HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A PATIENT/FAMILY CENTERED NURSING CARE STUDY ON

PEPTIC ULCER DISEASE

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

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PREFACE

Nursing is a professional health service that is directed towards the promotion and maintenance of health, treatment and prevention of diseases and the restoration of optimal functioning of the individual, family and communities. To be able to meet the various needs of patients and family, and thus give quality care to them, nursing care has moved from task-oriented approach to giving of total or individualized care involving both patient and family.

Patient/Family care study is carried out by student nurses to enable them put into practice the knowledge and skills which they have acquired from the three-year training period in school. This is to ascertain how best the theoretical knowledge could be used practically to help patient get the effective nursing care.

It helps the student nurse to encounter the patient closely, understand his/her condition and identify problems of the patient. It is satisfactory to both the nurse and patient, that is, the patient becomes satisfied with the care rendered to him or her. The student nurse also feels happy upon being able to achieve his or her goal.

The study serves as a requirement for the award of a professional license to practice by the Nurses and Midwives council of Ghana.

Patient/Family initial have been used instead of their full names to ensure privacy and confidentiality as part of the ethics of the Nurses and Midwives Council.

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INTRODUCTION

Patient/family care study is a written report of the care rendered to the patient/family which is required by The Nursing and Midwifery Council of Ghana in partial fulfillment for the award of License to practice as a Professional Registered General Nurse. This is an approach in nursing where a comprehensive and holistic nursing care is given to the patient/family from the time of admission to discharge, and ensuring continuity of care through follow-ups or home visits before the care is terminated.

This patient/family care study was carried out on a seven years old boy who for the purpose of confidentiality, will be referred to as O. F. in this study. O. F was admitted to the General males Ward at the Sampa Government Hospital,(Sampa)on the 1st th December, 2022 and was discharged on the 6th December, 2022. O. F. spent Six days in the hospital. I introduced myself to his mother as a final year student at Holy Family Nursing and Midwifery Training college, Berekum, who I would like to use him as a client for my Patient and Family Care Study which they agreed to gain more knowledge about the condition Peptic Ulcer Disease.

Data was collected from the patient/family through observations, interviews and other diagnostic procedures. Health problems such as Patient complain of abdominal pains , fatigue, anxiety, anorexia, insomnia, pyrexia and vomiting, altered nutritional pattern. Anxiety and knowledge deficit were identified and interventions made with patient and family's co-operation to achieve set goals. Due to effective medical and nursing care rendered to him, he was discharged without any complications.

Home visits were also made during admission and after discharge to identify predisposing factors of Patient's condition, to educate Patient's family on the condition and to ensure continuity of care.

O. F and his family appreciated the care given to them by the health team.

This script comprises six chapters which include;

1. Assessment of patient/family
2. Analysis of data collected
3. Planning for patient/family care
4. Implementation of patient/family care plans
5. Evaluation of care rendered to patient/family
6. Summary and conclusion.

Chapter one dealt with assessment of client and family comprising Patient particulars, family medical history, socio-economic history, lifestyle and hobbies, past and present medical history, admission of Patient, his concept of illness, literature review and validation of data.

Chapter two dealt with analysis of data involving comparison of data gathered with standard for literature, Patient and family strength, health problems and nursing diagnosis.

Chapter three dealt with planning of care for the patient/family, setting of objectives and the nursing care plans for objectives set.

In chapter four, nursing interventions of the nursing care plans were implemented thus; giving a summary of the actual nursing care plan, preparation of Patient and family towards discharge and rehabilitation and also follow-up home visit and continuity of care.

Chapter five dealt with evaluation of care consisting of statement of evaluation, amendment of nursing care for partially met or unmet outcome criteria, termination of care,

The last chapter which is chapter six dealt with summary and conclusion followed by bibliography and appendix.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

This chapter covers assessment which is the first phase of the nursing process that enables the nurse to collect data to aid in the identification of the patient's needs and health problems. Through assessment, information about the patient and family are obtained. Data is gathered from patient, relatives and friend through observations, physical examinations, interviews, x-ray reports and diagnostic investigations. This helps to identify patient and family's health problems in order to give effective nursing care towards recovery. The assessment of the patient and family is based on the patient particulars, family medicals and socio-economic history. It also includes patient's developmental experience and interaction with peers. Assessment takes into account patient's concept of illness including causation, patient concerns and expectations about treatment. Environmental and lifestyle factors which may affect the patient health are also assessed.

1.1 Patient's Particulars/Biographical Data

Patient particulars are information that is written about the patient .It is collected by asking the patient if he is able or a relative to help have best of health care and also make it simple. It is usually of an individual personal detail such as name, address, age, sex, date of birth and among others (Merriam Webster, 2019).

Mr. O.F. 30years old man was born on the 24th of September 1992 to Mr. P.K. of blessing memory and Mrs. L.F. at Chiraa, in the Bono Region. His parents gave birth to three (3) children, all of them are three (3) boys of which he is the first born of the family. He currently

resides at Sampa, the district capital of Jaman North, an area called Newtown with house number SAJ-SA087. He completed Nafana Presbyterian Senior High School. He is a Ghanaian by nationality and Bono by tribe. Mr. O.F is dark in complexion, 173cm tall and weighs 61 kilograms. He is a Christian by religion and a member of the Presbyterian church of Ghana. He speaks Twi and English language. His next of kin is his younger brother, Mr. S.O

1.2 Patient's Family Medical History

Patient has never been hospitalized nor transferred, neither has he been operated on. He has no history of any chronic diseases such as hepatitis, diabetes, hypertension and sickle cell and never be operated before and also has no allergies. According to the patient, this was not his first time he had experience severe abdominal pains. He treats with over-the-counter medications. Patient made it known that, he has never been involved in any domestic or road traffic accidents neither he has been hospitalized until present condition.

According to Mr. O.F. Diabetes Mellitus run through the family and has killed many family members, including his father, Mr. P.K. But however , not sure of other chronic diseases such as hypertension, asthma, etc. The family has no known allergic reactions to any food or drug. Further interaction revealed that, occasionally some members of the family suffer from minor illness such as headache, fever, diarrhea and abdominal pains of which they sometimes prepare some herbs and at times buy drugs from the chemical stores. They seek medical attention at the Sampa Government Hospital when the sickness is worsen.

1.3 Family's Socioeconomic History

Medical/Surgical history involves a brief history about patient's family health related issues and the type of medical care they adopt. Information is obtained on both paternal and maternal sides of the family (Hinkle&Cheever,2014).

Mr. O. F's family is nuclear type, which is made up of the mother and his siblings. Mr. O.F is a trader by occupation. His mother is a trader who sells clothing's and the father was a farmer. According to Mr. O.F, their income comes from the work they do and sometimes a helping hand from his aunty. The patient is insured with the national health insurance. He stated that he was brought up from a hardworking and morally upbringing family. The parents taught them good family values. He made mention of the fact that, the only taboo he was made known from childhood till date was that no member of the family should marry from the same clan. He participates in cultural practices like naming ceremony, marriage rites, and funeral rites among others.

With careful analysis and observation about the patient's family standard of living through interviews, Mr. O. F's family can be classified among the middle socio-economic class.

1.4 Patient's Developmental History

Development is the biological, physiological and emotional human beings between birth to the end of adolescent as the individual progress from dependency till increasing autonomy (Macmillan,2015).Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development (Weller,2015).). Maturation is the progression of the human body towards adulthood (Lloyd and Oliver, 2014).According to Mr. O.F, his mother did not experience any problem during his pregnancy. He attended antenatal clinic regularly. She was delivered at term through spontaneous vaginal

delivery on September 24th, 1992 at Chiraa Health Center. He was exclusively breastfed for six months and later introduced to supplementary foods such as porridge. Mr. O.F. had normal developmental growth without deformity. Although his parents did not know much about the modern health care of a baby, he was however immunized against the childhood killer diseases such as tetanus, measles, whooping cough and tuberculosis, yellow fever ,poliomyelitis and diphtheria so he was not attacked by them and which patient had immunization marked on the right upper arm . At the age of 4 to 7 months, He could grasp and release objects, showed signs of teething at six months , Mr. O .F sat at four month with support, sat without support at seven months and started crawling at eight months. He however started walking when he was 9 months. He could perform simple activities like eating by himself at 11 months. He developed secondary sexual characteristics like hair at the armpit and genital areas at age 14. He attended D.A primary school at Chiraa and completed S.H.S at Nafana Presbyterian Senior High School at Sampa. Patient stated that, he has not marry but still searching for a woman to stay with within the age of 35 years and want to give birth to three children ,two girls one boy if God permit. He made mention of the fact that ,his ambition was to become a footballer but because of financial problems he is now a trader and he is glad to be a trader because the income he gained every month is large amount. As specified by Jarvis,(2000),Erik Erikson (1902 to 1994) focused on cultural and societal influences as determinants of behavior. Mr. O.F fall within the sixth stage that is Intimacy versus Isolation (20 to 35). Mclead has that, Erik Erikson eight stages of psychosocial development is predetermined order through which personal develop from childhood to adulthood. During each stage they experience psychosocial crisis that could have a negative or positive outcome for personality development. A successful complete of each stage results in a healthy personality acquisition and unreliable. The first stage is trust

verses mistrust, from birth to 18 months.at this stage the child looks up to the care giver for stability and consistent care by providing their basic needs and teaching them that they can depend on you. This builds within them the psychological strength of trust .Mistrust can develop if the psychological strength is inconsistent unreliable. The second stage is autonomy verses shame and doubt from age 18 months to 3 years. The child develop physical and discover that he has many skills and abilities .Success at this stage results in the sense of independence and autonomy. Failure at this stage makes the child overly dependent upon others and feels the sense of shame or doubt in their abilities. The third stage is initiation verses guilt from age 3 to 6 years. Children at this stage begin interact socially and play with others, they may learn that ,they can take initiative and control what happens .However, if parents are controlling or don't support their child when they make decisions ,the child may not be equipped to take initiative, may look ambitious and could be filled with guilt. The fourth stage is industry verses inferiority , from age 6 to 12 years .The child learn how to read and write ,they start to compare themselves to others. When the child succeeds they will feel industrious and believe they can set goals and reach them. But if Children have repeated negative experience at home or feel that society is too demanding, they may develop feeling of inferiority. The fifth stage is identity verses confusion, from age 12 to 20 years. The child faces the challenge of developing sense of self. They form their identity by examining their belief goals and values .but when adolescent do not search for their identity they may not develop a strong sense of self and would not have a clear picture of their future .the same confusion may reign supreme if you, as their parents, try to pressure them to conform to your own values and belief. The sixth stage is the intimacy verses isolation. And this is the stage Mr. O. F is in. Intimacy is where deep relationship can be formed, close relationship with others as lovers ,friends leading to marriage because people are

vulnerable to adulthood , from young adulthood to later on in life, as well as the ability to listen to and support other people but Mr O. F. single still searching for who to marry in future. Isolation is when people do not foster relationships, and they socially isolate themselves , consequently leading to feeling loneliness and depression. The seventh stage is generativity verses stagnation from age 35 to 65 years. This the concern of guiding the next generation. During middle age the primary developmental task is one of contributing to society and helping to guide future generation .A person who is self –centered and unable to help society move forward developed a feeling of stagnation –a dissatisfaction with the relative lack of productivity. The eighth stage is integrity verses despair from age 65 to death. It is this time we contemplate our accomplishment and are able to develop integrity if we see ourselves as leading a successful life. If you feel that you did not accomplish our goals, we become dissatisfied with life and develop despair leading to depression and hopelessness and the final developmental task is retrospection.

