HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT / FAMILY CARE STUDY ON GASTROENTERITIS

BY

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

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PREFACE

The word nursing derives its meaning form the Latin word “nutricus” which means nourishing.

Many people believed that Nursing started with Florence Nightingale, however nursing dates back to the beginning of motherhood when nurses were traditionally female. The history of nursing has its origin in the care of infants and children, so all mothers were nurses.

The history of nursing first started to become more continuous and defined with Christianity when Christians cared for the sick, fed the hungry and buried the dead. Therefore, it was said that the history of nursing is tied to the church. When it became apparent that love and nurturing alone were not enough to cure disease, the need for a more educated frame work for nurses began to form. As a result of this, Florence nightingale in 1860, fulfilled her dream concerning nursing by establishing the Nightingale Training School for Nurses. It was the first formal, fully organized training program for nurses.

In this 21st century, many nursing schools have been established to help build on the previous skills and experiences that were acquired through long years of housekeeping, assisting in child bearing and care of formal sick relatives.

Based on the current trend in modern nursing, it is of importance that every final year student undertakes a patient and family care study.

The Patient/Family Care Study is a detailed written report of nursing care rendered to an individual and his or her family within a specific period of time. It explores nursing care rendered from the time of admission to termination of nurse-patient/family relationship. It gives an in-depth description and explanation of how a patient’s response to a specified disease condition is diagnosed and given intervention. The Patient/Family Care Study involves a record of nursing care, documenting the

problems of the patient and how they are dealt with by the nurse and other healthcare members. It provides a systematic way of collecting data, analyzing information and reporting the results of nursing care. This Patient/Family Care Study is based on the concept of holistic care, taking into account all factors impinging on the health of the individual. It is done using the nursing process approach. Nursing process is the deliberate problem-solving tool that nurses employ to resolve actual and prevent potential patient/family health problems. Its common components are assessment, diagnosis, planning, implementation, and evaluation. For the purpose of confidentiality, the initials of patient and family will be used throughout the care study. This care study was carried out as a partial fulfilment for the award of professional license by the Nursing and Midwifery Council of Ghana. It is an integral part of the curriculum for educating nursing students hence a prerequisite for completing the nursing program. It helps the nursing student gain opportunity to combine classroom academic work with clinical study of the practices of the nursing profession. It encourages learning by doing, developing of analytical and decision-making skills as well as reporting skills.

ACKNOWLEDGEMENT

All praise and thanks to God Almighty for a successful study. My gratitude goes to Miss. A. B., without her consent and cooperation, this care study would have not been successful. Exceptional thanks go to the Nursing administrator, the Preceptor, the Ward in-charge and the nursing staffs of Females' Ward of the ST. Mary's Hospital, Drobo. They ensured continuity of care for the patient and gave me support and morale for this care study. The supporting nursing service personnel's and colleague students whom I worked with on the Females' Ward are not forgotten for their diverse manners of help. Wonderful heartfelt thanks go to my supervising tutor, Mr. Emmanuel Ali for his persistent guidance which has ensured the successful completion of this care study. Also, to the entire staff of Holy Family Nursing and Midwifery Training College, Berekum for their support and directions. And thanks to my parents, Mr. Appah Henry Kuffour and Mrs. Appah Georgina Agyarko and siblings who have ensured this far. I appreciate Inusah Yakubu for his support throughout the study. Finally, I acknowledge and thank all authors and publishers whose works have been used as reference materials in this Care Study.

INTRODUCTION

"The unique function of the nurse is to assist the individual sick or well in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, knowledge or will, and to do so in such a way as to help him regain independence as quickly as possible" (Virginia Henderson, 1966.) The rationale behind the Care Study is to assist a patient to regain health or peaceful death and present a report of that assistance giving account of problems that were identified and how solutions were worked out from a nursing process perspective. Presented in this Care Study is a report of nursing care rendered to Miss. A.B. who was diagnosed of gastroenteritis. She was admitted to the females' ward of the ST. Mary's Hospital, Drobo and stayed on the ward for four days. The following treatment plans were used to manage her.

1. Tablet Zinc 20mg daily x 10 days
2. Intravenous promethazine 25 milligrams stat
3. Intravenous Ringers lactate 2.5 liter over 48 hours.
4. Intravenous dextrose in normal saline 1 liter over 24 hours
5. Intravenous Ciprofloxacin 400 milligrams bd x 48 hours.
6. Tablet Paracetamol 1-gram tds x 5 days.
7. Intravenous buscopan 40mg stat
8. Tablet buscopan 20mg bd x 5 days
9. ORS 2 sachet daily

Laboratory investigations requested by the doctor included;

1. Blood film for malaria parasite.
2. Full Blood Count.

3. Stool for H. pylori.
4. Abdominopelvic ultrasonography
5. Retro screen.

Patient problems included diarrhea and vomiting, abdominal pains, loss of appetite, general bodily weakness, difficulty sleeping and inadequate knowledge on condition. All these problems were nursed in accordance with the nursing process.

Miss. A.B. was on admission from Monday, 15th November,2021, to 19th November, 2021, where she was discharged. He was fairly ill, weak but fully conscious on admission and his condition at the time of discharge was satisfactory. The interaction with Patient/family continued after discharge with home visits and regular phone communication till nurse-patient/family relationship was terminated finally on 13th of November, 2021.

This care study report has been organized into six chapters in line with the phases of the Nursing Process.

Chapter one: Assessment of patient/family.

Chapter two: Analysis of data.

Chapter three: planning phase of the nursing process.

Chapter four: Implementation of the care plan.

chapter five: Evaluation of care rendered to patient and family

chapter six: Summary and conclusion as well as the recommendation.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

The first phase of the nursing process is assessment. It involves collecting, organizing, validating, and documenting the clients' health status. This data can be obtained in a variety of ways. Usually, when the nurse first encounters a patient, the nurse is expected to assess to identify the patient's health problems as well as the physiological, psychological, and emotional state and to establish a database about the client's response to health concerns or illness and the ability to manage health care needs (Gil, 2022).

The main methods used to collect data are health interviews, physical examination, and observation 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. This information gathered from patient will help identify patient/family's problems and the appropriate nursing interventions rendered to patient.

1.1 Patient's Particulars

The particulars of someone or something are facts or details about them which are written down and kept as a record (Collins,2016]

Miss A.B. is a 21year old young lady, born on 9th October, 2000 to Mr. A.G. and the late Madam S.G. She is a native and resident at Kwasibuokrom, Drobo in the Bono region. She is the second born of four children of which all are alive. Miss A.B. is chocolate in complexion and weighs 57kg and 1.65m and thus has a BMI of 20.9kg/m^2, which means she had healthy weight. The languages spoken

by Miss A.B. are Bono, Twi and English. She is a Christian and attends Catholic Church at kwasibuokrom. She is single and has no children or child. Her next of kin is her little sister, Miss A.A.G. Miss A.B. is a beneficiary of NHIS.

1.2 Family Medical History

Family medical history refers to the history of diseases in the family that may be communicable or possibly environmental in nature such as hypertension, diabetes, sickle cell or mental illness

According to Miss A.B., there are no known hereditary diseases like hypertension or diabetes, sickle cell disease and mental illness in the family. There is also no communicable disease like tuberculosis in the family. Miss A.B. has no known allergies. Her little sister had been admitted for three days about six months ago with complaints of chills, vomiting, fever and loss of appetite and was diagnosed of Malaria. She added that their main source of medical treatment is orthodox and if any family member experiences minor ailment such as headache, cold and abdominal pains, they go for over the counter medication to treat them. Both her paternal grandparents are still alive but her maternal grandfather and grandmother died of road traffic accident and pneumonia respectively.

The cause of her mother's deaths remains unknown till date but her father is alive and strong and has never been hospitalized before. Apart from her elder sister who have been hospitalized on several occasions on accounts of malaria, peptic ulcer disease and pregnancy related complications, none of her other siblings have been hospitalize before. Nevertheless, they do encounter minor ailment like cephalgia, myalgia, common cold, which are managed with over the counter medications.

1.3 Family Socio – Economic History

Socioeconomic history shows the social and economic state of a person thus how a person relates with the members of the family and the society and the differences between groups of people caused mainly by their financial situation (Weller, 2019). The family is made up of five members, their father

being the breadwinner who is into vegetable farming, and is exposed to waist pains since his work requires a lot of bending. Miss A.B. is a pupil teacher at a private primary school and also supports the family with what she earns. Being a teacher, Miss A.B. is prone to developing varicose veins as a result of prolong standing. In their perception they have adequate financial resources and can provide for all their basic needs and keep the family comfortable.

Miss A. B.'s family has very good relationship and strong cohesion. Socially, the family is not noted for smoking, or drinking of alcohol. The family practices Christianity and belongs to the Catholic Church at Kwasibuokrom. All the family members are beneficiaries of the National Health Insurance Scheme (NHIS), which supports them when the fall sick. The family is prohibited from eating pork as their family taboo however miss A.B. was reluctant explain further on that taboo.

1.4 Patient's Developmental history

Growth is an increase in size, function, or complexity up to some point of optimal maturity whereas development is the change in the structure, thought, or behavior of a person function of both biological and environmental influence. Maturation is a change in the function of an organism starting from the molecular level and involves various organs both metabolically and physically. (Tommy,2019)

The developmental history was given by patient herself as told by her late mother. Miss A.B. indicated that, his mother went through normal pregnancy of nine months' gestation without any pregnancy associated disorders and delivered spontaneously per vagina by a midwife at St Mary's Hospital Drobo, on the 9th of October, 2000. At the time of delivery, no congenital abnormalities were observed. She was immunized against all the vaccine preventable diseases, with a scar on her upper arm as an evidence of Bacillus Calmette Guerin Vaccine (BCG). Miss A.B. started crawling at age eight months and begun walking at age one year. She had her menarche at age fourteen years and

started developing secondary sexual characteristics such as widening of the hips and enlargement of breast, growing of pubic hair at age fifteen years. Miss A.B. has no history of pregnancy or child birth. She has not been on any contraceptive and has a normal menstrual flow of five days. She started kindergarten when she was 4 years at Saviour preparatory school and completed JHS in 2015 in the same school. She proceeded to Our Ladies of Providence SHS and completed in 2019 and currently a pupil teacher. She is inspired of furthering to higher level soon. Erikson's theory of psychosocial development in 1954 describes the human life cycle as a series of eight egos developmental stage from birth to death. The theory focuses on psychological task that are accomplished throughout the life cycle. Miss A.B. is a 21year old and thus falls under Intimacy versus isolation which is the sixth stage of Erick Erikson theory of psychosocial development. This stage takes place during young adulthood between the ages of 18 to 40years. During this stage, the major conflict centers on forming intimate, loving relationships with other people. Achievement of the task results in the capacity for mutual love and respect between two people and the ability of an individual to pledge a total commitment to another. The intimacy goes far beyond the sexual contact between two people. It describes a commitment in which personal sacrifices are made for another, whether it be another person, or if one chooses, a career or other type of cause or endeavour to which an individual elect to devote his or her life. Intimacy is achieved when an individual has developed the capacity for giving of oneself to another. This is learned when one has been the recipient of this type of giving within the family unit. Non-achievement results in withdrawal, social isolation, and aloneness. The individual is unable to form lasting, intimate relationships, often seeking intimacy through numerous superficial sexual contacts. No career is established; he or she may have a history of occupational changes (or may fear change and thus remain in an undesirable job situation). The task remains unresolved when love in the home has been deprived or distorted through the younger years (Murray et al, 2019). One

fails to achieve the ability to give of the self without having been the recipient early on from primary caregivers. Miss A.B. has almost achieved this developmental stage since she associates herself in social activities both at church and the school she teaches. She also behaves well towards the opposite sex, though she is not married but has a fiancée which they are moving on well.

1.5 Patient's Lifestyle/Hobbies

Miss A.B. normally wakes up early in the morning around 5:30am, says her prayer, lays her bed nicely and sweeps her room. She has good interpersonal relationship with people. She then goes out to wash her face, empty her bowel brushes her teeth and sometimes boil water for her father to bath. She takes breakfast around 7:30am. Miss A.B. is an extrovert. She takes pleasure in activities that involve large social gathering such as youth camps. She normally leaves for work early in the morning and comes back around 2:30pm. She takes her lunch around 12:00pm. In the evening, she prepares supper for the family with the assistance from her sisters. She likes ampesi with cabbage stew, and fufu with light soup. Her dislikes are noise making and truancy. She does no smoke or drinks any alcoholic beverage. She likes reading and singing at her leisure as her hobbies. On Saturdays, she either attends friends or family weddings or remains home with the family. She goes to church every Sunday with her family. She normally get stress up by her dad maltreatment. She has no known food and drug allergy. She engages herself in recreational sports like volleyball and swimming.

