygiene and took his bath. He took in porridge with bread as his breakfast. His due medications were served and documented, vital signs were also checked and documented as in appendix.

Patient did not have any complain but he said there is a greater improvement in his condition and wished to be discharged.

The medical Doctor came to review patient and placed him on the following medications.

1. Tab Ciprofloxacin 500mg bd x 5days
2. Tab Zinc 20mg od x 5
3. Celecoxib 200mg bd x 5

The doctor upon assessment of the patient got to know that he is well and so discharged him home.

I evaluated the objective set on the day of admission, Patient normal fluid volume and electrolyte balance will be restored within 72 hours. Goal was fully met as nurse observed that patient had a normal skin turgor.

Also, the goal set on the day of admission to make patient have good nutrition as required within 72 hours was fully met as evidenced by, nurse observing that patient ate two-thirds of food served.

I told Mr. A.K.E that he has been discharged home by the doctor and so I will take him through the discharge process. The date of discharge and remarks were entered into the admission and discharge book. I assessed them on the health educations given to them throughout the period of hospitalization and emphasis were made on their personal hygiene, food hygiene and environmental sanitation. He was to start with his drugs and then continue at home. I educated Patient and relative on his drugs. I thanked Patient and relative for their cooperation and support during the care delivery process. I also informed them of the date of review; which was 21<sup>st</sup> November, 2022. I helped them to pack their belongings and saw them off. I then removed the bed linens, and then bed and lockers were carbolized and well laid for new admission.

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

Preparation of patient/family for discharge started from the day of admission when I told my patient and his family that the hospital was not going to be his permanent living environment but he will be discharged home soon by

the competent care that will be rendered to him. My patient's relative was educated on the causes, signs and symptoms, complications and prevention of Gastroenteritis. This was to equip him to seek prompt medical attention whenever any member of the family was affected or advise any community member to report at the hospital when any of them is ill, for early prevention or detection and treatment.

I also educated patient's relatives to prepare food under hygienic environment, keep good personal hygiene, wash their hands with soap and water before and after eating. I educated my patient on the need to bath twice daily, wash clothes frequently, ensure proper disposal of refuse, and weed around the environment, and should ensure good drainage systems by draining all gutters. I also advised him to keep the windows in the house open to allow free movement of fresh air so that their room will be well ventilated. They were told to take the health education given seriously in order to promote and maintain their health even after discharge. The dangers of self-medication were spelt out to patient and his relative. I also educated him to report any change in his condition before the review date is due.

His name was entered into the admission and discharge book and also the ward state. Some of his bills were covered by health insurance and he settled the rest.

I helped them to pack the rest of their things. I accompanied them to the entrance of the hospital where they boarded a taxi. I bade them good-bye when the car set off. They left the entrance around 1:35pm on the day of discharge.

#### **4.3 Follow-Up/Home Visit/Continuity of Care**

Home visit is a family – nurse contact which allows the health worker to assess the home and family situation in order to provide the necessary nursing care and health related activities. The purpose of home visit in nursing is

to give care to the sick with the view to teach a responsible family member to give the subsequent care, also to assess the living condition of the patient and his family and their health practices in order to provide the appropriate health teaching.

**First Home Visit: 12<sup>th</sup> November, 2022.**

Saturday, 12<sup>th</sup> November, 2022 was my first home visit to my patient's house while he was still on admission at 2:20pm. I got to Suyani-Odumasi around 3:05pm after attending to my patient on the ward. The aim was basically to find out about the environment in which the family live, and also to help identify the possible health problems in the home environment and to establish a link between the problems of my patient's condition and then to help remedy the situation through health education.

My patient's father as well as his younger brother were in the house when I got there. They welcomed me and greetings were exchanged, a seat was offered to me as well as a glass of water. I told them that I have come to visit them in order to find out any information that can help in the management of my client.

My assessment of the house revealed that my client together with his younger brother live in one room. The bath house is a temporal detached building in front of the house with a drain into the main gutter. They share a common kitchen. The main source of fuel for cooking is firewood and charcoal which produced a lot of smoke into the rooms. I took the opportunity to educate them not to allow too much smoke indoors. The main source of water is a borehole not far from their house and rain water which they stored in barrels without fitting lids. I educated them on the need to cover the barrel, regular cleaning of the barrel and to boil rain water before drinking it.