1.5 Patient Lifestyle / Hobbies

Lifestyle is defined as the pattern of daily living that an individual develops (Weller,2014). According to Mr. O. F., he usually sleep around 9:00pm to 10:00pm and wakes up at around 5:00am. He observes his prayers and does his regular devotions as part of his religious obligations. He performs all his personal hygiene every morning such as bathing and brushing his teeth twice daily. He has good attitude toward his bowel elimination as he does that every morning and evening before bathing every day. He usually likes to take his breakfast at around 9:00am which usually consist of rice porridge and millet porridge. He prefers to eat them alone without any slice of bread.

Further interaction with him revealed that, since he is a devoted Christian, he attends church service every Sunday. He has no known allergies and his favorite food is rice ball and groundnut soup. patient's hobbies include listening to music, playing games and likes to watch football matches. He stated that he is a proud Chelsea fan. He neither drinks nor smokes.

He is regular at weddings and church services unlike community picnics, excursions and visits to places of interest. He is friendly and extrovert person who always want to mind his own business. My general impression about him is that, he's friendly and likes to open up to other people.

1.6 Patient's Past Medical History

Past medical history is the narrative or record of past events and circumstances that are or may be relevant to a patient's current state of health (Merriam Webster,2019).

Patient's made it known to me that, he has never been hospitalized until his present condition. Mr. O.F. has never experienced any childhood illness since he has already been immunized against the childhood killer diseases such as tetanus, measles, whooping cough and yellow fever.

He has no allergies to drugs, food, animals etc. He revealed that he usually suffers from minor ailments such as headache and common cold which he treats with over-the-counter medications. When symptoms persist or become worse, he visits a nearby hospital or clinic. Mr. O.F. also told me he couldn't remember getting involved in accidents or injuries. He has no physical impairments. He hardly goes for medical check-ups and treatment at the hospital due to far distance and the cost involved and also fear of hospitalization.

1.7 Present Medical History

History of present illness is a complete, clear, and chronologic account of the problem prompting the patient to seek care(Merriam Webster,2019). According to the patient, he was apparently well, going about his normal activities until 1st December, 2022 when he started experiencing severe abdominal pain in the early hours of the day. He said, he experienced a rise in his temperature not long after the pain had become severe, he couldn't eat or sleep. He was then brought to the outpatient department of Sampa Government hospital where he was examined and consulted by P.A. Abrefa. He presented with abdominal pains especially at the epigastric region, pyrexia, fatigue, anxiety, anorexia, insomnia and vomiting. On account of all these clinical features and few investigations made from lab results, the doctor diagnosed him of Peptic Ulcer Disease. The laboratory investigation requested includes,

- Full blood count
- Blood Film for Malaria Parasite
- HIV Screening
- Helicobacter Pylori Test.

- Widal Tests

1.8 Admission of Patient

Admission of patient means allowing and facilitating a patient to stay in the hospital unit or ward for observation, investigation, and treatment of the disease he or she is suffering from (Brainkart,2018).He was admitted into the Males medical ward on the 1st December, 2022. My interaction started with him at ward on that same day, 1st of December, 2022, at about 9:30am. He came to the ward in a conscious state accompanied by a relative. Patient was welcomed and reassured. He was introduced to the staffs present and was assured of the competency of the healthcare team. His particulars such as name, sex, age, and residential address were recorded in the admission and discharge book and the daily ward state. Patient complains of abdominal pains, fatigue, anxiety, anorexia, insomnia, pyrexia and vomiting. Vital signs were checked and recorded as

- Temperature: 37.1°C
- Pulse: 77bpm
- Respiration: 23 cpm
- BP: 130/90mmHg
- SPO2: 99%

Medication administered includes;

- IV Omeprazole 40mg bd x 1
- Tablet Omeprazole 20mg bd for 7 days
- Tablet Paracetamol 1g tid x 3

- IV Tramadol 100mg s
- IV Metronidazole 500mg tid x 1
- Tablet Metronidazole 400mg tid x 7 after IV
- Nugel O 10mls tid x 7
- Clarithromycin 500mg dly x 12 (Capsule)
- IV Ringer Lactate 500mls start

10.IV infusion Normal Saline 500mls was set up afterwards. Patient was placed in a comfortable bed and closely monitored.

Laboratory investigation was requested.

The Laboratory investigations includes,

- Blood Film for Malaria Parasite
- HIV Screening
- Full blood count
- Helicobacter pylori Test
- Widal Test

The specimen of blood was taken and sent immediately to the laboratory for examinations. All other health team members as well as co-patients were introduced to him for effective team work and communication. All belongings of Mr. O.F. were checked and secured in his locker.

There was no need for deposition of money since Mr. O.F. had register with the National Health Insurance Scheme. His relative was also welcomed. Visiting hours were made known to them again and the need for them to adhere to those protocols.

Before his relative left, I told him to bring his tooth brush and paste, sponge, towel, plates, cup, spoon and also bring him some bland diet at meal time. He was also reassured before he left the ward. His condition on admission was fairly normal. I later expressed interest using Mr. O.F and family for my care . Mr. O.F and his relatives were informed that the care study is a requirement of the Nursing and Midwifery Council of Ghana in partial fulfillment toward the award of License to practice as a Registered General Nurse and reintroduced myself to them as a second-year student of Holy Family Nursing and Midwifery Training College , Berekum, going to my final year. I made them aware that ,there will be the need for me to render individualized comprehensive nursing care to the patient and family until discharge and follow up after discharge until he recovers fully .I assured them of privacy and they were informed that they reserved the sole right to withdraw when they desired. They were all happy about the service and gave me their consent .I made it kwon to him that due to the nature of our work, I would not be with them throughout the day but I would be the one to coordinate their whole well –being on the ward as he is to cooperate with the other staffs each and every day. Assessing the patient for health problems began. Following the health problems identified, a nursing care plan was drawn for implementation. After admission, Mr. O.F. was feeling better after 24 hours as compared to when he came into the ward.

1.9 Patient's Concept of His illness

According to patient's, he has been taking very good care of himself, bathing twice daily even though he fails to eat at regular intervals, he did not understand why he became sick. He also made it known to me that he did not actually know the cause of his condition and also had no idea about his condition. Notwithstanding this, he does not attribute his condition to witches or superstitious belief, but believes he will get better with medical intervention

1.10 Literature Review

According to Hinkle and Cheever (2014), peptic ulcer is described as excavation(hollowed out area) that forms the mucosal wall of the stomach ,in the pylorus (the opening between the stomach and duodenum),in the duodenum(the first part of the small intestine),or in the esophagus. Peptic ulcer is an irritation of the mucosal membrane or a break in the continuity of the mucosal wall of the stomach in the pyloric which is exposed to Hydrochloric Acid (HCL) and pepsin. The most frequent sites of an ulcer are the stomach (gastric ulcer) and proximal portion of the duodenum (duodenal ulcer), but the esophagus or jejunum or any other part of the gastrointestinal mucosal may be susceptible if the surface comes in contact with gastric secretion.

Incidence

It occurs in males and females and all groups are age group but common between age 40-60years and uncommon in women of childbearing age. More men are affected than women in the ratio (3:1).

Types

1. Gastric ulcer
2. Duodenal ulcer
3. Esophageal ulcer
4. Stress ulcer

- **Gastric Ulcer**

It is erosion of the mucosal lining of the stomach. It is usually situated at the lesser curvature of the first part of the stomach near the pyloric

- **Duodenal Ulcer**

This is deep penetrating ulcer through the sub mucosal layers of the intestinal wall. It is located proximal to the pyloric junction.

- **Esophageal Ulcer**

This is an ulceration of the esophageal mucosal or the presence of sores in the esophagus. It also occurs as a result of backward flow of HCL from the stomach into the esophagus.

- **Stress Ulcer**

It is the term given to the acute mucosa ulceration of the duodenal or gastric area after physiologically stressful event such as burns, shock, severe sepsis and multiple organ trauma.

Etiology

Peptic ulcer can be caused by many factors which include;

- Increased gastric acidity
- Drugs used as anti-inflammatory drugs and steroids
- Chronic use of alcohol
- Decreased secretion of mucus
- Increased mucosal permeability
- Genetic factors
- Excessive secretion of histamine

Moreover, chronic peptic ulcer can be caused by bacteria known as “Helicobacter Pylori”.

Predisposing Factors

- Stress

- Sex
- Infection
- Hypersecretion of hydrochloric acid or pepsin
- Lifestyle
- Severe trauma or illness
- Hereditary

Pathophysiology

Peptic ulcer develops only in the presence of acidic environment. Under a specific circumstance, the mucosa barrier is impaired and there is diffusion of Hydrochloric acid (HCL) and Pepsin to cause the barrier to be broken. Then HCL freely enters the mucosa and erosion of the tissue occurs. A damaged mucosa is unable to secrete enough mucus to act as a barrier against HCL. Histamine is released in the damaged mucosa resulting in vasodilation and increased of melena permeability.

Other studies reveal that, chronic use of NSAIDS can cause mucosa irritation and inflammation, decrease mucosal blood flow and other adverse effects like inability to form mucosa cap after injury and increase rate of gastric emptying into the duodenum can result into peptic ulcer.

While helicobacter pylori infection yields proteases which also degrade mucous, cytotoxins cause inflammatory changes in mucosa. These cytotoxins causes epithelial cell injury and death, decreased duodenal bicarbonate secretion and the bacteria penetrates gastric cells and weakens mucous layer as well as trigger met aplastic changes in cells that support bacteria invasion.