1.6 Patient's Past Medical/Surgical History

Miss A.B. explained that, she had no accident or injury during childhood, nor suffered measles, chickenpox or any of the childhood illness. She was hospitalized about a year ago and underwent a successful appendectomy, at St Mary's Hospital, Drobo after been diagnosed of acute appendicitis. She spent 4 days and was subsequently discharged home with no post-operative complications. She has no known allergies to drugs or food and has no physical disabilities. Miss A.B. hardly attend

medical checkup unless she feels very ill. She was advised to embark on regular medical checkups, at least twice annually to ensure optimal health. Miss A.B. has easy access to quality healthcare since there is a CHPS Compound in her locality. Also, St Mary's Hospital Drobo, is not too far from her.

1.7 Patient's Present Medical/Surgical History

Miss A.B. was apparently well until the dawn of 15th November, 2021 around 4:30 am when she suddenly experienced abdominal pains and subsequently vomiting and diarrhea. She was given Aluminum hydroxide at home but there was no improvement. This became unbearable around 8:30 am the same day and her aunty had to rush her to the nearest facility and this ended her at the emergency department of St. Mary's Hospital, Drobo, where she was detained and stabilized and was later transferred out into the females ward of the same facility with diagnosis of gastroenteritis.

1.8 Admission of Patient

Miss A.B. arrived on the Males Ward on 15th November, 2021 at 12:00 pm from the emergency department. She was accompanied by her aunty and a staff nurse in a conscious and ambulatory state with the diagnosis of gastroenteritis. She was fairly ill and looked weak. I was at the nurses' station with the nurse in-charge at the time of his arrival, so I was charged with the responsibility to carry out her admission to the ward. It was a planned admission. The patient's identity was verified by mentioning her name for response. She was then welcomed and immediately admitted and made comfortable in an already prepared admission bed. She was introduced to the staffs present and was assured of the competent healthcare and speedy recovery. Her particulars such as name, sex, age, and residential address were recorded in the admission and discharge book and the daily ward state. Vital signs were checked and recorded accurately as follows:

Temperature	36.1 ^{O}C
Respiration	25 cycles per minute

Pulse 93 beats per minute

Blood Pressure 120/90millimeters of mercury (mm/Hg)

SPO_2 was 100%

Hospital policies regarding visiting periods, payment of bills and the four-hourly assessment of vital signs were explained. The national health insurance system was also explained to her.

The following treatment plans were used to manage her.

1. Tablet Zinc 20mg daily x 10 days
2. Intravenous promethazine 25 milligrams stat
3. Intravenous Ringers lactate 2.5 liter over 48 hours.
4. Intravenous dextrose in normal saline 1 liter over 24 hours
5. Intravenous Ciprofloxacin 400 milligrams bd x 48 hours.
6. Tablet Paracetamol 1-gram tds x 5 days.
7. Intravenous buscopan 40mg stat
8. Tablet buscopan 20mg bd x 5 days
9. ORS 2 sachet daily

Laboratory investigations requested by the doctor included;

6. Blood film for malaria parasite.
7. Full Blood Count.
8. Stool for H. pylori.
9. Abdominopelvic ultrasonography
10. Retro screen

Admission assessment revealed that patient had loss of appetite, was weak, at risk of dehydration as

a result of frequent vomiting and diarrhoea and also complained of abdominal cramps and pain which becomes better when she assumed a knee chest position. Patient was oriented to time, place and person. She was also orientated to the ward annexes. Patient and family were informed of the ward protocols the rules and regulations including visiting hours and meal time. She was asked to get her personal items that will be needed during the period of admission. Patient was then introduced to the other clients near her bed. I reintroduced myself to her as a final year student nurse of the Nursing and Midwifery Training College, Berekum, who would like to take her and her family for my care study. Miss A.B. and her aunty were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of license to practice as a Registered General Nurse. I explained to the patient and her aunty the concept of the patient/family care study and assured them of privacy and confidentiality. Weight and height were checked and recorded as 57kg and 1.65m respectively. This resulted in a BMI of 20.9kg/m^2 which indicates optimal nutrition.

Miss A.B. and her aunty agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. Discharge planning was initiated with the relatives; thus, they will continue the care at home once he is well. I decided to choose this patient for the study because I wanted to know more about gastroenteritis as the incidence of this condition is more prevalent in this locality, and identify empirical ways of preventing it.

1.9 Patient's Concept of Illness

Miss. A.B. did not attribute her illness to any spirituality. She was of the view that some conditions like epilepsy and other mental disorders can have spiritual implications. She did not know the exact cause of her condition however; she was quick to add that the signs and symptoms of her illness could be a result of the indiscriminate food combinations she took the previous day during a youth program

organized at their church premise. She was looking forward to recover speedily. She believed that her illness could be treated by modern medicines and was much specific about the need for orthodox medicine.

1.10 Literature Review on Gastroenteritis

Basic Anatomy of the Stomach and the Intestines

The gastrointestinal tract (GI tract, digestive tract, alimentary canal) is the tract or passageway of the digestive system that leads from the mouth to the anus. The GI tract contains all the major organs of the digestive system, in humans and other animals, including the esophagus, stomach, and intestines. Food taken in through the mouth is digested to extract nutrient and absorb energy, and the waste expelled at the anus as feces. Gastrointestinal is an adjective meaning of or pertaining to the stomach and intestines. (Desme, 2020)

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 1500 mL, the stomach stores food during eating, secretes digestive fluids, and propels the partially digested food, or chyme, into the small intestine. The gastroesophageal junction is the inlet to the stomach. The stomach has four anatomic regions: the cardia (entrance), fundus, body, and pylorus (outlet). Circular smooth muscle in the wall of the pylorus forms the pyloric sphincter and controls the opening between the stomach and the small intestine. The stomach is lined with columnar epithelial tissues. (Desme, 2020)

The small intestine is the longest segment of the GI tract, accounting for about two thirds of the total length. It folds back and forth on itself, providing approximately 7000 cm (70 m) of surface area for secretion and absorption**,** the process by which nutrients enter the bloodstream through the intestinal walls. It has three sections: The most proximal section is the duodenum, the middle section is the

jejunum, and the distal section is the ileum. The ileum terminates at the ileocecal valve. This valve, or sphincter, controls the flow of digested material from the ileum into the cecal portion of the large intestine and prevents reflux of bacteria into the small intestine. Attached to the cecum is the vermiform appendix, an appendage that has little or no physiologic function. Emptying into the duodenum at the ampulla of Vater is the common bile duct, which allows for the passage of both bile and pancreatic secretions.

The large intestine consists of an ascending segment on the right side of the abdomen, a transverse segment that extends from right to left in the upper abdomen, and a descending segment on the left side of the abdomen. The sigmoid colon, the rectum, and the anus complete the terminal portion of the large intestine. A network of striated muscle that forms both the internal and the external anal sphincters regulates the anal outlet (Hinkle & Cheever, 2018).

The Diagram Below Shows the Anatomy of the Stomach

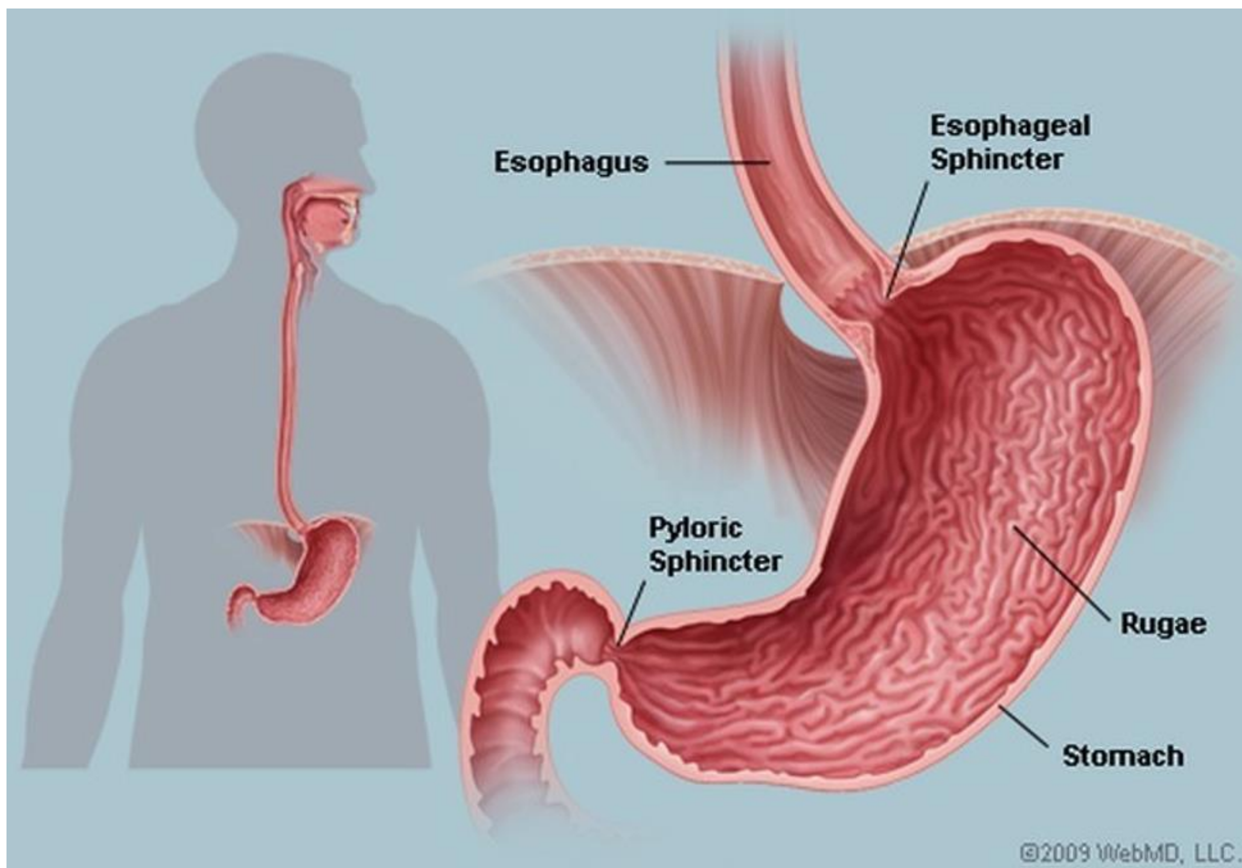

Figure 1

Definition of Gastroenteritis

Gastroenteritis is a medical condition from inflammation ("-itis") of the gastrointestinal tract that involves both the stomach ("gastro" -) and the small intestine ("entero" -). Gastroenteritis is inflammation of the mucosal lining of the stomach and intestines characterized by abdominal cramping, vomiting, nausea and diarrhea (Hinkle & Cheever, 2018).

Incidence/Epidemiology

Gastroenteritis occurs in persons of all ages and is a major cause of morbidity and mortality in most developing countries. It ranks second to common cold as a cause of loss of work time and fifth as the cause of death among children. It can be life threatening in the elderly. The very young, old and immune suppressed patients can become quite ill with this self-limiting condition (Hinkle & Cheever, 2018).

Causes/Aetiology

As specified by Walker and Whittlesea (2019), Gastroenteritis has many causes which include the following;

1. Bacteria such as; *Escherichia coli*, staphylococcus aureus, salmonella, shigella, and clostridium perfringes.

2. Parasites such as; Ascaris, enterobius and trichivellaspiralis

3. Viruses such as; Echo viruses, adenoviruses, norovirus, and rotavirus.

4. Amoeba like Entamoebahistolytica.

5. Reaction to some drugs like antibiotics.

6. Enzymes deficiencies.

7. Food allergies.

Types of Gastroenteritis

Gastroenteritis can basically be classified into:

1. Bacterial Gastroenteritis
2. Viral Gastroenteritis

3. Eosinophilic Gastroenteritis

Bacterial Gastroenteritis

Bacterial gastroenteritis is a very common disorder with many causes, ranges from mild to severe, and usually manifest with symptoms of vomiting, diarrhea, and abdominal discomfort.

