HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT/FAMILY CARE STUDY ON PEPTIC ULCER DISEASE

TWUMASIWAA MERCY

4120220053

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

AUGUST, 2024

PREFACE

Nursing was “untaught” and instinctive. It was performed out of compassion for others, out of the wish to help others. Nursing was a function that belonged to women. It was viewed as a natural nurturing job for women.

Nursing emerged as a profession in the mid-19th century. Historian’s credit Florence Nightingale, a well-educated woman from Britain, as the founder of modern nursing. Nightingale challenged social norms – and her wealthy parents – by becoming a nurse.

At the time, the public objected to the idea of women nursing strangers. But Nightingale saw nursing as an extraordinary opportunity for females. She believed they could use their education and scientific knowledge to improve patient care while gaining personal independence.

In 1854, during the Crimean War, the British government requested Nightingale’s aid at a military hospital in Turkey. Within weeks of her small team arriving, the mortality rate of British soldiers fell dramatically. Nightingale’s accomplishments impressed the public and ultimately helped convince the Western world of the dignity and value of educated nurses.

One prominent change in the evolution of the nursing profession is formalized education. The first training programs opened at hospitals in the late-19th century. Student nurses received clinical instruction in exchange for providing care to patients. During this period of training, nurses helped hospitals make tremendous improvements in safety and quality, and humanized medical care.

By the second half of the 20th century, patient needs became more complex and hospitals required skilled nurses to manage them. The hospital-based education model thus declined in favor of training programs at colleges and universities.

The patient/family care study is a report of nursing care rendered to a patient and family by a final year student nurse in which a patient is selected from the ward, nursed from the day of admission till discharge and possible follow – up visits are made to maintain optimum level of health of the patient.

The patient/family care study forms part of the assessment of every final year student. It is a prerequisite for every candidate in order to partially fulfill the award of license in Registered General Nursing by the Nursing and Midwifery Council of Ghana. It affords the student the opportunity to develop his/her skills for future use.

The patient and family care study enables the student nurse to do more research, interact and co–ordinate with other members of the health team for the promotion of comprehensive and quality health care to individuals and the community as a whole.

The study also provides opportunity for the student nurse to use scientific methodology and holistic approach to nursing care. It helps the student nurse transform his/her theoretical knowledge acquired into practice so that the necessary skills and knowledge could be obtained for professional work.

The care study builds up confidence in the student nurse and helps him/her to take up full responsibilities in caring for a patient and his/her family.

Finally, it gives the student nurse some level of competence in rendering accurate nursing care using the nursing process approach.

ACKNOWLEDGEMENT

My foremost appreciation is to the Almighty God for His guidance, knowledge, strength and wisdom in bringing this piece of work into reality.

I am very grateful to Mrs. Y.A.J. and her family for their co-operation during the care and providing me with all the necessary information needed for the study.

I appreciate the efforts of my supervisor, Mrs. Regina Henewaa who gave me valuable insights, guidance and support to perfect this work.

I also appreciate the efforts of the Staffs of the Female ward of Presbyterian Hospital Dormaa.

I am highly indebted to all authorities, various authors and publishers of all the references used for this piece of work.

Finally, I am very grateful to my parents for their upbringing and monitoring during my education, not forgetting my friends for their prayers, support and encouragement for making this patient and family care study a success.

God richly bless you all.

INTRODUCTION

Patient care study is an academic exercise carried out by a final year student nurse.

The care study uses the nursing process approach which is deliberate activity whereby the practice of nursing is performed in systematic manner. The nursing process has five components. These are assessment, analysis, planning, implementation and evaluation.

Using the nursing process in the nursing care of the patient emphasis is placed on health promotion, maintenance and restoration of health or even enhancing a peaceful death depending on the patient's condition.

The patient/family care study forms part of the requirements of the Nursing and Midwifery Council in fulfillment of the award of license in Registered General Nursing.

This study was carried out on Mrs. Y.A.J. She is a 33-year-old woman who was admitted on the Female Medical Ward on 24th August, 2023 at 9:0am in a wheel chair accompanied by a a staff nurse and her husband. Patient had been on detention at the Accident and Emergency Centre of Presbyterian Hospital-Dormaa for one day with the diagnosis of Acute Exacerbation of Peptic Ulcer Disease.

They were reassured and were given good nursing and medical care. I sought permission from the patient to use her in my studies. I introduced myself to patient and her daughter, assured them of my help and intention to use her for my care study and to nurse them holistically until they are discharged. During the period of hospitalization, patient was put on the following medication;

1. Intravenous Omeprazole 40mg bid x 24 hours
2. Intravenous Ciprofloxacin 400mg bd x 24 hours

3. Intravenous Paracetamol 1g tds x 24 hours
4. Intravenous Metoclopramide 10mg tds x 24hours
5. Intravenous DNS 1litre x 24 hours
6. Intravenous Normal saline 1litre x 24 hours
7. Intravenous Ringers' lactate 1litre x 24 hours
8. Intravenous Metronidazole 500mg tds x 24 hours
9. Sucrafil O Gel Suspension 15mls tds x 7 days

During the period of hospitalization, Mrs. Y.A.J. was nursed for five (5) days before she was discharged on 28th August, 2023. The (3) home visits were made during the period of interaction with my patient. My first home visit was made on 25th August, 2023 and second on the 2nd September, 2023 and last home visit was also made on 12th September, 2023. The nursing process was the tool adopted to determine the patient/family needs and problems for the appropriate nursing intervention to be carried out. At the time of discharge, her condition had tremendously improved. The care was terminated on the 12th September, 2023.

The description of the detailed care study is in six (6) chapters as follows;

1. Chapter one involves Assessment of the patient and family, literature review and validation of data.
2. Chapter two involves Analysis of data.
3. Chapter three involves Planning for patient family care.
4. Chapter four involves Implementation of the care plan.
5. Chapter five involves Evaluation of the care rendered to the patient/family,
6. Chapter six Summary and conclusion.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment is the action or an instance of making a judgment about something (Merriam-Wester, 2020). It is the first step in the nursing process. It is the first stage and a vital tool in the nursing process. Assessment can be done through observations, interviewing and investigations such as laboratory results, x-ray reports and physical examination of the patient. It includes the patient's particulars, patient/family medical and surgical history, patient's socioeconomic history, patient's developmental history, patient's lifestyle and hobbies, patient past medical and surgical history, patient present medical and surgical history. It also includes admission of patient, patient and family concept of his illness, literature review on the condition from which analysis will be made to identify the patient problems and validation of data. These help the nurse to determine the health status of the patient and her family in order to plan an effective nursing care towards recovery. All information was gathered from the patient and his relatives, as well as the patient's folder.

1.1 Patient's Particulars

Patient particulars refers to information about a patient's history and behavioral patterns, gathered by a therapist or medical professional primarily from the patient but sometimes from others who know or are related to him or her (American Psychological Association, 2020).

Mrs. Y.A.J. is the patient for the study. She is a 33-year-old woman, born on 4th July, 1990 to Mr. K.B.R. and Madam A.M. She comes from Dormaa Ahenkro in the Bono region of Ghana and currently resides at Awoase a suburb of Dormaa Ahenkro. with house number DAK/KS/191. She is fair in complexion, 1.69m tall and weighs 64kg with a Body Mass

Index (BMI) of 22.4kg/m^2 which clearly indicates that she has a normal weight. She is married to Mr. A.P. with two children (a boy and a girl). Mrs. A.Y.J. is a Christian who worships at the Presbyterian Church, Awase. She is the sixth born of ten children. Mrs. Y.A.J. is a seamstress. Her next of kin is her husband Mr. A.P. who also resides at the same place as his wife. Patient had her Primary and Junior High School education at Presbyterian Primary and JHS Dormaa Ahenkro. She speaks English language and Twi. Mrs. Y.A.J. is a National Health Insurance beneficiary. She has no physical impairments or disabilities.

1.2 Family's Medical/Surgical History

Health history is a series of questions used to provide an overview of the patient's current health status. Attention is focused on the impact of psychosocial, ethnic, and cultural background on a person's health. Information is obtained on both paternal and maternal sides of family (Hinkle, Cheever, & Overbaugh, 2022). Mrs. Y.A.J. stated clearly that her grandparents and her father are deceased and they died of unknown condition but she believed that it was as a result of old age. According to Y.A.J. her mother and nine siblings are alive and healthy. There are no identified hereditary disorders like diabetes mellitus, asthma, sickle cell, epilepsy nor any mental disorders in the family. However, the relatives present during her history taking said that, periodically, they do suffer some ailments like headache, fever and abdominal pains which are treated by self-medication (using both over-the-counter drugs and traditional medicines) but if symptoms persist, they report to the hospital. Based on this information I educated the patient and family about the effects of the use of over-the-counter drugs and urged them to seek medical care from any health center when they are feeling unwell. The source of medical treatment for Mrs. Y.A.J. and family are both orthodox and herbal medicine. There are no known allergies in the family. She said two of her sisters have undergone surgery (Cesarean Section).

1.3 Family Socio-Economic History

Socio economic history refers to the position of an individual or group on the socioeconomic scale, which is determined by a combination of social and economic factors such as income, amount and kind of education, type and prestige of occupation, place of residence, and in some societies or parts of society-ethnic origin or religious background (American Psychological Association, 2020).

Patient has a very good relationship and cohesion with her family. Socially the family is not noted for smoking, alcoholism and anti-social behaviors. She revealed that small proportion of her family members are into farming and majority of them are Civil servants. Her parents are retired teachers. Patient depends on her husband for financial support. Her family members are well known for their enormous participation in religious activities, their kindness and generosity. Patient is a member of the singing group at church. In terms of religious affiliations, she revealed that, all of her family members are Christians. She revealed that most of her family members are registered with the National Health Insurance Scheme which helps them in their medical expenses when they visit the health facility for healthcare. Family members are always ready and willing to support each other in times of financial hardships. She stated that there are no taboos governing the family.

1.4 Patient's Developmental History

Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development (Weller, 2019). Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Weller, 2019). Maturation is the process of developing (Weller, 2019). The developmental history was given by patient herself as told by her mother. Mrs. Y.A.J indicated that her mother went through normal pregnancy of nine months' gestation

without any pregnancy associated disorders and had spontaneous vaginal delivery with the help of medical staff at Presbyterian Hospital-Dormaa. She was born without any congenital abnormality such as cleft lip or palate, hydrocephalus and was immunized against the childhood vaccine preventable diseases as evidenced by Bacilli Calmet Guerin (BCG) scar on her right shoulder. Mrs. Y.A.J was breastfed for several months and was introduced to complementary foods. She was weaned off breastmilk at one and half years. She went through a normal developmental milestone. This includes sitting up at the 7^{th} month, crawling at the 10^{th} month, walking, talking and running between the ages of one and three. Mrs. Y.A.J around the age of thirteen begun to experience secondary sexual characteristics such as enlargement of breast, broadening of hips, growing of pubic hairs and had her menarche around the age of sixteen. Patient had her Primary and Junior High School education at Presbyterian Primary and JHS Dormaa Ahenkro. She had to stop schooling when she reached J.H.S. Two due to financial hardships. Upon asking patient about the aspirations and career plans, she said she wanted to become a teacher. She never had difficulties with learning. Currently, patient is happily married with two children (a boy and a girl).

As specified by Jarvis (2000), Erik Erikson (1902 to 1994) focused on cultural and societal influences as determinants of behavior. Erickson was concerned with the growth of **ego,** the conscious, organized, rational part of the personality. He described eight stages of ego development that encompass the life span. Each stage is characterized by a distinct conflict, or crisis, relating to the person's physiologic maturation and to what society expects of a person at that age. According to Erik Erickson's psychosocial development which encompasses eight stages, Patient is now in her adulthood age group where there is conflict between intimacy versus isolation (19 to 40 years), As youth move even deeper into adulthood, developing intimate relationships becomes particular salient. Importantly, intimacy here involves both romantic and platonic relations-it is about sharing oneself with

others. Indeed, once individuals develop a reasonable sense of identity, they are then prepared to share that identity with others in order to develop successful intimate relations. If people cannot form these relationships, perhaps because of their own needs, a sense of isolation may result arousing feelings of darkness and danger. Patient has demonstrated beyond reasonable doubt that she has achieved a sense of identity as she is happily married with children. These features makes it more convincing beyond reasonable doubt that patient is in the intimacy dimension of Erickson`s psychosocial development.

1.5 Obstetric History

An obstetric history involves asking questions relevant to a patient's current and previous pregnancies (Potter, 2020). According to patient she saw her menses at the age of thirteen. She is gravida 2 para 2. Patient indicated that she has never committed an induced abortion before. All her deliveries so far have been spontaneous vaginal delivery with no complications. Her menstrual cycle is regular with moderate flow days and she has 28days cycle with normal flow of five days without any complication such as dysmenorrhea and amenorrhea. She revealed that she uses the three-month duration injectable (Depo-Provera) contraceptive to prevent herself from getting pregnant.