Also, hyper secretion of acid is attributed to a greater mass of parietal cells as well as stimulation by high protein rich meals, calcium and emotional stress stimulation of the vagus nerve. All

these factors predispose the mucosa of the esophagus, stomach and duodenum to ulceration hence peptic ulcer.

Clinical Manifestation

- Pain occurring in the epigastric area radiating to the back
- Pain increases when the stomach is empty, approximately half to two hour
- Passage of melena stool
- Gastrointestinal bleeding
- Weight loss
- People with peptic ulcer are afraid to eat since eating brings about pain
- Constipation
- Insomnia

Diagnostic Investigations

- Hemoglobin level
- Barium meal
- Gastro-duodenoscopy plus urease test for helicobacter pylori
- Serial stool specimen to detect occult blood
- Endoscopy
- Gastric analysis
- Helicobacter pylori test

- Occult stool
- Gastric secretory studies
- Upper gastrointestinal series
- Physical examination

Specific Medical Treatment

- Fluids such as intravenous infusion, normal saline are given to prevent dehydration and to maintain electrolyte balance.
- Antacid such as magnesium trisilicate or aluminum hydroxide or to nugel-o may be used relieve Pain.
- Hyposecretive drug such ranitidine, cimetidine, omeprazole, misoprostol, famotidine may also be used to reduce gastric secretion.
- Amoxicillin plus flagyl may be prescribed for helicobacter pylori.
- Sedatives such as diazepam may be used to promote rest and sleep.

Specific Surgical Treatment

If the symptoms persist and the ulcer becomes intractable or if there has been bleeding or ulcer have resulted in some obstruction in the gastric outlet, surgical treatment may be considered necessary. Some operative procedures include;

- **Gastric resection (subtotal gastrectomy):** This is the removal of a portion of the stomach, including the ulcer bearing area and part of the parental cell mass. Resection and is performed because of the risk of the ulcer becoming malignant in the future. An anastomosis is then made

between the gastric stump and the duodenum (gastroduodenostomy) or jejunum (gastrojejunostomy) to restore gastrointestinal continuity.

- **Gastric resection plus vagotomy:** Vagotomy is the resection of the vagus nerve to reduce the stimulation of gastric secretion. It also reduces the motility of the stomach and may interfere with gastric emptying. For this reason, a highly selective vagotomy may be perfumed which leaves part of the vagus nerve intact particularly the section that supply the antrum. Vagotomy is combining with a gastric resection to provide effective gastric emptying.
- **Vagotomy with pyloroplasty**: This involves a longitudinal incision made in the pylorus, which is then surgically closed transversely. This produces an enlarged outlet which compensates for the impaired gastric emptying resulting from vagotomy.

Nursing Management

Psychological Care

The patient is reassured that, he is in the hands of competent medical team, hence, all effort being made to bring the disease under control in shortest possible time. It is done to relax the patient, gain his confidence, win his cooperation and allay fears and anxiety. Patient is encouraged to ask questions and appropriate answers are provided without excessive use of medical terms, should be delivered in calm manner to clear any misconception.

Rest and Sleep

Rest and sleep is ensured in order to enhance recovering process, conserve energy, reduce metabolic activity and promote healing. Patient is made to assume a position that is comfortable for him. Quite environment as well as limiting the number of visitors is ensured in order to

promote sleep. Warm baths are also given to induce sleep. Good ventilation is ensured by opening nearby windows. All procedures should be performed at a once in other not to disrupt sleep.

Observation

Patient is observed for signs and symptoms of respiratory distress. Vital signs such as temperature, pulse, respiration and blood pressure are checked 4 hourly to access whether patient's condition is improving or deteriorating. Observe for signs and symptoms patient's manifest such as vomiting, pallor, pain, etc. Intake and output chart is monitored and infusion rate is observed for and the dislodgement of needle of swelling as well as the flow rate is checked and compared with the treatment sheet. Possible complications and desired effect and side effect of the drugs are also observed. Also, stool is observed for occult blood.

Nutrition

Sometimes, they tend have poor appetite since they are afraid to eat. Hence, food that causes pain or distress should be eliminated. Meals should be provided on time. Patient should avoid coffee and other caffeinated beverages as well as carbonated drinks because these drinks help to promote acid secretion. Patient is advised to avoid extremely hot or cold foods or fluids.

Personal Hygiene

Patient is assisted to bath with warm water twice daily to remove dirt, improve circulation, relax and help him sleep well. It also provides comfort and boost patient's morale. Pressure areas are treated to prevent pressure sores. Mouth care is also ensured each morning with toothbrush and toothpaste to stimulate appetite and to prevent foul smell. Fingernails, toenails must be soaked in warm water and trimmed. It should be washed with soap and water to prevent them from

harboring dirt and microbes. Dirty linens are also changed, after visiting the nature's call, patient is advised to wash his hand thoroughly and before and after.

Relief of pain

Patient is encouraged to take bed rest to reduce physical activity. Small frequent meals should be served or provided to prevent gastric distention. Also, patient is advised to stay away from alcoholic beverages caffeine and nicotine because these may increase gastric acidity and promote erosion of gastric mucosa. Administer prescribed medication such as Nugel-o to relief pain.

Education

Patient is educated on lifestyle modification such as alcoholism and smooking to help prevent occurrence of ulcer pain and bleeding. Patient is also advice to prevent stress and promote rest and learn to cope with stressful situation. Again, patient is educated on irritant food such as caffeine, carbonated drinks, alcohol, extremely spiced foods, tart fresh fruits and rich pastries.

Avoid large meals as they tend to over- stimulates acidic secretion. Patient is advised to chew food thoroughly and eat in a leisurely manner and on a regular schedule. He should also be advised to take antacids one hour after meals, at bed time and when needed. Patient is also educated on the changes in bowel habits after taking antacids.

Complication

- Perforation
- Iron deficiency anemia
- Hemorrhage
- Gastric outlet obstruction

- Pyloric stenosis
- Peritonitis
- Shock

1.11 Validation of data

The data/information obtained from the patient's family, health professionals and references from books is considered valid for the purpose they have served because there were similarities between all the sources of the data. Findings from the home visit also authenticated the data making it valid to serve its usefulness in the care study. Also, the data presented by my patient and the investigations carried out were similar to those in the Literature review

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis is the act of determining the component of part of substance (Weller,2014).The second component of the nursing process, data analysis, was discussed in this chapter to aid in the development of a nursing diagnosis. It entails breaking down information into its essential parts. The comparison of data to the standard, the patient's strength, the health problem, and the nursing diagnosis are all part of the data analysis process. This aids in the planning of patient care.

2.1 Comparison of data with standards

This deals with comparing information gathered from patient to standard to help determine any deviation from normal. This includes comparison of diagnostic investigations, causes, clinical features, treatment and complications.

2.1.1 Diagnostics Test Investigations

The following investigations were requested and done. They include

- Full blood count
- Blood Film for Malaria Parasite
- Helicobacter Pylori test
- Widal Test

Table 1: Comparison of Diagnostic Investigations Performed on Mr. O. F with those in Literature

Diagnostic Test Outlined in Literature Review	Diagnostic Test Carried Out on The Patient
History and Physical examination	History and Physical examination was done
Barium study of the upper GI tract may show an ulcer;	Barium study of the upper GI tract was not done
Endoscopy for direct visualization of inflammatory changes, ulcers, and lesions.	Endoscopy was not comes on the patient.
Stool test to detect occult blood.	Stool test was not done.
Gastric secretory studies are of value in diagnosing achlorhydria and ZES. H. pylori infection.	Gastric secretory studies was not requested and not done.
Helicobacter Pylori test	Helicobacter Pylori test was done
Abdominal Ultrasound scan to visualize intestinal lesions	Abdominal ultrasound was done.

Blood film for Malaria Parasites was done to rule out Malaria. Full blood count was also done to confirm whether there is an infection characterized by elevated white blood cells or neutrophils count.

Table 2: Diagnostic Investigation Ordered for Mr. O.F

DATE	**SPECIMEN**	**INVESTIGATIONS**	**RESULTS**	**NORMAL VALUES**	**INTERPRETATION**	**REMARKS**
01/12/2022	Blood	**Full Blood Count**				
01/12/2022	Blood	Haemoglobin level estimation	13.0 g/dl	Male: 12-18g/dl Female: 11-	Above normal range	Patient did not show any signs of anemia.

				16g/dl		
01/12/2022	Blood	White blood cell count	14.8 x 10^3 /µl	3.8 x 10^3 /µl – 9 x 10^3 /µl	Above normal range	There is secondary infection Antibiotics were prescribed Clarithromycin 500mg was given.
01/12/2022	Blood	Red blood cell count [RBC]	4.89 x 10^6 /µl	3.50 X 10^9 /µl – 5.50 x 10^6 /µl	Within Normal	No intervention was given.
01/12/2022	Blood	Platelet count	288 x 10^9 /L	140-440 x 10^9 /L	Within Normal	No intervention was given.
01/12/2022	Blood	Neutrophils level estimation	77 x 10^3 /µl	40.00 - 75.00 x	Above normal	Antibiotics were prescribed

				10^3 /µl		e Clarithromycin 500mg was given.
01/12/2022	Blood	Malaria parasites	No malaria parasite was seen	Negative	No malaria parasite	No treatment was given.
01/12/2022	Blood	Helicobacter pylori	Present	Positive	H. Pylori present	Antibiotics were prescribed and Metronidazole 500mg was given.
01/12/2022	Blood	Widal Test	Negative	Negative	No typhoid	No treatment was given.

- **Causes of Patient's Condition**

  According to the literature review, helicobacter pylori and excessive use of non-steroidal anti-inflammatory drugs NSAIDS) are the two main causes of Peptic ulcer. Stress, heredity, gastrointestinal trauma, excessive alcohol use, smoking, infections, and so on are all predisposing factors. Mr. O.F's illness was brought on by the Helicobacter pylori, infection, stress, and a particular way of living, such as malnutrition (failing to eat at regular intervals and sometimes eating ones daily due to loss of appetite). This causes the stomach to secrete too much hydrochloric acid

Comparison of specific treatment given to Mr. O.F. to that of literature

Standard treatment for peptic ulcer compared with treatment given to patient.In literature review, the specific treatment for peptic ulcer includes;

Table 3: Comparison of specific treatment given to Mr. O.F. to that of literature

Medical treatment in the literature review.	**Medical treatment prescribed for the patient**
Acid neutralizing agents	Syrup Nugel O prescribed and 10mls administered accordingly.
Anti-cholinergic agent	Anti-cholinergic medication was not ordered.
Histamine receptor antagonist	Not prescribed for patient.
Cytoprotective drugs	Not prescribed for patient.
Anti-secretary(Proton pump inhibitor)	Tablet Omeprazole was prescribed and 40mg

	administered accordingly.
Antibiotic	Metronidazole and Clarithromycin was prescribed and 500mg administered accordingly.
I.V Normal saline	Given to maintain fluid and electrolyte balance. Intravenous infusion normal saline 500mls was given.