I educated them on the need for personal and environmental hygiene such as washing their hands with soap and water after visiting the washroom and before meals, trimming of finger and toe nails, the need to bath at least

twice daily, washing cooking utensils after meals and not leaving them overnight till the next morning, the need to protect food adequately from flies and dusts, clearing of bushes around the house and proper disposal of refuse as well as the disease condition Gastroenteritis: its causes, mode of transmission, signs and symptoms and prevention, the need to ensure adequate ventilation, visiting the hospital during pregnancy and established the link between them to aid their understanding. I allowed all the family members present to ask question and answered them tactfully. I told them of my next visit. I bade them goodbye and left the house around 4:10pm.

**Second Home Visit: 18<sup>th</sup> November, 2022.**

The second home visit was made on Friday 18<sup>th</sup> November, 2022 in the evening at 4:00pm. I was very happy to see Mr. A.K.E and the family. He was very well and his condition had improved. The purpose of the visit was to assess the health of Mr. A.K.E and to see whether the education given during admission and first home visit were being followed. There was a warm reception on arrival and they were very happy to see me again. A seat and a glass of water was offered to me. I asked about how he felt and he said his condition was better.

After assessing the surrounding, I congratulated them for keeping to the health education given. The barrel was well cleaned and fittingly covered with a lid. The backyard had also been cleared. The signs and symptoms, causes, prevention and complications of Gastroenteritis could easily be repeated to me by my client and the relatives. I encouraged them to do more. I also asked them if they have any concern to express in the care, they are given to Mr. A.K.E at home. I reminded them of the review date which was on the 22<sup>nd</sup> November, 2022. I then asked permission and left there around 6:10pm to my house and I was escorted by Mr. A.K.E.

### **Review (21<sup>st</sup> November, 2022)**

Early in the morning, I called my client to remind him and he told me that he is aware and he is preparing to come. On his arrival, I went with my client to the OPD to activate his folder. Upon my interaction with patient, I observed that his condition had really improved.

I escorted him to the consulting room and upon assessment by the doctor he confirmed the condition had improved. His vital signs were checked and were within normal range, thus, Temperature: 36.4°C, Respiration: 19cpm, Pulse: 86, Blood Pressure: 124/79 and weight: 58.4kg. No medication was given to him, he thanked me, I bade him goodbye and then he left.

### **Third Home Visit: 29<sup>th</sup> November, 2022.**

On the said date, I went for my third home visit. The aim of the visit was basically to terminate care with my patient and family and also to handover to a public health nurse for the continuity of care. I set off around 9:30am and I arrived at around 10:06am. When I got to the house, I was welcome by my patient's mother. I was offered a seat. My mission of the visit was asked and I told them that, I came to terminate the care I had with them and also to handover to a public health nurse. Upon my assessment, I realized that Mr. A.K.E was doing very well and they were also following the treatment regimen. To enhance the continuity of care, I handed them over to a Public Health Nurse at Kwatiri Poly Clinic for continuity of care. The in-charge told me she knows them since they have been accessing care from them. After explaining to them the need to follow up, I was assured that the public health care providers would pay regular visits to my patient and the family after I had handed them over to the clinic. I also told patient and his relatives not to hesitate to call me anytime they needed my help. I used this opportunity to thank them of giving me the chance to use them for the patient and family care study. I told

them that, I may not be able to visit them frequently but I will pay them friendly visit. They congratulated me for everything I did for the family and escorted me to the road side where I took a taxi to my house.

## **CHAPTER FIVE**

### **EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY**

#### **5.0 Introduction**

Evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process. The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to my patient and family.

#### **5.1 Statement of Evaluation**

Throughout the period, health problems were recorded and objectives were set to solve them. Below is the summary of the interventions carried out and to what extent the goals were met.

During my interaction with the patient seven problems were identified as follows:

##### 1. Patient was relieved of abdominal pain

On admission patient complained of abdominal pain hence the nursing diagnosis of altered body comfort related to abdominal pain was formulated. An objective was set to help alleviate patient from abdominal pain within 1 hour. The following interventions were implemented: Patient was reassured that the pain will subside in the course of treatment, patient's level of pain was assessed using the pain rating scale of 0 to 10, patient was engaged in conversation to divert his attention from the pain, nursing activities were scheduled to limit the number of visitors, patient was nursed on a comfortable bed free from creases and cramps and 1G of IV paracetamol was served to relieve patient of his abdominal pain.

On 11<sup>th</sup> November, 2022 at 11:15am evaluation of the set objective on 11<sup>th</sup> November, 2022 at 11:15am to relieve patient of abdominal pain within 1hours was done; goal was fully met as evidenced by nurse visualizing that patient did not exhibit any sign abdominal pain.