1.6 Patient’s Lifestyle and Hobbies

Life style is defined as the typical way of life of an individual, group, or culture (Merriam-Wester, 2020). Mrs. Y.A.J. goes to bed around 9:30 pm, she always prays before going to bed. She wakes up at 5:30am and says her morning prayers. She maintains her oral hygiene with the use of tooth brush and tooth paste. After that she sweeps her compound, empties her bowel, takes her bath with warm water. She also sees to the personal hygiene needs of her children and prepares them for school. Mrs. Y.A.J.’s favourite food is fufu with garden eggs soup and meat. Mrs. Y.A.J. does not have any fixated habit such as drinking, smoking,

gossiping etc. For breakfast, patient mostly takes porridge with bread. Mrs. Y.A.J. indicated that she normally gets to her workplace at 8:30am and closes at 5:00pm. She usually goes to the market on Tuesdays (Market Day) to buy food stuffs for the entire week. She prepares supper after returning from work. After supper she washes her utensils. At 7:00pm she brushes her teeth and takes her bath as well as that of her children. Afterwards she stays glued to her television until she feels the edge to sleep which usually happens around 9:30pm. On Wednesday evenings she attends church meetings at 7:30pm and closes at 9:00pm. On Saturdays she washes her clothes that of her children and husband. She goes to work after the house chores are done. On Sundays she gets ready for church and after church she prepares herself for the weekdays ahead. She described herself as an introvert but occasionally attends funerals and weddings on weekends. Patient has no known allergy to food or drugs. Patient cited that she mostly takes three square meals per day thus breakfast, lunch and supper. She sometimes enjoys snacks but she does so when she feels like taking it. Patient does not experience any difficulties when it comes to food preparation because her mum is always around if she needs extra hands. Her major medium of transportation is the tricycle which is popularly known as 'PRAGYA'. Through our interaction patient revealed that her major stress is the fact that she is always thinking about the wellbeing of her children, she vehemently believes that success will come their way. Patient indicated that she does a lot of singing whenever she is stressed up. Patient revealed that she tends to like the use of non-verbal communications such as eye movements to speak to her children to desist from going wrong. Patient cited that she likes honest people but dislikes dishonest individuals. As a mother, she always does what best for her family and has the interest of her family at heart. Patient is an active member of the singing band at church. My personal impression about patient is that, she is very calm, benevolent and generous.

1.7 Patient's Past Medical/Surgical History

Past medical history is a record of a past medical problems and treatments that a person has had (Merriam-Wester, 2020). Mrs. Y.A.J. never experienced any childhood illness like whooping cough, poliomyelitis, measles, tetanus, tuberculosis, and diphtheria and has not identified any allergy to drugs, animals or insects. She revealed that she usually suffers from minor ailments such as headache and common cold which she treats with over-the-counter medications. When symptoms persist or become worse, she visits a nearby hospital or clinic. Mrs. Y.A.J. said she has never had any major accident but cited that she sometimes suffers from minor cuts when performing household chores. Patient has been hospitalized on several occasions at Presbyterian Hospital-Dormaa two of these hospitalizations were on account of childbirth. She has never been admitted for more than a week at the hospital in any of these hospitalizations.

1.8 Patient's Present Medical/Surgical History

The history of the present health concern or illness is the single most important factor in helping the health care team arrive at a diagnosis or determine the patient's needs. The physical examination is helpful but often only validates the information obtained from the history. A careful history assists in correct selection of appropriate diagnostic tests (Hinkle, Cheever, & Overbaugh, 2022). On 22nd August, 2023 patient was apparently well when leaving home to the workplace. Whiles at the work, she started experiencing severe abdominal pain. The onset of the pain was gradual and was located in the epigastrium. Patient indicated that pressing on her abdomen was the major relieving factor when the pain started. Her husband suspended the days' work and went to purchase medication at the pharmacy. Medications given at the pharmacy were; Magnesium Trisilicate, Flagyl and Tab Paracetamol. In the evening of 23rd November, 2023, her conditioned worsened as she could no longer bear

the abdominal pain she was having. Her husband then brought her to the Accident and Emergency Centre at Presbyterian Hospital, Dormaa at 11:30pm. The Medical officer who attended to her diagnosed her of Peptic Ulcer Disease. He was detained at the accident and emergency unit for some hours before been admitted to the male ward. At the emergency unit she was managed on Intravenous Ringers lactate 1L x 24hours, IV Omeprazole 80mg stat and Injection tramadol 100mg stat. She was detained at the Accident and Emergency Centre for some hours and subsequently ordered to be trans-out to the Female Medical Ward.

1.9 Admission of the Patient

Mrs. Y.A.J. arrived on the Female Medical Ward on 24th August, 2023 at 9:00am in a wheel chair accompanied by a staff nurse and her husband. On arrival patient was fairly ill, weak and with an unsatisfactory level of hydration. Patient was fully conscious and alert. Patient had been on detention at the Accident and Emergency Centre of Presbyterian Hospital-Dormaa for one day with the diagnosis of Acute Exacerbation of Peptic Ulcer Disease with history of vomiting, epigastric pain and weakness. It was a planned admission.

Patient particulars were collected from the accompanying staff nurse. Her particulars such as name, sex, age, and residential address were entered into the admission and discharge book and the daily ward state. Patient and relative were welcomed and offered seats. Self-introduction was done, staffs present were also introduced to the patient. Patient was made comfortable in an already prepared admission bed.

Vital signs were checked and recorded accurately as follows:

1. Temperature 36.5^{o}C
2. Pulse 98bpm
3. Respiration 25cpm
4. Blood Pressure 100/80mm/Hg

Patients weight 64kg

Patient was introduced to her roommates and was assured of the competency of the healthcare team. They were also oriented to the ward and its annexes. She was asked to get her own bowl, spoon, drinking cup, bathing sponge, bucket, towel, pyjamas and other toiletries.

On admission, patient looked unwell with an unsatisfactory level of hydration. She complained of epigastric pain, weakness and have had three episodes of non-projectile vomiting which expelled food previously eaten but was non-bloody and contained no bile. A head to toe physical examination was conducted on patient and no abnormalities were seen. Patent was oriented to time, place and person.

Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained to her. Patient was properly orientated to the ward and its annexes. She was reassured to allay fears.

The following treatment plan were ordered:

1. Intravenous Omeprazole 40mg bid x 24 hours
2. Intravenous Ciprofloxacin 400mg bd x 24 hours
3. Intravenous Paracetamol 1g tds x 24 hours
4. Intravenous Metoclopramide 10mg tds x 24hours
5. Intravenous DNS 1litre x 24 hours
6. Intravenous Normal saline 1litre x 24 hours
7. Intravenous Ringers' lactate 1litre x 24 hours
8. Intravenous Metronidazole 500mg tds x 24 hours
9. Sucrafil O Gel Suspension 15mls tds x 7 days

Patient was to undertake series of investigations including:

1. Full Blood Count
2. Helicobacter pylori test
3. Upper GI Endoscopy

Patient had lost lots of fluids through vomiting hence IV Normal saline 500ml was set up. Patient looked anxious. She was reassured to allay all fears and anxiety. I reintroduced myself to patient as a student nurse of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take her and her family for a patient/family care study. Mrs. Y.A.J. and her family were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of license in Diploma in Registered General Nursing. I explained to the patient and her family about 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. Mrs. Y.A.J. and her relative agreed to my request and assured me of providing the necessary information and assistance. I congratulated them on such a decision. Discharge planning was initiated with the relatives; thus, they were told that the hospital will be a temporal place for their care and would have to continue the care at home once there is an improvement in her condition. I informed the ward in-charge about my interest in using this patient for my care study and a permission was granted for me to move on with the study. I decided to choose this patient for the study because I wanted to know more about Peptic Ulcer Disease and to be able to differentiate it from other similar abdominal conditions.

1.10 Patient's Concept of Illness

Mrs. Y.A.J. did not attribute her illness to any spiritual cause in spite of her spiritual believes as a Christian. She was of the view that some conditions like epilepsy and other mental disorders can have spiritual implications. She does not know the exact cause of her condition. Patient verbalized with doubt that her condition probably has a link with prolonged starvation. Patient believes that the treatment planned for her, in the hospital, will help treat her illness and prevent any complications.

1.11 Literature Review

This section deals with documented information about the condition the patient was diagnosed with (Peptic Ulcer Disease). Literature review of a condition gives a detailed insight into the condition. It talks about the established and laid down facts about the disease condition.

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

According to Hinkle, Cheever and Overbaugh (2022), the GI tract is a pathway 7 to 7.9 meters (23 to 26 feet) in length that extends from the mouth to the esophagus, stomach, small and large intestines, and rectum, to the terminal structure, the anus.

Oesophagus

Once food has been chewed and mixed with saliva in the mouth, it is swallowed and passes down the oesophagus. The oesophagus has a stratified squamous epithelial lining which protects the oesophagus from trauma; the sub mucosa secretes mucus from mucous glands which aid the passage of food down the oesophagus. The lumen of the oesophagus is surrounded by layers of muscle - voluntary in the top third, progressing to involuntary in the

bottom third and food is propelled into the stomach by waves of peristalsis (Tortora & Derrickson, 2023).

Stomach

The stomach is situated in the left upper portion of the abdomen under the left lobe of the liver and the diaphragm, overlaying most of the pancreas. A hollow muscular organ with a capacity of 1,500 ml, the stores food during eating, secretes digestive fluids and propels food or chime, into the small intestine (Hinkle, Cheever, & Overbaugh, 2022). The stomach is a 'j'-shaped organ, with two openings- the esophageal and the duodenal- and four regions- the cardia, fundus, body and pylorus. Each region performs different functions; the fundus collects digestive gases, the body secretes pepsinogen and hydrochloric acid, and the pylorus is responsible for mucus, gastrin and pepsinogen secretion (Tortora & Derrickson, 2023). According to Wagh and Grant (2018), The stomach is continuous with the oesophagus at the cardiac sphincter and with the duodenum at the pyloric sphincter. It has two curvatures; the lesser curvature and the greater curvature. When the stomach is empty, the mucosa appears wrinkled or folded. These folds are called rugae.

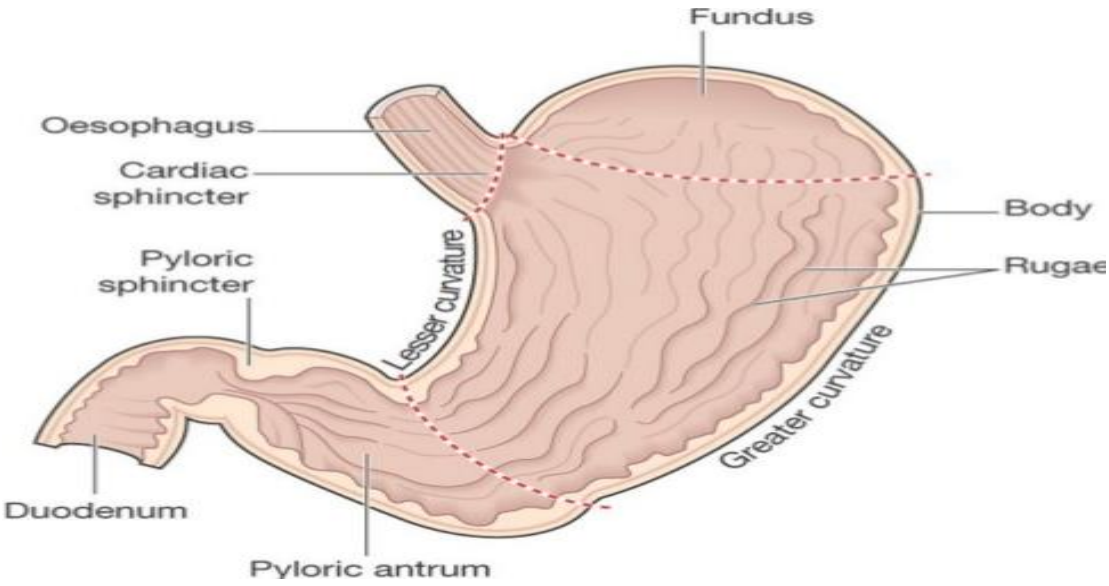

Figure 1. 1: Diagram of the Stomach

Source: (Wagh & Grant, 2018).

Functions of the Stomach

As specified in Tortora and Derrickson (2023) the stomach performs the following functions:

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

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

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

3. Entero-endocrine cells which secrete regulatory hormones (Tortora & Derrickson, 2023).

Small Intestine

According to Wagh and Grant (2018), the small intestine is the site where most of the chemical and mechanical digestion is carried out, and where virtually all of the absorption of useful materials is carried out. The whole of the small intestine is lined with an absorptive mucosal type, with certain modifications for each section. The intestine also has a smooth muscle wall with two layers of muscle rhythmical contractions force products of digestion through the intestine (peristalsis).

Duodenum

It forms a 'C' shape around the head of the pancreas. Its main function is to neutralize the acidic gastric contents called ‘chyme’ and to initiate further digestion; Brunner's glands in the submucosa secrete alkaline mucus which neutralizes the chyme and protects the surface of the duodenum (Wagh & Grant, 2018).