Bacterial gastroenteritis is usually self-limited, but improper management of an acute infection can lead to a protracted course. By far, the most complication is dehydration.

Shigella, Salmonella and Campylobacter are the top three leading cause of bacterial gastroenteritis followed by Aeromonas Species.

Viral Gastroenteritis

Viral gastroenteritis causes infection and inflammation of the stomach lining and intestines. It is contagious. You can get it easily by touching someone who is infected or touching an object that has come into contact with an infected person. Eating food prepared by someone who has viral gastroenteritis can make you sick. Contaminated shellfish can harbor gastroenteritis. The virus can live in contaminated water, so eating fruits and vegetables washed in contaminated water can make you sick.

Viral gastroenteritis is a common cause of morbidity and mortality worldwide.

Viral gastroenteritis ranges from a self-limited watery diarrheal illness (usually less than 1 week) associated with symptoms of nausea, vomiting, anorexia, malaise, or fever to severe dehydration resulting in hospitalization or even death. Rotaviruses, caliciviruses, astrovirus and norovirus are thought to be the cause of viral gastroenteritis. Rotavirus attach and enter mature enterocytes at the tips of small intestinal villi thereby causing structural changes to the small bowel including villus shortening and mononuclear inflammatory infiltration in the lamina propria (weller,2014).

Eosinophilic Gastroenteritis

Eosinophilic gastroenteritis is an uncommon inflammatory gastrointestinal disease affecting the both adults and children.

It is characterized by eosinophilic infiltration in one or more areas of the gastrointestinal tract, mainly the stomach and duodenum.

The presence of abnormal gastrointestinal symptoms, most often abdominal pain, nausea, vomiting, diarrhea and weight loss. Atopy or food allergies are often present (Melissa, 2020).

Mode of Transmission

Fecal-oral is the main mode of transmission. The human hand is the main medium for transmission aided by flies where these are prevalent or rampant. Infective materials spread to the hands and then to the mouth (Hinkle & Cheever, 2018).

Pathophysiology

Gastroenteritis is caused by different organism and non-infectious agents. Gastroenteritis is defined as vomiting or diarrhea due to inflammation of the small or large bowel, often due to infection. The changes in the small bowel are typically noninflammatory, while the ones in the large bowel are inflammatory. The number of pathogens required to cause an infection varies from as few as one (for Cryptosporidium) to as many as 10^8 (for Vibrio cholerae). The gastrointestinal tract reacts to any of these varied causes in a related fashion (Mandell 2020)

According to Silverman and Roy (2020), bacteria in the gastrointestinal tract use the following mechanism to bring about the disease condition.

A. Enterotoxin production; the organism gain entry into the GIT, multiply and release toxins that bind to the mucosa and cause a profuse secretion of water and electrolytes. Example; shigella and Vibrio cholerae.

B. Invasion of epithelial cells: The bacteria invade and destroy the cells of the intestinal epithelium. This therefore, leads to bloody mucoid stools. Example E- coli.

C. Penetration and systemic invasion: There are local inflammation in which the organisms try to penetrate the mucosa and gain access to the systemic circulation.

This inflammatory process goes a long way to bring about stimulation and secretion of intestinal fluids.

Because the mucosa lining of the GIT is inflamed, food cannot be retained and there is no alternative than to be vomited or passed out as watery stool. As a result of the excessive loss of water through vomiting and stool, dehydration becomes the order for the day and also the individual becomes very weak due to the inability to retain food. There is also scanty and concentrated urine because most of the fluid is passed out as stools and vomitus, (John, 2020)

Also, inflammation reaction and the presence of toxin also stimulate a sympathetic nerve which stimulates salivation, nausea and vomiting. It further increases intestinal activities leading to diarrhea and abdominal pain, (John, 2020).

Persistent diarrhea and vomiting subsequently lead to depletion of body fluid and electrolyte especially bicarbonate reserves. It predisposes to acidosis, fluid volume deficit and circulatory collapse. This further leads to fluid shift from intracellular compartment to extracellular compartment resulting in to systemic disturbances in cellular functions and changes in their shape which manifest as sunken eyes and dry mucous membrane.

Also, fluid volume deficit and subsequent electrolyte imbalance result in hypocalcemia which triggers the sympathetic nerve to stimulate the heart to increase pulse rate,

Clinical Features.

The clinical features vary depending on the type of organism and level of gastrointestinal tract involved.

However, gastroenteritis in adults is usually a self-limiting, non-fatal disease.

General signs and Symptoms include (John. 2020)

1. Frequent diarrhea stools which may be bloody or mucous.
2. Nausea and Vomiting.
3. Abdominal pains and cramp.
4. Anorexia or Loss of appetite.
5. Headache with chills.
6. Fever may be present.
7. General malaise.
8. Dizziness.
9. The abdomen is often distended.
10. Borborygmi (hyperactive bowel sounds) may be present.
11. Pulse is rapid.
12. Dehydration leading to; sunken eyes, weak pulse, low urine output, dry mucous membrane and low blood pressure

Signs and symptoms usually begin 12–72 hours after contracting the infectious agent, (Herdman&Kamitsuru, 2018) some bacterial infections may be associated with severe abdominal pain and may persist for several weeks.

Children infected with rotavirus usually make a full recovery within three to eight days.

However, in poor countries treatment for severe infections is often out of reach and persistent diarrhea is common.

Diagnostic Measures

A doctor will diagnose gastroenteritis by first taking a complete history of your symptoms. Often, lab test are not needed to diagnose this condition. However, if you have persistent fever or blood in your stool, the following investigations may be carried out (John we. 2020):

1) Blood culture identifies causative bacteria or parasites.

2) Serum electrolytes estimation. Example potassium and sodium calcium.

3) Full blood count for White blood cell and Neutrophil count.

4) Stool for routine examination to identify the presence of blood of leukocytes in stool.

5) Gastric analysis to evaluate gastric acid output.

6) Abdominal computed tomography scan helpful in diagnosing diseases that can present with diarrhea.

7) Abdominal ultrasonography: use to detect obstruction and other abnormalities in the abdominal and pelvic regions

8) Erythrocyte sedimentation rate: Helpful in determining the existence of the low-grade inflammation in irritable bowel syndrome patients.

Medical Management

According to (Hinkle & Cheever, 2018); Gastroenteritis when acute must be treated as a medical emergency for the following reasons,

1. To avoid the spread of disease to other people.
2. To avoid the complications of the disease.
3. Severe diarrhea is treated with oral rehydration salt (ORS) therapy in which physiological salt solutions are given orally to correct dehydration and electrolyte imbalance.
4. Hospitalization may be needed as the patient requires as support treatment consisting of bed rest, nutritional support and increase fluid which needs monitoring.
5. Histamine-receptor antagonist such as cimetidine may be prescribed as they block gastric secretion.
6. Antacids such as Aluminum Hydroxide may be used as buffers which can be administered hourly.
7. Analgesics such as Budesonide and Ibuprofen (NSAID) can also be given for abdominal pains.
8. Anti-emetics, for example Phenergan is given to reduce vomiting.
9. Intravenous fluids and electrolytes replacement can be given. The intravenous fluids which are normally given are normal saline, dextrose saline and ringers lactate.
10. Bismuth containing compounds such as prochlorperazine, or thiobenzamide can be given,
11. Antimicrobial agents are not usually used for gastroenteritis, although they are sometimes recommended if symptoms are particularly severe or if a susceptible bacterial cause is isolated or

suspected. If antibiotics are to be employed, a macrolide (such as azithromycin) is preferred. Other antibiotics prescribed may include metronidazole, cefuroxime and ciprofloxacin.

12. Antispasmodics example Buscopan.

Nursing Management

The nursing managements as identified by Justin Seroy 2021 are as follow;

- Assess vital signs
- Encourage intake of fluids
- Educate caregiver about viral gastroenteritis
- Assess infant/child for abdominal pain, nausea
- Monitor intake and output
- Assess for signs of dehydration and rehydrate. If patient cannot tolerate fluids orally, then intravenous fluids should be instituted.
- Educate about hand washing and proper hygiene measures
- Educate about the importance of clean water for cooking
- Encourage the parent to follow up with medical care
- Educate caregiver about the rotavirus vaccine

Prevention of Infection

1. The nurse should always wash hands thoroughly before and after carrying out any procedure on the patient to prevent the spread of infection.

2. The nurse should always teach client on ways to maintain personal hygiene.

3. Advice client to eat food cooked from home rather than buying from outside to minimize infections.

4. Patient should be instructed to wash hands immediately after visiting toilet and before and after handling food.

5. Client should always avoid the use of contaminated water, food and also avoid eating raw fruits and vegetable without washing them.

6. Linens soiled with stool should be disinfected to prevent the spread of the disease.

7. Isolation of patients should be done to prevent the spread of the disease.

8. Barrier nursing should be ensured to prevent cross infection.

9. Proper disposal of stools should be ensured and good hand washing practice should also be encouraged.

Monitoring and Observation of Patient to Prevent Complication

1. Vital signs, (temperature, pulse, respiration and blood pressure) should be monitored thoroughly to know whether the condition is improving or deteriorating.

2. The nurse should observe for the amount of urine passed and its degree of concentration by using intake chat.

3. Nurse should also observe for the presence of blood or mucus in the stool.

4. Client should be weighed weakly to check if there is any weight loss.

5. Patient should also be monitored for the desired and side effects of the drugs.

6. When patient is on intravenous infusion, it should be monitored. There should be frequent assessment of the intravenous site for infiltration.

Elimination

Bowel elimination should be encouraged by serving bed pan on request. Client should be encouraged to have regular bladder elimination. Urinals should be served when necessary.

Patient/Family Teaching and Education

According to Smeltzer and Bare (2018),

1. Educate the patient about the early signs of diarrhea and dehydration.
2. Let the patient know the need for personal and environmental hygiene.
3. Advise patient to always wash the hand before eating and after visiting the toilet.
4. Food must be well heated before eating and fruits also washed properly.
5. Advice patient not to expose foods to flies.
6. Educate patient and family on the need to avoid defecation in the bush.

Complications

If early treatment is not sought for, the following complications may develop.

1. Acute renal failure is due to frequent vomiting and diarrhea may lead to dehydration, which in turn may decrease blood volume and hence reduced circulatory volume. This therefore decreases renal perfusion and may lead to renal failure.

2. Fluid and electrolytes Imbalance as a result of diarrhea and vomiting may lead to loss of hydrogen ions from the stomach. Bicarbonate ions may also be lost through diarrhea which may cause imbalance in these electrolytes in the blood and may lead to acidosis or alkalosis.

3. Convulsions (in case of a child) due to inadequate blood supply to the brain and fever and also infections travelling to the brain causes problem to the brain which may lead to convulsion.

4.Malnutrition this occurs when the body doesn't get enough nutrients e.g., poor diet and digestive conditions.

5.Dehydration may occur as a result of diarrhea. In diarrhea, there is loss of bicarbonate ions from the intravascular component. The loss of these electrolytes goes along with plasma (water), causing the increase in osmotic/oncotic pressure. This causes fluid to shift from the extracellular and intracellular spaces, causing the cells to shrink causing dehydration.

6.Cardiac failure occurs as a result of decreased cardiac output. The heart is the first organ to receive oxygenated blood. In diarrhea, the patient losses fluid and subsequently lead to hypovolemia. This leads to decreased blood volume and hence decreased cardiac perfusion. This then leads to ischemia and may lead to cardiac failure.

7.Hypovolemic Shock occurs as a result of fluid lost along with electrolytes. As the fluids are lost from the intravascular spaces, the volume of the blood reduces, causing reduction in cardiac output, and hence, decreased perfusion to the vital organs, leading to shock.

