HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT AND FAMILY CARE STUDY ON PEPTIC ULCER DISEASES

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

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PREFACE

The patient and family care study is a study on patient with a particular disease condition. The study is based on the nursing process which has the assessment, analysis, planning, implementation and evaluation to be its components which follows a systematic method. Nursing is a health care profession which focuses on the care on individual, family and the communities so that they attain optimal health and quality of life from conception to death. In the past, nursing was basically about caring for the sick. Also, it did not require any formal training before one was permitted to practice until the era of Florence Nightingale.

Since the period of Florence Nightingale, nursing has gone through tremendous educational transformation such as the use of research and scientific data in the performance of the various roles in ensuring quality health care.

The study provides knowledge and understanding of the cause, pathology, diagnosis and treatment of the patient's condition. It gives an account of the actual nursing care rendered to a patient and her family from the time of admission until time of discharge.

The study forms part of the academic requirement on obtaining the Registered General Nursing Certificate awarded by the Nursing and Midwifery Council of Ghana.

It offers the student nurse the chance to put into practice the theoretical knowledge and experiences gained during the period of training. It broadens the knowledge of the student nurse in terms of a particular disease condition and its management. The study helps the patient /family to comprehend and gain insight into the condition.

Finally, it builds a good cordial relationship between the nurse and patient /family as well as other members of the health team.

The confidentiality of the patient and family were ensured by the use of patient and family initials instead of their full names.

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Lastly, I am very grateful to the various authors and publishers from whose books, valuable information was obtained during the literature review stage to bring this care study to a successful conclusion.

MAY GOD RICHLY BLES YOU ALL.

INTRODUCTION

This patient and family care study was carried out on Madam A.A, a 54-year-old woman. She was admitted into the Female ward of the Kintampo Municipal Hospital on 16th November, 2022 at 6:55pm with a diagnosis of peptic ulcer disease.

My first encounter with her was the day she was admitted (16th N0vember, 2022) and continued throughout her hospitalization and during follow up and home visits.

I welcomed them and reassured them as they appeared very anxious. I introduced myself to them and all the necessary procedures in relation to her condition were carried out. It was during my interaction with them that I sought permission to take Madam A.A for my Care study which they agreed.

My interaction with Madam A.A lasted for Five (5) days. Her condition improved as a result of the adequate nursing care interventions which led to her discharge (20th November, 2022) on the fifth day of admission. Madam A.A and her relatives were chosen for my care study in order to enable me widen my knowledge and understanding about the condition (Peptic Ulcer Diseases).

She was treated with the following medications during the period of stay on the ward Intravenous omeprazole 80mg stat, Iv Hyoscine 40g stat, Iv metoclopramide 40g stat. etc.

The patient/family care study was organized under six (6) chapters which are;

Chapter One: Assessment of Patient/Family Chapter

Two: Analysis of Data.

Chapter Three: Planning of Patient/Family Care.

Chapter Four: Implementation of Patient/Family Care Plan.

Chapter Five: Evaluation of Care Rendered to Patient/Family.

Chapter Six: Summary and Conclusion.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment as the first step in nursing process involves collection of information through interviewing, observing and investigation from patient's relatives and other sources from which analysis can be made in order to identify the problems of the patient so as to plan and implement care.

Assessment is the systematic and continuous collection of data; sorting, analyzing, and organizing data; and the documentation and communication of the data collected to determine the patient's health status and any actual or potential health problems (Butler & Pace, 2019).

Assessment involves collection of data, systematically from the patient or relatives through observation, interviewing and investigations such as laboratory results, x-ray reports and physical examination of the patient. It is the first stage of the nursing process. This information will serve as foundation upon which appropriate nursing intervention will be established and implemented for the speedy recovery of the patient.

1.1 Patient Particulars

According to the Collins English Dictionary, patient particulars are facts or details about them which are written down and kept as record. These details of information of the patient that has been recorded which include name, sex, and date of birth, religion, marital status, next of kin, address and occupation.

Madam A.A is the name of my patient She is 54 years old and was born on 19th May, 1968 at the Jirapa Municipal Hospital in the Upper West Region of Ghana. Madam A.A comes from Jirapa but currently resides at Kintampo as permanent resident with house number (XE1246).She is a Ghanaian by nationality and Dagari by tribe. She is married and has given birth to 4 Children (1-Boy and 3-Girls). Madam A.A has 5-siblings (3 males and 2 females). She is a member of the Church of Pentecost (Kintampo-branch),Patient next of kin is her sister called A.R who is in the same house with Madam A.A at Kintampo. Madam A.A is dark in complexion, weighs 68kg and height of 164cm. She has tribal mark on her face. She speaks Ashanti Twi and Dagari and has nodeformity. Madam A.A said she is a farmer but her husband suffered demise two years ago and therefore she mostly depends on her children for other support.

1.2 Patient/ Family Medical History

A family's medical history is a record of medical information about an individual and their biological family. Family history provides a ready view of problems or illnesses within the family and facilitates analysis of inheritance or familial patterns (Shiel, 2019). According to Madam A.A, there is no known hereditary disease such as tuberculosis, diabetes mellitus, hypertension, sickle cell disease and mental illness respectively in the family. Occasionally, members of the family suffer from minor conditions like cough, diarrhea and abdominal pain which are normally treated with over-the-counter drugs and there are no known allergies among the family and their major source of medical treatment is orthodoxically.

Patient said her parents died as a result of an unknown cause. The siblings of Madam A.A are all in good health condition and Madam A.A said she had been admitted to the hospital on several occasions with the history of peptic ulcer disease. According to my patient, the family has neither experienced any outbreak of communicable disease in their family. However, when any of the

family members experience minor sickness like malaria, common cold, headache or constipation, they resort to herbal medicine and when the illness becomes severe, they visit the hospital for medical assessment and treatment and there is no history of alcohol or any other substance use in the family.

1.3 Patient/Family's Socio-Economic History

According to WHO, socio-economic history is the social science that studies how economic activities affects and shaped by social processes. Madam A.A and her family belong to middle socio- economic class and they are able to provide all their basic needs. Client said she gets support from her children. She is a registered member of the National Health Insurance Scheme (NHIS). Patient's children are government workers and at the same time farmers. According to client, they are well known in their area because of their affinity for farming and their generosity towards others and to her, their annual income amounts is about 10,000.00 and about 70 percent of this income is derived from farming. The relationship between client and her family is cordial as relatives and friends visited her on admission. Her family is caring, loving and supportive. Patient also supports her family by impacting moral support in the younger ones and ensuring the maintenance of peace in the family and as a deaconess of the Church of Pentecost (Kintampo-branch), it has given her a great responsibility to impact in the church with positive influences especially to the youth in the church as expected of her.

1.4 Patient's Developmental History

Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Weller, 2017). Maturation is the process of developing

(Weller, 2017). Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development (Weller, 2017).

Madam A.A was born on 19th May, 1968 at the Jirapa Municipal Hospital. She was told by her late Parents that she was delivered in the hospital through spontaneous vaginal delivery without any complication or congenital abnormalities.

Patient said neither her Parents nor her could recall the exact time she sat, crawled and walked but confirmed that she was very active so she sat earlier and started walking before twelve months.

She developed her secondary sexual characteristic like pubic hair, broadening of hips and breast development at the age of 14years. She experienced her first menstruation at the age of 16years and got married at the age of 23 years but her first birth was at the age of 22 years and she gave birth to her last born at the age of 31 years, She started using contraceptives intermittently after she had given birth to her first child but currently at her menopausal stage. She started her primary education at the age of 6 years at D/A primary school in Jirapa. She was very intelligent at school and her aspiration was to become a Medical Doctor but she did not get the support to pursue her dream of becoming the Medical Doctor.

According Erik Eriksson's theory of psychosocial development which has 8 stages namely:

- Trust versus mistrust (birth to 1year)
- Autonomy versus shame and doubt (18 months to 3years)
- Initiative versus guilt (3 to 6years)
- Industry versus inferiority (6 to 12years)

- Identity versus role confusion (12 to 18years)
- Intimacy versus isolation (20 to 35years)
- Generativity versus stagnation (35 to 65years)
- Integrity versus despair (65 to death)

Madam A.A is 54 years old and falls within Generativity versus stagnation (35 to 65years)

Which is the seventh stage? At this stage, adults strive to create or nurture things, often through parenting, contribution to community, or some other positive change. Again, at this stage a person is motivated to redirect her or her energies into more meaningful activities and caring for the community or the future generation as a whole. If generativity is not developed, rejectivity, or a lack of meaning in one's actions can occur. My client can be said to have achieved Generativity since she is much concern in directing her energies into more meaningful activities and caring for her community and for the future generation as a whole.

1.5 Patient's Lifestyle and Hobbies

According to Madam A.A she wakes up every morning around 5:30am and says a word of prayer before getting out of bed. She empties her bowel, brushes her teeth with tooth brush and tooth paste and takes warm bath, empty her bladder. She goes to bed around 9:30pm.

Patient stated that she hardly takes breakfast but sometimes takes tea/beverage with fried egg at 7:30am before taking her due medications. I took the chance to educate her on the need for her to take her breakfast and the effect it has on her health if she doesn't do that. She is allergic to food rich in pepper, spicy food as well as allergic to amodiaquine and chroloquine because it always predisposes her to abdominal discomfort, nausea and vomiting and skin rashes. She normally takes tea with fried egg for breakfast, yam with "nkontomire" stew for lunch and "fufu" with groundnut

soup and fish for supper. She is able to cope with stress by addressing issues in a matured and appropriate way. She does not smoke nor takes in alcohol. At her leisure time, she listens to music especially gospel musician Anita Afriyie, listens to news and watch her favorite television program which is "Abrabo mu nsem". Patient stated that she has no sleeping difficulties but sometimes do not have the urge to eat. She does not like attending parties and dislikes gossiping, being deceived and lied to. Patient is caring, kindhearted, sociable and hardworking.