Definition

Peptic ulcers are most commonly located in the stomach or duodenum, but can also occur in the lower oesophagus, in the jejunum after surgical anastomosis to the stomach or, rarely, in the ileum adjacent to a Meckel’s diverticulum. Ulcers in the stomach or duodenum may be acute or chronic; both penetrate the muscularis mucosae, but the acute ulcer shows no

evidence of fibrosis. Erosions do not penetrate the muscularis mucosae (Penman, Ralston, Strachan, & Hobson, 2023).

A peptic ulcer is an evacuation (hollowed-out area) that forms in the mucosal wall of the stomach, the pylorus (the opening between the stomach and duodenum), in the duodenum (the first part of the small intestine), or in the oesophagus (Hinkle, Cheever, & Overbaugh, 2022).

Peptic ulcers are more likely to occur in the duodenum than in the stomach. As a rule they occur alone, but they may occur in multiples. Chronic gastric ulcers tend to occur in the lesser curvature of the stomach, near the pylorus (Hinkle, Cheever, & Overbaugh, 2022).

Figure 1. 2: Ulceration in the stomach

(Hinkle, Cheever, & Overbaugh, 2022)

Incidence

Peptic ulcer disease occurs with the greatest frequency in people between 40 and 60 years of age. Peptic ulcer disease is relatively uncommon in women of childbearing age, but it has been observed in children and even in infants. After menopause, the incidence of peptic ulcers in women is almost equal to that in men. The rates of peptic ulcer disease among middle-aged adults have diminished over the past several decades, whereas the rates among older adults have increased. Peptic ulcers in the body of the stomach can occur without excessive acid secretion. Peptic ulcer disease affects approximately 4.5 million Americans annually, and it requires inpatient hospitalization for an estimated 30 out of every 100 patients (Hinkle, Cheever, & Overbaugh, 2022).

As specified by Kumar and Clark (2017) Duodenal ulcers affect approximately 10% of the adult population and are two to three times more common than gastric ulcers. Ulcer rates are declining rapidly for younger men and increasing for older individuals, particularly women. Both duodenal and gastric ulcers are common in the elderly. There is considerable geographical variation, with peptic ulcer disease being more prevalent in developing countries related to high incidence of *H. pylori* infection. In the developed world, the percentage of NSAID-induced peptic ulcers is increasing as the prevalence of *H. pylori* declines.

Aetiology

The exact mechanism of causation is unknown. Among some of the causes found by researchers are:

1. *Helicobacter pylori*: this organism is a Gram-negative microaerophilic bacterium found primarily in the gastric antrum of the human stomach (Kumar & Clark, 2017).

2. Non-steroidal anti-inflammatory drugs (NSAIDs): Treatment with NSAIDs is associated with peptic ulcers due to impairment of mucosal defences as a result of inhibiting cyclo-oxygenase 2 (Penman, Ralston, Strachan, & Hobson, 2023).
3. Zollinger-Ellison Syndrome (ZES): Consists of severe peptic ulcers which involves extreme gastric hyperacidity (Hinkle, Cheever, & Overbaugh, 2022).

Predisposing Factors

1. Trauma: Critical illness, shock or severe tissue injury from extensive burns or intracranial surgery may lead to stress ulcer.
2. Exposure to irritants: Cigarette smoking appears to encourage ulcer formation by inhabiting pancreatic secretion of bicarbonate by a mechanism involving nicotine.
3. Normal Aging: As one grows the pyloric sphincter may wear down in the course which allows the reflux of bile into the stomach. This appears to be a common contributor to the development of gastric ulcers in the elderly persons.
4. Dietary: Certain foods can cause excessive acid production and irritation of the gastric mucosa leading to peptic ulcer. Highly spiced foods, milk, carbonated beverages, beans and fruits such as lemons, oranges etc. are all ulcerogenic.
5. Stress: Researchers consider stress as a possible cause of the development of peptic ulcer. Stress has been demonstrated to cause production of excess stomach acid and Helicobacter pylori thrives well in the acidic medium
6. Familial tendency also may be a significant predisposing factor.
7. People with blood type O are more susceptible to peptic ulcers than are those with blood type A, B, or AB. (Hinkle, Cheever, & Overbaugh, 2022).

Types of Peptic Ulcer

According to Penman et al., (2023), There are two main types of peptic ulcer:

1. Gastric ulcer: Ulcer that occurs in the stomach.
2. Duodenal ulcer: Ulcer that occurs in the duodenum

These two types can also be present in acute or chronic forms which depend on the degree of mucosal involvement. Chronic ulcers usually involve both the mucosa and sub mucosal linings. Acute ulcers are usually superficial affecting only the mucosal layer. They may bleed and perforate but heals in a relatively short time.

N.B: There are two common forms of peptic ulcer disease; those associated with the organism *H. pylori*, those associated with the use of NSAIDs. Less common is ulcer disease associated with massive hypersecretion of acid which occurs in the rare gastrinoma (Zollinger-Ellison) syndrome.

Comparison of Duodenal and Gastric Ulcers

Table 1. 1: Comparison of Duodenal and Gastric Ulcers

Duodenal ulcers	**Gastric ulcer**
Incidence	
Age 30-60	Usually, 50 and over
Male:Female 3:1	Male:Female 1:1
80% of peptic ulcers are duodenal	15% of peptic ulcers are gastric
Signs, Symptoms, and Clinical Findings	
Hypersecretion of stomach acid (HCl)	Normal-hyposecretion of stomach acid (HCl)
Weight gain	Weight loss

Pain occurs 2–3 hrs after a meal Ingestion of food relieves pain Vomiting uncommon Hemorrhage less likely than with gastric ulcer Melena more common than hematemesis More likely to perforate than gastric ulcers	Pain occurs 30mins to 1 hr after a meal May be relieved by vomiting Vomiting common Hemorrhage more likely to occur Hematemesis more common than melena Less likely to perforate than duodenal ulcers

Pathophysiology

Peptic ulcers occur mainly in the gastroduodenal mucosa because this tissue cannot withstand the digestive action of gastric acid (HCl) and pepsin. The erosion is caused by increased concentration of acid-pepsin or by decreased resistance of the mucosa. A damaged mucosa cannot secrete enough mucus to act as a barrier against HCl. The use of NSAIDs inhibits the secretion of mucus that protect the mucosa. Patients with duodenal ulcers secret more acid than normal, whereas patients with gastric ulcers tend to secret normal or decreased levels of acid. Damage to the mucosa results in decreased resistance to bacteria, and thus infection from *H. pylori* bacteria may occur. Zollinger-Ellison syndrome is suspected when a patient has several peptic ulcers that is resistant to standard medical therapy. It is identified by the following: hypersecretion of gastric juice, duodenal ulcers and gastronomas in the pancreas (Hinkle, Cheever, & Overbaugh, 2022).

N.B: The underlying pathophysiology associated with *H. pylori* infection involves the production of cytotoxin-associated gene proteins and vacuolating cytotoxins which activates an inflammatory cascade. Gastrin is the main hormone involved in stimulating gastric acid secretion, and gastrin homeostasis is also altered in *H. pylori* infection. This results in *H. pylori*-induced hypergastrinaemia (Kumar & Clark, 2017).

Clinical Manifestation

1. Upper abdominal pain (occurring 1-3 hrs after eating meals and relieved by food or antacids)
2. Anorexia
3. Weight loss
4. Nausea
5. Vomiting
6. Heartburn (Walker & Whittlesea, 2021)

Kumar and Clark (2017) added the following:

7. Burning epigastric pain; It is believed that the pain occurs when the increased acid content of the stomach and duodenum erodes the lesion and stimulates the exposed nerve endings.
8. Epigastric tenderness

Hinkle, Cheever and Overbaugh (2022) indicated the following features;

9. Diarrhoea
10. Constipation
11. Bleeding

Assessment/ Diagnostic Findings

As stated in Hinkle, Cheever and Overbaugh (2022), the following are assessment finding/diagnostic investigations for peptic ulcer disease;

1. Endoscopy is the preferred investigation because it allows direct visualization of inflammatory changes, ulcers and lesions.
2. Biopsy and histologic examination to detect *H. pylori* infection.
3. Physical examination may reveal pain, epigastric tenderness
4. History from patient
5. Presenting signs and symptoms
6. Complete or Full blood count (Reveals a decrease in hemoglobin (Hgb), hematocrit (Hct), and red blood cells when acute or chronic blood loss accompanies ulceration)
7. Stool antigen test
8. Serologic testing for antibodies against the *H. pylori* antigen.
9. Radiography

Specific Medical Intervention

The aim of treating peptic ulcer disease
includes:

1. To alleviate symptoms of the disease.
2. To prevent recurrence

H. pylori eradication is the cornerstone of the therapy for peptic ulcers, as this will successfully prevent relapse and eliminate the need for long-term therapy in the majority of patients (Penman et al., 2023).

Medical treatment

As specified by Kumar and Clark (2017), advances in drug therapy have dramatically changed the management of Peptic Ulcer Disease and significantly improved its

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

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

1. Antacids are given to neutralize the HCL. E.g. Magnesium Trisilicate, Aluminum Hydroxide.
2. Histamine 2 receptor antagonist is given to reduce gastric secretion.
   E.g. Cimetidine and Ranitidine.
3. Proton Pump inhibitors are given to eliminate acid secretions. E.g. Omeprazole, lansoprazole
4. Mucosal Protective Agent is given to form a protective coat that prevents further excavation. E.g. Sucralfate, Misoprostol.
5. Antimicrobial agent is given to prevent further infection. E.g. Metronidazole, Amoxicillin.
6. Analgesics to relive pain. E.g. Paracetamol, Tramadol.

Surgical intervention

Surgery is recommended for patients with intractable ulcers (those failing to heal after 12 to 16 weeks of medical treatment), life-threatening hemorrhage, perforation, or obstruction and for those with ZES that is unresponsive to medications (Hinkle, Cheever, & Overbaugh, 2022). Surgery may be performed using a traditional open abdominal approach (requiring a long abdominal incision) or through the use of laparoscopy (only requiring small abdominal incisions). Laparoscopy is a type of minimally invasive

surgery that involves the indirect visualization of the abdominal cavity through the use of a laparoscope (a thin flexible tube) attached to a camera (Hinkle, Cheever, & Overbaugh, 2022).

Surgery procedures adopted include:

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

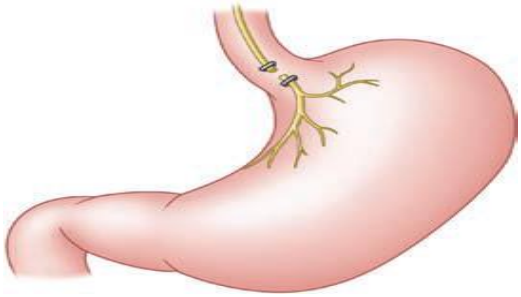

Figure 1. 3: Vagotomy

Source: (Hinkle, Cheever, & Overbaugh, 2022)

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

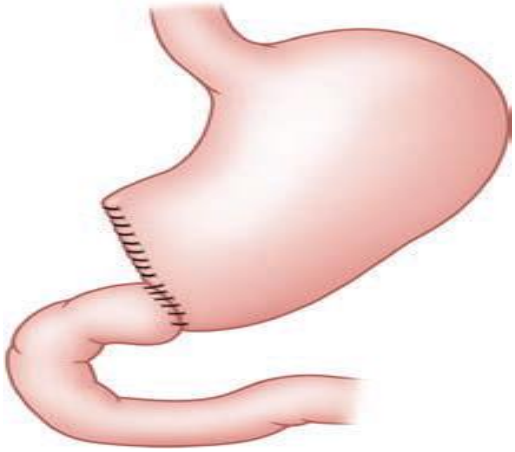

Figure 1. 4: Billroth I

Source: (Hinkle, Cheever, & Overbaugh, 2022)

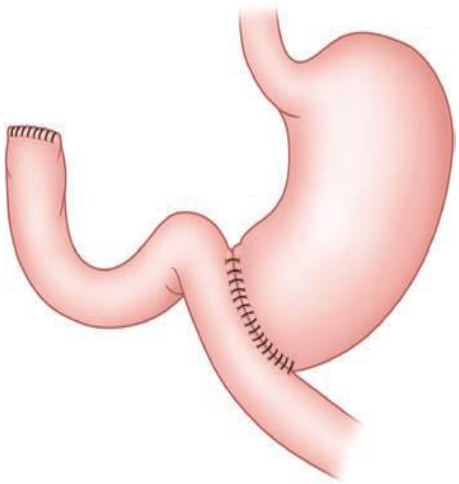

Figure 1. 5: Billroth II

Source: (Hinkle, Cheever, & Overbaugh, 2022)

3. Pyloroplasty: This is the surgical removal of the pyloric sphincter (Kumar & Clark, 2017).

Nursing Management

The goals for the patient may include relief of pain, reduced anxiety, maintenance of nutritional requirements, and absence of complications (Hinkle, Cheever, & Overbaugh, 2022);

Relieving Pain

1. Pain relief can be achieved with prescribed medications.
2. The patient should avoid aspirin and other NSAIDs as well as alcohol.
3. Meals should be eaten at regularly paced intervals in a relaxed setting.
4. Medications prescribed to treat the peptic ulcer should provide relief of ulcer-associated pain.