1.11 Validation of Data

Validation of data simply means to establish the soundness, accuracy or legitimacy of the data gathered so that it will be free from errors and misinterpretations. Data collected from A.B. were similar to those the relatives told me, also during my home visit most of the information given to me by A.B. and her family at the hospital were confirmed by other relatives in the house. Data presented by A.B. and her diagnostic investigations carried out were similar to those in the literature review. When the patient's condition became stable and all the relatives had calm down, I again asked them the same questions which were asked previously and the same response was given. Upon this I therefore believe the information gathered was authentic and valid for study.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Data analysis is a method in which data is collected and organized so that one can derive helpful information from it (Weller,2018)

This chapter forms the second phase of the patient/family care study. The nurse identifies the actual and potential client problem(s) based on review and interpretation of the client through 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 (Donna, 2019). 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 A.B. This chapter also captures the patient/family strengths, the health problems identified and nursing diagnoses formulated for given care to A.B.

2.1 Comparison of Data with Standards

This is done by assessing the similarities between data obtained from patient and that which is written in textbooks. These comparisons cover:

A. Diagnostic investigation/ Tests.
B. Causes/ Risk factors.
C. Clinical features/ Sign and Symptom.
D. Medical/ Surgical treatment.
E. Pharmacology of drugs
F. Complications

A. Diagnostic Investigations/Tests

A diagnostic test is a test used to identify a condition or its cause. A diagnostic test performed as a part of a medical exam may be used to identify the cause of symptoms or identify a disease (Jason. 2021)

The Literature points out; serum electrolyte estimation, blood culture, full blood count, stool for routine examination, gastric analysis, erythrocyte sedimentation rate and abdominal computed tomography scan as the diagnostic measures for confirming gastroenteritis. The following investigations were carried out on patient to aid in the diagnosis and treatment;

1. Blood film for malaria parasite.
2. Full Blood Count.
3. Stool for H. pylori.
4. Abdominopelvic ultrasonography
5. Retro screen

Table 1: Diagnostic Investigation Conducted for A.B. as Compared with Literature Review

Diagnostic Investigation in Literature Review	Diagnostic Investigation Conducted for A.B.
Serum Electrolyte Estimation	Serum Electrolyte Estimation was not done for patient
Blood Culture	Blood Culture was not done for patient
Full Blood Count	Full Blood Count was done for patient
Stool for Routine Examination	Stool for H. pylori was done
Gastric Analysis	Gastric Analysis was not done for patient
Erythrocyte Sedimentation Rate	Erythrocyte Sedimentation Rate was not done for patient

Abdominal Computed Tomography scan	Abdominal Computed Tomography Scan was not done for patient
Abdominal ultrasonography	Abdominopelvic ultrasonography was done for patient
No retro screen	Retro screen was done for patient
Blood film for malaria parasite not present	Blood film for malaria parasite was requested and done

With reference to table 1, Serum electrolyte estimation, Gastric analysis, Erythrocyte sedimentation rate and Abdominal Computed Tomography Scan were not carried out because the diagnosis was not found in literature but was arrived at those diagnostic investigations that were requested for him. Blood film for malaria parasite was not found in literature review but was requested to rule out malaria which shares some similar symptoms to gastroenteritis.

Retro screen was done for patient as part of hospital protocol to screen patients who are admitted into the facility.

Table 2: Diagnostic Investigation/ Test Carried on A.B. Compared with Standard

Date	Specimen	Investigations	Results	Normal Value	Interpretations	Remarks
15/11/2022	Blood sample	Blood film for malaria parasites (MP's)	No malaria parasites seen.	No malaria parasites should be seen	Malaria parasite absent	No treatment was given to patient.
15/11/2022	Blood Sample	**FULL BLOOD COUNT**				
		White blood cell count.	8.3×10^{3} /Ul	4.0-11.0$\times10^{9}$/litre	Normal value indicating absence of infection in the blood.	No treatment was given to patient.
		Neutrophil count	79.00%	40.00% – 70.00%	High Neutrophil count indicates infection.	Antibiotics such as Intravenous ciprofloxacillin were given.
		Red blood cell(RBC)	4.08x10^{6}/uL	4.30 -5.80x10^{6}/Ul	Lower than normal indicating inadequate	Tablet zinc 20mg was given for ten days

					cells for tissue oxygenation.	
		Hemoglobin (HB) level	11.2g/dl.	13-18 g/dl(male) 12-15 g/dl(female)	Patient was anemic.	Tablet zinc 20mg was given for ten days
15/11/2022	Stools	Stool for H pylori	H pylori was not seen in stool	No pathogen should be present	Diseases causing organism was absent.	No treatment was given to patient.
15/11/2021	Blood	Retro virus	Negative	No retro virus should be seen in blood	Diseases causing organism was absent.	No treatment was given to patient.

B. The cause of patient's illness

According to the history of patient's condition, she ate contaminated food at church which resulted in the clinical manifestations exhibited by patient. Further physical examinations performed on patient and the laboratory investigation carried out, on A.B. confirmed that she had bacterial infection of the stomach and the intestine as was evidenced by elevation of neutrophil count, an immune response by the body to bacterial infections.

C. Specific Medical Treatments Given to A.B.

Medical treatment means the management and care of a patient to combat disease or disorder ((Desme, 2020))

Various classes and examples of medications as stated in the literate review can be used in varied combinations to treat gastroenteritis. Though, lots of medications are mentioned in literature review, but based on clinical judgment by the physician who attended to A.B., the following medications were prescribed

1 Tablet Zinc 20mg daily x 10 days

2. Intravenous promethazine 25 milligrams stat

3. Intravenous Ringers lactate 2.5 liter over 48 hours.

4. Intravenous dextrose in normal saline 1 liter over 24 hours

5. Intravenous Ciprofloxacin 400 milligrams bd x 48 hours.

6. Tablet Paracetamol 1-gram tds x 5 days.

7. Intravenous buscopan 40mg stat

8. Tablet buscopan 20mg bd x 5 days

9. ORS 2 sachet daily

Table 3: A Comparison of Specific Medical Treatment Prescribed to A.B. Compared with Literature

Medical Treatments in Literature	Medical Treatments Prescribed for A.B.
1. Histamine – Receptor Antagonist a. Cimetidine	**1. Histamine- Receptor Antagonist** a. Cimetidine was not given to patient.
2. Antacids a. Magnesium Oxide	**2. Antacids** a. Magnesium Oxide was not given to patient.
3. Analgesics a. Budesonide b. Ibuprofen c. Paracetamol not present	3**. Analgesics** a. Budesonide was not administered b. Ibuprofen was not administered c. Tablet Paracetamol was administered to patient.
4**. Anti – emetics** a. Phenergan (Promethazine)	**4. Anti –emetics** a. Promethazine was administered to patient.
5. Intravenous fluids and electrolyte replacement a. IV Normal Saline, b. Dextrose Normal Saline c. Ringers Lactate	**5. Intravenous fluids and electrolyte replacement** a. IV Normal Saline was not administered to patient b. Dextrose Normal Saline was administered to patient c. Ringers Lactate was administered to patient

6 Bismuth containing compounds a.Thiobenzamide	7. Bismuth containing compounds a. Thiobenzamide was not prescribed for patient.
7. Antimicrobial agents a. Ciprofloxacin, b. Metronidazole c. Cefuroxime	**7. Antimicrobial agents** a. Ciprofloxacin was administered to patient b. Metronidazole was not prescribed for patient. c. Cefuroxime was prescribed for the patient.
8. Rehydration agents a. Oral rehydration solution	**8. Rehydration agent** a. oral rehydration solution was prescribed for the patient.
9. Antispasmodics a. Buscopan	**9. Antispasmodics** a. Buscopan was given to patient.

Drugs received by A.B. were in line with those outlined in the literature review and this aided in his speedy recovery without complications.

D. Pharmacology of Drugs

The medical treatment that was given to A.B. is outlined in the Table below. It consists of date of the order, the drug name, the dosage and route of administration for the patient, classification, desired effect, actual effect observed and remarks.

Table 4: Shows Pharmacology of Drugs Given A.B.

Date	Drug	Dosage/Route of Administration As shown in literature review	Dosage/Route of Administration to A.B.	Classification	Desired Effect	Actual Action Observed	Side Effects/Remarks
15/11/2022	Dextrose in Normal saline	**Dosage:** Depends on the patient's fluid and electrolyte imbalance levels. Route: **Intravenously**	**Dosage:** 1liter over 24 hours; **Route:** Intravenously	Crystalloid isotonic fluid	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
15/11/2022	Metronidazole	**Dosage** **Adult** 500mg 8-12 hourly 5-7 days. **Child:** 30 mg/kg/day q6h **Route;** Intravenously, oral.	**Dosage**: 500mg every 8 hours x 48 **Route**: Intravenously	Nitroimidazole, antiprotozoal, amoebicidal	Inhibits nucleic acid synthesis by Disrupting DNA and causing strand breakage.	Bacteria were killed and patient was free from infection.	Anorexia, diarrhea, nausea vomiting headache, dark urine, dizziness. None of the above effect was observed.

Date	Drugs	Dosage/Route of Administration As shown in Literature review	Dosage/Route of Administration to A.B.	Classification	Desired Effect	Actual Action Observed	Side Effects/Remarks
15/11 /2022	Ringers Lactate	**Dosage:** Depends on patient's fluid and electrolyte imbalance levels. **Route:** intravenously	**Dosage:** 1liter over 8hours; **Route:** Intravenously	Alkalinizing Agents, isotonic	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
15/11 /2022	Ciprofloxacin	**Dosage;** 400- 750 mg every 12 hours for 7- 14 days **Child**: 10 mg/kg 12 hourly for 7-14 days	**Dosage:** 400mg every 12houly in 48 hours	Antibiotic (Fluoroquinolone)	It inhibits relaxation of DNA; Inhibits DNA gyrase in susceptible organisms;	Patient's infection resolved.	Nauseas and vomiting, constipation, rash, flatulence. Headache, abdominal pain. No side effect was observed on patient.

		Route: Intravenously, oral	**Route:** **Intravenously**		promotes breakage of double stranded DNA.		
15/11 /2022	Promethazine	**Dosage:** **Adult:** 12.5-25 mg 4-6 hourly PRN, for nausea and vomiting. **Child**:1mg/kg 12 hourly PRN **Route:** intravenous, intramuscular and oral	**Dosage:** **25mg stat.** **Route:** **intravenous**	Phenothiazine derivative with antidopaminergic effect, H1-receptor blocker	Blocks mesolimbic dopaminergic receptors, alpha-adrenergic receptors in the brain and H1-receptors.	Patient's vomiting was stopped.	Sedation, confusion, blurred vision, hallucination, disorientation, dry mouth, urticarial and urinary retention. None of these side effects were observed.

15/11 /2022	Zinc	**Dosage :** 10-20 mg daily **Child**: 5-10mg daily Route: intravenous and oral	**Dosage :** 20mg daily x 10 days `	Inorganic Compound	Plays a role in DNA synthesis: supports the immune system and helps in diarrhea.	Diarrhea was stopped.	Nausea, vomiting, gastric irritation, neurologic disorientation.
15/11 /2022	ORS	**Dosage:** depends on the severity of dehydration. **Adult**: 200 to 400 ml after each loose stool (approximately 2000 ml daily) **Child**: 100 to 200 ml after each loose stool (approximately 1000 ml daily) **Route**: oral	**Dosage:** 2 sachets to be dissolved in two liters of water, I liter a daily x two days	Fluid and electrolyte.	Prevention and treatment of diarrhea and vomiting	Patient was well hydrated	Vomiting, high blood sodium, high blood potassium.

Table 4: Shows Pharmacology of Drugs Given to A.B. Cont'd

Date	Drug	Dosage/Route of Administration As shown in literature review	Dosage/Route of Administration to A.B.	Classification	Desired Effect	Actual Action Observed	Side Effects/Remarks
15/07/2022	Buscopan (Hyoscine butylbromide)	**Dosage;** **By mouth:** smooth muscle spasm, 20mg 4 times daily. But depends on how individual will present **Child**: 10mg 3times daily. **Route:** Intravenously, oral	**Dosage**: 40mg stat **Route:** Intravenously	Antispasmodics Anticholinergic	It suppresses spasms and contractions thereby blocking the action of acetylcholine on the receptors found within the smooth muscle walls of gastro and urinary tract	Patient was relieved of abdominal pains.	Nausea and vomiting, constipation, dry mouth, dizziness and reduced ability to sweat. No such side effects were observed on patient.