1.6 Patient's Past Medical History

According to patient she has no childhood illness but sometimes suffer from minor ailments like headaches, fever, diarrhoea and general body pains but it is usually managed at home by using over the counter drugs. She is a known peptic ulcer disease patient which started 21 years ago. She has been hospitalized eleven (11)times with the same condition. Drugs always given are cap omeprazole and amoxicillin. She does not attend regular check-ups. She has not undergone any surgery and transfusion before.

1.7 Patient's Present Medical History

According to Madam A.A., she had been in a normal usual state of health until two days to her admission thus 14th November, 2022 when she started experiencing epigastric pain and her relative bought her amoxicillin around 9:30pm.

On 16th November, 2022 around 5:30pm Patient was seen at the outpatient department examine and Diagnose of peptic ulcer diseases. She was in pain and admitted at the female's ward of the Kintampo Municipal Hospital. On her arrival she was further examined by P.A J. Oand was diagnosed as having Peptic Ulcer and was admitted to the female's ward.

1.8 Admission of the patient

On 16th of November, 2022 at 6:55pm, Madam A.A was brought to the females' ward per ambulation accompanied by a nurse. They were warmly welcomed to the ward. Patient complained of severe abdominal pain. She was diagnosed of peptic ulcer disease by P.A J. O she was given a bed and was made comfortable whiles the daughter was offered seats at the nurses' station.

A quick assessment of her general condition was made and her vital signs checked and recorded on admission as follows;

Temperature: 36.8degree Celsius

Pulse: 68 beat per minute

Respiration: 22cycle per minute

Blood pressure: 110/70 millimetres of mercury.

Weight: 60kg

The following drugs were ordered for my patient;

1. Intravenous Metronidazole 500mg tds x 24hours
2. Intravenous Omeprazole 80mg bd x 24hours
3. Syrup lactose 15mill tds x 5
4. Ringers 500mls Stat

5. IV metoclopramide 100g stat

6. IV tramadol 100mg bd x1 stat

Patient was ordered to do blood test for malaria parasites estimation test on admission. Since patient was in severe pain her daughter was orientated to the ward environment such as the nurses' station, toilet, bathroom, urinal and kitchen. They were also informed about the visiting hours which is 5:30am-6:30am in the morning, afternoon 12:00pm-1:00pm and evening 4:30pm5:30pm and I also told her about doctors daily routine ward rounds. I documented her information in the admission and discharge book and the daily ward state and her drugs were collected from the pharmacy and stat doses administered as ordered. I made her comfortable in bed and reassured her relative and her of being in the hands of competent health professionals, who will provide the best of care to ensure her speedy recovery and discharge. I went on further explain to her that the medication (IV tramadol 100mg bd x1 stat) will help relief the severe pains she is going through and all the necessary information taken will help in the continuity of care by the health team.

I went to her later after her pain had subsided and introduced myself to her again as a final year student of Holy Family Nursing and Midwifery Training College, Berekum. I made her aware that as a final year student, it is a requirement by the Nursing and Midwifery Council to take a patient, and render individualized nursing care to her from admission until discharge and carry out home visits before and after discharge until she recovers fully. Madam A.A and family agreed and promised to cooperate with me and give all the necessary information to complete the care rendering to them. I choose my client for the study in order to gain more insight about peptic ulcer disease so to help the patient to gain adequate knowledge about her condition and possible ways to help manage her condition to improve her health.

1.9 Patient's Concept of Her Illness

According to Madam A.A, it is normal for every human being to fall sick and she therefore did not associate her illness to any supernatural forces. Patient said she believe that her condition is as a result of starving and also whenever she takes in food containing high amount of pepper and spices. She believes that with good care given by the health team, she will recover from her illness.

1.10 Literature Review on Peptic Ulcer Disease

Anatomy and physiology of the Gastro-Intestinal Tract (GIT)

According to Smelter and Bare (2018), the GI tract is a 23- to 26-foot-long (7 m to 7.9 m) pathway that extends from the mouth to the esophagus, stomach, small and large intestines, and rectum to the terminal structure, the anus.

The esophagus

According to Tortora and Derrickson (2020), 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 secretes mucus from mucous glands which aid the 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.

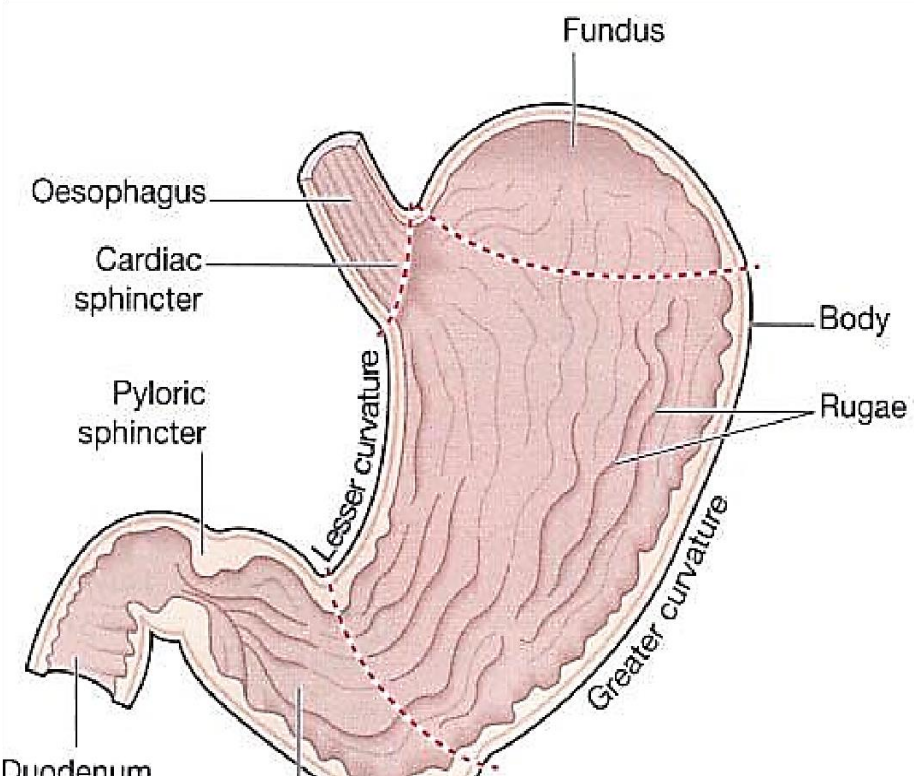
The stomach

According to According to Smelter and Bare (2018), the diagram below shows the anatomical structure of the stomach.

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. 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.

According to Tortora & Derrickson (2020), the stomach has five major functions.

1. Temporary food storage.
2. Control the rate at which food enters the duodenum.
3. Acid secretion and antibacterial action.
4. Fluidisation of stomach contents.
5. Preliminary digestion with pepsin, lipases.



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.

The Small Intestine

According to Waugh & Grant (2018)**,** 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 rhythmical 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 neutralise 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.

Definition of peptic ulcer Diseases

According to Smeltzer, Bare, Hinkle and heever (2018), peptic ulcer is an excavation (hollowed-out area) that forms in the mucosal wall of the oesophagus, stomach, in the pylorus (the opening between the stomach) and duodenum, or in the duodenum (the first part of the small intestine).

Peptic ulcer may be referred to as an oesophageal, gastric, or duodenal ulcer, depending on its location. It is cause by erosion of a circumscribed area of mucous membrane. This erosion may extend as deeply as the muscle layers or through the muscle to the peritoneum. Peptic ulcers are more likely to occur in the duodenum than in the stomach.

Incidence

According to Smeltzer, et al., (2018), the disease can occur anywhere, but it is common only in some area. Peptic Ulcer Disease occurs more in men than women with the ratio 3:1. It was recorded in London 20 years ago that duodenal ulcer was two to three time’s common than gastric ulcer. The prevalence of peptic ulcer is higher in Scotland and the `than gastric ulcer and occurs in younger age. Gastric ulcer becomes relatively common in elderly. After menopause, the incidence of peptic ulcer in women is almost equal to that of men with duodenal ulcer.

Causes of peptic ulcer disease (predisposing factors)

According to Kumar and Clark (2020), the causes of peptic ulcer are as follows;

1. Age (most often in people between the ages of forty and sixty years)
2. Emotion or stress and anxiety
3. Infection of a gram-negative bacterial (helicobacter pylori)
4. Familial tendency
5. Chronic use of Non-Steroidal Anti Inflammation Drugs E.g. Diclofenac, aspirin.
6. Alcohol ingestion
7. Intake of spicy foods
8. Excessive smoking
9. Irregularities in hormonal secretion e.g. estrogen and progesterone lower acid secretion.
10. Blood type; duodenal ulcer is common in blood type O and gastric ulcer in blood type A
11. Certain endocrine diseases such as hyperthyroidism, pituitary tumour
12. Impaired activity of the pancreas

Types of peptic ulcer disease

According to Smeltzer, et al., (2018), peptic ulcer can be classified according to the location or site of mucosal erosion.