Table 4: Pharmacology of Drugs Administered to Mr. O.F

DATE	DRUG	DOSAGE/ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE/ROUTE OF ADMINISTRATION	CLASSIFICATION	DESIRED EFFECT	ACTUAL EFFECT OBSERVED	SIDE EFFECTS /REMEDIES
02/12/2022	Tablet Omeprazole	Adult; 20mg-40mg Children; 5mg-20mg	20mg tds x 30 days Route: orally.	Anti-ulcer drug	It suppresses gastric acid secretion by specific inhibition of the H+K+ AT-pase in the gastric parietal cells leading to inhibition of gastric acid secretion in the stomach.	Acid secretion was reduced and patient experienced no pain.	None of these side effect was found.

Pharmacology of Drugs Administered to Mr. O.F. continued

DATE	DRUG	DOSAGE/ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE/ROUTE OF ADMINISTRATION	CLASSIFICATION	DESIRED EFFECT	ACTUAL EFFECT OBSERVED	SIDE EFFECTS /REMEDIES
01/12/2022	Nugel-0 Syrup.	Adult ;10mls-15mls Route: orally	Patient's dose: 15mls tds x 7 days. Route: orally	Antacid.	Neutralize the hydrochloric acid in the stomach.	The damaging effect of pepsin was reduced and patient did not complain of pain in the epigastric region.	Rebound acidity, hypocalcaemia, constipation or diarrhea constipation was observed and patient was encourage to take more fluids.

Pharmacology of Drugs Administered to Mr. O.F. cont'd

DATE	DRUG	DOSAGE/ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE/ROUTE OF ADMINISTRATION	CLASSIFICATION	DESIRED EFFECT	ACTUAL EFFECT	SIDE EFFECTS /REMEDIES
01/12/2022	Normal saline	Dosage: Depends on patient's fluid and electrolyte Level and age as well as by doctor's prescription. Route: Intravenous.	Dosage: 1 litre within 24hours Route: Intravenously	Isotonic solution of sodium chloride	To correct fluid and electrolyte imbalance	Patient's body fluids and electrolytes were raised.	Odema, over hydration, Hypocalcaemia. None of these Side effects were Observed.

Pharmacology of Drugs Administered to Mr. O.F. continued

DATE	DRUG	DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECTS/ REMEDIES
01/12/2022	Metronidazole (Flagyl)	Dosage: Mouth: 400mg tid daily. IV:500mg every 8 hours x7days Route: Oral and Intravenous.	Dosage: 400mg tds x 7 days, Route: Orally.	Nitro-imidazole Derivatives (Antibacterial and Antiprotozoal)	Metronidazole is an antimicrobial drug with high activity against anaerobic bacteria and protozoa. Metronidazole works by entering bacterial and protozoal cells and interfering with their DNA.	Patient was treated from any bacterial infection (*H. pylori*)	Arthralgia, Ataxia, Darkening of urine, Dizziness, Drowsiness, Erythema multiform, Headache None of these side effects were observed.

Pharmacology of Drugs Administered to Mr. O.F.

DATE	DRUG	DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECTS/ REMEDIES
01/12/2022	Tramadol	Dosage: 50–100mg every 4–6 hours Route: Intravenous, Oral, Intramuscular	Dosage: 100 mg Route: Intravenous	Narcotic/Opioid Analgesic	It binds to the opioid receptors and blocks the pathway of norepinephrine and serotonin which reduce pain.	Patient was relived of her pain.	Abnormal coordination, anorexia, changes in appetite, delirium, dyspnoea, muscle weakness, nightmares Paraesthesia, tremor, wheezing. None of these side effects were

							observed.

Pharmacology of Drugs Administered to Mr. O.F.

DATE	DRUG	DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECTS/ REMEDIES
01/12/2022	Tablet clarithromycin	Dosage: For adults 250-500mg Rout: Oral	500mg twice daily for 12 days. Rout: Oral	Macrolide antibiotic.	To combat bacteria in the body	Bacteria in the body was combated,	Vomiting, indigestion, Unpleasant taste in the mouth, headaches, insomnia, rashes, none observed. No remedy was given since there was no

							side effect of the drug.

Pharmacology of Drugs Administered to Mr. O.F con't

DATE	**DRUG**	**DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)**	**DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT**	**CLASSIFICATION**	**DESIRED EFFECT**	**ACTUAL ACTION OBSERVED**	**SIDE EFFECTS/ REMEDIES**
01/12/2022	Tablet Paracetamol	Dosage: Mouth:0.5–1 g every 4–6 hours; maximum 4g per day	Dosage: 1g tds x 48hrs Route: Orally	Antipyretic/Analgesic	To reduce pain and fever by preventing the releases of	Patient had a reduction in pain and did not experience any	Acute generalized exanthematous pustulosis, Malaise, skin reactions,

		IV: 1 g every 4–6 hours, dose to be administered over 15 minutes Route: Oral and Intravenous.			prostaglandins that increase pain and body temperature.	increase in temperature	Stevens-Johnson syndrome, Haematological reactions, allergic reactions and liver damage following overdose. Patient experienced no side effects.

Interpretation

From table three above, in view of the drugs administered, patient was given the right drug, right route and right dosage as stated in the literature review.

Complication

With reference to the complications stated under the literature review, Mr. O.F. did not exhibit any due to good nursing care rendered to him.

Table 5: Comparison of clinical features Given to Patient with those in Literature

Clinical Features Indicated In The Literature	**Clinical Features Exhibited By Patient**
Pain occurs in the epigastric area and it is increased by food.	Patient experienced pain in the epigastric area and increased by food intake and when hungry
Nausea and vomiting.	Patient did present with this
Heartburn	Patient did not present with this feature
Melena	Patient did not present with this feature
Anxiety	Patient did present with this
Insomnia.	Patient present with this feature
Constipation.	Patient did not present with this feature
There is weight loss	There was weight loss since she was not eating.

Pain is relieved after taking antacids	Patient did not complain of abdominal pain after she was given 15mls of Nugel-O
There is weakness and fatigue	Patient was weak because of vomiting.

Interpretation

From table two above, it clearly indicated that patient presented about 100% of the signs and symptom in the literature review. This confirms the condition diagnosed medically. (Peptic ulcer).

2.2 Patient / Family Strengths

This is explained as the ability of the patient to help in the achievement of health goals, sets for early recovery.

The under mentioned strengths were observed on my patient and family.

1. Patient is able to express the intensity of the pain and factors that aggravate the pain
2. Patient is able to express anxiety.
3. Patient can tolerate oral fluids and fibre diet.
4. Patient is able to sleep at least 2 hours during the day and at least 4 hours at night.
5. Patient could tolerate dry foods such as biscuits.
6. Patient can walk around his bed with minimal assistance.

2.3 Patient's Health Problems

Problem is defined as a situation, that needs attention and needs to be dealt with or solved . From the data collected during assessment, the following health problems were noticed on patient:

1. Patient had pain at his epigastric region (01/12/2022).
2. Patient and family were very anxious (01/12/2022).
3. Patient complained of vomiting (01/12/2022).
4. Patient was not able to sleep well (02/12/2022).
5. Patient complains of loss of appetite (02/12/2022).
6. Patient complained of body weakness (02/12/2022).

2.4 Nursing Diagnosis

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

1. Epigastric pain related to ulceration of the gastric mucosa (01/12/2022).
2. Anxiety related to unknown outcome of disease process and its management (01/12/2022).
3. Risk for fluid and electrolyte imbalance (less than boy requirement) related to vomiting (01/12/2022).
4. Disturbed sleep pattern (insomnia) related to change of environment.(02/12/2022).

5. Risk for nutritional imbalance (less than body requirement) related to loss of appetite. (02/12/2022).
6. Activity intolerance related to body weakness. (02/12/2022).

CHAPTER THREE

PLANNING FOR PATIENT / FAMILY CARE

3.0 Introduction

This chapter explains how the third stage of the nursing process, planning, is used to develop goals after a nursing diagnosis has been established. It entails establishing objective goals to address the patient's issues and identifying nursing intervention to achieve those goals. Once the diagnoses have been determined, the selected nursing diagnoses must be prioritized in order to identify care priorities. High priority nursing diagnoses need to be identified (i.e., urgent need, diagnoses with high level of congruence with defining characteristics, related factors, or risk factors) so that care can be directed to resolve these problems or lessen the severity or risk of occurrence (in the case of risk diagnoses). The patient and his family members and friends must be involved in the nursing care plan.

3.1 Objective/ Outcome Criteria

A nursing outcome refers to a measurable behavior or perception demonstrated by an individual, a family, a group, or a community that is responsive to nursing intervention

1. Patient will be relieved of epigastric pain within 24 hours as evidenced by;
    a. Patient verbalizing that he does not feel the pain anymore.
    b. Nurse observing patient to have relaxed facial expression.
2. Patient and family will be relieved of anxiety within 24 hours as evidenced by:
    a. Patient and family verbalizing that they are no longer anxious.
    b. Nurse observing that patient and family are relieved of anxiety and being cooperative.

3. Patient will maintain normal fluid and electrolyte balance throughout hospitalization as evidenced by;

   a. Patient verbalizing that nausea and vomiting has ceased.

   b.Nurse observing patient to have a normal skin turgor.

4. Patient will regain strength for his daily activities within period of hospitalization as evidenced by:

   a. Patient verbalizing that he no longer has any feeling of body weakness.

   b. Nurse observing that patient participate in activities that he can tolerate such as mouth care, walking around bed and bathing.

5. Patient will regain his normal sleeping pattern within 48 hours of hospitalization as evidence by:

   a. Patient verbalizing that he was able to sleep well.

   b. Nurse observing patient sleep for 6-8 hours at night without interruption.

6. Patient will maintain adequate nutrition throughout hospitalization as evidenced by:

   a. Patient verbalizing that he has gained appetite for food.

   b. Nurse observing that patient takes in at least two thirds of food served.

Table 6. Care plan for Mr. O. F.