## 2. Patient's fluid and electrolyte imbalance was restored normal

An objective was set on 11<sup>th</sup> November, 2022 at 11:30 to restore patient's fluid volume and electrolyte balance to normal within 72hours. The following nursing interventions were carried out; Patient and family were reassured of comprehensive nursing care, nauseating items such as bedpan were emptied immediately after use, patient's oral hygiene was done twice daily, signs of dehydration such as sunken eyes and poor skin turgor were monitored, patient was encouraged to take in oral fluids, prescribed IV RL were administered.

Goal was fully met on 13<sup>th</sup> November, 2022 as evidenced by patient verbalizing that he no more feel nauseated and vomit again.

## 3. Patient's body temperature was reduced to normal

It was found out on 11<sup>th</sup> November, 2022 at 11:40am, that patient had high temperature (38.6), an objective was set to enable patient maintain his normal body temperature that is within (36.2°C- 37.2°C) within 24hours. The following nursing interventions were carried out; Patient was reassured, cold don simon fruit juice was served, patient was tepid sponge to reduce temperature by 1°C within 30 minutes, windows were opened and the fans were switched on, tight clothing removed, temperature was checked and recorded every 30 minutes until temperature subsided and 1g of IV paracetamol served. Goal was fully met on 12<sup>th</sup> November, 2022 at 10:00am as evidenced by Nurse recording body temperature of 37.1° C which is normal.

#### 4. Patient was relieved of diarrhoea

It was found on day of admission at 12:00pm that patient was having diarrhoea, an objective was set to relieve patient of his diarrhoea within 48hours. The nursing interventions that were carried out were; Patient was reassured that the diarrhoea will subside with time, patient's skin turgor and mucous membranes were assessed to rule out any deviations, oral fluids intake of about 2-3 litres a day was encouraged to maintain a normal fluid volume, a strict intake and output was monitored, vital signs were checked and recorded as and when the time was due, intravenous RL was administered to cater for fluid deficit, patient was weighed each morning.

On 13<sup>Th</sup> November, 2022 at 11:30am, goal was fully met as nurse observed that patient has a normal skin turgor and mucous membranes.

#### 5. Patient gained adequate nutrition

It was found on the day of admission at 12:20pm that patient had loss of appetite hence the nursing diagnosis high risk of nutritional imbalanced (less than body requirement) related to low dietary intake was formulated and a goal was to make patient have good nutrition as required within 72 hours. The following nursing interventions were carried out; Patient's mouth was cleaned before and after meals, patient favourite meals were served, nauseating objects like bed pans and urinals were removed before food was served, food was served in bits, attractively and in frequent intervals and cold don simon fruit juice was served.

On 13<sup>Th</sup> November, 2022 at 3:43am, goal was fully met as nurse observed that patient ate two-thirds of food served in addition.

#### 6. Patient and his family were no more anxious

It was found on 11<sup>th</sup> November, 2022 at 12:35pm that patient and his relatives were anxious about the unknown outcome of the condition and hospitalization, an objective was set to relieve them from anxiety within 24hours. The nursing interventions included, patient was reassured that he was in the hands of competent nursing staff, patient was introduced to a man who has almost recovered from the same condition to share ideas, time was spent with patient and he was allowed to ask questions and express his fears, and patient's concerns about disease condition were addressed appropriately.

Goal was fully met as patient and his relatives verbalized that they were no more anxious on 12<sup>th</sup> November, 2022 at 10:00am.

#### 7. Patient performed activities of daily living without assistance

It was found out on day of admission at 12:50pm, that patient was very weak and therefore could not perform activities of daily living. An objective was set to enable him perform activities of daily living unassisted within 48hours. The following nursing interventions were carried out; Patient's level of activity intolerance was assessed, patient was assisted to do passive exercises, complete bed rest was ensured and visitors were restricted, patient was assisted to assume semi-fowlers position, respiratory response of patient activities was monitored and patient was encouraged to eat his meals regularly.

Goal was fully met on the 13<sup>th</sup> November, 2022 at 9:40am as patient was able to perform oral hygiene and also bath without any assistance.

## **5.2 Amendment of the Nursing Care Plan**

Despite the numerous problems identified, with the individualized comprehensive nursing care and support from other members of the health team and co-operation of patient and family, all of the goals set were fully met. The care plan was therefore not amended.