1. **Oesophageal Ulcer:** This is the less common type of Peptic Ulcer where there is an excavation in a part of the mucosal lining of the oesophagus.
2. **Gastric Ulcer:** This is an excavation formed in the mucosal wall of the stomach.
3. **Duodenal Ulcer**: This is an excavation formed on the mucosa wall of the duodenum.

Pathophysiology of peptic ulcer Diseases

According to Smeltzer, et al., (2018), peptic ulcers occur mainly in the gastro-duodenal mucosa because this tissue cannot withstand the digestive action of gastric acid (HCl) and pepsin. The erosion is caused by the increased concentration or activity of acid–pepsin or by decreased resistance of the mucosa. A damaged mucosa cannot secrete enough mucus to act as a barrier against hydrochloric acid. The use of Non-Steriodal Anti-inflammatory Drugs (NSAIDs) inhibits the secretion of mucus that protects the mucosa. Patients with duodenal ulcers secrete more acid than normal, whereas patients with gastric ulcers tend to secrete normal or decreased levels of acid. Damage to the gastro- duodenal mucosa results in decreased resistance to bacteria, and thus infection from Helicobacter pylori bacteria may occur. Diarrhoea and steatorrhea (unabsorbed fat in the stool) may be evident.

The most common symptom is epigastric pain. Patients may present with Gastrointestinal bleeding as evidenced by the passage of tarry stools. A small portion of patients who bleed from an acute ulcer have had no previous digestive complains, but they develop symptoms thereafter.

Clinical features of peptic ulcer Diseases

According Smeltzer, et al., (2018) clinical features of peptic ulcer are as follows;

1. Dull gnawing pain or burning sensation in the mid-epigastrium or the back (epigastric pain).
2. Feeling of hot water babbling in the back of the throat
3. Vomiting

4. Bloating (abdominal tenderness)
5. Nausea
6. Constipation or diarrhoea
7. Hematemesis (vomiting blood)
8. Gastrointestinal bleeding
9. Tarry stools
10. Anaemia (if the ulcer has bled)
11. Night awaking: this normally occurs in patients with duodenal ulcer due to severe pain that is relieved by eating.

Difference between gastric and duodenal ulcer

Smeltzer, et al., (2018), outlined the differences between gastric ulcer and duodenal ulcer.

The table below differentiates gastric ulcer from duodenal ulcer

Table 1: difference between gastric and duodenal ulcer

Gastric ulcer	**Duodenal ulcer**
Male-Female ratio is 1:1	Male-Female ratio is 2-3:1
There is loss of weight.	Rapid weight gain.
Vomiting is common.	Vomiting is uncommon.
Pain does not commonly occur at midnights	Pain commonly occurs at midnights.
Ulcerations normally occur at the antrum, body and fundus of the stomach.	Ulcerations normally occur in the first 1-2cm of the duodenum.
Pain is aggravated by the intake of food.	Pain is relieved by the intake of food.
Pain occurs ½-1 hour after meals.	Pain occurs 2-3 hour after meals.
Less likely to perforate	More likely to perforate.

Diagnostic investigations

According to Smeltzer, et al., (2018), diagnostic investigations for peptic ulcer are as follows;

1. Upper gastric intestinal tract endoscopy and biopsy to rule out cancer.
2. Stool analysis reveals occult blood.
3. Barium radiographic studies of the intestinal tract reveal changes in the mucosa.

4. Computed tomography scan of the stomach and duodenum.
5. History from patient.
6. Serum gastrin levels.
7. Antigen test to detect presence of helicobacter pylori antigen in blood.
8. Esophagogastroduodenoscopy (EGD) to determine the size and depth of the ulcer.
9. Presenting signs and Symptoms.

Medical treatment

According to Kumar and Clark (2020), advances in drug therapy have dramatically changed the management of Peptic Ulcer Disease and significantly improved its effectiveness.

A variety of changes exists and the specific protocol for any particular patient is determined based on the preference of the physician and the patient's unique profile. The goal of the management is to eradicate helicobacter pylori, to manage gastric acidity, promote healing of the ulcer, and prevent reoccurrence and complications and to alleviate symptoms.

Drug therapy control peptic ulcer symptom effectively often in a matter of days;

1. Antacids are given to neutralize the HCL. E.g. Magnesium Trisilicate, Aluminium Hydroxide.
2. Histamine 2 receptor antagonist is given to reduce gastric secretion. E.g. Cimetidine and Ranitidine.
3. Proton Pump inhibitors are given to eliminate acid secretions. E.g. Omeprazole, lansoprazole, rabeprazole.

4. Mucosal Protective Agent is given to form a protective coat that prevents further excavation. E.g. Sucralfate, Misoprostol.
5. Antimicrobial agent is given to prevent further infection. Eg Metronidazole, Amoxicillin.
6. Analgesics to relive pain. E.g., Paracetamol, Tramadol.

Specific medical and surgical intervention

According to Kumar & Clark (2020), peptic ulcer disease can be treated both medically and surgically. The aim of treating peptic ulcer disease includes:

1. To prevent complications and recurrence.
2. To alleviate symptoms of the disease.
3. To optimize the condition that promotes healing.
4. To decrease the offensive factors responsible for ulceration.

Surgical intervention

According to Kumar & Clark (2020), Surgery is used primarily for the management of complication such as perforation, suspected cancer and the treatment of the occasional interact able ulcer that is resistant to all standard therapy. Surgery procedures adopted include:

1. **Vagotomy** – This is the surgical removal of the vagus nerves. There are three types and these are truncal, selective and highly selective.

2. **Antrectomy**–This is the surgical removal of the pyloric (antrum) portion of the stomach with anastomosis to the duodenum either (gastroduodenostomy or Billroth I) or jejunum (gastrojejunostomy on Billroth II).

3. **Pyloroplasty** – This is the surgical removal of the pyloric sphincter

Nursing management

According to Smeltzer, et al., (2018), nursing management of patient with peptic ulcer include;

Position

Patient was made comfortable on a well-prepared admission bed with enough pillows for comfort. Patient was made to assume a normal position that was not contrary to her health example supine position. This helps the patient to relax and reduce pain. The patient was positioned to avoid neck pain and joint stiffness.

Reducing anxiety / reassurance

1. The nurse assesses the patient's level of anxiety and reassured that she was in the hands of competent and well-trained staff that are always ready to offer care and support to ensure good health.
2. She was also introduced to other patients who have similar conditions as her and have had their treatment waiting to be discharged
3. Relatives were also reassured that all necessary procedures will be done for her.
4. Diversional activities such as watching of televisions and the use of slide pictures were provided to divert patients mind from her condition.

5. Patients with peptic ulcers are usually anxious, but their anxiety is not always obvious. Appropriate information is provided at the patient's level of understanding, all questions are answered, and the patient is encouraged to express fears openly. Explaining diagnostic tests and administering medications on schedule also help to reduce anxiety.
6. The nurse interacts with the patient in a relaxed manner, and relaxation methods, such as biofeedback, hypnosis, or behavior modification.
7. The patient's family is also encouraged to participate in care and to provide emotional support.

Rest and sleep

1. A quiet environment was provided by reducing noise to allow patient to get enough rest.
2. Windows were opened to allow ventilation.
3. Visitors were also restricted to allow patient gets enough rest and sleep.
4. Bed is being made free from creases and cramps by straighten the bed linen. Warm beverages were served.
5. Warm bath was given with warm water, soap, sponge and towel in order to relax patient and to induce sleep.
6. Teach patient rest and relaxation techniques e.g. guided imagery emphasizes the need to avoid stress.

Observation

1. Vital signs were also checked and recorded which comprises of temperature, pulse,
2. Intake and output chart were also monitored by observing intake and output chart to know patient's fluid and electrolyte balance.

3. The desired effect and side effect of drugs served were also observed.
4. Side effects of drugs should be observed and reported if any and skin and mucous membrane for signs of dehydration.
5. Physical findings of epigastric or abdominal pain, nausea, vomiting, tarry stools, bleeding was observed.
6. Patient's response to medication therapy, nutritional therapy and emotional rest was observed.

Personal hygiene

1. Body hygiene is done by giving an assisted bed bath twice daily with warm water, soap, sponge and towel to prevent offensive odour and to remove microorganisms from the skin. Bony prominences, which are prone to be sore, are well cared for by treating the area to prevent bedsore.
2. Soiled bed linens are also changed when dirty or wet to prevent bad odour and harboring of microorganisms.
3. Oral hygiene was also done twice daily with toothpaste and toothbrush. This was done to prevent oral offensive smell and to prevent the harboring of micro bacteria.
4. Her hair was also cared for by washing it with soap and water and drying it with a towel.
5. Patient's hands and feet were cared for by soaking them in water and trimming the nails with nail clippers, washing and filling the nails. This will prevent harboring of microbes or prevent injury from scratching.

Nutrition / Diet

1. The intent of dietary modification for patients with peptic ulcer is to avoid over secretion of acid and hypermobility in the gastric intestinal tract.
2. These can be minimized by avoiding extremes of temperature and over secretion from consumption of meat extracts, alcohol, and coffee (including decaffeinated coffee, which also stimulates acid).
3. Dietary compatibility becomes an individual matter. The patient eats food that can be tolerated and avoids those that produce pain. Certain substance such as spicy food causes severe pain and has to be avoided.
4. Smoking should be avoided as it has been shown to delay ulcer healing regardless of the therapy.
5. Serve small frequent and bland foods. Avoid alcohol and give milk in between meals. Patient is encouraged to take enough roughage to enhance bowel elimination.
6. Vitamin and minerals such as fruits like orange, banana, pawpaw should be encouraged to boost up the immune system.