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	SIGN
01/12/22 at 10:00am	Epigastric pain related to ulceration of the gastric mucosa	Patient will be relieved of epigastric pain within 24 hours as evidenced by; 1. Patient verbalizing that he does not feel the pain anymore.	1. Reassure the patient/family. 2. Assess the pain level of the patient, using the pain rating scale as patient point three.	1. Patient/family was reassured that measures were been put in place to relive pain and also to improve his health. 2. Pain level of the patient was assessed using the pain rating scale. Patient pointing 4 as the level of pain	02/12/2022 at 10:00am Goal fully met as 1. patient verbalized that he no longer feels pain	N.E

		2. Nurse observing patient to have relaxed facial expression	3. Ensure noise reduction to encourage rest. 4. Assist patient to a position he feels comfortable with. 5. Encourage frequent intake of fluids. 6.Administer prescribe drugs.	3. All forms of noise were reduced by restricting visitors, reducing volume of radio and television. 4. Patient was assisted to be in a position he felt comfortable with. 5.Sips of water was served to help neutralize the acidity in the stomach. 6.Prescribed Nigel O syrup, IV Omeprazole 40mg and Paracetamol 1g was served. .	2. patient was observed to have a relaxed facial expression by the nurse.	

CARE PLAN FOR MR O. F

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	SIGN
01/12/22 at 10:45am	Anxiety related to unknown outcome of disease process and its management.	Patient and family will be relieved of anxiety within 24 hours as evidenced by: 1. Patient and family verbalizing that they are no longer anxious. 2. Nurse observing that patient and family	1. Reassure patient and family. 2. Establish rapport with patient so as to gain patient's confidence 3. Allow patient and family to express their fears and ask questions	1. Patient and family were reassured. 2. Rapport was established with the primary aim of winning the confidence and trust of patient. 3. Patient and family were encouraged to ask questions that bothered them in order to clear all doubts and to	02/12/2022 at 10.45am Goal fully met as 1. Patient and family verbalized they are no	N. E

		are relieved of anxiety and being cooperative	bothering them. 4. Provide answers simply and in a tactful manner. 5. Provide diversional activity (Television) to divert her mind from the anxiety.	gain their cooperation and they were answered accordingly. 4. Answers were provided in both English and Twi and in simple terms in which patient and family understood. 5. Diversional activity was provided e.g. watching of television.	longer anxious 2. Nurse observed that patient and family were relieved of anxiety and were cooperative	

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	SIGN
01/12/2022 at 11:00am	Risk for fluid and electrolyte imbalance (less than body requirement) related to vomiting	1.Patient will maintain normal fluid and electrolyte balance within 24hours as evidenced by; 1. Patient verbalizing that nausea and vomiting has ceased.	1. Reassure patient that vomiting will subside with treatment. 2. Maintain and keep strict intake and output. 3. Ensuring adequate intake of liberal fluids such as water and soft drinks.	1. Patient was reassured that vomiting will subside with treatment. 2. Patient's intake and output was monitored and maintained in the chart. 3. Intake of adequate liberal fluids such as water and soft drinks was ensured.	02/12/2022 at 11:00am Goal fully met as 1. patient verbalized that vomiting and nausea has	E. N

		2. Nurse observing patient to have a normal skin turgor.	4. Provide frequent oral hygiene 5.Note the colour and frequency of vomitus	4. Oral hygiene was provided twice daily. 5. Colour and frequency of vomitus was documented.	ceased 2. Nurse observed that patient have a normal skin turgor	

Patient/Family care plan continue.

Date and Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Evaluation	Sign
02/12/22 at 7:45am	Disturbed sleep pattern (insomnia) related to environmental barriers such as noise.	Patient will regain his normal sleeping pattern within 48 hours as evidence by 1.pattient verbalizing that he was able to sleep well. 2.Nurse observing patient sleep for 6-8 hours at night	1. Reassure patient and family. 2. Assess patient sleep pattern. 3. Ensure quite environment. 4. Plan nursing activities in order not to disturb patient during sleep.	1.Patient and family were reassured that he is in hand of competent staffs and all measures will be put in place to help patient. 2.Patient's sleep pattern was assessed. 3.Aquite environment was ensured by reducing the volume of radio and television sets. 4.plan nursing activities in order not to disturb patient during his sleep.	04/12/2023 at 07:35am Goal fully met as 1.patient verbalized that he was able to sleep. 2.Nurse	E. N

		without interruption.	5. Reduce the number of visitors 6. Discourage the intake of caffeine.	5.Number of visitors were reduced. 6.Intake of caffeine was discouraged.	observed patient sleep for 6- 8 hours at night	

Patient/Family care plan continued

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	SIGN
02/12/2022 at 8:05am	Risk for imbalanced nutrition (less than body requirement) related to loss of appetite.	Patient will maintain adequate nutrition throughout hospitalization as evidenced 1.Patient verbalizing that he has gained appetite for	1. Reassure patient. 2.Assess the nutritional status of patient to serve as a baseline data. 3.Maintain patient's oral hygiene twice a day (morning	1.patient was reassured that measures will be taken to restore adequate essential nutrients to balance his nutritional needs. 2.The nutritional status of patient was assessed hence aiding in the kind of food to include in his diet. 3.Patient oral hygiene was observed twice daily.(morning and evening)	06/12/2022 at 10:00am Goal fully met as 1.Patient verbalized that he has gained appetite for food.	E. N

		food. 2.Nurse observing that patient takes in at least two third of food served.	and evening). 4.Plan meals with patient and dietician in order to provide patient with meals of choice. 5.Educate patient on the need to take in nutritionally rich diets.	4.Meals were planned with patent. 5.patient was educated on the need to maintain his nutritional status.	2.Nurse observed that patient was able to eat two thirds of food served.	

Patient/Family care plan continue.

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	SIGN
02/12/2022 at 8:40am	Activity intolerance related to body weakness.	Patient will regain strength for his daily activities within period of hospitalization as evidenced by; 1patient verbalizing that he no longer has any feeling of	1. Reassured patient of regaining strength for daily activities with the available measures. 2.Assess the patient ‘s level of physical activity and mobility. 3.Observe and document response to activity. 4.Provide emotional support	1.Patient was reassured those appropriate measures will be taken to help regain strength for his daily activities. 2.Level of physical activity and mobility was assessed. 3.Patient’s response to activities were observed and documented. 4.Emotional support was	`06/12/2022 at 10:00am Goal fully met as 1.Patient verbalized that he no longer has feeling of body	N. E

		body weakness. 2.Nurse observing that patient participate in activities that he can tolerate.	while increasing activity. 5.Plcae items of daily us close to patient.	provided while activity was increased for patient. 5.place items of daily use such as comp, minor, and bottled water was kept close to patient.	weakness. 2.Nurae observed that patient participate in activities that he could tolerate.	

CHAPTER FOUR

IMPLEMENTATION OF PATIENT AND FAMILY CARE PLAN

4.0. Introduction

The nursing process' implementation phase is carrying out the recommended nursing care plan, which is just a summary of the actual nursing care provided to the patient and family from admission through discharge. It also covers follow-up visits and home visits to ensure care continuity. The nurse assumes responsibility for the implementation and coordinates the activities of all those involved in implementation, including the patient and family, other members of the nursing team, and other members of the health care team, so that the schedule of activities facilitates the patient's recovery

4.1. Summary of Actual Nursing Care Provided to Patient/Family

The actual nursing care rendered to patient and his family started on the day of admission, 1st December, 2022 to the time care was terminated on 6th December, 2022. The management of patient and his family was planned to meet their physiological, emotional, spiritual and physical needs. Whiles on admission, routine nursing actions, for example, oral care and medication administration were done and the necessary documentations were also carried out.

4.1.1 First Day of Admission (1st December, 2022)

Mr O.F. arrived on the Males Ward on 1st December, 2022 at 9:30am, per ambulation through O.P.D unit accompanied by a staff nurse and a relative, with the diagnosis of Peptic ulcer disease with history of Abdominal pains, Fatigue, anxiety, vomiting and epigastric pain at Sampa Government Hospital. He was fairly ill, partially weak and with an unsatisfactory level of hydration. Patient was fully conscious. Happening to be at the nurses' station with the nurse in-charge at the time of his arrival, I was subsequently charged with the responsibility to carry out

his admission to the ward. It was a planned admission. The patient's identity was verified by mentioning his name for response. He was then welcomed and immediately admitted and made comfortable in an admission bed; patient looked anxious. He was reassured to allay all fears and anxiety. He was introduced to the staffs present and was assured of the competency of the healthcare team. His particulars such as name, sex, age, and residential address were recorded in the admission and discharge book and the daily ward state. Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained. Vital signs were checked and recorded accurately as follows:

- Temperature: 37.1°C
- Pulse: 77bpm
- Respiration: 23 cpm
- BP: 130/90mmHg
- SPO2: 99%.

He was then placed on medication which includes

- IV Omeprazole 40mg bd for 24hrs
- IV Tramadol 100mg st
- Syrup Nugel O 10mls tid for 7 days
- IV Metronidazole 500mg tid for 24hrs

Other IV infusions were given including

- IV Ringer lactate 500mls

- IV Infusion Normal Saline 500mls was set up afterwards. Patient was placed in a comfortable bed and closely monitored.

Laboratory investigation was requested. The laboratory investigation includes,

- Full blood count for white blood cell count
- Blood film for malaria parasite
- HIV Screening
- Helicobacter pylori test
- Widal test

Physical examination on the patient was performed from head to toe and no abnormalities were seen. At the time of admission, Assessment revealed that the abdominal pain was colicky in quality ‘’severe pain in the abdomen’’, located at the epigastric region and was non-radiating with vomiting identified as the relieving factor and eating identified as the aggravating factor. He had two episodes of non-projectile vomiting which expelled food previously eaten but was non-bloody and contained no bile. Inquiry about food eaten revealed that the patient had rice porridge with bread for breakfast and took banku and okro stew for supper a day before the admission day. Patient was oriented to time, place and person. He was also orientated to the ward annexes. I reintroduced myself to patient as a final year student nurse of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take him and his family for my care study. Mr. O.F and his family were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of license in Registered General Nursing. I explained to the patient and his family the concept of the patient/family care study and assured them of privacy and confidentiality. It was added that a report will be written

after the entire event. Mr. O.F and his family 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 Peptic Ulcer Disease.

On admission at 10:00am, mr .O. F complained of pain at the chest level and the nursing diagnosis was formulated as, epigastric pain related to ulceration of the gastric mucosa. As such an objective was set to relieve patient of epigastric pain within 24 hours. The following interventions were carried out; Patient/family was reassured that measures were been put in place to relive pain and also to improve his health, pain level of the patient was assessed using the pain rating scale, all forms of noise were reduced by restricting visitors ,reducing volume of radio and television, patient was assisted to be in a position he felt comfortable with, sips of water was served to help neutralize the acidity in the stomach, prescribed IV Omeprazole 40mg and Paracetamol 1g was served. His 10:00am vitals were checked and recorded as in the appendix.