## **5.3 Termination of Care**

Care of patient and family ended on the 29<sup>th</sup> November, 2022 which was my last home visit. This ended the interaction between the health team and the patient and his family. The preparation for termination started on day of admission through discharge, review to the third home visit. During these periods, patient and family were educated on various topics. I congratulated the family for the care they had rendered to the patient. They were thanked for their co-operation and patient was handed over to his parents. They were told that now that Mr. A.K.E health had been restored, the care for him has officially ended. I informed them of my desire to visit them unofficially whenever I had the opportunity. They were happy and noted that they would miss my care and would strictly adhere to all instructions given to them. It was a moment to remember when I told them of my intention to leave. There was no separation anxiety as patient and the relatives had enough psychological preparations from the day of admission till discharge but it was still difficulty bidding them farewell.

## CHAPTER SIX

### SUMMARY AND CONCLUSION

#### 6.0 Introduction

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

#### 6.1 Summary

Mr. A.K.E, a 26years old man was admitted on the 11<sup>th</sup> November, 2022 to the male's ward of SDA Hospital-Suyani with a diagnosis of Gastroenteritis. On admission, Mr. A.K.E presented the following problems; nausea and vomiting, passing loose stools (bloody and mucoid- 4 times), inability to sleep, cannot eat well, fatigue, high body temperature and abdominal pain. During the period of hospitalization, roles such as, checking and recording of vital signs, educating patient on his condition etc were done. Administration of antibiotics, antipyretics and analgesics to prevent infection, reduce fever and to relieve the patient of pain were also done. Patient`s condition improved satisfactorily due good nursing and medical interventions. It was observed that a successful patient and family care depends on the cooperation of the patient and family with the nurse. Three home visits were embarked on. The first home visit was done while patient was still on admission on 12<sup>th</sup> November, 2022, second home visit was on the 18<sup>th</sup> November, 2022 and third home visit was on the 29<sup>th</sup> November, 2022. The care of Mr. A.K.E and His family care was terminated on 29<sup>th</sup> November, 2022, during the third home visit when patient had fully recovere

#### 6.2 Conclusion

In conclusion, my choice of nursing Mr. A.K.E has increased my knowledge into his condition, gastroenteritis. It has given me in depth knowledge on the causes, signs and symptoms, diagnosis, treatment, complications and possible prevention of the disease condition. This study has also enabled me gain knowledge on how to practically

care for a patient with gastroenteritis using the nursing process. I therefore recommend that every health institution should employ the use of the nursing process, so as to enable them provide individualized, holistic and comprehensive nursing care to help decrease re-occurrences of diseases in our hospitals as well as reducing mortality rate. I also recommend that every nursing student should be given the opportunity to embark on the patient/family care study to enable them obtain more insight on the condition under study.

## APPENDIX

**Table 6: Vital Signs of Mr. A.K.E**

Date	Time	Temperature (°C)	Pulse (bpm)	Respiration (cpm)	Blood pressure (mmHg)	Weight (kg)
11/11/22	11:00am	38.6	100	25	90/40	50
	2:00pm	37.5	71	23	98/55	
	06:00pm	37.6	73	24	107/60	
	10:00pm	37.4	78	22	122/73	
12/11/22	06:00am	37.0	92	24	120/77	51.4
	10:00am	37.1	88	22	115/72	
	02:00pm	37.0	90	24	118/82	
	06:00pm	36.9	78	20	125/79	
	10:00pm	36.8	81	22	121/81	
13/11/22	06:00am	36.8	84	22	115/75	53.1
	10:00am	36.6	88	22	120/80	
	02:00pm	37.0	104	26	119/68	
	06:00pm	35.7	98	26	124/77	
	10:00pm	36.6	84	21	120/81	
14/11/22	06:00am	36.5	78	23	122/81	56
	10:00am	36.7	82	21	124/80	

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Patient's Folder Number: 7304/19 Suyani-SDA

## SIGNATORIES

The Student Nurse

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Date:.....

The Supervisor, Holy Family Nursing and Midwifery Training College, Berekum

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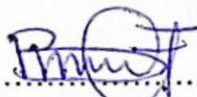
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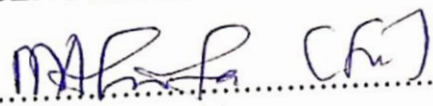
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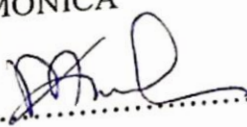
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