5. Some patients benefit from learning relaxation techniques to help manage stress and pain

Reducing anxiety / reassurance

1. The nurse assesses the patient's level of anxiety and reassured that she was in the hands of competent and well-trained staff that are always ready to offer care and support to ensure good health.
2. Patients are introduced to other patients who have similar conditions as her and have had their treatment waiting to be discharged
3. Relatives were also reassured that all necessary procedures will be done for her.
4. Diversional activities such as watching of televisions and the use of slide pictures were provided to divert patients mind from her condition.
5. Patients with peptic ulcers are usually anxious, but their anxiety is not always obvious.
6. Appropriate information is provided at the patient's level of understanding, all questions are answered, and the patient is encouraged to express fears openly. Explaining diagnostic tests and administering medications on schedule also help to reduce anxiety.
7. The nurse interacts with the patient in a relaxed manner, and relaxation methods, such as biofeedback, hypnosis, or behavior modification.
8. The patient's family is also encouraged to participate in care and to provide
9. Emotional support.

Rest and sleep

1. A quiet environment was provided by reducing noise to allow patient to get enough rest.

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

Observation

1. Vital signs were also checked and recorded which comprises of temperature, pulse, respiration and blood pressure.
2. Intake and output were also monitored by observing intake and output chart to know patient's fluid and electrolyte balance.
3. The desired effect and side effect of drugs served were also observed.
4. Side effects of drugs should be observed and reported if any and skin and mucous membrane for signs of dehydration.
5. Physical findings of epigastric or abdominal pain, nausea, vomiting, tarry stools, bleeding were observed.
6. Patient's response to medication therapy, nutritional therapy and emotional rest were observed.

Personal hygiene

1. Body hygiene is done by giving an assisted bed bath twice daily with warm water, soap, sponge and towel to prevent offensive odour and to remove microorganisms from the skin.

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

Nutrition / Diet

1. The intent of dietary modification for patients with peptic ulcer is to avoid over secretion of acid and hypermobility in the gastric intestinal tract.
2. These can be minimized by avoiding extremes of temperature and over secretion from consumption of meat extracts, alcohol, and coffee (including decaffeinated coffee, which also stimulates acid).
3. Dietary compatibility becomes an individual matter. The patient eats food that can be tolerated and avoids those that produce pain. Certain substance such as spicy food causes severe pain and has to be avoided.
4. Smoking should be avoided as it has been shown to delay ulcer healing regardless of the therapy.

5. Serve small frequent and bland foods. Avoid alcohol and give milk in between meals. Patient is encouraged to take enough roughage to enhance bowel elimination.
6. Vitamin and minerals such as fruits like orange, banana, pawpaw should be encouraged to boost up the immune system

Patient / family education

1. Patient is educated on the factors that trigger the condition.
2. Modify lifestyle include health processes that will prevent recurrence of ulcer pain and bleeding.
3. Avoid eating large meals, as they tend to over stimulate acid secretion.
4. Adhere to prescribed treatment.
5. Educate patient to report on signs and symptoms.
6. Educate patient that antacids cause changes in bowel movement.
7. Avoid over – the counter drugs unless prescribed by doctor.
8. Encourage stress-reducing activities
9. Educate patient on medication to be taken home, its doses, frequency, therapeutic effects and possible side effects and explain maximum compliance.
10. Educate patient to come for regular check-ups.
11. Educate patient to avoid irritating substances such as caffeine, carbonated drinks, alcohol, and extremely spiced foods.

Evaluation

Expected patient outcomes may include:

1. Reports freedom from pain between meals and at night
2. Reports feeling less anxiety
3. Maintains weight

4. Demonstrates knowledge of self-care activities
    a. Avoids irritating foods and beverages (alcohol) and medications (NSAIDs)
    b. Takes medications as prescribed
5. No evidence of complications (e.g., hemorrhage, perforation or penetration, gastric outlet obstruction)

Indications for Surgery in Peptic Ulcer

According to Penman et al., (2023), these are the indications for surgery in peptic ulcer;

1. Perforation
2. Hemorrhage
3. Persistent ulceration despite adequate medical therapy
4. Recurrent ulcer following gastric surgery
5. Gastric outflow obstruction.

Complications

As specified in Hinkel and Cheever (2022), complications of peptic ulcers include:

1. **Hemorrhage**: Gastritis and hemorrhage from peptic ulcer are the two most common causes of upper GI tract bleeding (which may also occur with esophageal varices). Hemorrhage in patients with peptic ulcers is associated with a 10% mortality rate. Bleeding peptic ulcers account for 36% of all upper GI bleeds and it may be manifested by hematemesis or melena. The vomited blood can be bright red, or it can have a dark coffee grounds appearance from the oxidation of hemoglobin to methemoglobin.
2. **Perforation and Penetration**: Perforation is the erosion of the ulcer through the gastric serosa into the peritoneal cavity without warning. It is an abdominal

emergency and requires immediate surgery. Perforation of a peptic ulcer is associated with a 10% to 25% mortality rate, making it the most lethal of all complications. Penetration is erosion of the ulcer through the gastric serosa into adjacent structures such as the pancreas, biliary tract, or gastrohepatic omentum (membranous fold of the peritoneum).

3. **Gastric Outlet Obstruction**: Gastric outlet obstruction occurs when the area distal to the pyloric sphincter becomes scarred and stenosed from spasm or edema or from scar tissue that forms when an ulcer alternately heals and breaks down. The patient may have nausea and vomiting, constipation, epigastric fullness, anorexia, and, later, weight loss
4. **Stomach Cancer**: Patients with *H. pylori* associated ulcers have a 3-6-fold increased risk of gastric cancer later in life.
5. **Recurrence**: Factors that affect recurrence of ulcer are failure to eradicate *H. pylori*, continued NSAID use, smoking. The 3-year recurrence rate for gastric and duodenal ulcers is less than 10% when *H. pylori* is successfully eradicated and greater than 50% when it is not.

Post-Operative Complications

According to Kumar and Clark (2017), these are the long-term post-operative complications of peptic ulcer

1. Dumping Syndrome
2. Recurrent ulcer
3. Diarrhoea
4. Nutritional complications (iron deficiency due to poor absorption, weight loss) (Hinkle, Cheever, & Overbaugh, 2022)

Prevention of Peptic Ulcer Disease

1. As far as possible emotional trauma leading to stress and anxiety should be reduced.
2. Individuals belonging to blood group type A and O should adopt good lifestyles in order not to be predisposed to the condition.
3. High intake of spicy and fried foods should be avoided as much as possible.
4. A regular eating pattern should be established and abnormal long periods between meals should be discouraged.
5. Smoking and alcohol intake should be avoided since they irritate the gastric mucosa.
6. Intake of ulcerogenic drugs such as salicylates, other non-steroidal anti-inflammatory drugs and corticosteroids should be avoided.

1.12 Validation of Data

Validation is the extent to which a measure, indicator, or a method of data collection possesses the quality of being sound or true as far as it can be judged (Weller, 2019). All the information gathered from the patient was found to be true after comparing with information obtained from patient's relative through series of interviews. Also, the patient's folder provided the information to confirm the data collected. The information from the literature review also confirmed the data gathered. After collecting all this information, I realized that the data collected were similar and so considered valid for the study.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis refers to a comprehensive examination of anything complex in order to find out its nature or to determine its essential features (Merriam-Wester, 2020). It also involves grouping identical materials meaningfully for the purpose of identification. This is the second stage of the nursing process and it deals with comparing data obtained on the patient with standards to help determine any deviation from normal physiological functions of the body and this help the nurse formulate appropriate nursing intervention. This chapter entails comparison of data with standards, patient/family strengths, patient/family health problems and the corresponding nursing diagnosis.

2.1 Comparison of Data with Standards.

This is where the data collected on the health of the patient is compared with those in the literature review. These includes diagnostic investigations, causes, signs and symptoms, treatments and complications. Information which were analytically obtained from patient are compared to what is standardized in literature in order to solicit for more understanding about patient course of treatment and their effectiveness in patient's improvement.

A. Diagnostic Investigation/Test

Diagnosis is the determination of the nature of a disease and Test is defined as an examination or trial. Investigation refers to procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatment (Weller, 2019).

Investigations which were carried out on Mrs Y.A.J. during her period of hospitalization compared with literature;

Patient was to undertake series of investigations including:

1. Full Blood Count
2. Helicobacter pylori test
3. Upper GI Endoscopy

Table 2. 1: Comparison of Test Done to Literature

Test outlined in literature review	**Test Carried out on Patient**
1. Endoscopy	1. Endoscopy was conducted
2. Biopsy and histologic examination	2. Biopsy and histologic examination were not conducted
3. Physical examination	3. Physical examination was conducted which revealed pain and epigastric tenderness.
4. History from patient	4. History from patient was taken
5. Signs and symptoms	5. Signs and symptoms were taken
6. Full blood count	6. Full blood count was conducted
7. Stool antigen test	7. Stool antigen test was not conducted
8. Serologic testing	8. Serologic testing was not conducted
9. Radiography	9. Radiography was not conducted

Although biopsy and histologic examination, stool antigen test, serologic testing and radiography were not done. However, the other tests performed proved that the patient was diagnosed correctly.

Table 2. 2: Results of Diagnostic investigations carried Out on Patient

Ordered Date	**Specimen**	**Investigations**	**Results**	**Normal values**	**Interpretation**	**Remarks**
24/08/23	Blood	**Full Blood Count** Haemoglobin	14.8g/dL	**Males:** 14 g/dL -17.5g/dL **Females:** 11.3 g/dL -16.5g/dL	Haemoglobin level was normal	No treatment given
		Haematocrit	35.5%	**Males:** 41.5%-50.5% **Females:** 36.9%-44.6%	Haematocrit count was normal	No treatment given
		Red Blood Cell	$4.8x10^{12}$/L	**Males:** 4.5 $x10^{12}$/L -5.9 $x10^{12}$/L **Females:** 4.1 $x10^{12}$/L-5.1 $x10^{12}$/L	RBC count was normal	No treatment given
		White Blood Cell	$9.12x10^{9}$/L	4.5 $x10^{9}$/L -10.0 $x10^{9}$/L	WBC count was normal	No treatment given

Table 2.2: Results of Diagnostic investigations carried Out on Patient Cont'd…

Ordered Date	Specimen	Investigations	Results	Normal values	Interpretation	Remarks
24/08/23	Blood	Helicobacter pylori test	Positive	No Helicobacter pylori seen	Patient had Gastric ulcer	IV Omeprazole 40mg bd x 3days and Syrup Nugel'0' 15mls tds x 5days
24/08/23	Upper GI	Endoscopy	Patient had ulcerations in the stomach	No ulcerations detected	Patient had ulcerations in the stomach	IV Omeprazole 40mg bd x 3days, Sucrafil O Gel Susp. 15mls tds for 7 days and Intravenous Metronidazole 500mg tds for 24 hours

B. Causes of Patient's Condition

With references to the literature review on the causes of peptic ulcer disease and the diagnostic investigations carried out on Mrs. Y.A.J the exact predisposing factor of patient's condition could be due helicobacter pylori test which was positive.

C. Clinical Features/ Signs and Symptoms

Table 2. 3: Clinical Features of patient compared with those in the literature review

Clinical Features in Literature Review	**Clinical Features Exhibited by Patient**
1. Upper abdominal pain	1. Patient experience upper abdominal pain
2. Anorexia	2. Patient experienced anorexia
3. Weight loss	3. Patient did not experience weight loss
4. Nausea	4.Patient complained of nausea
5. Vomiting	5. Patient vomited.
6. Heartburns	6. Patient experienced heartburns.
7. Burning epigastric pain	7. Patient complained of burning epigastric pain.
8. Epigastric tenderness	8. Patient complained of epigastric tenderness
9. Diarrhoea	9. Diarrhoea was not experienced by patient
10. Constipation	10. Constipation was not experienced by patient.
11. Bleeding	11. Bleeding was not experienced by patient

The above comparison indicates that patient's condition is truly peptic ulcer disease since most of her exhibited signs and symptoms appeared in literature.

D. Specific Medical Treatment Given to Patient

Treatment refers to the mode of dealing with a patient or disease (Weller, 2019). Peptic ulcer disease may be treated surgically or medically. Mrs. Y.A.J. was treated medically with the aim of relieving pain and preventing the occurrence of the attacks.