15/07/2022	Buscopan (Hyoscine butylbromide)	**Dosage;** **By mouth:** smooth muscle spasm, 20mg 4 times daily. But depends on how individual will present **Child**: 10mg 3times daily. **Route:** Intravenously, oral	**Dosage**: 20mg bd x 5 days **Route:** Oral	Antispasmodics Anticholinergic	It suppresses spasms and contractions thereby blocking the action of acetylcholine on the receptors found within the smooth muscle walls of gastro and urinary tract	Patient was relieved of abdominal pains.	Nausea and vomiting, constipation, dry mouth, dizziness and reduced ability to sweat. No such side effects were observed on patient.
15/07/2022	Tablet Paracetamol	**Dosage;** **Adult**:1g every 4 – 6 hours; maximum daily dose is 4g. **Child:**500mg every 4 – 6 hours;	**Dosage**: 1gram 8hourly for 5days. **Route:** Orally.	Antipyretics/Analgesics	To relieve pain by blocking generation of pain impulses, probably by inhibiting prostaglandin synthesis in the central nervous system.	Patient was relieved of fever.	Dizziness, urticarial, liver damage and disorientation. Patient exhibited none of these side effects.

		maximum daily dose is 2g **Route;** oral,rectal, IV.					

E. Clinical Manifestations Exhibited by A.B.

The comparison of the clinical manifestation in the literature review with those manifested by patient is shown in table below.

Table 5: Comparison of A.B.'s Clinical Manifestation with Literature.

Clinical Manifestation in Literature	Clinical Manifestation Exhibited by A.B.
Frequent diarrhea stools	Patient experienced diarrheal stool (3 times in a day)
Nausea and vomiting	Patient experienced nausea and vomiting
Abdominal pain and cramping	Patient experienced Abdominal pain and cramping
Headache with chills	Patient did not experience Headache with chills
Fever	Patient did not experience Fever
General malaise	Patient experienced General malaise
Dizziness	Patient did not experienced dizziness
Distended abdomen	Patient did not experience distended abdomen
Borborygmi	Patient did not experience borborygmi
Rapid pulse	Patient did not experience rapid pulse
Dehydration	Patient had a risk of developing dehydration
Anorexia	Patient experienced anorexia

The patient on admission exhibited most cardinal signs and symptoms of acute gastroenteritis similar to those outlines in the literature review. These signs and symptoms provided the clue and aided in his early diagnosis and treatment.

F. Complications Developed by Patient.

Complication of a disease is a condition, coexistent with and modifying a primary disease but not necessarily connected with it. (Jason, 2021)

Table Six: Comparison of Complications in Literature Review with Complications Developed by Patient.

COMPLICATIONS IN LITERATURE REVIEW	COMPLICATIONS DEVELOPED BY A. B.
Acute renal failure	Patient did not suffer renal failure
Fluid and electrolytes Imbalance	Patient did not experience fluid and electrolytes imbalance
Convulsions	Patient did not experience convulsions
Malnutrition	Patient did not suffer malnutrition
Dehydration	Patient did not experience dehydration
Cardiac failure	Patient did not suffer Cardiac failure
Hypovolemic Shock	Patient did not suffer Hypovolemic Shock

With regards to the complications outlined under the literature review, A.B. 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

Patient and family strengths refers to the resources that can enable them to cope with stressful conditions leading to patient's recovery. These involve the activities that contribute to the well-being of patient and his family as well as his speedy recovery.

1. Patient could verbalize the frequency of vomiting and loose stool passed.

2. Patient could indicate location and intensity of pain
3. Patient could eat about 300ml of Hausa porridge.
4. Patient can turn herself on bed.
5. Patient could sleep for about four (4) hours at night.
6. Patient was able to mention the cause of her disease condition.

2.3 Patient /Family Health Problems

Patient health problems are issues that make them disrupt their homeostatic balance and render them physiologically imbalanced. These problems need be resolved to return the patient back to physiologically stable state (Campbell, 2020). During assessment, the following health problems were noticed on patient:

1. Patient complained of vomiting two times and passing watery stool three times (15/07/2022).
2. Patient complained of abdominal pain, (15/07/2022).
3. Patient had loss of appetite 15/07/2022).
4. Patient was weak, (15/07/2022).
5. Patient complained she was not able to sleep well. (16/07/2022).

6. Patient had inadequate knowledge about her disease condition (18/07/2022).

2.4 Nursing Diagnosis

A nursing diagnosis is a part of the nursing process and is a clinical judgment that helps nurses determines the plan of care for their patients (Kathleen, 2022). These nursing diagnoses were formulated based on the health problems that were identified.

1 Risk for fluid volume deficit: related to vomiting and passing of loose stools. (15/07/2022).

2. Acute pain (abdomen): related to inflammatory process in the stomach and intestine (15/07/2022).

3. Risk for imbalanced nutrition: less than body requirement: related to anorexia (15/07/2022).

4. Self-care deficit (total): related to skeletal muscle weakness (15/11/21).

5. Insomnia: related to abdominal pain and unfamiliar environment (16/07/2022).

6. Knowledge deficit: related to inadequate information about the causes, sign, symptoms, management and prevention of the condition (18/07/2022).

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is the process of thinking regarding the activities required to achieve a desired goal. Planning is based on foresight, the fundamental capacity for mental time travel. Planning is a fundamental property of intelligent behavior. It involves the use of logic and imagination to visualize not only a desired end result, but the steps necessary to achieve that result (Gabby, 2020). This is the third phase in the nursing process which deals with setting of goals and objective/outcome criteria to meet the health needs of the patient. These objectives/outcome criteria are set in order of priority which can be long or short term. This is made possible based on the actual and potential problems identified.

3.1 Objectives and Outcome Criteria for Patient/Family Care

Objective most commonly means not influenced by an individual's personal viewpoint. It's often used to describe things like observations, decisions, or reports that are based on an unbiased analysis. An outcome is a "measurable behavior demonstrated by the patient responsive to nursing interventions. Outcomes should be identified before nursing interventions are planned. After nursing interventions are implemented, the nurse will evaluate if the outcomes were met in the time frame indicated for that patient (Gabby, 2019). As a result of the patient/family health problems identified, the following objectives were set for the patient/family.

1. Patient would maintain adequate fluid volume throughout hospitalization as evidenced by;

a. The nurse observing that patient has normal skin turgor as an indicator of good hydration.

b. Patient verbalizing absence of extreme thirst

c. Patient verbalizing vomiting and diarrhea has stopped.

2. Patient's abdominal pains would resolve within 72 hours of hospitalization as evidenced by;

a). The nurse observing patient been calm in bed with a relaxed facial expression.

b). Patient rating pain as 0 on the 0-10 numeric rating scale.

3. Patient would regain and maintain adequate nutritional status within 72 hours as evidenced by;

a. The nurse observing patient eating at least 80% of her usual meal served.

b. Patient verbalizing that her normal eating habit has been established.

4. Patient would regain her strength and perform activities without assistance within 48 hours as evidenced by;

a). Nurse observing that patient can perform activities unassisted

b). Patient verbalizing that she no longer has any feeling of bodily weakness.

5. Patient will maintain her normal sleep pattern (6-8hours and 3hours in a day time) within 72hours as evidenced by;

a). Nurse observing that patient had uninterrupted sleep for 6-8 hours at night.

b). Patient verbalizing that she had uninterrupted sleep.

6. Patient and family would gain adequate knowledge on gastroenteritis within 24 hours as evidenced by;

a). Nurse observing that patient and relatives practice knowledge gained on gastroenteritis

b). Patient and family being able to provide correct answers to questions posed to them on the causes, management and prevention of gastroenteritis.

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 7: Nursing Care Plan for A.B. and Family

Date/ Time	Nursing Diagnosis	Objective Outcome Criteria	Nursing Orders	Nursing Intervention	Evaluation	Signature
15/11/21 12:25pm	Risk for fluid volume deficit: related to vomiting and passing of loose stools	Patient would maintain adequate fluid volume throughout hospitalization as evidenced by; a. The nurse observing that patient has normal skin turgor as an indicator of good hydration. b. Patient verbalizing absence of extreme thirst c. Patient verbalizing vomiting and diarrhea have stopped.	1. Assess patient for signs of dehydration such as extreme thirst and poor skin turgor. 2. Serve emesis bowl or bedpan for patient to vomit or pass stool. 3. Encourage the intake of fluids. 4.Rinse patient's mouth after vomiting 5. Monitor intake and out put 6. Administer prescribed intravenous fluid.	1. Patient was asked if she experience thirst and dry throat. Also, patient skin was pinched between two fingers and observed for its return. These were done to assess for dehydration. 2. Emesis bowl and bedpan was served for patient appropriately for vomiting and passing of stool. 3. Patient was made to take in lots of fluids, example ORS to prevent dehydration 4 Patient's mouth was rinsed thoroughly after vomiting to stimulate appetite 5. Intake and output were recorded on the fluid chart to ascertain fluid status. 6. Prescribed intravenous fluids (normal saline, dextrose and ringers' lactate) were served to hydrate patient.	Goal fully met as nurse observed that patient has normal skin turgor and patient verbalized diarrhea and vomiting have stopped	19/11/21 9:00am A.S.P.

Table 7: Nursing Care Plan for A.B. and Family Cont'd

Date and Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Evaluation	Signature
15/11/21 12:50pm	Acute pain (abdomen): related to inflammatory process in the stomach and intestine	Patient's abdominal pains would resolve within 72 hours of hospitalization as evidenced by; a). The nurse observing patient been calm in bed with a relaxed facial expression. b). Patient rating pain as 0 on the 0-10 numeric rating scale.	1. Reassure patient that the pain would subside 2. Assess the level of pain on a pain rating scale. 3 Provide diversionary therapy to take patient mind off the pain 4 Monitor vital signs 5. Provide patient with warm comfortable bed. 6. Serve prescribed pain medications.	1. Patient was reassured that the pain will subside following competent nursing. This was done to allay anxiety. 2. The level of pain was assessed on a pain scale of 0 – 10 and indicated as 5 by patient. This was done to reveal the severity of pain. 3 Patient was made to watch her favorite movie on television to divert her attention from the pain. 4. Vital signs were monitored regularly to monitor the effect of the pain on the vital signs for appropriate action. 5. Patient was provided with warm comfortable simple bed devoid of creases and cramps to induce sleep. 6. Intravenous buscopan 40mg stat and tablet Paracetamol 1-gram was served as prescribed to relieve pain.	Goal fully met as nurse observed patient exhibit relaxed facial expression in bed and patient rated pain as 0 on the 0-10 numeric rating scale	18/11/21 12:50pm A.S.P.

Table 7: Nursing Care Plan for A.B. and Family Cont'd

Date and Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Evaluation	Signature
15/11/21 1:15pm	Risk for imbalanced nutrition: less than body requirement: related to anorexia	Patient would regain and maintain adequate nutritional status within 72 hours as evidenced by; a. The nurse observing patient eating at least 80% of her usual meal served. b. Patient verbalizing that her normal eating habit has been established.	1. Provide frequent oral care. 2.Remove all nauseating items from sight of patient 3. Serve small, frequent meals: 6 per day 4. Encourage patient to take in well-balanced diet. 5.Consider patient preferences in planning meals 6. Limit fluids 1 hour before meals and with meals.	1. Patient mouth was rinsed before and after eating to stimulate appetite. 2. Items like vomitus bowl and bedpan were removed from sight of patient to prevent nausea. 3.Food was served in small quantity at frequent intervals to promote enough intake as well as easy digestion 4. Patient was encouraged to take in well-balanced diet for adequate nutrition. 5. Patient's preference of food was considered in meal planning to promote individuality and to know the food she likes. 6. Fluid intake was limited 1 hour to and with meals to promote adequate food intake.	Goal fully met as nurse observed patient eating at least 80% of her usual meal served and patient verbalized that her normal eating habit has been established.	18/11/21 1:00pm A.S.P.