At 10:45am, patient was anxious about his diagnoses, so the nursing diagnosis of anxiety related to unknown outcome of diseases condition was formulated. An objective was then set to relieve patient from anxiety within 24hours. The following nursing intervention were carried out, patient was to express his anxiety, he was reassured of the available treatment and the availability of competent nurses, the cause of the diseases were explained to him and was encourage to ask questions that bothered his mind and to which tactful answers were provided, diversional activity was provided e.g. watching of television. Patient was made comfortable in bed.

At 11:00am, patient was dehydrated and complained of vomiting more than 3times in the morning, so the nursing diagnosis of risk for fluid and electrolyte imbalance (less than body requirement) related to vomiting was formulated. An objective was set to relive patient of vomiting within 24 hours. The following nursing interventions were carried out; Patient was reassured that vomiting will subside with treatment, patient's intake and output was monitored and maintained in the chart, intake of adequate liberal fluids such as water and soft drinks was ensured, oral hygiene was provided twice daily, colour and frequency of vomitus was documented, prescribed IV Fluid such as 0.5L Normal saline was administered.

At 1:30pm, afternoon vitals were checked and recorded as in the appendix. He took in rice and stew with egg which was prepared by his relatives for lunch. Syrup Nugel O 10mls and IV Metronidazole 500mg was administered at 2pm.

At 5:00pm, evening vitals were checked and recorded as in the appendix. He took in Fufu with kontomire soup and meat which was prepared by his relative for supper. IV Omeprazole 40mg was administered at 6pm.

4.1.2 The Second Day of Admission (2nd December, 2022)

On the second day of admission, at 7:00am I went to the ward to continue with my nursing care for Mr. O.F, his morning vital signs had already checked at 5:30am and recorded as in the appendix. Patient bathing has already been taken and his teeth too were brushed and he was assisted by the night nurses. His due medications were served, patient was served with white porridge with bread as his breakfast.

On 2nd December, 2022, the night nurses reported that patient was not able to sleep well, I interacted with the patient and he confirmed it to be true.

At 7:45am a nursing diagnosis was formulated as, Disturbed sleep pattern (insomnia) related to environmental barriers such as noise. An objective was set to help patient regain his normal sleeping pattern within 48 hours. Nursing actions implemented are as follows; Patient/family was reassured that he is in hands of competent staffs and all measures will be put in place to help patient, patient's sleep pattern was assessed, a quiet environment was ensured by reducing the volume of radio and television sets, nursing activities were planned in order not to disturb patient during his sleep, number of visitors were reduced, intake of caffeine was discouraged.

Based on my observation, I conducted a nursing assessment on patient and it was realized that patient had a poor nutritional status. This was evident as patient and his relatives attested to the fact that patient is able to consume only one-third of food he is been served with.

At 8:05am a nursing diagnosis was formulated as, Imbalanced nutrition (less than body requirement) related to loss of appetite. As such, an objective was set to help patient attain and maintain adequate nutrition throughout hospitalization. The following nursing actions were implemented; Patient was reassured that measures will be taken to restore adequate essential nutrients to balance his nutritional needs, the nutritional status of patient was assessed hence aiding in the kind of food to include in his diet, patient's oral hygiene was observed twice daily (morning and evening), meals were planned with patient, patient was educated on the need to maintain his nutritional status and food was served at frequent intervals.

At 8: 40am.Upon interacting with Mr.O. F, he complained of body weakness and further observation on patient in relation to how he carried out his activities, it was observed that patient has lost strength as he could not fully tolerate activities. So the nursing diagnoses of activity intolerance related to body weakness was made. An objective was set to restore Mr. O.F strength in order to perform his daily activities on his own throughout hospitalization. The following

interventions were carried out; Patient was reassured that appropriate measures will be taken to help him regain strength for his daily activities, level of physical activity and mobility was assessed, nutritional status was assessed since adequate energy is needed for activities, patient's response to activities were observed and documented, emotional support was provided whiles activity was increased for patient, items of daily use such as comp, mirror, bottled water was kept close to patient..

At 10:00am, the objective that was set on 1st December, 2022 to relieve patient of epigastric pain within 24 hours was evaluated and goal fully met as patient verbalized he no longer feel pain at the chest and nurse observed patient to have a relaxed facial expression. Patient 10:00am vitals was checked and recorded as in appendix

patient verbalized that he no longer feels pain

At 11:00am, the objective that was set on 1st December, 2022 to relieve patient of vomiting within 24 hours was evaluated and goal fully met as patient verbalized that nausea and vomiting has ceased and it was observed that patient had a normal skin turgor.

At 1:30pm, patient afternoon vitals were checked and recorded as in the appendix. He took in yam with beans stew and flied fish which was prepared by his relatives for lunch. Syrup Nugel O 10mls and IV Metronidazole 500mg was administered at 2pm.

At 5:30pm, evening vitals were checked and recorded as in the appendix. He took in rice ball with groundnut soup and meat which was prepared by his relative for supper. IV Omeprazole 40mg was administered at 6pm. Patient evening personal hygiene was performed and he was made comfortable in bed.

4.1.3 Admission on the Third Day (3rd December, 2022)

On the third day of admission, patient woke up at 6:00am, he was assisted to brush his teeth and take his bath. His vital signs were checked and recorded as in appendix. His due medication Metronidazole 400mg was administered at 6:30am and recorded. He was served with rice porridge with bread as his breakfast, patient was encouraged to take in oral fluids 2-3 liters a day to maintain his fluid and electrolytes balance. Permission was sought from patient to visit his home for assessment which he obliged by giving me direction to his place

Patient 10:00am vital signs was checked and recorded as in the appendix.

At 2:00pm, patient afternoon vitals were checked and recorded as in the appendix. He took in kenkey with beans stew and flied fish which was prepared by his relatives for lunch. Syrup Nugel O 10mls and IV Metronidazole 500mg was administered and IV Infusion Normal Saline 500mls was set up afterwards at 2:15pm.

At 5:40pm, evening vitals were checked and recorded as in the appendix. Patient was served with banku and okro stew and meat which was prepared by his relative for supper. IV Omeprazole 40mg was administered at 6pm. Patient evening personal hygiene was performed and he was made comfortable in bed.

4.1.4 Admission on the Fourth Day (4th December, 2022)

On the fourth day of admission, patient woke up at 6:30am, He prayed, brushed his teeth, free his bowel and took his bath. Patient was served with tom brown and bread with flied egg as his breakfast. His vital signs checked and recorded as in the appendix. His due medication was administered. There was improvement in patient condition.

On 4th December, 2022 at 7:45am, the objective that was set on 2nd December, 2022 to regain patient normal sleeping pattern within 48 hours was evaluated and goal fully met as patient verbalized that he has regain his normal sleeping pattern and Nurse observed patient sleep for 6-8 hours at night.

The physician Assistant came for Ward rounds at 9:00am and patient was reviewed and plan was to continue all medications which included confirm continuation of patient care. His 10:00 am vital signs were checked and recorded as in the appendix**.**

At 2:00pm, patient afternoon vitals were checked and recorded as in the appendix. He was served with rice and stew with egg which was prepared by his relatives for lunch. Syrup Nugel O 10mls and IV Metronidazole 500mg was administered and IV Infusion Normal Saline 500mls was set up afterwards at 2:15pm.

At 5:40pm, evening vitals were checked and recorded as in the appendix. Patient was served with banku and okro stew with meat which was prepared by his relative for supper. IV Omeprazole 40mg was administered at 6pm. Patient evening personal hygiene was performed and he was made comfortable in bed.

4.1.5 Fifth Day on Admission (05/12/2022)

On the fifth day of admission, Patient woke up around 5:30am. patient looked cheerful that morning, he was assisted in brushing his teeth, had his bath and emptied his bowel. Report from the night nurses read that he was able to sleep well upon the measures put in place and even performed his daily activities well as compared to the previous days. Vital signs checked and recorded as in the appendix**.** His due medications were served. He was served with porridge and

bread as his breakfast at 7:40am., I asked of patient and confessed that he was strong with no complained. Patient locker was cleaned and made patient comfortable in bed.

At 8:00am, Physician Assistant on duty came to review patient, she was very excited with patient progression on how patient was very active and cooperating.

Patient 10:00am vitals was checked and recorded as in the appendix.

At 2:00pm, patient afternoon vitals were checked and recorded as in the appendix. He was served with rice and stew with egg which was prepared by his relatives for lunch. Syrup Nugel O 10mls and IV Metronidazole 500mg was administered and IV Infusion Normal Saline 500mls was set up afterwards at 2:15pm.

At 5:00pm, evening vitals were checked and recorded as in the appendix. Patient was served with banku and okro stew with meat which was prepared by his relative for supper. IV Omeprazole 40mg was administered at 6pm. Patient evening personal hygiene was performed and he was made comfortable in bed.

4.1.6 Sixth Day on Admission (Day of discharge) (06/12/2022).

I went to continue the nursing care rendered to patient at 7:35am. Patient woke up feeling strong and better. Report from night nurses indicated that patient was able to sleep well. I greeted patient and relatives, they responded with a cheerful facial expression. I was inquisitive enough to ask patient why he has put up a smiley face. Upon asking, patient said that he feels grateful to have special nursing care rendered to him over the past few days since he was admitted. His morning vitals had already been checked and recorded as in the appendix at 6:00am

Due medications of Syrup Nugel 'O' 15mls and Tab Paracetamol were administered at 6:10am.

At 9:00am the objective set on 2nd December, 2022 to enable patient gain his nutritional balance throughout hospitalization was evaluated. Goals were fully met as patient and family were able to verbalize. that he has gained appetite for food and Nurse observed that patient was able to eat more than two thirds of food served.

At 9:20am the objective set on 2nd December, 2022 to restore patient's strength for his daily activities throughout hospitalization was evaluated and goal fully met as patient confirmed he no longer feels weak and it was observed that patient took part in activities like walking to and from washroom and feeding himself.

During routine ward rounds, patient was discharged since his condition was stable and he had no complains. His relatives was informed and the bills were assessed to be paid. An amount of sixty-five Ghana Cedi's for medications which was not covered by National Health Insurance Scheme was paid. Patient was educated on the need to eat food containing high fiber like whole grains, the entire essential food nutrients, for example protein, vitamins and irons, as well as maintaining good personal hygiene. Mr O.F was discharged on Syrup Nugel 'O' 15mls tds for 5days. Patient was informed to come for review on 13th, 2022 at the main Out Patient Department. The need to continue with medications was emphasized and review date was stretched on. I helped the patient and the relatives to pack their belongings, Patient and the family bid the ward inmates and staff goodbye and saw them off at the gate of the ward. I then removed the bed linens and the bed and lockers were carbonized and well laid for new admissions.