Patient / family education

1. Patient is educated on the factors that trigger the condition.
2. Modify lifestyle include health processes that will prevent recurrence of ulcer pain and bleeding.
3. Plan for rest periods.
4. Learn to cope with stressful situation.
5. Chew food thoroughly and eat in leisurely manner.
6. Eat meals in regular schedule.

7. Avoid eating large meals, as they tend to over stimulate acid secretion.
8. Adhere to prescribed treatment.
9. Educate patient to report on signs and symptoms.
10. Educate patient that antacids cause changes in bowel movement.
11. Avoid over – the counter drugs unless prescribed by doctor.
12. Explain pathophysiology of condition to patient and family.
13. Encourage stress-reducing activities
14. Educate patient on medication to be taken home, it doses, frequency, therapeutic effects and possible side effects and explain maximum compliance.
15 Educate patient to come for regular check-ups.
16. Educate patient to avoid irritating substances such as caffeine, carbonated drinks, alcohol, and extremely spiced foods.
17. Patient shoul d identify and avoid foods that cause distress and pain

Indications for surgery in peptic ulcer

According (Smeltzer, et al., 2018) these are the indication of surgery in peptic ulcer

1. Failure of ulcer to heal.
2. Increased risk of bleeding.
3. Multiple ulcer sites.
4. Pyloric or pre-pyloric ulcer.

Complications of peptic ulcer

1. Haemorrhage with hematemesis and Melena-This occurs as a result of the erosion of blood vessels due to the actions of the HCL.
2. Pyloric Obstruction-Pyloric stenosis is the narrowing of part of the stomach (the pylorus) that leads into the small intestines. This occurs as a result of scars which forms when worn out tissues are been repaired.
3. Perforation-Perforation is the erosion of the ulcer through the gastric serosa into the peritoneal cavity without warning. It is an abdominal catastrophe and requires immediate surgery.
4. Penetration-Penetration is erosion of the ulcer through the gastric serosa into adjacent structures such as the pancreas, biliary tract, or gastro-hepatic omentum.
5. Anaemia-This occurs as results of excessive bleeding from the eroded vessels.

Post-operative complications

According to (Smeltzer, et al., 2018) these are the post-operative complications of peptic ulcer

- Dumping Syndrome
- Bile reflux

Prevention of peptic ulcer disease

(Smeltzer, et al., 2018)

1. High intake of spicy and fried foods should be avoided as much as possible.

2. A regular eating pattern should be established and abnormal long periods between meals should be discouraged.

3. Intake of ulcer genic drugs such as salicylates, other non-steroidal anti-inflammatory drugs and corticosteroids should be avoided.

4. Individuals with blood type O should adopt good lifestyle in order not to be predisposing to the condition.

5. As far as emotional trauma, leading to stress and anxiety should be reduced.

6. Smoking and alcohol intake should be avoided since they irritate the gastric mucosa.

1.11 Validation of Data

According to Weller (2017), validation is the extent to which a measure, indicator or a method of data collection, possesses the quality of being sound or true as far as it can be judged. Since I want to be certain about the information given to me by my patient and family, I continuously assessed the information by asking these questions in different ways and all the time I had the same answers from them. The visit to their home and the interaction I had with other family members of the patient confirm the information given to me by patient. Again, the same information gathered from the doctors' notes, nurses' records, investigations carried out and the results and literature review of the condition strongly confirms the validity of the information gathered.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

According to Weller (2017), analysis is the process of studying or examining something in detail in order to understand it or explain it. Analysis involves making of conclusion from data collected from a patient and relative. The signs and symptoms exhibited are compared to what exist in the literature review and various laboratory investigations. The nurse analyzed such information to deduce the exact nursing diagnosis to enable her or her to formulate appropriate nursing care plans for the patient. Based on the analysis, the nurse is able to identify the problems and strengths of the patient and makes her nursing diagnoses, objectives and gives appropriate interventions.

2.1 Comparison of Data with Standard.

A. Diagnostic investigate on / Tests

The following diagnostic investigations/tests were carried out on client;

1. Blood Film for malaria parasites
2. Stool for routine examination

Table 2 below shows the comparison of diagnostic tests carried out on client and those listed in the literature review.

Table 2: Diagnostic test/ investigation in literature review compared with those carried out on Madam A.A

Diagnostic test outline in the Literature Review	**Diagnostic test conducted on Madam A.A**
Upper gastric intestinal tract endoscopy.	Upper gastric intestinal tract was not done on patient.
Stool analysis.	Stool analysis was done on patient.
Barium X-ray of the intestinal tract.	Barium X- ray was not done on patient.
Computed tomography scan of the stomach and duodenum.	Computed tomography scan was done on patient.
Physical examination	Physical examination was done on patient.
History from client.	History was taken from client.
Clinical features presented by patient	Patient's clinical features presented were examined.

Although most of the diagnostic investigation found in the literature review were not conducted on my patient. The few done were enormous to confirm the peptic ulcer.

Table 3: Diagnostic Investigation carried out on Madam A.A

DATE	SPECIMEN	INVESTIGATION	RESULTS	NORMAL VALUE	INTERPRETATION	REMARKS
16/11/2022	Blood	Malaria parasite	No malaria parasite seen	Negative (-) Plasmodium falciparum was not seen.	No malaria	No treatment given.
17/11/2022	Stool	Stool for routine examination (R/E)	Macroscopic: Formed specimen Microscopic: Intestinal spiral flagellates seen	There should not be any spiral intestinal flagellates in stool	Helicobacter pylori identified	Capsule Amoxicillin 1g bd X 7 was prescribed for patient.

B. Causes of patient's condition

With reference to the literature review, some of the causes of peptic ulcer are excessive smoking, alcohol, stress and infection (helicobacter pylori) etc. Madam A, A's condition was caused by infection with helicobacter pylori as revealed by stool for routine examination. Also, according to patient, starving forms part of her life style which might have also predisposed her to the condition and this is in line with the causes of peptic ulcer disease as outlined in the literature review.

C. Clinical Features / signs and symptoms

Comparison of clinical features exhibited by client with those outlined in the literature review.

Table below shows comparison of clinical features presented by Madam A.A to that in the literature review.

Table 4: Clinical features exhibited by client compared with those in literature review

Clinical features outlined in literature review	**Clinical features exhibited by client**
There is epigastric pain	Patient complained of abdominal pain which started as an epigastric pain
There is loss of appetite	Patient complained of loss of appetite
There is nausea and vomiting	Patient complained of nausea and vomiting
There is dizziness	Patient did not complain of dizziness
There is heartburns	Patient did not complain of heartburns
Bleeding	Patient did not complain of bleeding
There is intermittent insomnia	Patient complained of intermittent insomnia

From the above comparison, Madam A.A exhibited most of the clinical manifestations as stated in the literature review. However, she did not experience other clinical manifestations like hemorrhage and bleeding. Patient did not experience all the clinical features because she reported to the hospital quite early and right treatment given immediately.

D. Treatment Given to my patient

The drugs below were prescribed for Madam A.A to treat her condition:

1. Intravenous Metronidazole 500mg tds x 24hours
2. Iv tramadol 100mg bd × 1
3. Iv Hyoscine 40g stat
4. Iv metoclopramide 100g stat
5. Intravenous Omeprazole 80mg bd x 24hours
6. Syrup lactulose 15mls tds x 5
7. Domperidone 30 nocte ×5
8. Capsule Amoxicillin 1g bd × 7
9. Iv Dextrose 5% 1.5 liters for 24 hours
10. Ringers lactate 500ml set up

Table below shows the treatment given to Madam A.A compared with those outlined in the literature review.

Table 5: Comparison of treatment outlined in the Literature Review with those given to patient.

Treatment outlined in literature review	**Treatment given to my client**
Antacids eg. Magnesium Trisilicate	None was ordered for patient.
Anticholinergic eg Hyoscine butylbromide	Anticholinergic (Hyoscine butylbromide 40g stat) was given
Proton Pump Inhibitors e.g: Omeprazole	Proton Pump Inhibitors **(**Intravenous omeprazole 40mg bd x24hours**)** was given.
Antibiotics eg. Clarithromycin, Metronidazole, Amoxicillin	Antibiotics (Intravenous Metronidazole 500mg tds x 24hours and Amoxicillin 1g bd x 7) was given.
Analgesics e.g Paracetamol tramadol	Analgesics (Iv tramadol 100mg bd x 1) was given
Histamine 2 receptor antagonist E.g. Cimetidine and Ranitidine	None was ordered for patient
Mucosal protective agent eg. Sucralfate,	None was ordered for patient
Anti-sickness medicine	Anti-sickness medicine (Domperidone 30mg nocte ×5)

From the comparison in table above the treatment given to my client was in line with the standard treatment. Most of the drugs given to my patient can be found in the literature review, patient had the right treatment which contributed to her early recovery.

The table 6 below shows the pharmacology of drugs administered to my patient.