Table 7: Nursing Care Plan for A.B. and Family Cont'd

Date/Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Evaluation	Signature
15/11/21 2:00 pm	Self-care deficit(total): related to skeletal muscle weakness	Patient would regain her strength and perform activities without assistance within 48 hours as evidenced by; a). Nurse observing that patient can perform activities unassisted b). Patient verbalizing that she no longer has any feeling of bodily weakness.	1. Assess patient hydration and nutritional status. 2. Reassure patient and family. 3. Assist patient to carry out activities of daily living such as bathing, grooming and washing of her teeth. 4. Encourage patient to carry out activities she can tolerate with rest periods when tired. 5. Place items of daily use close to patient. 6. Engage patient in passive range of motion exercise.	1. Fluid status was monitored and balanced every 24 hours. Caloric intake was also checked. These were ensuring adequate fluid and caloric intake. 2. Patient and family were reassured that she will regain strength for her daily activities with available measures. This was done to allay anxiety 3. Patient was always assisted in bathing, grooming and brushing of her teeth. 4. Patient was encouraged to carry out activities he could tolerate such as walking around bed with rest periods when tired to prevent exhaustion 5. Items of daily use such as comb, tooth brush and paste were laced within reach of patient. 6. Patient was engaged in passive range of activity like walking from bed to nurses' station, flexion and extension of hands to promote muscle strength.	Goal was fully met as nurse observed patient perform activities unassisted and patient verbalized absence of bodily weakness.	17/11/21 2:00pm A.S.P.

Table 7: Nursing Care Plan for A.B. and Family Cont'd

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Evaluation	Signature
16/11 /21 08:15 am	Insomnia: related to abdominal pains and unfamiliar environme nt	Patient will maintain her normal sleep pattern (6-8hours and 3hours in a day time) within 72hours as evidenced by; a). Nurse observing that patient had uninterrupted sleep for 6-8 hours at night. b). Patient verbalizing that she had uninterrupted sleep.	1. Reassure patient that his sleep pattern will be restored. 2. Reduce noise in the ward. 3. Ensure warm bath at night to induce sleep. 4. Ensure comfortable bed and good ventilation. 5. Plan and carry out nursing activities together. 6. Restrict visitors to prevent distraction of patient sleep	1. Patient was reassured that his sleep pattern will be restored with available measures to alleviate anxiety 2. Television sets were lowered, staffs on the ward were encouraged to reduce noise making to promote sleep 3 Patient was provided with warm water to bath to induce sleep. 4. Patient bed was properly made free from creases to promote sleep 5. Nursing procedures were carried out together to prevent interrupting patient sleep. 6. Visitors were restricted to prevent distraction of patient sleep	Goal fully met as nurse observed that the patient slept throughout the night without interruptions and patient verbalized that she slept well	19/11/21 08:15am A.S.P.

Table 7: Nursing Care Plan for A.B. and Family Cont'd

Date/Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Evaluation	Signature
18/11/21 10:30am	Knowledge deficit: related to inadequate information about the cause, management and prevention of the condition	Patient and relative will gain adequate knowledge on gastroenteritis within 24 hours as evidenced by; a). Patient and relative being able to provide correct answers to questions regarding the causes, management and prevention of gastroenteritis. b). Nurse observing that patient and relatives practice knowledge gained on gastroenteritis	1. Assess knowledge of patient and relative on condition. 2. Inform patient and relative about ways of preventing the symptoms and some management for the disease. 3. Allow patient and relative to ask questions for clarification. 4. Answer questions in simple understandable language without using professional jargons. 5. Ask patient and relative to summarize what they heard. 6. Give patient and relative pamphlet containing information about condition	1. Their knowledge on the condition was assessed to know what they know about the condition. 2. Patient and relative were informed about ways of preventing the symptoms and some management for the disease. 3. Patient and relative were allowed to ask questions for clarifications on issues bothering their minds about the disease. 4. All questions were answered in simple, plain and clear language without the use of professional jargons to promote understanding. 5. Patient and relative were asked to give a feedback on what they heard to confirm their understanding. 6) Pamphlet containing information on condition was given to patient and relative to serve as a reminder	Goal fully met as patient and family verbalized the causes, management and prevention of the condition and nurse observed that patient and relatives practice knowledge gained on gastroenteritis such as hand hygiene.	19/11/21 @ 10:30am A.S.P.

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 actualization of the nursing care plan through nursing intervention (Hinkle&Cheever,2018). It gives the vivid account of the actual nursing care that was rendered to the patient/family from the day of admission until discharge based on the patient's health problems identified. This chapter also includes the preparation of the patient and his family towards discharge, home visit and continuity of care.

4.1 Summary of the Actual Nursing Care

The actual nursing care rendered to patient and his family commenced on the day of admission, 15th November, 2021 to the time care was terminated. The management of patient and his family was planned to meet their physiological, psychological, emotional and spiritual needs

Day of Admission, 15th November, 2021.

Miss A.B. arrived on the Females Ward on 15th November, 2021 at at 12:00pm from the emergency department. She was accompanied by her aunty and a staff nurse in a conscious and ambulatory state with the diagnosis of gastroenteritis. She was fairly ill, and looked weak. I was at the nurses' station with the nurse in-charge at the time of her arrival, so I was charged with the responsibility to carry out her admission to the ward. It was a planned admission. The patient's identity was verified by mentioning his name for response. She was then welcomed and immediately admitted and made comfortable in an admission bed. She was introduced to the staffs present and was assured of competent healthcare and speedy recovery. Her particulars such as name, sex, age, and

residential address were recorded in the admission and discharge book and the daily ward state.

Vital signs were checked and recorded accurately as follows:

Temperature	36.1 ^{O}C
Respiration	25 cycles per minute
Pulse	93 beats per minute
Blood Pressure	120/90millimeters of mercury (mm/Hg)

SPO_2 was 100%

Hospital policies regarding visiting periods, payment of bills and the four-hourly assessment of vital signs were explained.

The following treatment plans were used to manage her;

1. Tablet Zinc 20mg daily x 10 days
2.Intravenous promethazine 25 milligrams stat
3. Intravenous Ringers lactate 2.5 liter over 48 hours.
4. Intravenous dextrose in normal saline 1 liter over 24 hours
5. Intravenous Ciprofloxacin 400 milligrams bd x 48 hours.
6. Tablet Paracetamol 1-gram tds x 5 days.
7. Intravenous buscopan 40mg stat
8. Tablet buscopan 20mg bd x 5 days
9. ORS 2 sachet daily

Laboratory investigations requested by the doctor included;

1. Blood film for malaria parasite.
2. Full Blood Count.

3. Stool for H. pylori.

4. Abdominopelvic ultrasonography

5. Retro screen.

Admission assessment revealed that patient had loss of appetite, was weak, at risk of dehydration as a result of frequent vomiting and diarrhoea and also complained of abdominal cramps and pain which becomes better when she assumed a knee chest position. Patient was oriented to time, place and person. She was also orientated to the ward annexes. Patient and family were informed of the ward protocols the rules and regulations including visiting hours and meal time. She was asked to get her personal items that will be needed during the period of admission. Patient was then introduced to the other clients who were on the ward.

I reintroduced myself to her as a final year student nurse of the Nursing and Midwifery Training College, Berekum, who would like to take she and her family for my care study. Miss A.B. and her aunty were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of license to practice as a Registered General Nurse. I explained to the patient and her aunty the concept of the patient/family care study and assured them of privacy and confidentiality.

Miss A.B. and her aunty agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. Discharge planning was initiated with the relatives; thus, they will continue the care at home once she is well. I decided to choose this patient for the study because I wanted to know more about gastroenteritis as the incidence of this condition is more prevalent in this locality, and identify empirical ways of preventing it.

A nursing diagnosis of "Risk for fluid volume deficit: related to vomiting and passing of loose stools" was made at 12.25pm and a goal was set to maintain adequate fluid volume throughout hospitalization. The following nursing interventions were carried out; Assessment of patient for signs of dehydration such as extreme thirst and poor skin turgor, serving of emesis bowl or bedpan for patient to vomit or pass stool, patient was encouraged to take in more fluids, patient's mouth was rinsed after vomiting. Other interventions included monitoring of intake and output and administration of prescribed intravenous fluid.

At 12:30pm, a nursing diagnosis of acute pain (abdomen): related to inflammatory process in the stomach and intestine, was made to help manage patient abdominal pain. A goal was set to help resolve patient's abdominal pain within 72hours. The following interventions were carried out: Patient was reassured that the pain will subside following competent nursing. This was done to allay anxiety; the level of pain was assessed on a pain scale of 0 – 10 and indicated as 5 by patient. This was done to reveal the severity of pain. Patient was made to watch her favorite movie on television to divert her attention from the pain, vital signs were monitored regularly to monitor the effect of the pain on the vital signs for appropriate action and patient was provided with warm comfortable simple bed devoid of creases and cramps to induce sleep and Intravenous buscopan 40mg stat and tablet Paracetamol 1-gram was served as prescribed to relieve pain.

Miss A.B. loss of appetite was managed at 1:15pm with a care plan. A nursing diagnosis of risk for imbalanced nutrition: less than body requirement: related to anorexia was formulated. A goal was set to help patient regain and maintain adequate nutritional status within 72 hours and the interventions to help achieve this goal were; Patient mouth was rinsed before and after eating to stimulate appetite, items like vomitus bowl and bedpan were removed from sight of patient to prevent nausea, food was served in small quantity at frequent intervals to promote enough intake as

well as easy digestion. Patient was encouraged to take in well-balanced diet for adequate nutrition. Patient's preference of food was considered in meal planning to promote individuality and to know the food she likes. Fluid intake was limited 1 hour to and with meals to promote adequate food intake.

At 2:00 pm, a nursing care plan was formulated to manage patient body weakness, a nursing diagnosis of Self-care deficit (total): related to skeletal muscle weakness was formed. An objective to help patient regain her strength and perform activities without assistance within 48 hours was set as the following interventions were carried out: Fluid status was monitored and balanced every 24 hours. Caloric intake was also checked. These were ensuring adequate fluid and caloric intake; patient and family were reassured that she will regain strength for her daily activities with available measures. This was done to allay anxiety. Patient was always assisted in bathing, grooming and brushing of her teeth. Patient was encouraged to carry out activities he could tolerate such as walking around bed with rest periods when tired to prevent exhaustion. Items of daily use such as comb, tooth brush and paste were laced within reach of patient. Patient was engaged in passive range of activity like walking from bed to nurses' station, flexion and extension of hands to promote muscle strength

Miss A.B. took her afternoon medication at 2:00pm and vital signs were checked and recorded as in the appendix. Miss A.B. took rice and tomato stew at 3pm but she ate a little of it because she has lost appetite. She was later served child vitamilk and she drank all, which was 350ml and slept around 4:00pm.

At 4:30pm, she had some visitors but since she was resting, they were not allowed to see her. She woke up at 5:50pm and was assisted to take her bath. Vital signs were also checked and recorded as in the appendix at 6:15pm, drugs were served as prescribed. She took three slices of boiled plantain

as supper at 6:30pm and that was almost half of the food served. She was congratulated after eating. Patient was reassured and she was served a Milo drink at 7:30pm and she drank all in bits. Since she had already taken her bath, she brushed her teeth and a conducive environment was created for her to induce sleep, afterwards she went to bed around 9:30pm.

Second Day of Admission, 16th November, 2021.

On the second day of admission, at 7:00am, I went to the ward to continue with my nursing care for Miss A.B., her morning vital signs had already been checked and recorded as in the appendix.

At 8:00am, Patient took three table spoon of Hausa porridge with one slice of bread and was congratulated. Patient was clinically fair as at then. Information from the night nurses during taking over at 08:15am in addition to what Miss A.B. verbalized indicated that she was unable to have adequate sleep throughout the night. A nursing diagnosis of Insomnia: related to abdominal pain and unfamiliar environment was formed. An objective to help patient restore her normal sleep pattern within 72 hours was created. The following interventions were carried out to achieve the said objective; Patient was reassured that his sleep pattern will be restored with available measures to alleviate anxiety. Television sets were lowered, staffs on the ward were encouraged to reduce noise making to promote sleep. Patient was provided with warm water to bath to induce sleep. Patient bed was properly made free from creases to promote sleep. Nursing procedures were carried out together to prevent interrupting patient sleep. Visitors were restricted to prevent distraction of patient sleep.

During the ward rounds at 8:40am, the physician attended to Miss A.B. and the plan was to continue her treatment. Assessment on patient's condition revealed that, patient abdominal pain has reduced. She confirmed that abdominal pain has reduced and had regained strength as compared to the day of admission.

Her 10:00am vital signs were checked and recorded as in the appendix. Her 02:00pm medication, tablet Paracetamol 1-gram was duly served. Miss A.B. took rice and light soup as supper. She ate greater part of the food though she could not eat all. Vital signs were checked as in appendix and all his due medications were served and patient slept around 9: 30pm.