4.2 Patient/Family Preparation for Discharge and Rehabilitation

Preparation for discharge commenced from the time of admission at the hospital, at 9:30am on 1st December, 2022 till the last day of visit, 23rd December,2022. The patient and family were informed that staying in the hospital was for a temporal period of time. Education of patient and family on the causes, clinical features, treatment and management of peptic ulcer disease were reemphasized. This was aimed at helping the patient and relatives in the provision of adequate care. Prior to patient discharge, health education was given to the patient and relative on the importance of eating fiber-rich diets, including food prepared from cereals such as 'kenkey' and 'Fufu' and to take in more fluids (at least 3litres of water a day), avoid spicy foods and over the counter medication, should neither smoke nor drink alcohol. Patient was encouraged to take in food rich in the essential food nutrients especially iron such as 'kontomire', garden eggs, plantain and others. Patient and his family were also educated on the need to maintain personal and environmental hygiene to help improve immunity. A great emphasis was made on the need to continue with medication and to report to the hospital if any problem does occur. I educated patient about the effects of the use of over the counter drugs and urged him to seek medical care from any health center. Patient was informed to come for review on Tuesday 13th December, 2022. Necessary documents were recorded into the admission and discharge book as well as the ward state. Assessment of patient bills were made with the help of National health insurance scheme and paid GH¢ 65.00 for medications that were not covered by the NHIS. Patient belongings were packed and I accompanied patient and relatives to the ward gate and they bid me goodbye.

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

Home visit is a family –nurse contact which allow the health worker to assess the home and family situation in order to provide the necessary nursing care and health related service(Weller,20140).

The purpose of a home visit is to analyze the nature of the patient's and family's home/community, as well as the individuals who live there. It also assists the client's family in becoming informed on any unhealthy living habits or elements that are discovered. Both before and after the discharge, the health of the patients and his family is checked and documented.

4.31 First Home Visit (3rd December, 2022)

My first home visit was made on the 3rd December, 2022 at 10:00am which was Saturday while patient was on admission. A planned visit was made to Sampa New town in the Brong region where patient resides close to Presbyterian Congregation. The purpose of this visit was to know patient's residence and the environment in which he lives, verify the information given to me as well as to identify the risk factors such as familial tendency and stresses that can lead to his condition and also to identify any nearest health facility at the area. To enable me know patients nearest health facility for possible referral and validation of patient data. Patient and relative were informed about my intention to visit their home whiles he was still on admission on 3rd December, 2022. I set off from my house around 9:40am and the distance between my house to my patient house was not too far which I used twenty minutes to walk. Patient mother was in the house when arrived, I greet her and introduce myself and the purpose of being to their house. She was happy to see me and I was provided with a chair and she welcome me. After conversation with the mother, I was allowed to go on with my aim of being there. Mr. O.F house is a three-

bedroom building, with a toilet and bath attached to each room. The house is built with blocks, painted brown and is wired correctly with electricity power, had windows but most of them were closed so I educated the mother on the need to open the windows to promote proper ventilation. They have a dustbin with a well-fitting lid in which they dump their waste materials and it is emptied every morning into Zoom lion waste-truck. They have a well, connected to a poly tank which serves as the source of water in the house. The environment was well swept and clean. The patient lives in the house with his mother and three siblings, in total they were five people staying in the house. Observations made in patients' room revealed well-furnished wall with television set, sound system, a ceiling fan, bed, couch and a wooden center table, it was very neat and well organized and they were applauded for that. I also entered the toilet and saw that it is a water closet. The place was clean, with the container for toilet papers emptied. Patient mother was educated on the need to practice good environmental and personal health and also encouraged them to continue to keep their home and surroundings clean. I reassured patient mother of competent nursing care and that he will be well very soon. I had an extensive interaction with the mother and through that I was able to confirm most of the information I have been given by Mr. O.F. No identifiable factor to patient's condition was made during the visit. Patient mother thanked me and assured me that she will ensure that all what I said will be done before I come for my next home visit. I left Sampa New Town at 12:30pm and got to my house at 1:00pm. I identified on the first home visit that patient's house was not very far from Fountain care clinic and for that reason on my return to my house, I passed by the clinic to inform one community health nurse about handing the patient to her.

4.32 Second Home Visit (December 8th, 2022. Thursday)

This visit was made on 8th, 2022. I made this visit to find out how patient was doing and to see if he was following his treatment regimen and also to remind the patient of the review date which was 13th December, 2022. On assessment patient windows were opened as they were educated to do. The environment was neat and they were commended for that. The importance of taking drugs as ordered was reinforced to patient and family. Education on good nutrition was stressed on to help protect patient and family from any diseases. Patient and family were thanked for their cooperation and permission was sought to leave. I promised them of another visit which will be my last visit. Patient's mother escorted me and she was much excited for the care I rendered to her son during his hospitalization.

4.33 Day of Review (13th December, 2022)

On Tuesday 13th December,2022, patient and relative were met at the Out-Patient Department of Sampa Government Hospital at 9:00am looking cheerful and lovely as noted from facial expression. I accompanied them to go for patient's folder. Patient vital signs were checked and recorded as in the appendix.

At the Out-Patient Department, patient was seen by the medical officer at consulting room 3. Upon assessment by the doctor, Mr.O.F was healthy. Patient did not have complains. He was told not to hesitate to report to the hospital if he encounters any health problem. He was encouraged to eat more of fiber-rich diets like cereals and iron rich diets.

He was also encouraged to practice personal and environmental hygiene to protect himself from getting diseases. He was given Syrup Nugel 'O' 15mls tid for 5 days. Patient was assured of a third home visit. I then accompanied them to the hospital gate where they board a taxi to their house.

4.34 Third Visit to His House (23rd December, 2022, Friday)

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.

On the said date, I set off early Friday afternoon around 12:10pm to my patient house which is few distance. I got to the patient at around 12:30pm. I passed by Fountain care clinic to inform the community health nurse about what we had previously discussed and so she accompanied me to patient's house. We were welcomed and offered seats. The purpose of this visit was to terminate care since patient was in good health and also was adhering to the treatment regimen. I introduced the community health nurse to the patient and his relatives. Patient and family were doing well as they looked cheerful and had no complains. After series of conversation, I handed over patient to the community health nurse to continue with care. Mr. O.F commended me for good work done and accepted to continue the care of Mr. O.F at home. The environment was tidy as there were no rubbish nor stagnant water around. I however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick and rather than relying on self-medication.

I asked about patient's drugs and it was found that he had been taking his medications and the recommended foods had also been adhered to. After interacting with patient and family for a while, I reemphasized on health educations 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 successful one. 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 eventually sought permission to leave and bid them the final farewell. I set off to the house at 3:30pm.

CHAPTER FIVE
EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

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

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

1. **Patient was Relieved of Epigastric Pain on the 2nd December, 2022**

On admission, on 1st December at 10:00am, patient complained of acute epigastric pain and at 10:00am a nursing diagnosis was formulated as, epigastric pain related to ulceration of the gastric mucosa. As such an objective was set to relieve patient of epigastric pain within 24 hours.

The following interventions were carried out to meet the objective set; Patient/family was reassured that measures were been put in place to relive pain and also to improve his health, pain level of the patient was assessed using the pain rating scale, all forms of noise were reduced by restricting visitors, reducing volume of radio and television, patient was assisted to be in a position she felt comfortable with, sips of water was served to help neutralize the acidity in the stomach, prescribed IV Omeprazole 40mg and Paracetamol 1g was served.

On 2nd December, 2022 at 10:00am an evaluation of the objective set on 1st December at 10:00am to relieve patient of epigastric pain within 24 hours was done and goal fully met as patient verbalized that she does not feel pain anymore and it was observed

2. Patient and Family Were Relieved of Anxiety on the 2nd December, 2022

On 1st December, 2022 at 10:45am, as part of my nursing actions, I went to patient to encourage him to take in fluids to correct his fluid deficits and also to teach him relaxation techniques such as knee-chest position to help reduce his pain, patient manifested a feeling of apprehension as he was not cooperating. So, I asked patient to verbalize his fears with regards to his stay in the ward. She then revealed to me that he was anxious because he does not know the outcome of the disease process and its management. Nursing diagnosis was made as anxiety related to unknown outcome of disease process and its management. An objective was therefor set to relieve patient of anxiety within 24 hours. Nursing interventions carried out to meet set objectives were as follows;

Patient and family were reassured that patient is in the hands of competent staff who will do their possible best to manage his condition, rapport was established with the primary aim of winning the confidence and trust of patient, patient and family were encouraged to ask questions that bothered him in order to clear all doubts and to gain his cooperation, answers were provided in both English and Twi and in simple terms in which patient and family understood, diversional therapy was provided e.g. watching of TV and the need for hospitalization was explained to patient and family.

On 2nd December, 2022 at 10:45am, objective that was set on 1st December, 2022 to relieve patient and family of anxiety within 24 hours was evaluated and goal fully met as patient and

family verbalized, they are no longer feeling anxious and it was observed that patient and family were being cooperative.

3. Patient was Relieved of Vomiting on the 2nd December, 2022

Assessment on admission revealed that patient has had two episodes of non-projectile vomiting which non-bloody and non-bilious. At 11:00am nursing diagnosis was formulated as, risk for fluid and electrolyte imbalance related to vomiting. As such, an objective to help relive him of vomiting within 24 hours was set. The following nursing interventions were carried out to achieve the set objective; Patient was reassured that vomiting will subside with treatment, patient's intake and output was monitored and maintained in the chart, intake of adequate liberal fluids such as water and soft drinks was ensured, oral hygiene was provided twice daily, colour and frequency of vomitus was documented, prescribed IV Fluid such as 0.5L Normal saline was administered.

On 2nd December, 2022 at 11:00am, objective that was set on 1st December,2022 to relieve patient of vomiting within 24 hours was evaluated and goal fully met as patient verbalized that nausea and vomiting has ceased and it was observed that patient had a normal skin turgor.

4. Patient Sleeping Pattern was Restored on the 3th December, 2022.

On 2nd December, 2022, the night nurses reported that patient was not able to sleep well, I interacted with the patient and he confirmed it to be true. So, at 7:45am a nursing diagnosis was formulated as, sleeping pattern disturbance (insomnia) related to environmental barriers such as noise. An objective was set to help patient regain his normal sleeping pattern within 48 hours. Nursing actions implemented to achieve set objectives were as follows; Patient/family was reassured that she is in hands of competent staffs and all measures will be put in place to help

patient, patient's sleep pattern was assessed, a quiet environment was ensured by reducing the volume of radio and television sets, nursing activities were planned in order not to disturb patient during her sleep, number of visitors were reduced, intake of caffeine was discouraged.