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

1. Intravenous Omeprazole 40mg bid x 72 hours
2. Intravenous Ciprofloxacin 400mg bd x 24 hours
3. Intravenous Paracetamol 1g tds x 24 hours
4. Intravenous Metoclopramide 10mg tds x 24hours
5. Intravenous DNS 1litre x 24 hours
6. Intravenous Normal saline 1litre x 24 hours
7. Intravenous Ringers' lactate 1litre x 24 hours
8. Intravenous Metronidazole 500mg tds x 24 hours
9. Sucrafil O Gel Suspension 15mls tds x 7 days

Table 2. 4: Treatment Given to Patient as Compared with Literature Review

Treatment as in literature review	**Treatment given to my patient**
1. Antacids e.g.; Magnesium Trisilicate, Aluminum Hydroxide.	1. Sucrafil O Gel Suspension was given
2. Histamine 2 receptor antagonist eg: Cimetidine, Ranitidine	2. None was ordered for patient

Table 2.4: Treatment Given to Patient as Compared with Literature Review Cont'd…

Treatment as in literature review	**Treatment given to my patient**
3. Proton-pump inhibiters e.g.; Omeprazole, Lansoprazole	3. Intravenous Omeprazole was given to patient
4. Mucosal Protective Agent eg: Sucralfate, Misoprostol	4. None was ordered for patient
5. Antimicrobial agent eg: Metronidazole, Amoxicillin	5. Patient was given Metronidazole and Ciprofloxacin
6. Analgesics e.g.; Paracetamol, Tramadol	6. Patient was given Paracetamol
7. Surgery I. Vagotomy II. Antrectomy III. Pyloroplasty	7. No surgical treatment was carried out

From the above table, comparison of drugs in the literature review with drugs given to my patient, the treatments given to patient were in line with the literature. Intravenous Metoclopramide was given to patient because she was vomiting. Intravenous infusions such as normal saline, ringers' lactate and dextrose normal saline were given to patient to maintain her optimal hydration status. No surgical intervention like Vagotomy, Pyloroplasty and Antrectomy was done for patient

Table 2. 5: Pharmacology of Drugs Administered to Patient

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effect/ Remedies
24/08/23	Omeprazole	**Dosage** 40 mg once daily **Route** IV, Oral	**Dosage** 40mg twice daily x 3 days **Route** Intravenously	Proton pump inhibitor	Reduces hydrochloric acid secretion	Patient's condition improved due to reduction in her abdominal pains	Agitation, Impotence Patient experienced no side effects.
24/08/23	Ciprofloxacin	**Dosage** 400gm twice daily **Route** Oral, IV	**Dosage** 400mg bd for 24 hours **Route** Intravenously	A broad-spectrum antibiotic of the fluoroquinolone class	An antibiotic used to treat a number of bacterial infections	Patient condition improved	Stomach pain, heartburn, diarrhoea, vaginal itching, pale skin. None of these side effects were observed.

Table 2.5: Pharmacology of Drugs Administered to Patient Cont'd…

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effect/ Remedies
24/08/21	Paracetamol	**Dosage** 0.5–1 g every 4–6 hours; maximum 4g per day **Route** Oral and IV.	**Dosage** 1g tds x 24 hours **Route** Intravenously	Analgesic	To reduce pain	Patient had a reduction in pain and did not experience any increase in temperature	skin reactions, reactions, allergic reactions and liver damage following overdose. Patient experienced no side effects.
28/08/23	Metoclopramide Hydrochloride	**Dosage** 10 mg, repeated up to 3 times daily **Route** IV, IM, Oral	**Dosage** 10mg tds for 24 hours **Route** Intravenously	Prokinetic agent (antiemetic)	It works by speeding the movement of food through the stomach and intestines.	Patients vomiting was resolved	Asthenia, depression, diarrhoea, drowsiness, hypotension, menstrual cycle irregularities None of these side effects were observed.

Table 2.5: Pharmacology of Drugs Administered to Patient Cont'd…

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effect/ Remedies
28/08/23	Dextrose normal saline	Amount depends on patient's fluid and electrolyte level and age.	**Dosage** 1 litre **Route** Intravenously	Crystalloid (Isotonic solution)	Provides supplementary calories and fluids	Client was hydrated and energy restored.	Glucosuria, confusion, Oedema, over hydration, hypocalcaemia. None of these side effects were observed.
28/08/23	Normal saline (0.9%)	Amount depends on patient's fluid and electrolyte level and age.	**Dosage** 1 litre **Route** Intravenously	Isotonic solution of sodium chloride	To correct fluid and electrolyte imbalance	Patient's body fluids and electrolytes were raised	Oedema, over hydration, hypocalcaemia. None of these side effects were observed.

Table 2.5: Pharmacology of Drugs Administered to Patient Cont'd…

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effect/ Remedies
28/08/23	Ringers Lactate	Amount depends on patient's fluid and electrolyte level and age.	**Dosage** 1 litre **Route** Intravenously	Crystalloid (Isotonic solution)	Restores normal fluid and electrolyte balance especially bicarbonates	Patient was provided with the needed body fluid and electrolyte	Over hydration, hypocalcaemia, alkalosis None of these side effects were observed.
28/08/23	Metronidazole (Flagyl)	**Dosage** 500mg three times daily. **Route** Oral and IV.	**Dosage** 500mg tds x 24 hours **Route** Intravenously	Antibacterial and Antiprotozoal	To treat bacteria and protozoa infection.	Patients condition improved.	Arthralgia, Ataxia, Darkening of urine, Dizziness, Drowsiness, None of these side effects were observed.

Table 2.5: Pharmacology of Drugs Administered to Patient Cont'd…

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/ Remedies**
28/08/23	Sucrafil O Gel Suspension	**Dosage** 10ml to 15ml every 8 hours for adults **Route** Oral	**Dosage** 15ml tid × 7 days **Route** Orally	Antacid	Reduce stomach acidity by neutralizing gastric hydrochloric acid by preventing the secretion of acid.	Gastric acid secretion was suppressed resulting in relieve of epigastric pains	Nausea, constipation, diarrhea, headache. Patient experienced no side effects.

E. Complications

With reference to the complications listed in the literature review such as gastric outlet obstruction, perforation, hemorrhage etc., Mrs.Y.A.J. exhibited no complications throughout the period of hospitalization which resulted in her early recovery. Patient did not develop any complications because of the early seeking of medical help and prompt treatment given to her throughout her period of hospitalization.

2.2 Patient/Family Strengths

Strength refers to the quality or state of being strong (Merriam-Wester, 2020). The following strengths were observed in my patient and family during their period of hospitalization.

1. Patient could express the intensity of the pain (24/08/23).
2. Patient could take in liberal fluid (half glass of fluid without vomiting) (24/08/23).
3. Patient could verbalize her state of anxiety (24/08/23).
4. Patient could take in 1/3 of 500ml of porridge served (25/08/23).
5. Patient could sit up in bed without assistance (25/08/23).
6. Patient could answer few questions on risk factors of Peptic Ulcer Disease (25/08/23).

2.3 Patient's Health Problems

Problem is defined as a question raised for inquiry, consideration, or solution (Merriam-Wester, 2020). From the data collected during assessment, the following health problems were noticed on patient:

1. Patient had pain at her epigastric region (24/08/23).
2. Patient was vomiting (24/08/23).
3. Patient was very anxious about the outcome of acute illness (24/08/23).

4. Patient complained of loss of appetite (24/08/23).
5. Patient complained of body weakness (25/08/23)
6. Patient had little knowledge about her condition (25/08/23).

2.4 Nursing Diagnosis

According to Hinkle, Cheever and Overbaugh (2022), nursing diagnosis is the organization, analysis, synthesis and summarization of data collected and determines the patient's need for care.

1. Acute pain (epigastrium) related to the effect of gastric acid secretion on damaged tissue (24/08/23).
2. Risk for deficient fluid volume as evidenced by vomiting (24/08/23).
3. Anxiety related to unknown outcome of acute illness (24/08/23).
4. Imbalanced nutrition (less than body requirement) related to loss of appetite (25/08/23).
5. Partial self-care deficit related to body weakness (25/08/23).
6. Deficient knowledge related to unfamiliarity with condition, drug therapy and dietary precautions (25/08/23).

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 Introduction

Planning is the third stage of nursing process in which the nurse and the patient together consider the goals to achieve in meeting the patient's identified or potential problems in meeting the daily life and produce an individual care plan (Weller, 2019). Planning for the care of patient and family is a process that involves formulation of nursing strategies that are required in reducing the actual and potential health problems of the patient and family, be it physical, social, emotional or even spiritual that were identified during the analysis phase. When the problems were identified, nursing diagnoses are formulated, priorities are set and expected outcomes designed. It also involves setting goals and objectives which are evaluated continuously until the patient is discharged.

3.1 Objective/Outcome Criteria for Patient and Family

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

1. Patient will be relieved of epigastric pain within 48 hours as evidenced by;
    i. Patient verbalizing that she does not feel pain anymore.
    ii. Nurse observing Patient to have a relaxed facial expression.
2. Patient will maintain her normal fluid volume level within 3 days of hospitalization as evidenced by;
    i. Patient verbalizing, she is able to take in adequate fluid such as Malt without vomiting.

ii. Nurse observing an improvement in skin turgor and good hydration upon assessment.

3. Patient will be relieved of anxiety within 24 hours as evidenced by;
    i. Patient and her family verbalizing that they are no longer anxious
    ii. Nurse observing Patient feeling calm and relaxed at the ward.
4. Patient will be able to attain and maintain adequate nutrition within 48 hours as evidenced by;
    i. Patient verbalizing that she has gained appetite for food.
    ii. Nurse observing that patient takes in at least two thirds of food served.
5. Patient will be able to perform self-care activities without assistance within 48 hours as evidenced by;
    i. Patient verbalizing that she can perform self – care activities such as bathing, grooming and toileting without assistance.
    ii. Nurse observing patient performing activities of daily living without assistance.
6. Patient and relatives will gain adequate knowledge on the drug therapy and diet within 24 hours as evidenced by;
    i. Patient and relatives verbalizing that they have a better understanding of the diet and drug for managing the condition
    ii. Nurse observing that Patient and relatives are able to answer some questions correctly on what diet and drugs to take to manage PUD

Table 3. 1: Nursing Care Plan for Patient

Date/ Time	Nursing Diagnosis	Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
24/08/23 9:00am	Acute pain (epigastrium) related to the effect of gastric acid secretion on damaged tissue	Patient will be relieved of epigastric pain within 4 hours as evidenced by; 1. Patient verbalizing that she does not feel pain anymore. 2. Nurse observing Patient to have a relaxed facial expression.	1. Assess pain level using the pain rating scale (0-10). 2. Monitor vital signs 4 hourly 3. Encourage frequent fluid intake. 4. Reduce noise and improve adequate ventilation at the ward. 5. Encourage frequent but small intake of food in between meals. 6. Teach relaxation techniques to help alleviate pain. 7. Serve prescribed pain relievers.	1. Patients pain was assessed to be within 7 per the numerical pain rating scale 2. Patients vital signs were monitored 4 hourly and were within normal range 3. Sips of water was served at frequent intervals. 4. All forms of noise were reduced by restricting visitors, reducing volumes of radio and television set. Windows and nearby fans were opened to allow in fresh air to promote patient's comfort 5. Frequent but small intake of food was encouraged 6. patient was encouraged on relaxation technique like meditation. 7. Intravenous Paracetamol 1g tds was served to relieve her of epigastric pains.	24/08/23 1:00am	Goals fully met as patient had a relaxed facial expression and patient verbalized that she does not feel pain anymore.	T.M

Table 3.1: Nursing Care Plan for Patient Continued

Date/ Time	Nursing Diagnosis	Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
24/08/23 9:10am	Risk for deficient fluid volume as evidenced by vomiting	Patient will maintain her normal fluid volume level within 3 days of hospitalization as evidenced by; 1. Patient verbalizing she is able to take in adequate fluid such as Malt without vomiting. 2. Nurse observing an improvement in skin turgor and good hydration upon assessment.	1. Reassure Patient of competent healthcare delivery. 2. Assess the nature of vomiting 3. Remove all nauseating items from the patient sight 4. Maintain Patient's oral hygiene 5. Encourage intake of fruits to alleviate nausea and vomiting. 6. Encourage oral fluid intake. 7. Serve prescribed intravenous fluid. 8. Serve prescribed medication	1. Patient was reassured that she is in the care of competent health team and that everything possible will be done to relieve her of vomiting 2. Patient's vomitus contained no bile or blood. 3. Nauseating items such as bedpan were emptied immediately after use. 4. She was encouraged to do oral hygiene twice daily 5. Fruits like mango and watermelon were given to patient. 6. Oral fluid intake of water and drinks were encouraged. 7. Prescribed IV N/S and IV R.L were served 8. Prescribed IV Metoclopramide was served.	27/08/23 9:10am	Goal fully met as patient verbalized she no longer vomits and nurse observing an increase in skin turgor upon assessment.	T.M