Third Day of Admission, 17th November, 2021

Information from night nurses indicated that Miss A.B. woke up around 5:30am, she still complained of on and off sleep, how she clarified that it was better than the previous nights. She was then assisted by her aunty to brush her teeth, and also took her bath. At 6:00am, routine vital signs were checked accordingly and recorded in the appendix

During the ward rounds at 8:40am, the medical officer attended to Miss A.B. and plan was to continue with treatment regimen.

At 08:05am, as part of the nursing actions, patient was encouraged to take in fluids to maintain her fluid volume. She was also taught relaxation techniques such as knee-chest position to help palliate her pain. Routine assessment on patients' condition demonstrated that patient vomited a little and also verbalize improved appetite hence interventions continued. Patient also verbalized massive reduction of pain and rated pain as 1 on the scale of 0-10 on assessment. At 2:00pm, the objective set to help patient regain her strength and perform activities without assistance within 48 hours was evaluated as nurses observed that patient can perform activities unassisted and patient verbalized that she no longer has any feeling of bodily weakness.

Patient was served with fufu with light soup and meat for lunch but she ate almost half of it after that she was given two slices of water melon and she ate all. She was made comfortable in a well straightened bed after taking her meals. Vital signs were checked and recorded at 2:00pm as in the

appendix. I embarked on my first home visit on this day. I took direction from Miss. A.B. and set off to her house around 2:20pm. Upon return, I came back to see my patient.

She was served with tea with fried egg as supper. Patient appetite was improving at this point so she was able to eat the egg with the tea. Her due 6:00pm medications were administered and her vital signs were checked and recorded as shown in the appendix.

Client was observed to perform her personal hygiene (bath and oral care) at 6:30pm and was handed over to the night nurses.

Fourth Day of Admission, 18th November, 2021

Patient slept peacefully during the night according to night staffs and woke up at 6:00am. Her 6:00am vital signs recorded as indicated in the appendix. Patient was served with porridge with koose for breakfast at 7:30am and she was able to eat all.

During the ward routine rounds at 08:00am, treatment was to be continued and possible discharge to be considered the following day. Patient and relatives were informed about possible discharge the next day and were educated on the significance of follow up and the need to continue treatment at home. There was no diarrhea or vomiting on assessment.

At 10:00am, vital signs were checked and recorded as in the appendix.

At 10:30am patient and her aunty were engaged in an interaction and it was realized that they did not have adequate knowledge on patient's condition (gastroenteritis). A nursing diagnosis of Knowledge deficit: related to inadequate information about the cause, management and prevention of the condition (gastroenteritis) was formed. Interventions carried out were; Their knowledge on the condition was assessed to know what they know about the condition.

Patient and relative were informed about ways of preventing the symptoms and some management for the disease. Patient and relative were allowed to ask questions for clarifications on issues

bothering their minds about the disease. All questions were answered in simple, plain and clear language without the use of professional jargons to promote understanding.

Pamphlet containing information on condition was given to patient and family to serve as a reminder

At 12:50pm, an evaluation of the objective set on 15/11/21 to resolve patient abdominal pains within 72 hours of hospitalization was done and goal was fully met as the nurse observed patient been calm in bed with a relaxed facial expression and patient rating pain as 0 on the 0-10 numeric rating scale. At 1:15pm, evaluation on the objective set to help patient regain and maintain adequate nutritional status within 72 hours was done and goal was fully met as the nurse observed patient eating at least 80% of her usual meal served and patient verbalizing that her normal eating habit has been established.

Her vital signs at 2:00pm were checked and recorded as in the appendix and due medications were served and the necessary documentations were done. Miss A.B. ate banku with groundnut soup with chicken for lunch and was later handed over to the afternoon nurses for continuity of care. According to the afternoon nurses, in the evening, patient took yam and kontomire stew as supper; it was observed that patient was able to eat all of the food served. Patient then had her bath and also maintained her oral hygiene. Vital signs were checked and recorded as shown in the appendix. She performed her evening prayers and afterwards she was made comfortable to sleep. She slept around 10:00pm.

Fifth Day of Admission, 19th November, 2021 (Day of Discharge)

According to the night nurse, patient woke up early feeling strong and better. Her personal hygiene had already been kept and maintained by herself. Her 06:00am vital signs checked and recorded by the night nurses were as follows:

Temperature - 36.2^{o}c,

Pulse - 72bpm,

Respiration - 18cpm

Blood pressure- 106/74mmHg

At 08:15am, an evaluation of the objective set on 16th November, 2021 to resolve patient's insomnia before discharge was done and goal was fully met as nurse observed that patient had uninterrupted sleep for 6-8 hours at night and patient verbalizing that she had uninterrupted sleep.

At 9:00am, an evaluation of the objective set to help maintain adequate fluid volume throughout hospitalization was evaluated and goal was fully met as the nurse observed a normal skin turgor and verbalized absence of extreme thirst.

At 10:30am, an evaluation of the objective set on November 18th, 2021 to help patient and relative gain adequate knowledge on gastroenteritis within 24 hours was done and goal was fully met as patient and relative being able to provide correct answers to questions regarding the causes, management and prevention of gastroenteritis and the nurse observing that patient and relatives practice knowledge gained on gastroenteritis. During routine ward rounds, patient was discharged at 11:00am since her condition was stable and she had no complains. There were no bills to be settled because all her bills were covered by the NHIS. Patient was educated on his drugs as well as maintaining good personal hygiene and the need for follow ups and regular check-ups. No new medications were prescribed. Patient was informed to come for review on the 25th November, 2021.

The need to continue with medications and review date were emphasized. They were helped to pack their belongings. Bed linens were sent to the laundry, the mattress and bed lockers were as well disinfected. Patient and the family bade the ward inmates and staffs goodbye. I accompanied patient to the hospital taxi rank. The discharge procedure was documented in the admission and discharge book and in the daily ward state.

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

Preparation of patient/family for discharge started from the day of admission when patient and family were told that the hospital was not going to be her permanent living environment but she will be discharged home soon by the competent care that will be rendered to her. Miss A.B. and his aunty were educated on the causes, signs and symptoms, complications and prevention of Gastroenteritis. This was to equip them 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 detection and treatment.

Also, patient's relatives were educated to prepare food under hygienic environment, keep good personal hygiene, and wash their hands with soap and water before and after eating. She was educated to ensure proper disposal of refuse, and weed around the environment, and should ensure good drainage systems by draining all gutters. 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 her aunty. She was educated to report any change in her condition before the review date is due. She was educated on the need to keep drugs out of reach of children.

Her name was entered into the admission and discharge book and also the ward state. All her bills were covered by health insurance. They were educated on the importance of sleeping under treated

mosquito net. The importance of healthy diet was also stressed. Finally, I educated them on family planning and its importance.

I helped them to pack their belongings. Also 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 12:35pm 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: 16th November, 2021.

Wednesday, 17th November, 2021 was my first home visit to my patient's house whiles she was still on admission. I got to kwasibuokrom around 03:00pm 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. The house is situated few meters from the community funeral grounds and immediately adjacent a grocery store. My patient's grandmother and her two younger siblings were in the house when I got there. They welcomed me and greetings were exchanged, a seat was offered as well as a glass of water. I introduced myself as a student nurse who was using Miss A.B as my patient for a care study. 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 patient. I asked of their health and Miss A.B.'s grandmother replied they were

doing well but quickly added she occasionally experience joint pains. I encouraged her to eat balanced diet to help her build strong immune system to prevent her from being vulnerable to diseases. They were preparing banku as I arrived in the house. I observed that the banku was left uncovered and there was some dirty water in an uncovered bowl as well. They were glad to see me. They lived in a compound house which was painted with white paint and made up of 12 rooms with nine inhabitants. Two old men and a neonate were identified in the other household within the compound house. I approached them and gave educated them on proper hygiene and balanced dieting to improve their immunity and protect then against diseases.

My assessment of the house revealed their bath house was a temporal detached building at a corner of the house with a drain into a bucket behind it which they empty whenever it is full. Apparently, they don't have a well-built kitchen. The main source of heat 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 pipe born water which is not far from their house and rain water which they stored in barrels without fitting lids. They also obtain electricity from the national grid. Their means of transportation is either by motor bike or taxi. I educated them on the need to cover the barrel, regular cleaning of the barrel and keep rain water clean. Their toilet facility was an aqua privy type with one hole and a container for collecting the toilet papers, which they burn when it's full. Though the toilet was clean, however the hole and the container were not covered and flies were hovering around. Lastly, some bowls which they ate in the morning were kept unwashed at one Corner of the compound.

I educated them on the need for personal and environmental hygiene such as washing their hands with soap and water after toilet and before meals, trimming of finger and toe nails, the need to bath at least twice a day, washing cooking utensils after meals and not leaving them overnight till the

next morning, the need to protect food adequately from flies and dusts, and proper disposal of refuse. I again encouraged then to continue to adhere to the covid-19 safety protocols such as regular hand washing wearing of nose mask when going to the public. They were again educated on healthy life styles such as regular exercise, regular medical check-ups drinking enough water daily and inclusion of fruits and vegetable to their diets boost their immune system and enhancing their general well-being. They were also given education on the disease condition (Gastroenteritis); its causes, mode of transmission, signs and symptoms and prevention. I informed them of my next visit and bade them goodbye and left the house around 04:00pm.

Second Home Visit: 22nd December, 2020.

The second home visit was made on, 22nd November, 2021 in the morning at 10:35am, and was very happy to see Miss A.B. and the family. She was very well and her condition had improved. The purpose of the visit was to assess the health of Miss A.B. and to see whether the education given during admission and first home visit were being adhered to. There was a warm reception on arrival and they were very happy to see me again. A seat and a glass of water were offered. I was very grateful to see her doing very well.

After assessing the surrounding, and congratulated them for keeping to the health education given. The barrel was well cleaned and fittingly covered with a lid. To inquired whether she had adhered to the instructions given to her on how to take her medications and she brought out her medications to confirm. I congratulated her and encouraged them to do more and also asked them if they had any concern to express in the care. I reinforced the education given to them from admission till discharge and reminded them of the review date which was on the 26th November, 2021 and its importance. I then asked permission and left there around 01:10pm for the house and I was escorted by Miss A.B.

Review (25th November, 2021)

On Monday 25th November, 2021, Miss A.B. was met at the Out-Patient Department of the St. Mary's Hospital, Drobo at 9:00am looking cheerful and lovely as noted from her facial expression. I accompanied her to go for patient's folder. The vital signs checked and recorded as follows;

Temperature 36.2°C

Pulse 70bpm

Respiration 18cpm

Blood pressure 110/70mmHg

At the Out-Patient Department, patient was seen by the medical officer at the consulting room. Upon assessment by the doctor, Miss A.B. was healthy. Patient did not have complains. No medication was given to her. She was told not to hesitate to report to the hospital should she encounter any health problem. She was also encouraged to practice personal and environmental hygiene to protect her from getting diseases. Patient was assured of a third home visit. I then accompanied them to a lorry station which is about three minutes' walk from the hospital entrance where they board a taxi to their home.

Third Home Visit: 9th December, 2021

The main reason for conducting the third home visit was to: Assess the general condition of patient and family, reinforce the need to comply with treatment regimen and finally terminate care and to hand over the patient.

On the said date, I set off early in the afternoon around 12:00pm with a taxi and arrived at Miss A.B.'s house at 12:40pm. Patient and family were doing well as they looked cheerful and had no complains. The family received me warmly and offered me some water to drink. The environment was tidy as there was neither rubbish nor stagnant water around. I terminated my care and handed

over client to her aunty who is in the same house with him, I thanked them for their cooperation which made my study a success. Miss A.B. and family commended me for good work done. There was no public health nurse around I handed my patient over to her aunty to continue care and she gladly accepted. I however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick rather than relying on self-medication. After interacting with patient and family for a while, I reemphasized on health education that had been given to them already. Since it happened to be my last day of therapeutic relationship with patient and family, I terminated my care and thanked them for their cooperation which made my study a success. Again, patient and his family expressed their gratitude by showing how grateful they were to me for the support and care given to them. I promised to check on them anytime I visit their locality. I eventually sought permission to leave and bid them the final farewell. I boarded a taxi to Drobo at 2:15pm.