On 4th December, 2022 at 7:45am, the objective that was set on 2nd December, 2022 to regain patient normal sleeping pattern within 48 hours was evaluated and goal fully met as patient verbalized that he has regain his normal sleeping pattern and Nurse observed patient sleep for 6-8 hours at night.

5. Patient Attained and Maintained Adequate Nutrition on the 6th December, 2022.

On 2nd December, 2022, I conducted a nursing assessment on patient and it was realized that patient had a poor nutritional status. This was evident as patient and his relatives attested to the fact that patient is able to consume only one-third of food he is been served with.

At 8:05am a nursing diagnosis was formulated as, altered nutritional pattern (less than body requirement) related to loss of appetite. As such, an objective was to help her attain and maintain adequate throughout hospitalization was set. The following nursing actions were implemented to achieve the set objectives: Patient was reassured that measures will be taken to restore adequate essential nutrients to balance her nutritional needs, the nutritional status of patient was assessed hence aiding in the kind of food to include in her diet, patient's oral hygiene was observed twice daily (morning and evening), meals were planned with patient, patient was educated on the need to maintain her nutritional status and food was served at frequent intervals.

On 6th December, 2022, at 9:00am the objective set on 2nd December, 2022 to enable patient gain his nutritional balance throughout hospitalization was evaluated. Goals were fully met as

patient and family were able to verbalize. that he has gained appetite for food and Nurse observed that patient was able to eat more than two thirds of food served.

6. Patient Regained Strength for His Daily Activities on the 6th December, 2022

Upon interacting with patient on 2nd December,2022, at 8:40am, Mr. O.F complained of body weakness and on further observation of patient in relation to how he carried out his activities, it was observed that patient has lost strength as he could not fully tolerate activities. Nursing diagnoses of activity intolerance related to body weakness was made. An objective was set to restore patient strength in order to perform his daily activities on his own throughout hospitalization. The following interventions were carried out to meet the set objective; Patient was reassured that appropriate measures will be taken to help him regain strength for his daily activities, level of physical activity and mobility was assessed, nutritional status was assessed since adequate energy is needed for activities, patient's response to activities were observed and documented, emotional support was provided whiles activity was increased for patient, items of daily use such as comp, mirror, bottled water was kept close to patient.

On 6th December, 2022, at 9:20am the objective set on 2nd December, 2022 to restore patient's strength for his daily activities throughout hospitalization was evaluated and goal fully met as patient confirmed he no longer feels weak and it was observed that patient took part in activities like walking to and from washroom and feeding himself.

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 Mr. O.F. and family, all the goals set were fully met. The care plan was therefore not amended.

5. 3 Termination Of Care

Care of patient and family ended on the 23TH December, 2022 on Friday which was my last home visit. This ended the interaction between the health team and Mr. O.F. and his family. The preparation for termination started on day of admission through discharge, review to the third home visit. During these periods, patient and family were educated on various topics. But on this very day, I went to Mr.O. F home with a community health nurse in charge of the area and handed over patient to them to continue with care.

We congratulated the family for the care they had rendered to Mr. O.F. They were thanked for their co-operation and patient was handed over to his mother to continue with care at home. They were told that now that Mr. O.F. health had been restored, the care for him has officially ended. I informed them of my desire to visit them unofficially whenever I had the opportunity. They were happy and noted that they would miss my care and would strictly adhere to all instructions given to them. It was a moment to remember when I told them of my intention to leave. There was no separation anxiety as patient and the relatives had enough psychological preparations from the day of admission till discharge but it was still difficulty bidding them farewell.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation, or compendium of previously stated fact or statements. Conclusion is something that you decide when you have thought about all the information connected with the situation(weller,2014). This is the last chapter of the patient/family care study which entails the student's personal appreciation of the therapeutic relationship with the patient as well as the use of the nursing process.

6.1 Summary

Mr. O. F. the 30year-old man was admitted to the male's medical ward through the OPD of the Sampa Government Hospital on the 1st December, 2022 with the diagnosis of peptic ulcer disease. On admission, patient had the following health problems: abdominal pains, fatigue, anxiety, anorexia, insomnia, and vomiting.

Patient was educated on peptic ulcer disease and its management. Patient was also assisted in maintaining his personal hygiene, rest and sleep, nutrition, and exercises were also ensured.

On the 13rd December, 2022 patient scheduled for review. This was done to find out if patient was adhering to the advice and all the education given to improve his health and standard of living. Three home visits were embarked on. The first home visit was done while patient was still on admission on 3rd December, 2022, second home visit was on the 8th December, 2022 and third home visit was on the 23th December, 2022. The care of Mr. O.F. and his family care were

terminated on the 23th December, 2022, during the third home visit when patient had fully recovered.

6.2 Conclusion/Recommendation

The study has equipped me with knowledge on how to care for patients with similar disease conditions. Through this study, I have been able to put into practice actual and holistic nursing care as it has been learnt theoretically. The study provided a therapeutic environment for nursing patient as an individual and has promoted a good nurse-patient (family) relationship as well as broadened my knowledge on peptic ulcer disease, its prevention, management and treatment. It has also helped me to practice my skills acquired in the classroom theoretically. It has deepened my relationship with patients, families and the people in a given community as a whole. The study also provided the platform for the patient/family to receive individualized care. Based on the testimonies given by patients who receive individualized nursing at hospitals, it prompts most of the community members to seek medical help at the various hospitals.

Finally, it has also been beneficial to the patient and family as they learnt from a wide range of health education topics. For a successful patient and family care study, it depends on the co-operation of patient and family as well as the nurse's willingness to help. I hereby recommend that the application of the nursing process in the patient/family care study should be sustained and fully incorporate into the health delivery system.

APPENDIX

Table 7: Vital signs of Mr. O.F.

DATE	**TIME**	**TEMPERATURE**	**PULSE**	**RESPITATION**	**BLOOD PRESSURE**	**SPO2 %**
01/12/2022	9:30am 2:00pm 6:00pm	37.1°C 36.3°C 36.4ºC	77bpm 74bpm 82bpm	23 cpm 24 cpm 20cpm	130/90mmHg 136/88mmHg 128/85mmHg	99 96 97
02/12/2022	6:00am 10:00am 2:00pm 6:00pm 10:00pm	36.1 ° C 36.0°C 36.2°C 36.4°C 36.4°C	98 bpm 80 bpm 78 bpm 80 bpm 64 bpm	21 cpm 23 cpm 26 cpm 21 cpm 22 cpm	123/82 mmHg 130/80 mmHg 120/80 mmHg 126/80 mmHg 120/80 mmHg	100 95 96 98 97

03/12/2022	6:00am 10:00am 2:00pm 6:00pm 10:00pm	35.9°C 36.4°C 36.9°C 37.4°C 36.5°C	60 bpm 66 bpm 70 bpm 80 bpm 82 bpm	22 cpm 24 cpm 23 cpm 21 cpm 20 cpm	130/90 mmHg 123/70 mmHg 110/70 mmHg 100/60 mmHg 120/80 mmHg	96 97 99 98 96
04/20/2022	6:00am 10:00am 2:00pm 6:00pm 10:00pm	36.4°C 35.8°C 36.1°C 36.3°C 36.5°C	90 bpm 89 bpm 81 bpm 91 bpm 82 bpm	25 cpm 22 cpm 24 cpm 21 cpm 22cpm	130/88 mmHg 142/86 mmHg 124/60 mmHg 130/66 mmHg 125/76 mmHg	99 96 97 98 95

05/12/2022	6:00am 10:00am 2:00pm 6:00pm 10:00pm	36.1°C 36.4°C 36.9°C 36.5°C 36.1°C	104 bpm 80 bpm 81 bpm 92 bpm 84 bpm	23 cpm 25 cpm 22 cpm 23 cpm 24 cpm	136/85 mmHg 130/89 mmHg 130/66 mmHg 120/70 mmHg 128/80 mmHg	97 99 99 97 98
06/12/2022	6:00am 10:00am	36.1°C 36.3°C	83 bpm 86 bpm	25 cpm 24 cpm	120/70 mmHg 128/80 mmHg	97 96

BIBLIOGRAPHY

Bickley, L. S., & Szilagyi, P. G. (2009). *Bates' guide to physical examination and history taking* (10th ed.). Philadelphia: Walters Kluver Health/Lippincort Williams & Wilkins.

Chang, L. (2018, December 2018). *What is complete blood count.* Retrieved January 20, 2019, from WebMD: https://www.webmd.com/a-to-z-guides/complete-blood-count

Colledge, N. R., Penman, I. D., Raltston, S. H., & Walker, B. R. (Eds.). (2014). *Davidson's principlses & practice of medicine* (22nd ed.). Edinburgh: Churchill Livingstone Elsevier.

Esena, R. K. (2011). *A dictionary of health care.* Accra, Ghana: Reuben Kwasi Esena (PhD).

Herdman, H. T., & Kamitsuru, S. (Eds.). (2018). *NANDA Internation, Inc. nursing diagnosis: definitions and classifications: 2018-2020* (11th ed.). New York: Thieme.

Hinkle, J. L., & Cheever, K. H. (2014). *Brunner & Suddarth's textbook of medical-surgical nursing* (13th ed.). Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Hornby, A. (2006). *Oxford Advanced Learner's Dictionary of current English* (7th ed.). (M. Ashby, C. McIntosh, J. Turnbull, & S. Wehmeier, Eds.) New York: Oxford University Press.

Joint Formulary Committee (2018). *British national formulary 74*. London: BMJ Publishing & the Royal Pharmaceutical Society of Great Britain.

Weller, B. F. (2014). *Bailliere's nurses' dictionary: for nurses and healthcare workers* (25th ed.). London: Elsevier Health Sciences.

SIGNATORIES

THE STUDENT NURSE

NAME: MISS NYINI ELIZABETH ABENA.

SIGNATURE: .....

DATE: 10th July, 2023

THE NURSE-IN-CHARGE OF THE MALES WARD (SAMPA GOVERNMENT HOSPITAL, SAMPA)

NAME: MISS. YAA FRIMPOMAA.

SIGNATURE: .....

DATE: 14/07/2023

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

NAME: MR.SHADRACK.OSEI OWUSU

SIGNATURE: .....

DATE: 10/07/2023

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

NAME: MONICA NKRUMAH.

SIGNATURE: .....

DATE: 17th July, 2023

PRINCIPAL
HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE
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