Table 3.1: Nursing Care Plan for Patient Continued

Date/ Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
24/08/23 9:15am	Anxiety related to unknown outcome of acute illness	Patient will be relieved of anxiety within 24 hours as evidenced by; 1. Patient and her family verbalizing that they are no longer anxious. 2. Nurse observing Patient feeling calm and relaxed at the ward.	1. Reassure patient of competent health care 2. Orientate Patient to the ward and it routines 3. Explain every procedure to patient. 4. Employ diversional activities such as TV, Radio, etc. 5. Allow Patient to ask questions and explain in simple terms. 6. Make available patients who have successfully recovered from the same condition to patient. 7. Teach Patient relaxation techniques. 8. Provide patient with simple pamphlet or handout	1. Patient was reassured of safe care by competent healthcare team to allay her fears. 2. Patient was orientated to the ward by introducing other patients to her. 3. All procedures performed on patient were explained to gain her co-operation and also allay her fears. 4. Television was switched on for patient to watch. This was to help patient relax and to give diversional therapy. 5. All questions patient asked were answered well 6. Patients who have recovered from the same condition were introduced to the patient 7. Deep breathing exercises were taught. 8. Patient was provided with a simple handout	25/08/23 9:15am	Goal fully met as Patient expressed a relaxed facial expression and verbalizing that she and her family are no more anxious.	T.M

Table 3.1: Nursing Care Plan for Patient Continued

Date/ Time	Nursing Diagnosis	Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
25/08/23 8:05am	Imbalanced nutrition (less than body requirement) related to loss of appetite	Patient will be able to attain and maintain adequate nutrition within 48 hours as evidenced by: 1. Nurse observing that patient complains of hunger 2. Patient verbalizing that she can now eat of more than 2/3 of 500ml of porridge served	1. Reassure patient of competent nursing care 2. Assess the nutritional status of patient to serve as a baseline data. 3. Check weight of patient 4. Maintain patient's oral hygiene twice a day (morning and evening). 5. Plan diet with patient 6. Remove nauseating items 7. Serve food in bit and attractively 8. Serve nourishing food and encourage patient to eat 9. Serve patient with prescribed medication.	1. Patient was reassured measures will be taken to restore adequate essential nutrients to balance her nutritional needs. 2. The nutritional status of patient was assessed and this helped to form a baseline data hence aiding in the kind of food to include in her diet for example protein and vitamins 3. Patient's weight was checked 4. Patient's oral hygiene was observed by assisting patient to brush her teeth with the use of tooth brush twice daily (morning and evening). 5. Diet was planned with patient 6. Nauseating items were removed 8.patient was served with fufu and groundnut soup with fish. 7. Food was served in bit and attractively 9. Patient was served with prescribed medication	25/08/23 8:05am	Goal fully met as 1. Patient verbalized that she has gained appetite for food 2.Nurse observed that patient was able to eat at least two thirds of food served	T.M

Table 3.1: Nursing Care Plan for Patient Continued

Date/ Time	Nursing Diagnosis	Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
25/08/23 11:40am	Partial self-care deficit related to body weakness	Patient will be able to perform self – care activities without assistance within 48 hours as evidenced by; 1. Patient verbalizing that she can perform self – care activities such as bathing, grooming and toileting without assistance. 2. Nurse observing Patient performing activities of daily living such as bathing, grooming and toileting without assistance.	1. Reassure patient of competent nursing care 2. Assess patient strength for self-care activities 3. Perform assisted bathroom bath and groom Patient. 4. Maintain patient's oral hygiene 5. Ensure patients items for self-care are put within reach of patient 6. Care for patient's hands and feet. 7. Care for patient's hair. 8. Assist and encourage patient to perform self-care activities 9. Educate on the need to perform self-care activities	1. Patient was reassured that measures will be put in place to assist her to bath, care for her mouth and care for her hands and feet. 2. Patient strength for self-care activities was assessed 3. Patient was assisted to bath. Patient was groomed and made comfortable in bed. 4.patient twice daily (morning and evening) 5. Patient items for self-care were put within her reach oral hygiene was observed by assisting patient to brush her teeth with tooth brush 6. Patient's hands and feet were cared for using warm water into which she soaked her feet and hands. 7. Patient's hair was washed and groomed with shampoo and other hair products. 8. Patient was assisted and encouraged to perform self-care activities 9. Patient was educated on the need to perform self-care activities	26/08/23 11:40am	Goal fully met as Patient was able to perform activities of daily living without assistance and by Patient verbalizing that she can now bath, brush her teeth and keep her nail.	T.M

Table 3.1: Nursing Care Plan for Patient continued

Date/ Time	Nursing Diagnosis	Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
25/08/23 4:00pm	Deficient knowledge related to unfamiliarity with drug therapy and dietary precautions	Patient and relatives will gain adequate knowledge on the drug therapy and diet within 24 hours as evidenced by; 1. Patient and relatives verbalizing that they have a better understanding of the diet and drug for managing the condition 2. Nurse observing that Patient and relatives are able to answer some questions correctly on what diet and drugs to take to PUD.	1. Establish an environment of trust and respect. 2. Assess the knowledge level of patient on diet and drugs 3. Educate Patient and relatives on the drugs and diet to overcome the disease condition 4. Draw a dietary and dug menu for patient 5. Allow Patient and relatives to ask questions and provide answers in simple terms that they can understand. 6. Adjust teaching on diet and drug therapy to the level of understanding and educational background of patient 7. Give patient leaflets concerning the diet and drugs for managing peptic ulcer.	1. Procedure was explained to patient 2. Patient's knowledge on diet and drugs were assessed. 3. Patient and relatives were educated on the drugs side effects, therapeutic effects, dosage and timing of drugs and diet to overcome the disease condition. 4. A dietary menu was drawn for patient. 5. Tactful answers were provided to questions asked by patient and relatives. 6. Education on drug and diet were explained in simple words. 7. Patient was given leaflets about diet and drugs for managing peptic ulcer.	26/08/23 4:00 pm	Goal fully met as patient and relatives verbalized they have a better understanding of the diet and drug for managing the condition and nurse observed the Patient and relatives were able to answer some questions correctly on what diet and drugs to take.	T.M

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

The implementation phase of the nursing process involves carrying out the proposed plan of nursing care. 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 (Hinkle, Cheever, & Overbaugh, 2022). This chapter gives a vivid account of the nursing care that was rendered to the patient/family from the day of admission until discharge based on the health problems identified. It also deals with follow up visits/home visits to ensure continuity of care.

4.1 Summary of Actual Nursing Care Rendered to Patient/ Family

The actual nursing care rendered to patient and her family started on the day of admission, 24th August, 2023 to the time care was terminated on 21st November, 2020. The management of patient and her 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 Day of Admission (24th August, 2023)

Mrs. Y.A.J. arrived on the Female Medical Ward on 24th August, 2023 at 9:00am in a wheel chair accompanied by a staff nurse and her husband. On arrival patient was fairly ill, weak and with an unsatisfactory level of hydration. Patient was fully conscious and alert. Patient had been on detention at the Accident and Emergency Centre of Presbyterian Hospital-

Dormaa for one day with the diagnosis of Acute Exacerbation of Peptic Ulcer Disease with history of vomiting, epigastric pain and weakness. It was a planned admission.

Patient particulars were collected from the accompanying staff nurse. Her particulars such as name, sex, age, and residential address were entered into the admission and discharge book and the daily ward state. Patient and relative were welcomed and offered seats. Self-introduction was done, staffs present were also introduced to the patient. Patient was made comfortable in an already prepared admission bed.

Vital signs were checked and recorded accurately as follows:

1. Temperature 36.5^{o}C
2. Pulse 98bpm
3. Respiration 25cpm
4. Blood Pressure 100/80mm/Hg

Patients weight 64kg

Patient was introduced to her roommates and was assured of the competency of the healthcare team. They were also oriented to the ward and its annexes. She was asked to get her own bowl, spoon, drinking cup, bathing sponge, bucket, towel, pyjamas and other toiletries.

On admission, patient looked unwell with an unsatisfactory level of hydration. She complained of epigastric pain, weakness and have had three episodes of non-projectile vomiting which expelled food previously eaten but was non-bloody and contained no bile. A head to toe physical examination was conducted on patient and no abnormalities were seen. Patent was oriented to time, place and person.

Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained to her. Patient was properly orientated to the ward and its annexes. She was reassured to allay fears.

The following treatment plan were ordered:

1. Intravenous Omeprazole 40mg bid x 24 hours
2. Intravenous Ciprofloxacin 400mg bd x 24 hours
3. Intravenous Paracetamol 1g tds for x hours
4. Intravenous Metoclopramide 10mg tds x 24hours
5. Intravenous DNS 1litre x 24 hours
6. Intravenous Normal saline 1litre x 24 hours
7. Intravenous Ringers' lactate 1litre x24 hours
8. Intravenous Metronidazole 500mg tds x 24 hours
9. Sucrafil O Gel Suspension 15mls tds x 7 days

Patient was to undertake series of investigations including:

1. Full Blood Count
2. Helicobacter pylori test
3. Upper GI Endoscopy

Patient had lost lots of fluids through vomiting hence IV Normal saline 500ml was set up. Patient looked anxious. She was reassured to allay all fears and anxiety. I reintroduced myself to patient as a student nurse of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take her and her family for a patient/family care study. Mrs. Y.A.J. and her family were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of license in

Diploma in Registered General Nursing. I explained to the patient and her family about 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. Mrs. Y.A.J. and her relative agreed to my request and assured me of providing the necessary information and assistance. I congratulated them on such a decision. Discharge planning was initiated with the relatives; thus, they were told that the hospital will be a temporal place for their care and would have to continue the care at home once there is an improvement in her condition. I informed the ward in-charge about my interest in using this patient for my care study and a permission was granted for me to move on with the study. I decided to choose this patient for the study because I wanted to know more about Peptic Ulcer Disease and to be able to differentiate it from other similar abdominal conditions.

At 9:00am, patient complained of pain for this reason a nursing diagnosis of Acute pain (epigastrium) related to the effect of gastric acid secretion on damaged tissue was formulated. An objective was set to help relieve of epigastric pain within 4 hours of hospitalization. The following interventions were carried out; Patients pain was assessed using the numerical pain rating scale (0-10), Sips of water was served at frequent intervals, all forms of noise were reduced by restricting visitors, reducing volumes of radio and television set, and windows and nearby fans were opened to allow in fresh air to promote patient's comfort, frequent but small intake of food was encouraged, relaxation techniques were taught to patient like the knee-chest position and Intravenous Omeprazole 40mg daily was served to relieve her of epigastric pains.

At 9:10am, patient was vomiting hence a nursing diagnosis of Risk for deficient fluid volume as evidenced by vomiting was formulated. An objective was set to restore patient's fluid volume within 3 days of hospitalization. The following interventions were carried out; patient

was reassured that she is in the care of competent health team and that everything possible will be done to relieve her of vomiting, nature of patients vomitus was assessed, nauseating items such as bedpan were emptied immediately after use, patient's oral hygiene was done twice daily, fruits like mango and watermelon were given to patient, oral fluid intake of water and drinks were encouraged, prescribed IV N/S and IV R.L were served, prescribed IV Metoclopramide was served.

At 9:15am, patient manifested a feeling of apprehension as she was not cooperating with care hence a nursing diagnosis of Anxiety related to an acute illness was made. An objective was set to relieve patient from anxiety within a period of 24 hours. The following interventions were carried out; patient was reassured of safe care by competent health team to allay her fears, patient was orientated to the ward by introducing other patients to her. all these were done to allay her fears and to win her co-operation, all procedures performed on patient were explained to gain her co-operation and also allay her fears, television was switched on for patient to watch. this was to relax patient, patient was educated on disease condition, patient asked questions on her condition, purpose of treatment and possible duration of her hospitalization of which answers were given in simple terms to understanding, patients who have recovered from the same condition were introduced to the patient, deep breathing exercises were taught, patient was provided with a simple handout.

Later in the evening patient was assisted to take her bath. She took her supper around 5:30pm which was ampesi and kontomire stew. At 6:00pm, vital signs were checked and recorded as indicated in the appendix. As part of the nursing actions to relieve anxiety patient watched television whiles lying on her bed. At 10pm, vital signs were checked and recorded as indicated in the appendix and due medications were served. Patient was made comfortable in bed and she sept around 10:30pm.

4.1.2 Second Day of Admission (25th August, 2023)

On the second day of admission as I went to the ward to continue with my nursing care to my patient, her due medications had been served and her vital signs had already been checked and recorded at 6am as indicated in the appendix. Patient was assisted to perform her personal hygiene and her bed was straightened to make it free from creases and crumps. At 7:30am, patient took porridge with bread as breakfast.

At 8:05am, Patient verbalized that she had lost appetite hence the nursing diagnosis of Imbalanced nutrition (less than body requirements) related to loss of appetite was formulated. An objective was set so that patient's nutritional status will be restored and maintained within 48 hours of hospitalization. The following interventions were carried out; patient was reassured measures will be taken to restore adequate essential nutrients to balance her nutritional needs, the nutritional status of patient was assessed and this helped to form a baseline data hence aiding in the kind of food to include in her diet for example protein and vitamins, patient's weight was checked, patient's oral hygiene was observed by assisting patient to brush her teeth with the use of tooth brush twice daily (morning and evening), diet was planned with patient, nauseating items were removed, food was served in bit, attractively and at regular interval, patient was served with nourishing food and encouraged to eat, patient was served with prescribed medication.