Table 6: Pharmacology of Drugs administered to Madam A.A

Date	**Name of Drug**	**Dosage**	**Route of Administration**	**Classification**	**Desired Effects**	**Actual Action Observed**	**Side Effects / Remarks**
16/11/2022	Metronidazole	80mg stat	It was given Intravenously	Antimicrobials	Use to stop the growth of bacteria.	Client was relieved of infection.	Stomach pain, hot flushes, difficulty breathing, palpitation. None was observed on my patient.
16/11/2022	IV Tramadol	100mg twice daily x 1.	It was given intravenously.	Opioid Analgesics	Binds to opioid receptors and inhibits the reuptake of nor epinephrine and serotonin; causes many similar to the opioid.	Client was relieved of pains	Dizziness, somnolence, have nausea, constipation- but does not have the respiratory depressant effects. None was observed

16/11/2022	Cap Amoxicillin	1g two times daily for 14 days	orally.	Broad spectrum antibiotic.	A bactericidal antibiotic that assists with eradicating *H pylori* bacteria. To prevent or control infection by inhibiting bacteria growth.	Therapeutic effect of the drug was observed as there was a remission of signs and symptoms of infections.	Diarrhea, nausea, vomiting, fever and furry tongue. None was observed.
16/11/2022	Syrup Lactulose	15mg tid x 5.	It was given orally.	Laxative	Stool softer use in the treatment of constipation.	Client was relieved of constipation.	Diarrhea, bloating, stomach pain, feeling sick. None was observed
16/11/2022	IV Omeprazole	40 mg 2 times daily x 24hours.	It was given Intravenously	Proton Pump Inhibitor.	It decreases the amount of acid production in the stomach.	Acid production was decreased.	Headache, diarrhoea, abdominal pain, nausea, constipation. None was observed on my patient.
16/11/2022	Metoclopramide	40g stat.	It was given Intravenously	Anti-sickness medicine	Use to treat nausea and vomiting and certain	Client was relieved of nausea and vomiting and free	Difficulty in speaking, disorientation, dizziness, irregular heartbeat.

					gastrointestinal problems	from all allergic reactions	None was observed on my patient.
16/11/2022	Hyoscine	40 mg stat.	It was given Intravenously	Anticholinergic	Use to treat crampy abdominal pain, esophageal spasms, renal colic and bladder spasms.	Client was relieved of crampy abdominal pain, esophageal spasms.	Dry mouth, constipation, fast heart rate, blurred vision, etc
16/11/2022	Domperidone	30mg nocte ×5	It was given Intravenously	Antiemetics	Use to treat nausea and vomiting and certain gastrointestinal problems	Client was relieved of nausea and vomiting and free from all allergic reactions	Difficulty in speaking, disorientation, dizziness, irregular heartbeat. None was observed on my patient.
16/11/2022	IV Dextrose 5%	1.5 litres for 24 hours.	Intravenously	Glucose solution	Provide supplementary calories and fluids.	There was increase in fluid volume and glucose level in the blood.	Confusion, pulmonary edema, hyperglycemia, heart failure, osmotic diuresis. None was observed.

16/11/2022	IV Ringers lactate	500ml for 24 hours.	Intravenously	Isotonic solution	Provide supplementary fluids.	There was increase in fluid volume level in the blood.	Confusion, pulmonary edema, hyperglycemia, heart failure, osmotic diuresis. None was observed.

E. Complications

With reference to the literature review, the complications of peptic ulcer disease include; haemorrhage with hematemesis and melena, pyloric obstruction, perforation, penetration, Anaemia. Madam A.A did not experience any of the above-mentioned complication because she reported to the hospital early and received the right treatment.

2.2 Patient/family's strength

Strength refers to the physical power and energy that makes an individual determined in dealing with difficult or unpleasant situations (Longman Dictionary, 2019). A patient and family strengths refer to the resources that can enable them to cope with stressful conditions leading to patient's recovery.

The under mentioned strengths were identified in Madam A.A;

1. Patient was able to describe the intensity of the epigastric pain on numeric pain rating scale and also point to the site of the pain.
2. Patient could tolerate liberal fluid intake (half glass of fluid without vomiting)
3. Patient could eat about100mls of liquid diet served.
4. Patient was able to voice her fears.
5. Patient could sleep for about 4 hours during the night

2.3 Patient/Family Health Problems

Problem is defined as a situation that causes difficulties or a disorder with your health or with part of your body (Longman Dictionary, 2019).

Patient health problems were identified for effective nursing care to be rendered throughout the period of hospitalization. This is done through collection of data, observation and interviewing. The following problems were identified:

1. Patient complained of epigastric pain. (16/11/2022)
2. Patient was vomiting. (16/11/2022)
3. Patient complained of loss of appetite. (16/11/2022)
4. Patient was anxious. (16/11/2022)
5. Patient could not sleep well (insomnia) at night. (16/11/2022

2.4 Nursing Diagnosis

Nursing diagnose is a statement of a health problem or of potential health problems in the patient's /patient's health status that a nurse is professionally competent to treat, (Weller, 2017). Nursing diagnosis deals with the identification of the actual and potential problems from the information gathered. After assessing Madam, A.A, the following nursing diagnosis were formulated based on the patient's health problems identified;

1. Epigastric pain related to ulceration of the gastric mucosa. (16/11/2022)
2. Vomiting related to nausea (16/11/2022)
3. Loss of appetite related to disease process (16/11/2022)
4. Anxiety related to unknown outcome of condition. (16/11/2022)
5. Sleep pattern disturbance (insomnia) related to epigastric pain. (17/11/2022)

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan (Weller, 2017).

Planning is the third phase of the nursing process, which deals with identification of the patient's problems, formulation of nursing diagnosis and setting of goals and objectives to meet the health needs of the patient. It also involves setting objectives in short and long term in order of priority, which is part of the nursing care process and if they are not met after implementation, then it means the care rendered had to be reassigned and new plan of action taken to help meet the problems that were not met.

3.1 Objectives for patient and family care

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

1. Patient would be relieved of epigastric pain within 48 hours as evidenced by;
    i. Patient verbalizing that she no longer feels the epigastric pain.
    ii. Nurse observing that patient looks relaxed in bed and has cheerful facial expression
2. Patient would be relieved of vomiting within 48 hours as evidenced by
    i. Patient verbalizing that nausea and vomiting has ceased**.**
    ii. Nurse observing patient having normal skin turgor

3. Patient would regain her normal eating pattern within 48 hours as evidenced by:
    i. Nurse observing patient eat all meal served.
    ii. Patient verbalizing that she has regained her normal eating pattern
4. Patient would be relieved of anxiety within 48 hours as evidence by:
    i. Patient verbalizing she is no more anxious.
    ii. Nurse observing that, patient having cheerful facial expression.
5. Patient would regain her normal sleeping pattern within 48 hours as evidenced by:
    i. Patient verbalizing that she is able to sleep well
    ii. Nurse observing patient sleep for about 6 – 8 hours at night without interruption

Table 7: below shows nursing care plan for madam AA

3.2 Nursing Care Plan for Madam A.A

Date / Time	Nursing diagnosis	Objective/ outcome Criteria	Nursing Orders	Nursing Intervention	Date / Time	Evaluation	Sign
16/11/2022 7:00pm	Epigastric pain related to ulceration of the gastric mucosa	Patient will be relieved of epigastric pain within 48 hours as evidenced by; 1. Patient verbalizing that she no longer feels the epigastric pain. 2. Nurse observing that patient looks relaxed in bed and has	1. Reassure the patient/family that measures will be put in place to relieve her pain. 2. Assess the pain level of the Patient, using the numerical pain rating scale. 3. Reduce noise to promote rest. 4. Assist patient assume position she feels comfortable in.	1.Patient/family was reassured that Measures were put in place to relieve pain and also to improve her health. 2. Pain level of the patient was assessed using numerical pain rating scale. 3. All forms of noise were reduced by restricting visitors, reducing volume of radio and television. 4. Patient was assisted to assume position she felt comfortable in.	18/11/2022 7:00pm	Goal fully Metas nurse observed that patient was relaxed, looks comfortable, and has a cheerful facial expression and verbalized absence of epigastric pain.	E,T

		cheerful facial expression.	5. Serve prescribes analgesic. 6. Encourage intake of bland diet.	5. Prescribe analgesic was served. Eg Intramuscular tramadol. 6. Patient was supervised to take in yam and stew with little pepper and no spices.			

3.2 Nursing Care Plan for Madam A.A Continued

Date / Time	Nursing diagnosis	Objective/ outcome Criteria	Nursing Orders	Nursing Intervention	Date / Time	Evaluation	Sign
16/11/2022 7:00pm	Vomiting related to nausea.	Patient will be relieved of vomiting within 48 hours as evidenced by: Patient verbalizing that nausea and vomiting has ceased. 2.Nurse observing patient having normal skin turgor	1. Reassure patient of competent nursing skills. 2. Observe for signs of dehydration such as skin turgor. 3. Assist patient to perform regular mouth wash 4. Remove all nauseating articles such as bed pan from patient 5. Serve prescribed IV fluids	1. Patient was reassured that vomiting will subside with treatment. 2. Patient was observed for signs of dehydration such as skin turgor. 3. Patient was assisted to perform regular mouth care 4. All nauseating articles such as bed pan were taken away from patient. 5. Prescribed iv fluid was served.	18/11/2022 7:00pm	Goal was fully met as Patient verbalized that the nausea and vomiting were no more. Nurse observed patient having normal skin turgor	**E.T**

3.2 Nursing Care Plan for Madam A.A Continued

Date / Time	Nursing diagnosis	Objective/ outcome Criteria	Nursing Orders	Nursing Intervention	Date / Time	Evaluation	Sign
16/11/2022 7:00pm	Loss of appetite related to disease process	Patient will regain her normal eating pattern within 48 hours as evidenced by: Nurse observing patient eat all meal served. Patient verbalizing that she has regained her normal eating pattern.	1. Reassure patient/family that measures will be put in place to regain her appetite. 2.Assist patient perform Mouth care. 3. Plan diet with patient /family. 4.Remove all nauseating articles from patient 5. Serve meals in smaller quantities at frequent intervals	1. Patient and family were reassured. 2. Patient was assisted to perform the Mouth care. 3. Patient diets were planned as expected together with patients and family 4. All nauseating articles were removed from patient 5. Patients meals were served as instructed	19/11/2022 7:00pm	Goal was fully met as patient verbalized that has regained her normal eating pattern and Nurse observing patient eat all meal served	E.T

3.2 Nursing Care Plan for Madam A.A Continued

Date / Time	Nursing diagnosis	Objective/ outcome Criteria	Nursing Orders	Nursing Intervention	Date / Time	Evaluation	Sign
16/11/2022 7:00pm	Anxiety related to unknown outcome of condition.	Patient will be relieved of anxiety within 48 hours as evidence by: 1. Patient verbalizing, she is no more anxious. 2. Nurse observing that, patient having cheerful facial expression.	1. Reassure patient and family. 2. Orientate patient/family to the ward and its annexes. 3. Introduce patient/family to patients recovering with the same condition. 4. Employ diversional therapy. 5. Explain every procedure performed on the patient. 6. Educate patient on her condition. 7. Provide answers to all questions asked to clarify misconceptions.	1. Patient and family were reassured. 2. Patient was orientated to the ward and its annexes. 3. Patient was introduced to other patients recovering at the ward with same condition. 4. Patient was allowed to watch television to make her feel at home. 5. All procedure performed on patient was explained to patient to allay anxiety. 6.Patient was educated on her condition 7. Tactful answers were given to patient in simple terms to clarify their misconceptions.	18/11/2021 7:00pm	Goal fully met as nurse observe patient having cheerful facial expression and verbalized absence of anxiety.	**E.T**

3.2 Nursing Care Plan for Madam A.A Continued

Date / Time	Nursing diagnosis	Objective/ outcome Criteria	Nursing Orders	Nursing Intervention	Date / Time	Evaluation	Sign
17/11/2022 8:00am	Sleep pattern Disturbances (insomnia) related to epigastric pain	Patient will regain her normal sleeping pattern within 48 hours as evidenced by: . Patient verbalizing that she is able to sleep well. Nurse observing patient sleep for about 6-8 hours at night without interruption	1. Reassure patient/family that she is in the hands of a competent health team who will put in place measures to reduce her pain. 2. Assess the pain level of the patient, using the pain rating scale. . Restrict visitors . Encourage patient to take a warm bath prior to bed time 5. Plan nursing activities in order not to disturb patient during sleep.	1. Patient/family s reassured that she is in hands of competent staffs and all measures will be put in place to reduce the level of pain. 2. Pain level of the patient was assessed using the pain rating scale. 3. Visitors were restricted. 4. Patient was encouraged to take a warm bath prior to bed time. 5. Nursing activities were planned in order not to disturb patient during her sleep.	19/11/2022 8:00am	Goal was fully met as patient verbalized that She has regained her normal eating pattern and Nurse observing patient eat all meal served.	E.T

CHAPTER FOUR

IMPLEMENTING PATIENT/FAMILY CARE PLAN

4.0 Introduction

According to Smelter and Bare (2018), implementation is the actualization of the plan of care through nursing intervention.

This chapter is the fourth part of the nursing process. It deals with detail description of the actual nursing care rendered to my patient and family during the period of hospitalization. The implementation of nursing orders in the care plan ensures that the nurse performs established activities on the patient. Such activities are geared towards the promotion of patient's recovery and to limit complications if any.

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

Day of Admission (16th November, 2022)

On 16th of November, 2022 at 6:55pm, Madam A.A was brought to the Females' ward per ambulation accompanied by her daughter with a nurse from the out- patient department. They were warmly welcomed to the ward. Patient complained of severe abdominal pain. She was diagnosed of peptic ulcer disease by P.A J.O. She was given a bed and was made comfortable whiles the daughter was offered seats at the nurses' station.

A quick assessment of her general condition was made and her vital signs checked and recorded on admission as follows;

Temperature: 36.8degree Celsius

Pulse: 68 beat per minute

Respiration: 22cycle per minute

Blood pressure: 110/70 millimetres of mercury.

Weight: 68kg

The following drugs were ordered or my patient;

1. Intravenous Metronidazole 500mg tds x 24hours
2. Iv tramadol 100mg bd × 1
3. Iv Hyoscine 40g stat
4. Iv metoclopramide 40g stat
5. Intravenous Omeprazole 80mg bd x 24hours
6. Syrup lactulose 15mill tds x 5
7. Domperidone 30mg nocte ×5
8. Capsule Amoxicillin 1g bd × 7
9. Iv Dextrose 5% 1.5 liters for 24 hours
10. Ringers lactate 500ml set up

Patient was ordered to do blood test for malaria parasites estimation test on admission.

Since patient was in severe pain her daughter was orientated to the ward environment such as the nurses' station, toilet, bathroom, urinal and kitchen. They were also informed about the visiting hours which is 5:30am-6:30am in the morning, afternoon 12:00pm-1:00pm and evening 4:30pm5:30pm and I also told them about doctors daily routine ward rounds. I documented her

information in the admission and discharge book and the daily ward state and her drugs were collected from the pharmacy and stat doses administered as ordered. I made her comfortable in bed and reassured her relative and her of being in the hands of competent health professionals, who will provide the best of care to ensure her speedy recovery and discharge.

On admission at 6:55pm, patient complained of acute epigastric pain and at 7:00pm an objective was set to relieve patient of the acute epigastric pain within 48 hours and the following interventions were carried out; Patient was reassured that measures were put in place to relive her pain and also to improve her health, pain level of the patient was assessed using numerical pain rating scale, patient was assisted to assume a position she felt comfortable in, prescribed medications were served. Patient was supervised to take in yam and stew with little pepper and no spices.

On admission at 7:16pm patient complained of nausea and vomiting and at 7:00pm an objective was set to relieve patient of the vomiting within 48 hours and the following interventions were carried out: Patient was reassured that vomiting will subside with treatment, Patient was observed for signs of dehydration such as skin turgor, Patient was assisted to perform regular mouth care, All nauseating articles such as bed pan was taken away from patient and Prescribed iv fluid was served

On admission at 7:21pm,patient complained of loss of appetite and at 7:00pm an objective was set to enable patient regain her normal eating pattern within 48 hours and the following interventions were carried out: Patient and family were reassured, Patient was assisted to perform the Mouth care, Patient diets were planned as expected together with patients and family, all nauseating articles were removed from patient and Patients meals were served as instructed.

On admission at 7:30pm, patient was observed to be anxious and at 7:00pm an objective was set to relieve patient of the anxiety within 48 hours and the following interventions were carried out: Patient and family were reassured, Patient was orientated to the ward and its annexes, Patient was introduced to other patients recovering at the ward with same condition, Patient was allowed to watch television to make her feel at home, All procedure performed on patient was explained to patient to allay anxiety, Patient was educated on her condition and tactful answers were given to patient in simple terms to clarify their misconceptions.

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

I went to her later after her pain had subsided and introduced myself to her again as a final year student of Holy Family Nursing and Midwifery Training College, Berekum. I made her aware that as a final year student, it is a requirement by the Nursing and Midwifery Council to take a patient, and render individualized nursing care to her/her from admission until discharge and carry out home visits before and after discharge until she recovers fully. Madam A.A and family agreed and promised to cooperate with me and give all the necessary information to complete the care rendering to them. I chose my client for the study in order to gain more insight about peptic ulcer disease. Patient slept at 10:15pm

Second day of admission (17th November, 2022)

According to my client relatives, she woke up around 5:30am, she had her teeth brushed and had her bath. Her bed was laid and the locker and bed side table cleaned. Vital signs checked and recorded at 6:00am read;

Temperature 36.1 degrees Celsius (^{o}C)

Blood pressure 110/70 millimeters of mercury (mmHg)

Pulse 70 beats per minute (bpm)

Respiration 20 cycles per minute (cpm).

At 8:00am, client reported that she was unable to sleep well which was as a result of epigastric pain. An objective was set to help patient regain her normal sleeping pattern within 48 hours and the following intervention were put in place; patient was reassured that she is in the hands of competent staff and all measures will be put in place to reduce the level of pain, Pain level of the patient was assessed using numerical pain rating scale, Visitors were restricted, patient was encourage to take a warm bath prior to bed time, a quiet environment was ensured by reducing the volume of radio and television sets, nursing activities were planned in order not to disturb patient during her sleep. She was fed with porridge and bread as breakfast.

During the ward rounds at 8:00am, the doctor ordered for computer tomography, patient was prepared to the computer tomography department for the computer tomography scan.

Nursing interventions initiated on 19/11/22 to relieve patient of epigastric pain, vomiting, loss of appetite and anxiety were continued.

At 12:00pm, Client was encouraged to take her lunch which was rice with cabbage stew.

At 2:00pm, vital signs were checked and recorded and due medications. Results for the computer tomography scan were retrieved from the computer tomography department. At 5:30pm, client had her bath and took yam and stew for supper. The vital signs were checked and recorded and

evening medications served at 6:00pm. At 10:00pm, vital signs were checked and recorded and due medications served. Patient slept at 11:30pm

Third Day of Admission: 18/11/2022

According to client relatives, at exactly 5:30am, Madam A.A was out of bed, brushed her teeth, emptied her bowel and took her bath.

Her bed was laid and the locker cleaned. Her vital signs were checked and recorded at 6am as;

Temperature	36.9 degrees Celsius (^{o}C)
Pulse	67 beats per minute (bpm)
Respiration	18 cycles per minute (cpm).
Blood pressure	110/80 millimeters of mercury (mmHg)

She took rice porridge and bread as breakfast around 7:30am.

During ward rounds, client was reviewed by J.O and to continue treatment.

Nursing interventions that were initiated on 19/11/22 to enable patient regain her normal sleeping pattern were continued.

Tuo-zaafi with green leafy soup was served as lunch. At 2:00pm, vital signs were checked and recorded and due medications served.

Patient had rice and stew for supper and after which she took her bath. Vital signs were checked and recorded and prescribed medications were administered and recorded at 6:00pm.

At 7:00pm, objective that was set on (16/11/2022) to relieve patient of epigastric pain was evaluated and goal fully met as evidenced by patient verbalizing that the epigastric pain was no more.

At 7:00pm also, objective that was set on (16/11/2022) to relieve patient of vomiting was evaluated and goal fully met as evidenced by patient verbalizing that the vomiting has ceased.

Also, at 7:00pm, objective that was set on (16/11/2022) to enable patient regain her normal eating pattern was evaluated and goal fully met as evidenced by patient verbalizing that she has regained her normal appetite.

At 7:00pm also, objective that was set on (16/11/2022) to relieve patient of anxiety was evaluated and goal fully met as evidenced by patient verbalizing that the anxiety was no more.

At 10:00pm, vital signs were checked and recorded and due medications served. Patient slept at 10:20pm.

Fourth day of Admission- 19/11/2022

Madam A.A woke up around 5:30am in the morning and had her bath and mouth care carried out. The night nurse reported that client had a good night sleep. She was doing well and wanted to know when she would go home. I explained to her that, she will be discharged as soon as the doctor declares her fit to go home. Morning ward routines such as straightening of bed linens, changing of soiled bed linen were done. Her vital signs were checked and recorded in the vital signs chart at 6am as;

Temperature	-	36.6 degree Celsius
Pulse	-	78 beats per minutes (bpm)
Respiration	-	20 cycle per minute (cpm)
Blood Pressure	-	110/70 mmHg

At 8:00am the objective set on 17/11/2022to aid client regain her normal sleeping pattern was evaluated and fully met as evidenced by patient verbalizing that, she was able to sleep well and nurse observing patient sleep for 6-8 hours at night without interruption.

Patient took ‘hausa porridge and koose’ for breakfast after which prescribed medications were served and recorded. She was made comfortable in bed waiting for doctor’s rounds. During the

ward rounds, patient did not have any complains so P.A J.O ordered a continuation of the patient's treatment.

Yam and kontomire stew were served as lunch. Afternoon medications were served, vital signs were checked and documented. Patient took Banku and Okro stew for supper. At 6:00pm, patient's medications were served and vital signs were checked and recorded. Madam A.A took a warm bath at 7:00pm. At 10:00pm, vital signs were checked and recorded and due medications served. Patient slept at 10:20pm.

Fifth day of admission (Day of Discharge) -20/11/2022

I arrived at the ward at 7:40am on this day to find Madam looking cheerful and fit. Client told me she had a sound sleep throughout the night. She had her mouth care, had her bath and had emptied her bowel. Took porridge and bread for breakfast.

Vital signs checked and recorded at 6:00am were as follows:

Temperature	-	36.6 degree Celsius
Pulse	-	74 beats per minutes (bpm)
Respiration	-	22cycle per minute (cpm)
Blood Pressure	-	100/70 mmHg

During ward rounds, patient had no complains so she was discharged home to continue treatment with already prescribed medications and to come for review on 27th November,2022. Education was given to patient on the need to complete the prescribed medication, diet and the need to report any observed ailment and side effect of drugs. I also explained her medications and its dosage to her and her relative. The date for review which was 27th November, 2022 was again mentioned to patient and relative.

Her particulars were entered into admissions and discharges book and daily ward bed state. After she had settled her bills. I helped her to pack all her belongings. Madam A.A thanked the staff present and other patients at the ward and bid them goodbye. I escorted them to the hospital gate and bid them goodbye. I came back to the ward to remove patient's bed linen and put into the laundry container, then patient's bed was carbolized with parazone cleaned and left to dry. All care done was documented.

4.2 Preparation of Patient/ Family for Discharge and Rehabilitation

Preparation of Madam A.A for discharge actually started on the day she was admitted till the day of discharge. Though patient and relative were worried about her condition, they were reassured that her hospitalization was temporal and will be discharged when her condition improve.

During the ward rounds on the 20st November, 2022, my patient was examined and her condition improved greatly so she was discharged. Patient and relative were educated to have enough rest and to avoid stressful activities and on the causes, signs and symptoms of peptic ulcer disease. Client and family were educated on the following;

Drugs

Client was educated on how to take her drugs, the dose to be taken and side effects of the drugs were also explained to her. I educated her on the importance of the continuity of treatment at home. Patient was advised to abstain from taking Non-Steroidal Anti-inflammatory drugs (NSAIDs) like Aspirin, since it increases secretion of hydrochloric acid. Client was also advised to abstain from taking herbal drugs and the use of over the counter drugs.

Diet

Client was advice to avoid starving, encouraged to take meals that are well balanced and free from spices to improve her health and foods that cause over secretion of hydrochloric acid. She was also

discouraged from the intake of caffeinated beverages, alcohol intake and cigarette smoking since it causes delay in ulcer healing. Patient and family were encouraged to take enough roughage to enhance bowel elimination. Vitamin and minerals such as fruits like banana and pawpaw should be encouraged to boost up her immune system.

Personal and environmental hygiene.

Client and family were educated on the need to adhere to good personal hygiene practice. Oral hygiene should be done twice daily with toothpaste and toothbrush to prevent mouth odour and to prevent the harboring of micro bacteria. Bathing twice daily with water, soap, sponge and towel to prevent body odour and to remove microorganisms from the skin was encouraged. Client's was also educated to care for hands and feet by soaking them in water and trimming the nails with nail clippers and washing the nails, which will prevent harboring of microbes and to prevent injury from scratching. Client and family were also encouraged to weed their surroundings and also to avoid littering the environment with rubbish to prevent infections.

4.3 Follow Up/Home Visit/ Continuity of Care

First Home Visit (18/11/2022)

On 18th November, 2022, I made my first visit to my client's home while she was still on admission. The purpose of this visit was to know my patient's residence and the environment in which she lives. I set off at 2:30pm after work and safely arrived at 3:00pm. I met client's son. I was warmly welcomed by her son A.J and she offered me a seat. I introduced myself as a final year student of Holy Family Nursing and Midwifery Training College Berekum who is rendering care to Madam A.A as a fulfillment of my care study. I made various observations whiles I was in the compound. Their house was located near the roadside. There were three bed rooms, one bathroom and one wooden kitchen. The house is plastered but not painted and roofed with iron

sheets. The windows were made of wooden louvers with net in the windows. The house has electricity supply and they obtain their water from a pipe. Their household refuse is kept in a basket well covered and disposed daily at the main refuse dump of the community every morning. They also empty their bowels at the community public toilet. There was cobwebs and dust on the louvers and weeds at the back of the house. I encouraged them to clean the dusty windows and net of their rooms often to prevent upper respiratory tract infection like common cold and to clear around the house to prevent mosquitoes from breeding and also sleep in insecticide treated nets. They were much grateful and I asked permission to leave. I left the house around 4:30pm

Second Home Visit (25/11/2022)

My second home visit was on 25TH November, 2022 after client's discharge. This was to assess the state of health of my patient at home and also to find out if Madam A.A was following her treatment regimen and to remind her of the review date which was 27/11/2022. My client was the first person I met and we exchanged greeting. I was warmly welcomed. Madam A.A said, she had no complains and because she wanted a speedy recovery, she takes her drugs as prescribed. I educated Madam A.A and family on peptic ulcer on the cause, signs and symptoms and how it can be prevented. Madam A,A was reminded to avoid starving, spicy food and also take her daily meals as required. After interaction for a while, I requested that she take me round the yard which she did. I was much happy for seeing some changes. She assured me to practice the health education delivered to her. They were informed of the intention to hand them over to the community health nurse at their clinic for continuity of care on my next visit. She was reminded of the date of review (27thNovember, 2022) which she assured me she would comply. I asked permission to leave and they thanked me for the visit and she accompanied me to the road side. I left around 4:20pm.

Day of Review – 27/11/2022

On 27th November, 2022, Madam A.A was scheduled for review. Patient was met at the Out-Patient Department. I helped patient to take her folder from the records room. Her vitals were checked and recorded as;

Temperature	-	36.7 degree Celsius
Pulse	-	80 beats per minutes (bpm)
Respiration	-	18 cycle per minute (cpm)
Blood Pressure	-	120/80 mmHg

She was reviewed by PA, J.O with no new complaints so no new drugs were prescribed for her. She was encouraged to complete her medication and also to avoid starving, spicy food and take her daily meals as expected. Patient was reminded of the third visit which will be my last visit. I escorted her to the hospital entrance and bid her good bye.

Third Home Visit (30TH November, 2022)

I visited patient/family on the said date. The purpose of the visit was to find out how client was doing after review and to terminate care. I was welcomed and offered a seat. Madam A.A looked cheerful, active and healthy. Patient's conditions had improved and no complaints were presented. Since this was my last visit, I took my time and highlighted on the various health education that I had previously given. They were also advised to seek medical treatment whenever they fall sick to prevent complications and should not practice self-medication. Patient was reminded again to avoid starving, spicy food, hot pepper and also take her daily meals as expected. They were grateful and promised to adhere to the education given. I educated client on the need for continuity of care and the importance of the community health nurse. Patient and family went with me to the

Kintampo Municipal Hospital. I introduced myself and the reason for our visit was made known to the nurse-in charge. She then introduced one community health nurse E T to me and I handed Madam A.A to her for continuity of care. I explained everything to the community health nurse taking notes of client diet, medication and lifestyle modification during the handing over. The community health nurse promised to take good care of the patient and promised to visit them at home. Client and family also promised to give their maximum co – operation to the community health nurse.

I thanked Madam A.A and family for the cooperation and opportunity offered me to take her and the family for the care study and promised to keep any information confidential. They were informed that this was my last official visit but I promised to pay them friendly visit, whenever I find myself in the area. At 3:30pm I sought permission to leave and finally we exchanged good-bye

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

According to Smelter and Bare (2018), Evaluation is the determination of the patient's responses to the nursing interventions and the extent to which the outcomes have been achieved.

Evaluation is the final phase of the nursing process.

5.1 Statement of Evaluation

1. Patient was relieved of epigastric pains

On the day of admission 16th November, 2022 at 7:00pm, patient complained of epigastric pain. Objective was set to relieve patient of the epigastric pain within 48 hours and the following interventions were carried out; Patient/family was reassured that measures were put in place to relive her pain and also to improve her health, pain level of the patient was assessed using numerical pain rating scale, patient was assisted to assume a position she felt comfortable in, prescribed medications were served. Patient was supervised to take in yam and stew with little pepper and no spices. On 18th November, 2022 at 7:00pm objective was evaluated and the goal was fully met as nurse observed that patient had a cheerful facial expression and also verbalized relieve of epigastric pain.

Patient was relieved of vomiting

On the 16th November, 2022 at 7:00pm, client was observed to be vomiting and a nursing objective was set for client to be relieved of vomiting within 48 hours. The following intervention was put in place; Patient was reassured that vomiting will subside with treatment, Patient was observed for signs of dehydration such as skin turgor, patient was encouraged to take adequate liberal fluids

such as water, all nauseating articles such as bed pan and urinals were removed from patient's sight, Frequent oral hygiene was provided for patient, Prescribed IV metoclopramide 40g and IV Dextrose 5% was administered. On 18th November, 2022 at 7:00pm, objective was evaluated and goal was fully met as evidence by client verbalizing vomiting has ceased.

Patient regain her appetite

On the 16th November, 2022 at 7:00pm, client complained of a loss of appetite. A nursing objective was set to assist patient regain her appetite within 48 hours and interventions carried out were as follows; patient was reassured that she will be able to eat well, patient was assisted to care for her mouth before and after each meal in other to stimulate her appetite, patient's diet was planned with her considering her like and dislikes,

All nauseating articles such as bed pan and urinal were removed from patient's sight; Food was served frequently and in small quantities. On 18thNovember,2022 at 7:00pm, objective set was evaluated and goal was fully met as evidenced by patient verbalizing that she has regained her normal eating pattern and nurse observing that patient eat all meal served.

Patient was relieved of anxiety

On 17th November, 2022 at 7:00pmduring my interaction with Madam A.A, I observed that client was anxious which was due to unknown outcome of condition. An objective was set to relieve patient of anxiety within 48 hours. The nursing intervention carried out included; Patient was reassured, patient/family was orientated to the ward and it annexes, patient was introduced to other patient recovering at the ward with the same condition, patient was allowed to watch television to make her feel at home, all procedures performed on patient were explained to patient to allay anxiety, causes, sign and symptoms, management and prevention of the condition were explained

to the patient to relieved anxiety, tactful answers were given to patient in simple terms to clarify their misconceptions. On 19th November, 2022 at 7:00pm, objective set was evaluated and goal was fully met as evidence by patient verbalizing that she was no more anxious.

Patient regained her normal sleeping pattern

On the 19th November, 2022 at 8:00am, client complained of inability to sleep which was as a result of epigastric pain. An objective was set to help patient regain her normal sleeping pattern within 48 hours. The following intervention were put in place; patient was reassured that she is in the hands of competent staff and all measures will be put in place to reduce the level of pain, Pain level of the patient was assessed using numerical pain rating scale, Visitors were restricted, patient was encourage to take a warm bath prior to bed time, a quiet environment was ensured by reducing the volume of radio and television sets, nursing activities were planned in order not to disturb patient during her sleep and prescribed medications. On 20th of November, 2022 at 8:00am, objective set was evaluated and goal was fully met as evidence by patient verbalizing she was able to sleep well and nurse observing patient sleep for 6-8 hours without interruption at night.

5.2 Amendment of Nursing Care Plan for Partially met or Unmet Outcome Criteria.

No amendments were made in the care plan written for Madam A.A and her family. All goals set were achieved due to proper nursing intervention rendered and necessary co-operation from client and her family.

5.3 Termination of Care

The nursing care of my patient started on the 16th November, 2022 and came to an end 30thNovember 2022 after my last home visit. Patient/family was made to understand that patient's hospitalization was temporal and would be discharged to go home after her condition had

improved. Patient and family were educated during admission and after discharge. They were also advised during home visits on measures to promote health, the need for review and continuation of medication. On 18th November, 2022 I embarked on my first home visit, purpose of this visit was to know my patient's residence and the environment in which she lives. On 25thNovember,2022 my second home visit was made, this was to assess the state of health of my client at home and also to find out if Madam A.A was following her treatment regimen and to remind her of the review date which was 27th November,2022. Patient was told about the termination of care. I embarked on the third home visit 30th November, 2022; the purpose of the home visit was to terminate care and hand over patient into the care of a community health nurse.

I thanked Madam A.A and family for the cooperation and opportunity offered me to take her and the family for the care study and promised to keep any information confidential. I sought permission to leave and permission granted and I left at 3:30pm.

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

According to Merriam-Webster (2020), Summary is giving a concise overview of a text's main points in your own words.

Madam A.A, a 54year-old woman was admitted to the females' ward of the Kintampo Municipal hospital on 16th of November, 2022 at 6:55pm and she was diagnosed of Peptic Ulcer Disease by P.A J.O She was managed on the following medications; Intravenous Metronidazole 500mg tds x 24hours, IV tramadol 100mg bd × 1 stat, IV Hyoscine 40g stat, Iv metoclopramide 40g stat, Capsule Amoxicillin 1g bd × 7, Iv Dextrose 5% 1.5 liters for 24 hours, Ringers lactate 500ml set up ,Intravenous Omeprazole 80mg bd x 24hours, Syrup lactulose 15mill tds x 5, Domperidone 30mg nocte ×5,Computed tomography scan of the stomach and duodenum and laboratory investigation include; blood for Malaria Parasites estimation .Nursing problems identified, nursing diagnoses were formulated, and objectives set, nursing orders carried out and goals fully met within the expected time. Patient was discharged on 20stNovember, 2022 and came for review on 27th Novenber,2022. Patient and relatives were educated on peptic ulcer and its preventive measures and early seeking of medical treatment. Three home visits were made and care was

terminated on 9th December, 2022. During the third home visit, patient was handed over to a community health nurse for continuity of care.

6.2 Conclusion

According to Hornby 2018, Conclusion refers to the final part that brings something to a close.

The patient and family care study has helped me to know and understand comprehensive nursing care that has to be given to individual patient. This study has equipped me with much knowledge on peptic ulcer disease. It has also helped me to put into practice the knowledge and skills acquired during the course of the training.

The study has aided me to comprehend and gain insight into patient conditions so as to offer the necessary remedy to solve and improve upon their health status.

Finally, it builds a good cordial relationship between the nurse and patient /family as well as other members of the health team.

I recommend that every student should write a care study as it helps enrich one's knowledge and practice. Therefore, it should be maintained in the nursing program by the nursing and midwifery council.

APPENDIX

Table 8: Vital Signs of Madam A.A throughout hospitalization

Date	Time	Temperature	Pulse	Respiration	Blood Pressure
16/11/2022	7:00pm	36.8^0C	68bpm	22cpm	110/70mmHg
	10:00pm	36.4^0C	70bpm	18cpm	100/70mmHg
17/11/2022	6am	36.1^0C	70bpm	20pm	110/70mmHg
	2pm	36.5^0C	74bpm	18cpm	120/80mmHg
	10pm	36.2^0C	60bpm	16cpm	100/60mmHg
18/11/2022	6am	36.9^0C	67bpm	18cpm	110/80mmHg
	2pm	37.1^0C	78bpm	19cpm	110/80mmHg
	10pm	36.0^0C	60bpm	18cpm	100/70mmHg
19/11/2022	6am	36.6^0C	78bpm	20cpm	110/70mmHg
	2pm	36.4^0C	72bpm	20cpm	120/70mmHg
	10pm	36.8^0C	68bpm	18cpm	110/80mmHg
20/11/2022	6am	36.6^0C	74bpm	22cpm	100/70mmHg

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Others

Patients folder Number-12822\20, Municipal Hospital, Kintampo

SIGNATORIES

THE STUDENT NURSE

NAME: BASOWA EMELIA TAKYIWAA

SIGNATURE: .....

DATE: 7th July 2023

THE NURSE IN-CHARGE OF THE FEALES WARD (KINTAMPO MUNICIPAL HOSPITAL)

NAME:

SIGNATURE: .....

DATE: 17/07/2023

THE SUPERVISOR

NAME: OWUSU AMOS

SIGNATURE: .....

DATE: 07/07/23

THE PRINCIPAL, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

NAME: MONICA NKRUMAH

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