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 (Hinkle &Cheever,2018)

The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to patient and family.

5.1 Statement of Evaluation

According to Tammy (2020), evaluation is defined as the final stage in the learning process and is a measure of the degree to which the patient has mastered the learning objective. Patient was admitted to the females Ward with the diagnosis of Gastroenteritis. All goals and objectives were fully met. Below is the summary of the interventions carried out and to what extent the goals were met:

1. Patient was prevented from fluid volume deficit.

Assessment on admission at 12:25pm revealed that patient had diarrhea and vomiting so a nursing diagnosis of risk for fluid volume deficit: related to vomiting and passing of loose stools was formulated and a goal was set to maintain adequate fluid volume throughout hospitalization. The following nursing interventions were carried out; Patient was asked if she experience thirst and dry throat. Also, patient skin was pinched between two fingers and observed for its return. Emesis bowl and bedpan was served for patient appropriately. For vomiting and passing of stool. Patient was made to take in lots of fluids, example ORS to prevent dehydration. Patient's mouth was rinsed thoroughly after vomiting to stimulate appetite. Intake and output were recorded on

the fluid chart to ascertain fluid status. Prescribed intravenous fluids (normal saline, dextrose and ringers' lactate) were served to hydrate patient. On 19th November, 2021 around 9:00am, the objective that was set was fully met as patient maintained adequate fluid volume throughout the period of hospitalization as the nurse observed patient with a normal skin turgor and patient verbalized diarrhea and vomiting have stopped

2. Patient was relieved of abdominal pains.

On 15th November, 2021 around 12:50pm, patient gave a verbal complaint of abdominal pains. A nursing diagnosis of acute pain (abdomen): related to inflammatory process in the stomach and intestine was formulated. A goal was set to relieve patient of the abdominal pains within 72hours. The following interventions were carried out to meet the objective set; Patient was reassured that the pain will subside following competent nursing. The level of pain was assessed on a pain scale of 0 – 10 and indicated as 5 by patient. This was done to reveal the severity of pain. Patient was made to watch her favorite movie on television to divert her attention from the pain. Vital signs were monitored regularly to monitor the effect of the pain on the vital signs for appropriate action. Patient was provided with warm comfortable simple bed devoid of creases and cramps to induce sleep. Intravenous buscopan 40mg stat and tablet Paracetamol 1-gram tds x 5 days was served as prescribed to relieve pain.

On 18th November, 2021 at 12:50pm, the objective that was set was evaluated and goal was fully met as the nurse observed patient been calm in bed with a relaxed facial expression and patient rating pain as 0 on the 0-10 numeric rating scale.

3. Patient's nutritional status was maintained

On 15th November, 2021 at 1:15pm, patient had loss of appetite. Imbalanced nutrition: less than body requirement: related to anorexia. A goal was set for patient to regain and maintain adequate

nutritional status within 72 hours. Interventions carried out were; Patient mouth was rinsed before and after eating to stimulate appetite. Items like vomitus bowl and bedpan were removed from sight of patient to prevent nausea. Food was served in small quantity at frequent intervals to promote enough intake as well as easy digestion. Patient was encouraged to take in well-balanced diet for adequate nutrition. Patient's preference of food was considered in meal planning to promote individuality and to know the food she likes. Fluid intake was limited 1 hour to and with meals to promote adequate food intake.

On 18th November, 2021 at 1:15pm, the objective that was set was evaluated and goal was fully met as the nurse observed patient eating at least 80% of her usual meal served and patient verbalized that her normal eating habit has been established.

4. Patient regained strength for her daily activities.

On 15th November,2021 around 2:00pm, patient was observed to be weak, a nursing diagnosis of Self-care deficit(total): related to skeletal muscle weakness was formulated. A goal was set to help patient regain her strength and perform activities without assistance within 48 hours. The following interventions were carried out to meet the objective set; Fluid status was monitored and balanced every 24 hours. Caloric intake was also checked. These were ensuring adequate fluid and caloric intake. Patient and family were reassured that she will regain strength for her daily activities with available measures. This was done to allay anxiety. Patient was always assisted in bathing, grooming and brushing of her teeth. Patient was encouraged to carry out activities she could tolerate such as walking around bed with rest periods when tired to prevent exhaustion. Items of daily use such as comb, tooth brush and paste were laced within reach of patient. Patient was

engaged in passive range of activity like walking from bed to nurses' station, flexion and extension of hands to promote muscle strength

On 17th November, 2021 at 2:00pm, the objective was evaluated and goal was fully met as nurse observed patient perform activities unassisted and patient verbalized absence of bodily weakness

5. Patient insomnia was resolved.

Information from the night nurses during taking over in addition to what was said by patient herself at 08:15am of november16th, 2021 indicated that patient did not have a restful sleep. A nursing diagnosis of Insomnia: related to abdominal pain and unfamiliar environment was formulated and an objective to help resolve patient insomnia within before discharge was set. Nursing interventions carried out were as follow: Patient was reassured that his sleep pattern will be restored with available measures to alleviate anxiety. Television sets were lowered, staffs on the ward were encouraged to reduce noise making to promote sleep. Patient was provided with warm water to bath to induce sleep. Patient bed was properly made free from creases to promote sleep. Nursing procedures were carried out together to prevent interrupting patient sleep. Visitors were restricted to prevent distraction of patient sleep.

On November 19th, 2021 at 8:15am, the objective was evaluated and goal was fully met as nurse observed that the patient slept throughout the night without interruptions and patient verbalized that she slept well

6. Patient/family gained knowledge on gastroenteritis.

On 18th November, 2021 at 10:30am patient and aunty were engaged in an interaction and it was revealed that they had less knowledge on gastroenteritis. A nursing diagnosis of Knowledge deficit: related to inadequate information about the cause, management and prevention of the condition was formulated; Knowledge deficit: related to inadequate information about the cause,

management and prevention of the condition (gastroenteritis). Interventions carried out were; their knowledge on the condition was assessed, patient and relative were informed about ways of preventing the symptoms and some management for the disease, patient and relative were allowed to ask questions for clarifications on issues bothering their minds about the disease, all questions were answered in simple, plain and clear language without the use of professional jargons, patient and relative were asked to give a feedback on what they heard, pamphlet containing information on condition was given to patient and relative to serve as a reminder

On 19th November, 2021 at 10:30am the objective set to enable patient gain adequate knowledge on gastroenteritis within 24 hours was fully met as patient and relative were able to provide correct answers to questions posed to them on the causes, management and prevention of gastroenteritis and nurse observed that patient and relatives practice knowledge gained on gastroenteritis.

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 Miss A.B. and family, all of the goals set were fully met. The care plan was therefore not amended.

5.3 Termination of Care

Every nurse-patient relationship at the hospital needs to be terminated. However, this is a very difficult step to take after a good rapport has been established. Because of this, the reality of termination of care has to be made known to both patient and family from the day of admission. Care of patient and family ended on the 9th December, 2021which was my last home visit. This ended the interaction between the health team and Miss A.B. and his family. The preparation for termination started on day of admission through to discharge. Patient was clinically ill on admission but became stable before discharge. During these periods, patient and family were educated on

various topics such as; good personal and environmental hygiene, heating and covering of foods with well-fitting lids from flies, and washing of fruits thoroughly before eaten. I thanked and congratulated the family for their support throughout the interaction. Miss A.B. was then handed over to her aunty to continue care at home. They were told that now that Miss A. B.'s health had been restored, the care for her 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

On the 15/16/21 at 10:44am, Miss A.B., a 21year old woman was admitted to the females Ward of St. Mary's Hospital Drobo. Patient complained of excessive vomiting and diarrhea, anorexia, abdominal pains and weakness. Laboratory investigations such as full blood count, blood film for malaria parasite, stool for H. pylori test, abdominopelvic ultrasonography
and retro screen were conducted to confirm the cause of the condition (gastroenteritis).

During the period of admission, Miss A.B. was put on both oral and intravenous medications including;

1 Tablet Zinc 20mg daily x 10 days

2. Intravenous promethazine 25 milligrams stat

3. Intravenous Ringers lactate 2.5 liter over 48 hours.

4. Intravenous dextrose in normal saline 1 liter over 24 hours

5. Intravenous Ciprofloxacin 400 milligrams bd x 48 hours.

6. Tablet Paracetamol 1 gram tds x 5 days.

7. Intravenous buscopan 40mg stat

8. Tablet buscopan 20mg bd x 5 days

9. ORS 2 sachet daily

The health problems identified were: diarrhoea and vomiting, abdominal pain, loss of appetite, body weakness, difficulty sleeping and inadequate knowledge about the disease condition.

Some of the nursing interventions carried out were reassurance, thorough education on the disease condition and assisting patient in maintaining her personal hygiene. Adequate rest and sleep, nutrition, and exercises were also ensured. Patient condition was very stable on discharge, that is, 19th November, 2021. Education on personal hygiene, healthy lifestyles such regular exercise were reinforced. They were also encouraged to sleep under mosquito nets. Miss A.B. and her aunty were encouraged to continue care at home after discharge.

On the 25th of November, 2021 patient reported for review as scheduled and she had greatly improved. Three home visits were embarked on. The first home visit was done while patient was still on admission on 17th November, 2021, second home visit was on the 22nd December, 2020and third home visit was on the 9th December, 2021. The care of Miss A.B. and her family were terminated on the 9th of December, 2021, during the third home visit when patient had fully recovered and handed over to her aunty.

6.2 Conclusion

In conclusion, my choice of nursing Miss A.B. has greatly increased my knowledge into her condition, gastroenteritis. It has enabled me delve more into the causes, signs and symptoms, treatment, complications and possible prevention of the disease condition. This study has also equipped me knowledge on how to practically care for a patient with gastroenteritis using the nursing process.

It also informed the patient and her family of the risk factor and causes of gastroenteritis and how to prevent themselves from acquiring the infection. I therefore recommend that every health institution employs 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. Miss A.B. had a speedy recovery from her condition because of the competent care rendered by the medical team and they also gained knowledge on the condition

, therefore she will propagate the good work of the hospital which will increase the patronage of the services of ST. Mary's Hospital, Drobo.

I also recommend that every nursing student be given the opportunity to embark on the patient/family care study to enable them obtain more insight on the condition under study.

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Unpublished data: patient's folder

APPENDIX

Date	**Time**	**Temperature (°C)**	**Pulse (Bpm)**	**Respiration (Cpm)**	**Blood pressure (mmHg)**
15/11/21	12:25Pm	36.1	93	25	120/90
	02:00pm	36.5°c	85	22	110/70
	06:00pm	36.6	82	24	110/60
	10:00pm	36.4	100	21	120/70
16/11/21	06:00am	36.5	77	18	110/80
	10:00am	36.3	114	2O	115/65
	02:00pm	36.6	100	21	110/70
	06:00pm	36.5	92	19	120/80
	10:00pm	36.0	76	21	120/70
17/11/21	06:00am	36.0	64	20	120/75
	10:00am	36.7	74	18	110/70
	02:00pm	36.3	82	22	120/90
	06:00pm	36.5	70	18	110/70
	10:00pm	36.1	70`	22	120/80
18/11/21	06:00am	36.0	81	20	110/70
	10:00am	36.4	85	20	120/80
	02:00pm	36.3	82	22	120/80
	06:00pm	36.7	75	20	110/70
	10:00pm	36.1	70	18	100/60
19/11/21	06:00am	36.2	70	18	106/74

SIGNATORIES

The Student Nurse

Name: Appah serwaa priscilla

Signature:

Date: 5th/10/2022

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

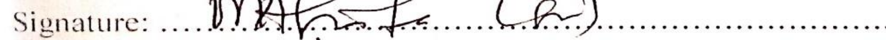
Name: MR. Emmanuel Ali

Signature:

Date: 05/10/2022.

The Nurse-In-Charge of the Females Ward (Saint Mary`s Hospital, Drobo)

Name: MRS. Oppong-Yeboah Mary

Signature: 

Date: 06/10/2022

The Principal, Holy Family Nursing and Midwifery Training College, Berekum.

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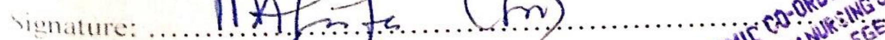
Signature: 

Date: 6th/10/2022

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