At 9am, patient was reviewed by the medical team and the plan was to continue treatment and also to see the nutritionist for nutritional counseling.

I gave my patient and her relatives a prior notice that I would want to go and see their house and a permission was granted after they gave me the direction to their house. I embarked on my first home visit this day and that was to know patient's residence and the environment in

which she lives, verify the information given to me as well as to identify the risk factors such as familial tendency.

At 11:40am, several assessments revealed that patient was weak hence the nursing diagnosis of Partial self-care deficit related to body weakness was made. An objective was set so that patient will be able to perform self-care activities without assistance within 48 hours of hospitalization. The following interventions were carried out; patient was reassured that measures will be put in place to bath her, care for her mouth and care for her hands and feet, patient strength for self-care activities was assessed, patient was assisted bathroom bath with soap, sponge, towel, and water, patient was groomed and made comfortable in bed, patient's mouth was cared for using tooth brush and paste and rinsed with water, patient items for self-care were put within her reach, patient's hands and feet were cared for using warm water into which she soaked her feet and hands, patient's hair was washed and groomed with shampoo and other hair products, patient as assisted and encouraged to perform self-care activities, patient was educated on the need to perform self-care activities.

Her 2pm vital signs were checked and recorded in the afternoon as indicated in the appendix. She ate water melon in the afternoon after which she slept for a while.

At 4:00pm patient was engaged in an interaction and it was realized that patient had less knowledge on her condition. The nursing diagnosis formulated was Deficient knowledge related to unfamiliarity with drug therapy and dietary precautions. An objective was set to enable patient gain adequate knowledge on peptic ulcer disease within 24 hours of hospitalization. The following interventions were carried out; patient was told that everything discussed was between the two of us and that nobody will ever hear of it, patient's knowledge on diet and drugs were assessed, patient and relatives were educated on the drugs and diet to overcome the disease condition, a dietary and drug menu were drawn for patient, tactful

answers were provided to questions asked, teaching on diet and drug therapy was adjusted to the level of understanding and educational background of patient, patient was given leaflets about diet and drugs for managing the condition.

At 5pm, she was served with her evening meal. Patient took her bath afterwards. Her 6pm vital signs were checked and recorded as shown in the appendix. Patient was then engaged in an interaction geared towards deepening her understanding about her disease condition.

At 9:15am, an evaluation of the set objective on 24th August, 2023 to help relieve patient from anxiety within 24 hours was done. Goals were fully met as patient expressed a relaxed facial expression and verbalizing that she and her family are no more anxious.

At 10pm, her due medications were served, her vital signs were checked and recorded as shown in the appendix. Patient went to bed around 10:20pm.

4.1.3 Third Day of Admission (26th August, 2023)

On the third day of admission patient was assisted in maintaining her oral hygiene, she had her bath and emptied her bowel. Report from the night nurses read that she was able to sleep well upon the measures put in place. Her due medications were served and her vital signs had already been checked and recorded at 6am as indicated in the appendix. At 7:50am, she was assisted and encouraged to take about 500mls of brown porridge with bread.

During the ward rounds at 9:30am, patient made no new complains so the medical team ordered for treatment to continue.

At 4:00pm, evaluation of the set objective on 25th August, 2023 to help patient and relatives gain adequate knowledge on diet and drug therapy within 24 hours of hospitalization was done. Goals were fully met as patient and relatives verbalized they have a better

understanding of the diet and drug for managing the condition and nurse observed the patient and relatives were able to answer some questions correctly when asked on diet and drug for managing the condition.

In the evening, she took rice and stew around 5:30pm for supper. She stayed glued to the ward Television afterwards watching the news and other programs as well.

At 9:00am, evaluation of the set objective on 24th August, 2023 to relieve patient of epigastric pain within 4 hours of hospitalization was done. Goals were fully met as patient had a relaxed facial expression and patient verbalized that she does not feel the pain anymore.

At 10pm, her due medications were served, her vital signs were checked and recorded as shown in the appendix. Patient went to bed around 10:30pm.

4.1.4 Fourth Day of Admission (27th August, 2023)

Mrs Y.A.J. was seen in bed in good health and was responding to treatment given. The usual routine nursing care was provided and documented in the nurses' notes. At 7:45am, Patient took brown porridge with koose for breakfast. Patient gave no new complains per my conversation with her, likewise during ward rounds. Current treatment being given was to be continued.

At 8:05am, evaluation of the set objective on 25th August, 2023 to restore and maintain patient's nutritional status within 48 hours of hospitalization was done. Goals were fully met as patient verbalized that she has gained appetite for food and nurse observed that patient was able to eat at least two thirds of food served.

At 11:40am, evaluation of the set objective on 25th August, 2023 to enable patient perform self-care activities without assistance within 48 of hospitalization was done. Goals were fully

met as patient was able to perform activities of daily living without assistance and patient verbalized that she was able to perform self-care activities.

At 2pm, vital signs were checked and recorded as indicated in the appendix. Patient ate ampesi with garden eggs stew. Afterwards, patient slept for a while and woke up around 5:00pm. At 6:00pm vital signs were checked and recorded as indicated in the appendix.

At 9:10am, evaluation of the set objective on 24th August, 2023 to help maintain her normal fluid volume was done. Goals were fully met as patient verbalized, she no longer vomits and nurse observing an increase in skin turgor upon assessment.

At 10pm, her due medications were served, her vital signs were checked and recorded as shown in the appendix. Patient went to bed around 10:30pm.

4.1.5 Fifth Day of Admission (28th August, 2023)

I went to continue the nursing care rendered to my 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 her, she responded with a cheerful facial expression. I was inquisitive enough to ask why she had put up a smiley face. Upon asking, patient said that she feels grateful to have special nursing care rendered to her over the past few days since she was admitted.

Her due medications had been served and her vital signs had already been checked and recorded at 6am as indicated in the appendix. Patient performed her personal hygiene and her bed was straightened to make it free from creases and crumps.

At 7:50am, patient had brown porridge with koose for breakfast. During the ward routine rounds, treatment was to be continued and discharge to be considered the following day.

At 10pm, her due medications were served, her vital signs were checked and recorded as shown in the appendix. Patient went to bed around 10:30pm.

4.1.6 Day of Discharge/Sixth Day of Admission (29th August, 2023)

I went to continue the nursing care rendered to my patient at 7:00am. Patient woke up feeling strong and better. Her due medications had been served and her vital signs had already been checked and recorded at 6am as indicated in the appendix. The report from the night nurse read that patient had a sound sleep at night. Patient maintained her personal hygiene; her bed linens were changed and replaced. The bed was laid nicely making sure it was free from creases and cramps.

At 9:00am, during ward rounds, patient did not make any complains, hence was discharged by the doctor as planned the previous day. After the ward rounds patient was informed about her discharge from the ward and she responded with a smile and high sense of relief. She was told to visit the nutritionist for counseling before leaving the ward.

Her daughter was informed and the bills were assessed to be paid. Few amount which was not covered by National Health Insurance Scheme was paid. I called the nutritionist through the ward phone to come and see my patient before she leaves for home. I together with the nutritionist provided Mrs Y.A.J. and her daughter with a clear and understandable education on how she should live her life, creating an awareness on her diets and how important it is in the management of peptic ulcer disease. Patient was informed to come for review on 4th September, 2023 at the main OPD. The need to continue with medications were emphasized and review date was stretched on. I assisted in packing patient's belongings, did disinfection of patient bed and locker to enhance infection prevention. At exactly 12:00pm, patient and relative left the ward. Patient and the family bid the patients at the ward and staff goodbye. I

accompanied them to the hospital entrance; said goodbye and also informed them that I will be coming to their house to check on her.

4.2. Preparation of Patient/Family for Discharge and Rehabilitation

Preparation for discharge commenced from the time of admission at the hospital, at 9:00am on 24th August, 2023 till the last day of visit, 12th September, 2023. 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 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 relatives on the importance of diet and avoiding over the counter medication, should neither smoke nor drink alcohol. Patient was encouraged to take in food rich in the essential food nutrients. Patient was also told to exercise more often. Patient and her 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. Patient was informed to come for review on Monday 4th September, 2023. Necessary information was recorded into the admission and discharge book as well as the ward state.

4.3 Follow Up / Home Visit / Continuity of Care

Home visit is a visit made by a health professional to a patient's home, usually with face-to-face contact between the health professional and the patient, less commonly between health professional and the patient's family.

Home visits were done before and after patient's discharge. It is friendly but a purposeful visit to patient home. Health educations were given and the need for the prevention of

complication was reemphasized. It provided a good account on the causes and predisposing factors of patient's illness.

4.3.1 First Home Visit (25th August, 2023)

First home visit was made on 25th August, 2023 while patient was still on admission. A planned visit was made to Awoase a suburb of Dormaa Ahenkro where patient resides. The purpose of this visit was to know patient's residence and the environment in which she 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 her condition and also to identify any nearest health facility at the area for possible referral. Patient and relatives were informed about my intention to visit their home whiles she was still on admission. I left the hospital premises around 2:10pm, boarded a vehicle at the hospital gate and alighted at Awoase around 2:40pm. There was no difficulty in locating where patient lives because I am familiar with the area and also patients house is just about 5 minutes, walk away from the roadside where I alighted. The house consists of five different apartments. They were many people in the house including the landlord and tenants. The house is built with blocks, painted blue and there is electricity in the house, had windows. I met patient's husband in the house. He offered me a seat in their hall and a glass of water.

The room was very clean but most of the windows were closed so I educated his husband on the need to open the windows to promote proper ventilation. 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 was in a good state. The entire household have a dustbin with a well-fitting lid in which they dump their waste materials and it is emptied every morning into Zoomlion waste-truck. They have a pipe, which serves as the source of

water in the house. They also have a toilet facility in each of the apartment. The environment was a little bit untidy. The husband and the rest of the household were educated on the need to practice good environmental and personal health and also encouraged them to continue to keep their home and surroundings clean. Emphasis was also placed on ensuring that they sleep under insecticide treated mosquito nets to prevent malaria. I reassured the relatives of competent nursing care and that she will be well very soon. No identifiable factor to patient's condition was made during the visit. He 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 Awoase at 3:30pm and got to the hospital at 4:20pm. Comments made on the condition of the house, education and recommendations were repeated to Mrs Y.A.J. and she also promised to do everything in her power to ensure that all the recommendations are done. I identified on the first home visit that patient's house was not very far from Presbyterian Hospital Dormaa and for that reason on my return I informed one community health nurse about handing over the patient to her.

4.3.2 Second Home Visit (2nd September, 2023)

This visit was made on 2nd September, 2023. I made this visit to find out how patient was doing and to see if she was following her treatment regimen and also to remind the patient of the review date which was on Monday 4th September, 2023.

On assessment patient windows were opened as they were educated to do. The environment was neat and they were recommended for that. The importance of taking drugs as ordered was reinformed 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. Patient's daughter escorted me to the road side where I bordered a vehicle to my house.

4.3.3 Review (4th September, 2023)

On 4th September, 2023 patient and her daughter were met at the Out-Patient Department of Presbyterian Hospital Dormaa at 10:00am looking cheerful and lovely as noted from facial expression. I accompanied them to register at the O.P.D. The vital signs were checked and recorded as follows;

1. Temperature 36.0°C
2. Pulse 66bpm
3. Respiration 18cpm
4. Blood pressure 120/70mmHg

At the Out-Patient Department, patient was seen by the medical officer at consulting room 3. Upon assessment by the doctor, Mrs Y.A.J. was healthy. Patient did not have complains. She was told not to hesitate to report to the hospital if she should encounter any health problem. She was encouraged to adhere to the diet and medication therapy. She was also encouraged to practice personal and environmental hygiene to protect herself from getting diseases. Patient was assured of a third home visit. I then accompanied them to the hospital entrance where they left to their home.

4.3.4 Third Home Visit (12th September, 2023)

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 Monday afternoon around 12:00pm with a tricycle. I passed by Presbyterian Hospital Dormaa 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 her 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. Her husband (next of kin) recommended me for good work done and accepted to continue the care of Mrs Y.A.J. at home. The environment was tidy as there was neither 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 she had been taking her medications and the recommended diet 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 success. Again, patient and her 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.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process (Hinkle, Cheever, & Overbaugh, 2022). The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to my patient and family.

5.1 Statement of Evaluation

Throughout the period 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.

a. Patient was relieved of epigastric pian (26th August, 2023)

On 24th August, 2023 at 9:00am, patient complained of pain for this reason a nursing diagnosis of Acute pain (epigastrium) related to the effect of gastric acid secretion on damaged tissue was formulated. An objective was set to help relieve of epigastric pain within 4 hours of hospitalization. The following interventions were carried out; Patients pain was assessed using the numerical pain rating scale (0-10), Sips of water was served at frequent intervals, all forms of noise were reduced by restricting visitors, reducing volumes of radio and television set, and windows and nearby fans were opened to allow in fresh air to promote patient's comfort, frequent but small intake of food was encouraged, relaxation techniques were taught to patient like the knee-chest position and Intravenous Omeprazole 40mg daily was served to relieve her of epigastric pains.

On 26th August, 2023 at 9:00am, evaluation of the set objective on 24th August, 2023 to relieve patient of epigastric pain within 48 hours of hospitalization was done. Goals were fully met as patient had a relaxed facial expression and patient verbalized that she does not feel the pain anymore.

b. Patient fluid volume was restored and maintained (27th August, 2023)

On 24th August, 2023 at 9:10am, patient was vomiting hence a nursing diagnosis of risk for deficient fluid volume as evidenced by vomiting was formulated. An objective was set to restore patient's fluid volume within 3 days of hospitalization. The following interventions were carried out; patient was reassured that she is in the care of competent health team and that everything possible will be done to relieve her of vomiting, nature of patients vomitus was assessed, nauseating items such as bedpan were emptied immediately after use, patient's oral hygiene was done twice daily, fruits like mango and watermelon were given to patient, oral fluid intake of water and drinks were encouraged, prescribed IV N/S and IV R.L were served, prescribed IV Metoclopramide was served.

On 27th August, 2023 at 9:10am, evaluation of the set objective on 24th August, 2023 to help maintain her normal fluid volume was done. Goals were fully met as patient verbalized, she no longer vomits and nurse observing an increase in skin turgor upon assessment.

c. Patient was relieved from anxiety (25th August, 2023)

On 24th August, 2023 at 9:15am, patient manifested a feeling of apprehension as she was not cooperating with care hence a nursing diagnosis of Anxiety related to an acute illness was made. An objective was set to relieve patient from anxiety within a period of 24 hours. The following interventions were carried out; patient was reassured of safe care by competent health team to allay her fears, patient was orientated to the ward by introducing other patients

to her. all these were done to allay her fears and to win her co-operation, all procedures performed on patient were explained to gain her co-operation and also allay her fears, television was switched on for patient to watch. this was to relax patient, patient was educated on disease condition, patient asked questions on her condition, purpose of treatment and possible duration of her hospitalization of which answers were given in simple terms to understanding, patients who have recovered from the same condition were introduced to the patient, deep breathing exercises were taught, patient was provided with a simple handout.

On 25th August, 2023 at 9:15am, an evaluation of the set objective on 24th August, 2023 to help relieve patient from anxiety within 24 hours was done. Goals were fully met as patient expressed a relaxed facial expression and verbalizing that she and her family are no more anxious.

d. Patient nutritional status was restored and maintained (27th August, 2023)

On 25th August, 2023 at 8:05am, Patient verbalized that she had lost appetite hence the nursing diagnosis of Imbalanced nutrition (less than body requirements) related to loss of appetite was formulated. An objective was set so that patient's nutritional status will be restored and maintained within 48 hours of hospitalization. The following interventions were carried out; patient was reassured measures will be taken to restore adequate essential nutrients to balance her nutritional needs, the nutritional status of patient was assessed and this helped to form a baseline data hence aiding in the kind of food to include in her diet for example protein and vitamins, patient's weight was checked, patient's oral hygiene was observed by assisting patient to brush her teeth with the use of tooth brush twice daily (morning and evening), diet was planned with patient, nauseating items were removed, food was served in bit, attractively and at regular interval, patient was served with nourishing food and encouraged to eat, patient was served with prescribed medication.

On 27th August, 2023 at 8:05am, evaluation of the set objective on 25th August, 2023 to restore and maintain patient's nutritional status within 48 hours of hospitalization was done. Goals were fully met as patient verbalized that she has gained appetite for food and nurse observed that patient was able to eat at least two thirds of food served.

e. Patient energy for daily activities was restored (27th August, 2023)

On 25th August, 2023 at 11:40am, several assessments revealed that patient was weak hence the nursing diagnosis of Partial self-care deficit related to body weakness was made. An objective was set so that patient will be able to perform self-care activities without assistance within 48 hours of hospitalization. The following interventions were carried out; patient was reassured that measures will be put in place to bath her, care for her mouth and care for her hands and feet, patient strength for self-care activities was assessed, patient was assisted bathroom bath with soap, sponge, towel, and water, patient was groomed and made comfortable in bed, patient's mouth was cared for using tooth brush and paste and rinsed with water, patient items for self-care were put within her reach, patient's hands and feet were cared for using warm water into which she soaked her feet and hands, patient's hair was washed and groomed with shampoo and other hair products, patient as assisted and encouraged to perform self-care activities, patient was educated on the need to perform self-care activities.

On 27th August, 2023 at 11:40am, evaluation of the set objective on 25th August, 2023 to enable patient perform self-care activities without assistance within 48 of hospitalization was done. Goals were fully met as patient was able to perform activities of daily living without assistance and patient verbalized that she was able to perform self-care activities such as bathing.

f. Patient gained adequate knowledge on her drug therapy and diet (26th August, 2023)

On 25th August, 2023 at 4:00pm, patient was engaged in an interaction and it was realized that patient had less knowledge on her condition. The nursing diagnosis formulated was Deficient knowledge related to unfamiliarity with drug therapy and dietary precautions. An objective was set to enable patient gain adequate knowledge on peptic ulcer disease within 24 hours of hospitalization. The following interventions were carried out; patient was told that everything discussed was between the two of us and that nobody will ever hear of it, patient's knowledge on diet and drugs were assessed, patient and relatives were educated on the drugs and diet to overcome the disease condition, a dietary and drug menu were drawn for patient, tactful answers were provided to questions asked, teaching on diet and drug therapy was adjusted to the level of understanding and educational background of patient, patient was given leaflets about diet and drugs for managing the condition.

On 26th August, 2023 at 4:00pm, evaluation of the set objective on 25th August, 2023 to help patient and relatives gain adequate knowledge on diet and drug therapy within 24 hours of hospitalization was done. Goals were fully met as patient and relatives verbalized they have a better understanding of the diet and drug for managing the condition and nurse observed the patient and relatives were able to answer some questions correctly when asked on diet and drug for managing the condition.

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

5.3 Termination of Care

Care of patient and family ended on the 12th September, 2023 which was my last home visit. This ended the interaction between the health team and Mrs. Y.A.J. and her family. The preparation for termination started on day of admission through discharge, review to the third home visit. During these periods, patient and family were educated on various topics. I congratulated the family for the care they had rendered to Mrs. Y.A.J. They were thanked for their co-operation and patient was handed over to a community health nurse. They were told that now that Mrs. Y.A.J. health had been restored, the care for her has officially ended. I informed them of my desire to visit them unofficially whenever I had the opportunity. They were happy and noted that they would miss my care and would strictly adhere to all instructions given to them. It was a moment to remember when I told them of my intention to leave. There was no separation anxiety as patient and the relatives had enough psychological preparations from the day of admission till discharge but it was still difficulty bidding them farewell.

CHAPTER SIX

SUMMARY OF CARE RENDERED TO PATIENT AND FAMILY

6.0 Summary

On 24th August, 2023 at 9:00am, patient was received into the Females ward from the Accident and Emergency Unit of Presbyterian Hospital-Dormaa. Patient was diagnosed of Acute Exacerbation of Peptic Ulcer Disease. With the use of nursing process, the problems identified were developed into nursing diagnosis with nursing orders which were implemented to help solve these problems and promote recovery.

Using the nursing care plan, effective nursing care was carried out on the patient to ensure full recovery of Mrs. Y.A.J. Among the care provided to her were bed making, monitoring of vital signs (temperature, pulse, respiration, and blood pressure), proper positioning in bed, administration of medication, and patient / family education on personal hygiene. She was discharged on 29th August, 2023 when her condition had improved and was declared fit to go home with no complains.

Goals were fully met during evaluation of care. Three home visits were paid to her to assess progress of her condition at home. She reported to the hospital for review on the 4th September, 2023. The care was finally terminated on 12th September, 2023 after handing over her to the public health nurse.

6.1 Conclusion

The patient care study has helped me gain knowledge about nursing care rendered to clients, this study has also helped me to know how to collect relevant information from patients, identify health problems, analyze and formulate a nursing care plan using the nursing process

approach. Recommendations of patient /family, medical team, opinions and appraisal of their co-operation towards the achievement of goals which promoted the well-being of patient / family physically, psychosocially and spiritually.

This study has enabled me to put into practice the knowledge acquired during my three year training in the institution, it has helped me to be prepared to nurse clients effectively in the near future regardless of their condition with the help of nursing process adopted.

I therefore recommend that the patient/family case study should be maintained as a part of the nurse trainee and fully establish in the country health care delivery system to aid in the improvement of health for the country.

BIBLIOGRAPHY

American Psychological Association. (2020). Retrieved from https://dictionary.apa.org

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

Hinkle, J. L., Cheever, K. H., & Overbaugh, K. (2022). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th 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.

Kumar, P., & Clark, M. (2017). *Kumar & Clarks clinical medicine* (9th ed.). Philadelphia: Elsevier.

Merriam-Wester. (2020). doi:https://www.merriam-webster.com/dictionary/

Penman, I. D., Ralston, S. H., Strachan, M. W., & Hobson, R. P. (Eds.). (2023). *Davidson's principlses & practice of medicine* (24th ed.). Edinburgh: Churchill Livingstone Elsevier.

Potter, L. (2020, October 28). *Geekymedics*. Retrieved from Obstetric history taking: https://geekymedics.com/obstetric-history-taking/#:~:text=An%20obstetric%20history%20involves%20asking,respectful%20manner%20are%20absolutely%20essential.

Tortora, G. J., & Derrickson, B. (2023). *Principles of anatomy and physiology* (16th ed.). Hoboken, N.J: John Wiley & Sons, Inc.

Wagh, A., & Grant, A. (2018). *Ross and Wilson anatomy and physiology in health and illness* (13th ed.). Edinburgh: Churchill Livingstone Elsevier.

Walker, R., & Whittlesea, C. (Eds.). (2021). *Clincal pharmacy and therapeutics* (5th ed.). Edinburgh, United Kingdom: Churchill Livingstone Elsevier.

Weller, B. F. (2019). *Bailliere's nurses' dictionary: for nurses and healthcare workers* (27th ed.). London: Elsevier Health Sciences.

APPENDIX

Table 6. 1: Vital Signs of Mrs. Y.A.J. throughout the period of hospitalization

Date	Time	Temperature (^{o}C)	Pulse (bpm)	Respiration (cpm)	Blood Pressure (mmHg)
24/08/23	9:00am	37.0	100	25	100/80
	2:00pm	35.9	80	27	120/70
	6:00pm	36.1	78	25	130/80
	10:00pm	35.7	70	18	110/70
25/08/23	6:00am	36.3	57	19	110/80
	10:00am	36.3	62	24	120/80
	2:00pm	36.4	65	18	110/70
	6:32pm	36.4	73	18	120/80
	10:38pm	36.0	80	20	120/60
26/08/23	6:00am	35.3	73	18	130/90
	10:00am	36.0	68	20	120/80
	2:00pm	35.9	84	27	120/70
	6:00pm	36.1	78	25	130/80
	10:00pm	36.5	81	20	120/70

Table 6.1: vital signs of Mrs. Y.A.J. throughout the period of hospitalization cont.…

Date	Time	Temperature (^{o}C)	Pulse (bpm)	Respiration (cpm)	Blood Pressure (mmHg)
27/08/23	6:00am	35.2	73	18	120/80
	10:00am	36.6	82	20	120/80
	2:00pm	36.5	92	22	120/80
	6:00pm	36.6	80	20	120/70
	10:00pm	35.7	84	21	100/60
28/08/23	6:10am	35.3	71	24	120/90
	10:00am	34.7	84	21	100/60
	2:00pm	35.9	74	27	120/70
	6:00pm	36.1	78	25	120/80
	9:55pm	36.5	81	20	120/70
29/08/23	6:00am	35.2	73	18	120/80
	10:00am	36.6	82	20	120/80

SIGNITORIES

1. THE STUDENT NURSE

NAME: TWUMASIWAA MERCY

SIGNATURE: .....

DATE: 7th June 2024

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

NAME: MISS REGINA HENEWAA

SIGNATURE.....

DATE.....11-06-2024.....

3. NURSE IN-CHARGE OF FEMALES WARD PRESBYTARIAN HOSPITAL DORMAA AHENKRO

NAME: AZIZ FATIMA

SIGNATURE.....

DATE.....11/06/2024.....

ACADEMIC CO-ORDINATOR NURSING
HOLY FAMILY NURSING AND MIDWIFERY
TRAINING COLLEGE
BEREKUM

4. THE PRINCIPAL, HOLY FMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

NAME: MONICA NKRUMAH

SIGNATURE.....

DATE.....11/06/2024.....

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM