HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT/FAMILY CARE STUDY ON ACUTE GASTRITIS

KONADU VINCENTIA ATAA

(4120190090)

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

AUGUST, 2023

HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT/FAMILY CARE STUDY ON ACUTE GASTRITIS

BY

KONADU VINCENTIA ATAA

(4120190090)

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

AUGUST, 2023

PREFACE

Nursing existed as far as the first human being lived on planet earth. It entails giving care to the needed beings. Parents give care to their young ones by nourishing them until they are able to provide their necessary day to day activities. Also the aged has to be supported in their daily doings to make life endurable for them. The modern-day nursing has gone through series of changes with the help of science, technologies and various researches. Nursing has been accepted as a profession and it entails comprehensive and individualized care of patients. New techniques are employed into the scope of patient's care making nursing as a fully accepted profession in this 21st century.

The patient care study forms part of the academic programme of all Diploma nursing students in Ghana which require the student to carry out total nursing care to patient and their family from time of admission to discharge. It is a partial requirement by Nursing and Midwifery Council of Ghana for the award of license to practice as a registered nurse.

The care study takes into account of the physical, psychological, social and spiritual welfare of the family which aid in the recovery of the patient. Patient's home is visited on a number of occasions to ensure patient adhere to treatment regimen and education. Also through the study, patient and family will have insight knowledge into the condition and improve upon their health status through the interaction and various educations they receive from the student nurse.

The study equips the student nurse with certain qualities such as practical skills on the condition, patient and family interactions, as well as therapeutically communicating to family when there is fear and anxiety. Also the student is able to practice a wide range of nursing activities acquired during the three years training as a nurse using specifically the nursing process.

The nursing and midwifery council uses the care study as evaluation tool in assessing and awarding the student a certificate and practice as a certified nurse. In the write up of the study, initials of patient were used instead of names in order to maintain confidentiality

ACKNOWLEDGMENT

My ultimate appreciation goes to the Almighty God for providing me with strength and knowledge for this project to materialize.

Special thanks go to Madam N.G., the subject of the study and his family for the smooth interactions and co-operation.

I am much grateful to my supervisor Mr. Eric Obeng for his tireless efforts, sleepless nights, guidance and corrections for this successful script.

I am also grateful to the medical doctors and nursing staff of St Mary`s Hospital, Drobo especially the ward in charge of the female`s ward for his immense contribution and good nursing care given to my patient during his admission till discharge.

Further, I would like to extend my appreciation to my wonderful parents, Mr. and Mrs.Ofori for their unending emotional, moral, spiritual, and financial support throughout the period of the study.

I am very grateful to all the publishers and authors whose books I used during the course of my Study.

Lastly but not the least, I remain thankful to my colleges of RGN 23 for their device support that has made this study a reality God bless you all.

INTRODUCTION

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

This patient/family care study was carried out on a fifty-one old woman who for the purpose of confidentiality will be referred to as N.G in this study. Madam N.G was admitted to the Females Ward of the St Mary's Hospital, Drobo on the 14th December, 2023 on account of acute gastritis and was discharged on the 18th December, 2023. Madam N.G. spent five days in the hospital.

Data was collected from the patient/family through observations, interviews and other diagnostic procedures. Health problems such as abdominal pain, hyperthermia, risk for fluid volume deficit and imbalanced nutrition were identified and interventions made with patient and family's co-operation to achieve the set goals. Due to the effective medical and nursing care given to her, she was discharged without any complications.

Three home visits were made during admission and after discharge to identify predisposing factors of patient's condition, to educate patient's family on the condition and to ensure continuity of care. Madam N.G and her family appreciated the care given to them by the health care team.

The following investigation were ordered and carried out.

- Blood for full blood count
- Blood specimen for malaria parasite
- Urine for routine examination

Medications ordered and served were;

1) IV Omeprazole 80mg stat then 40mg bd for 24 hours

2) Syrup Aluminum hydroxide 15mls tds for 5day
3) Tablet Paracetamol 1g tid for 3days
4) IV ciprofloxacin 400mg bd for 24hours
5) IV metoclopramide 10mg tds for 24hours
6) Inj Hyoscine Butylbromide 40mg stat
7) IVF Ringers Lactate 2L for 24hours
8) IVF Normal Saline 1Lfof 24hours
9) IV Dextrose in Normal Saline 0.5L stat
10) Tablet Nefidepine 30mg bd for 30 days

This script comprises of six chapters which include;

Chapter one deals with assessment of patient and family comprising patient particulars, family medical history, socio-economic history, lifestyle and hobbies, past and present medical history, admission of patient, her concept of illness, literature review and validation of data.

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

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

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

Chapter five deals with evaluation of care consisting of statement of evaluation, amendment of the nursing care for partially met or unmet outcome, termination of care.

The chapter six deals with summary and conclusion followed by bibliography and appendix.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURS

CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment of patient and family is the first step in the nursing process. Nursing assessment is the gathering of information about a patient's physiological, sociological and spiritual status by a licensed registered nurse (Schreiber, 2017). It is the systematic method of collection of vital information from the patient, relatives, health team and medical note on laboratory investigation report, to determine patient's health status and identifying the actual or potential health problems. It deals with the collection of data through observation investigations such as laboratory results and x-ray reports, interviewing and physical examination from which analysis can be made to help in planning and implementation of care. This chapter includes patient's particulars, patient and family medical history and surgical history, Patient's socioeconomic history, patient's developmental history, past and present obstetric history and patient's lifestyle. All the information about my patient was gathered from the patient and her relative as well as on the computer system.

1.1. Patient's Particulars

Collins English Dictionary (2018), defines patient's particulars as facts or details about the patient which are written down and kept as a record. Madam N.G is a 51-year –old woman was born at Boadwo in the Bono Region on 1st July, 1971 to Mr B.J and Madam A.R both of blessed memory. She currently resides at Suma with GPS number BI-148495003. She is the fifth of the six children (2 females and 4 males). She is fair in complexion. Her height is 160meters and weight 65 kg with no physical impairment. Miss N.G is single with three children. Madam N.G and family worship at the Assemblies of God at Boadwo. According to her she went to school up to class 4 and stopped because of financial difficulties. She speaks Twi and is a farmer who cultivates seasonal crop

specifically Cashew. Her father is dead and her mother is alive who leaves with her. Madam N.G's next of kin is her daughter Miss B.N.

1.2 The Patient's Family's Medical/Surgical History

A patient and family medical history is a record of health information about a person and his or her relatives. A complete record includes information from three generation of relatives, including children, brothers and sisters, parents, nephews, nieces, etc. Together with these factors can give clues to medical conditions that may run in a family (Weller, 2016)

According to Madam N.G, her entire lineage had no history of chronic illness such as; asthma, diabetes, as well as mental illness such as psychosis neither do they have communicable diseases such as tuberculosis but there is a history of hypertension in her family. She however admitted that her family occasionally suffers minor ailments such as; headache, diarrhea, cold and cough of which they rely on drugs from chemical sellers and herbalist as treatment. She emphasized that there is no known allergies with her or any of the family members. With the exception of Madam N.G, none of the family members has ever been hospitalized.

1.3 The Patient/Family's Socio Economic History

It is the social science that studies how economic activities are affected and shaped by social processes. In general, it analyses how families progress, stagnate, or regress because of their local economy. Family socio-economic history deals with the social background and economic status of the patient and the family. Social-economic history gives more information about the patient's environment, housing types, parent's occupation and marital status, number of individuals living in the house and sleeping arrangement, religious affiliations and others (Hornby, 2017).

Madam N.G revealed that she is into farming with most of the family members. She now has the full support of her grown up children. Due to her occupation, she is prone to hazards like cuts, falls

and trauma from fallen trees. Their income is used for the up keeping of the family and health needs when insurance does not cover because patient and family are beneficiaries of the national health insurance scheme. Madam N.G is an Assembly of God but does not perform any major role in the church. Madam N.G made me wear of some cultural practices, norms, values and taboos such as; not going to the farm on taboo day, respecting the elderly, promoting of heath in the community, and not bathing or washing in streams around. She said when one goes contrary to the set rules and regulation in the community, sanctions are applied.

1.4 Patient's Developmental History

Development is defined as the process of growth and differentiation. Growth, as well, is the progressive development of a living thing, especially the process by which the body reaches its point of complete physical development. (Weller, 2016).

According to Madam N.G her mother had successful Spontaneous Vaginal Delivery (SVD) at Boadwo with the help of traditional birth attendant. Miss N.G said she does not know the name of the traditional birth attendant. She was born on the on the 1st July 1971. She was not immunized against vaccine preventable diseases and was also breastfed exclusively for six mouths. She had a normal developmental milestone. According to patient she started crawling when she was eight months, and started walking when she was twelve months. At age one year she started talking and at age eight years patient started schooling. She started developing secondary sexual characteristics at age fifteen, thus the growth of hair under the armpit and her genitalia, enlargement of her breast and widening of hips among others, her menarche was the age of seventeen years. She had her menopause at the age of fifty.

Eric Erickson propounded eight stages of psychosocial development, with each stage representing an important stage in a person's life, which begins from birth to death.

According to Eric Erickson's theory of psychosocial development (1959), there are eight distinct stages with each possible result thus either success or crises personality. These stages include:

1. Trust versus Mistrust (0 to18 months)
2. Autonomy versus shame and doubt (18month to 3 years)
3. Initiative versus Guilt (3 to 6 years)
4. Industry versus Inferiority (6 to 12 years)
5. Identity versus role confusion (12 to 18 years)
6. Intimacy versus isolation (18 to 35 years)
7. Generativity versus stagnation (35 to 60 years)
8. Integrity versus despair (60years and above)

Comparing patient's age with Eric Erickson's theory, patient (51 years) falls within Generativity versus stagnation (age 35 to 60).

According to Erickson, as one grows older and becomes a senior citizen, his productivity tends to slow down, and explores life as retired person. It is during the time that we contemplate our accomplishments and are able to develop integrity if we see our lives productive. However, feel guilt about our pasts, or feel that we did not accomplish our life goals, we become dissatisfied with life and develop despair, often leading to depression and hopelessness.

Comparing the two, I can say the patient exhibited more of generativity than stagnation because Madam N.G has 3 children of which the first born is in abroad working there and the second one is a trader and the last one is still schooling. She therefore sees herself as leaving successful life, and feels happy with her personal achievement as a mother and a farmer. She is satisfied with her life even though she had education up to class four.

1.5 Obstetric History

Obstetric is a field of study concentrated on pregnancy, childbirth and the postpartum period (Roth, 2018).

Madam N.G. is Gravida 3 Para 3 mother who had all her pregnancies safely delivered per vaginum (spontaneous vaginal delivery) without any complication. All her children are alive and happily living their normal life. Madam N.G had no known bad obstetrical history. She is in her menopausal age which makes her incapable of giving birth again. According to patient with the exception of natural contraception or birth control measures she has never use any form of contraceptives in an attempt to prevent pregnancy. She stated that she experienced some form of abdominal pain during her menstrual period and that she does not take in any medication to reduce the pain. She said the pain resides on its own. She confirmed that she did not encounter any difficulty in breastfeeding with any of her children. Madam N.G said that she did not have any postpartum disorders.

1.6 Patient's Lifestyle and Hobbies

Lifestyle is the pattern of daily living that an individual develops (Weller, 2016). Hobbies are activities one does for pleasure when he/she is not working. (Hornby, 2017)

Madam N.G wakes up around 5:00am and performs personal hygiene such as caring for her mouth and bathing which she does twice daily. She trims her nails whenever they grow long. She usually takes her breakfast at 6:00am and goes to farm after taking her breakfast, have her lunch around 12:00pm and rest after having her lunch. She takes her supper at 5:00pm and washes the cooking utensils after having her supper, takes her bath and sleeps around 7:00pm.On Saturdays, patient washes her cloth and goes to farm afterword. Madam N.G says she goes to church on Sundays and toes not play any role in the church. According to the patient, her favorite food is fufu with garden

eggs soup. She does not take alcohol, tobacco and other illicit drugs because of her religion (Christianity). Watching of television is her hobby.

1.7 The Patient's Past Medical History

Past medical history is the total sum of a patient's health status prior to a presenting illness. It is also a narrative or record of past events and circumstances that are or may be relevant to a patient's current state of health informally, an account of past disease, injuries, treatment, and other strictly medical fact (Medilexican, 2018).

According to Madam N.G she never had any congenital disease. The patient revealed that she never experienced any childhood aliment such as poliomyelitis, measles or tetanus. However she suffers from minor illness like abdominal pain, headaches, fever and general body pains which subsides after taking over-the- counter drugs. She has never been involved in any car accident. She also revealed that she has no known allergies. Madam N.G is a member of the National Health Insurance Scheme and she always get access to health care whichever hospital she goes to seek for health care. Madam N.G was admitted to ST.Marys Hospital Drobo because of hypertension in the year 2021.

1.8 The Patient's Present Medical History

Present medical history according to the medical dictionary (2015) is a chronologic description of the development of the patient's present illness, from the first sign and/or symptom or from the previous encounter to the present which includes the location, quality, severity, duration, timing, and content, modifying factors and associated signs and symptoms.

Madam N.G was well until Friday, December 9th, 2022 when she was passing watery stool in the night and vomiting after eating mashed kenkey. According to her, she has been experiencing pains at the epigastric region whenever she finishes eating for about a month. She used to seek for health

services at a clinic in Boadwo, with failure in the treatment of her last visit, she was rushed to the Out- Patient Department of St.Marys Hospital Drobo on the 14TH December, 2022 for medical attention. According to Madam N.G, she was seen in the consulting room by a physician and was diagnosed of acute Gastritis. He therefore admitted her to the Female Medical Ward of the same hospital.

1.9 Admission of the Patient

Admission of a patient means allowing and facilitating a patient to stay in the hospital unit or ward for observation, investigation and treatment of the disease he or she is suffering from (BrainKart, 2018). On the 14th December, 2022, around 9:30am Madam N.G was admitted through O.P.D to the Females ward of St. Mary's Hospital-Drobo per wheel chair accompanied by one student nurse and two relatives, with diagnosis of Acute Gastritis. She complained of fever, abdominal pain, headache, diarrhea, general body weakness, vomiting and anorexia. Madam N.G was admitted in a conscious state with the diagnoses of Acute Gastritis. I welcomed them and made them comfortable. Madam N.G was immediately ushered into an already prepared admission bed because she was very weak. They were reassured of competent nursing care by the health team to improve her current health status. Madam N.G's folder was collected from the accompanying nurse. The folder was cross-checked to confirm the information on the patient which includes her name, age, residential address, next of king and religion. A quick assessment of her general appearance was made. Vital signs were checked and the following results were obtained and recorded;

- Temperature: 37.5 degree Celsius
- Pulse Rate: 96 beats per minute
- Respiration: 21 cycles per minute
- Blood pressure: 150/90 millimeters of mercury

- SPO2: 98%

Her weight and height were 65kg and 160cm respectively.

I oriented her relatives within the ward by showing them the toilet and bathroom, the kitchen and nurses' station, and other places to avoid like the sluice room. She was introduced to other staff who were present for the morning duty. I told her about the time for medication and other routine activities at the ward. I made them aware of time for visiting, as morning 5:30am-6:30am, afternoon 12:30pm-1:30pm and evening 5:30pm to 6:30 pm. All valuables were kept in his locker. No consent form was signed but he verbally accepted to be treated. He is a registered national health insurance scheme member so he was made to understand the policy would absorb most of her bills. I made her aware that some medications were not covered by the NHIS and have to pay when discharged. I documented her particulars in the admission and discharge book, the daily ward state and rest of the progress sheets.

The following investigation were ordered and carried out.

- Blood for full blood count
- Blood specimen for malaria parasite
- Urine for routine examination

Medications ordered and served were;

1. IV Omeprazole 80mg stat then 40mg bd for 24 hours
2. Syrup Aluminum hydroxide 15mls tds for 5day
3. Tablet Paracetamol 1g tid for 3days
4. IV ciprofloxacin 400mg bd for 24hours
5. IV metoclopramide 10mg tds for 24hours
6. Inj Hyoscine Butylbromide 40mg stat
7. IVF Ringers Lactate 2L for 24hours

8. IVF Normal Saline 1Lfof 24hours
9. IV Dextrose in Normal Saline 0.5L stat
10. Tablet Nefidepine 30mg bd for 30 days

Patient was already on Nefidepine because of her already diagnosed Hypertension

Patient particulars were entered into the system. Nurses' notes were also typed, on admission, Intravenous line was passed for her and she was given Intravenous Omeprazole 500mg, Intravenous Metoclopramide 10mg and IM Injection Hyoscine Butylbromide stat. Patient and her relatives promised to co-operate fully with the health team and to adhere to all instructions.

I told her that her admission would last for few days and she would be discharged home. After Madam N.G and relative were relaxed, I went to her and introduced myself to her again as a final year student of Holy Family Nursing and Midwifery Training College Berekum. I made her aware that as a final year student, it is a requirement by the Nursing and Midwifery Council of Ghana to take a patient, to render individualized nursing care to her and family until discharge and follow up visit after discharge until she recovers fully. I told them this is in partial fulfilment of an award of a Registered General Nursing Certificate. I explained to the patient and her relatives the concept of the patient/family care study and assured them of privacy and confidentiality. Madam N.G and her daughter agreed to my request and promised to offer me the necessary information and assistance. I expressed my gratitude to them. The ward in-charge was also informed of my intentions and he granted me permission. A nursing care plan was therefore drawn to serve as a perfect guide to the care of the patient and her family. Discharge planning was initiated with the relatives, thus, that they would continue the care at home once she is well.

1.10 Patient/ Family Concept of His Illness

Patient/Family Concept of health portrays how they understand the condition and what they think might be the cause for the condition.

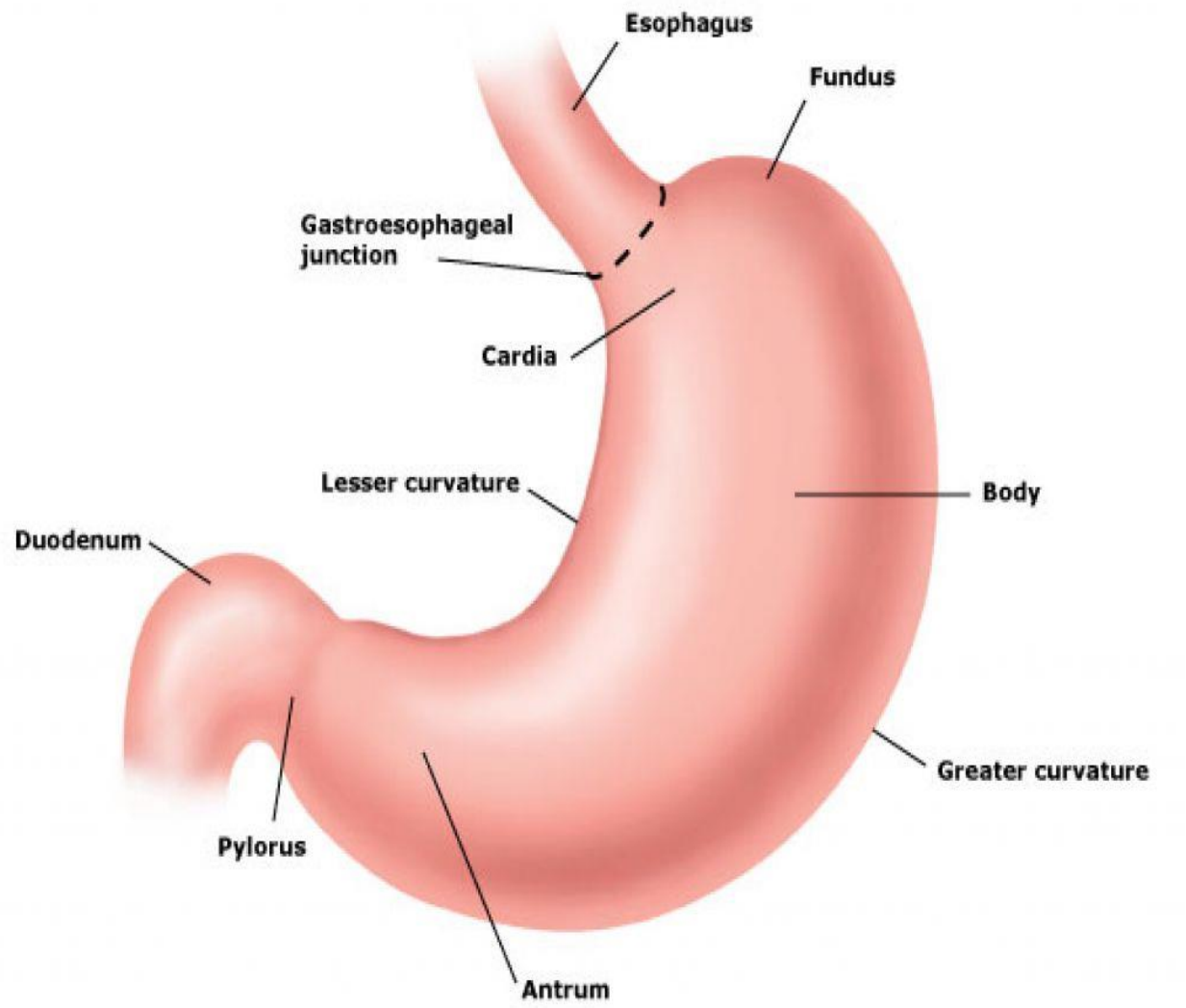
Madam N.G and her family had little idea about the predisposing factors of acute gastritis and so did not know that the cause of it was food contamination (mashed kenkey) she took attribute to the causes of the illness. Her concern was about the outcome of the illness but was optimistic that with good care given by the health team, she would recover fully by God‘s grace.

1.11 LITERATURE REVIEW ON GASTRITIS

Brief Anatomy and Physiology of the stomach

According to (Grant, Ross and Willson Anatomy and Physiology, 2014), the stomach is a J-shaped dilated portion of the alimentary tract situated in the epigastric, umbilical and left hypochondriac regions of the abdominal cavity. It is continuous with the esophagus at the cardiac sphincter and with the duodenum at the pyloric sphincter and it have two curvatures; the posterior lesser curvature and the anterior greater curvature. The stomach is divided into three regions: the fundus, the body and the pylorus. At the distal end of the pylorus is the pyloric sphincter, guarding the opening between the stomach and the duodenum.

FIGURE 2: Diagram Showing the Anterior View of the Stomach



https//www.google.com/url/2016/01.what-is-stomach-in-human-body.com

Walls of the Stomach

The walls of the stomach as described by (Allison, 2014) are formed by four layers of tissue:

1. Outermost adventitia or serosa called peritoneum

2. Muscular layer consisting of three layers of smooth muscle fibre

- An outer layer of longitudinal fibre
- A middle layer of circular fibre
- An inner layer of oblique fibre

3. Sub mucosa consisting of loose areola connective tissue containing collagen and some elastic fibre which binds the muscle layer to the mucosa.

4. Mucosa: When the stomach is empty the mucous membrane lining is thrown into longitudinal folds or rugae, and when full the rugae are 'ironed out' and the surface has a smooth, velvety appearance. Numerous gastric glands are situated below the surface in the mucous membrane and open onto it. They consist of specialized cells that secrete gastric juice into the stomach.

Overview of Acid Secretion/ Gastric Juice and Function of the Stomach

Acid secretion is initiated by food: the thought, smell, or taste of food effects vagal stimulation of the gastrin-secreting G cells located in the distal one third (antrum) of the stomach. The arrival of protein to the stomach further stimulates gastrin output. Circulating gastrin trigger the release of histamine enterochromaffin-like cells into the body of the stomach. Histamine stimulates the parietal cells through their H2 receptors. The parietal cells secrete acid, and the resulting drop in pH causes the antral D cells to release somatostatin, which inhibits gastrin release (negative response mechanism). According to Smelzer and Bare, acid secretion is present at birth and reaches adult levels by age 2. There is a decline in acid output in elderly patients who develop chronic gastritis, but acid output is otherwise maintained throughout life. Stomach size varies with the

volume of food it contains, which may be 1.5 liters or more in an adult. When a meal has been eaten, the food accumulates in the stomach in layers (mucosa, sub mucosa, muscular is and serosa), the last part of the meal remaining in the fundus for some time. Mixing with the gastric juice takes place gradually and it may be some time before the food is sufficiently acidified to stop the action of salivary amylase. The activity of gastric muscle consists of a churning movement that breaks down the bolus and mixes it with gastric juice and peristaltic waves that propel the stomach contents towards the pylorus. When the stomach is active the pyloric sphincter closes. Strong peristaltic contraction of the pylorus forces chime, gastric contents after they sufficiently liquefied, through the pyloric sphincter into the duodenum in small spurts. Parasympathetic stimulation increases the motility of the stomach and secretion of gastric juice; sympathetic stimulation has the opposite effect.

Composition of Gastric Juice

Gastric juice is about 2 liters of gastric juice are secreted daily by specialized secretory glands in the mucosa and it consists by:

1. Water-produce by gastric gland
2. Mineral salt-produce by gastric gland
3. Mucus secreted by mucous neck cells in the glands and surface mucous cells on the stomach surface
4. Hydrochloric acid-produce by parietal cells
5. Intrinsic factor Inactive enzyme-parietal cells.

Functions of Gastric Juice

The functions of gastric juice as outlined include;

1. Water liquefies the food swallowed

2. Hydrochloric acid functions by

a. Acidifies the food and stops the action of salivary amylase

b. Kills ingested microbes

4. Intrinsic factor (a protein) is necessary for absorption of vitamin B12 from the ileum

5. Mucus prevents mechanical injury to the stomach wall by lubricating the contents. It prevents chemical injury by acting as a barrier between the stomach wall and the corrosive gastric juice.

Function of the Stomach

The functions of the stomach that were described include;

1. Temporary storage allowing time for digestive enzymes and pepsin to act
2. Chemical digestion-pepsin converts proteins to polypeptides
3. Mechanical digestion-muscular layers' churn food into chime
4. Production and secretion of intrinsic factor needed for absorption of vitamin B12 in the ileum
5. Regulation of the passage of gastric contents into the duodenum
6. Secretion of the hormone gastrin.

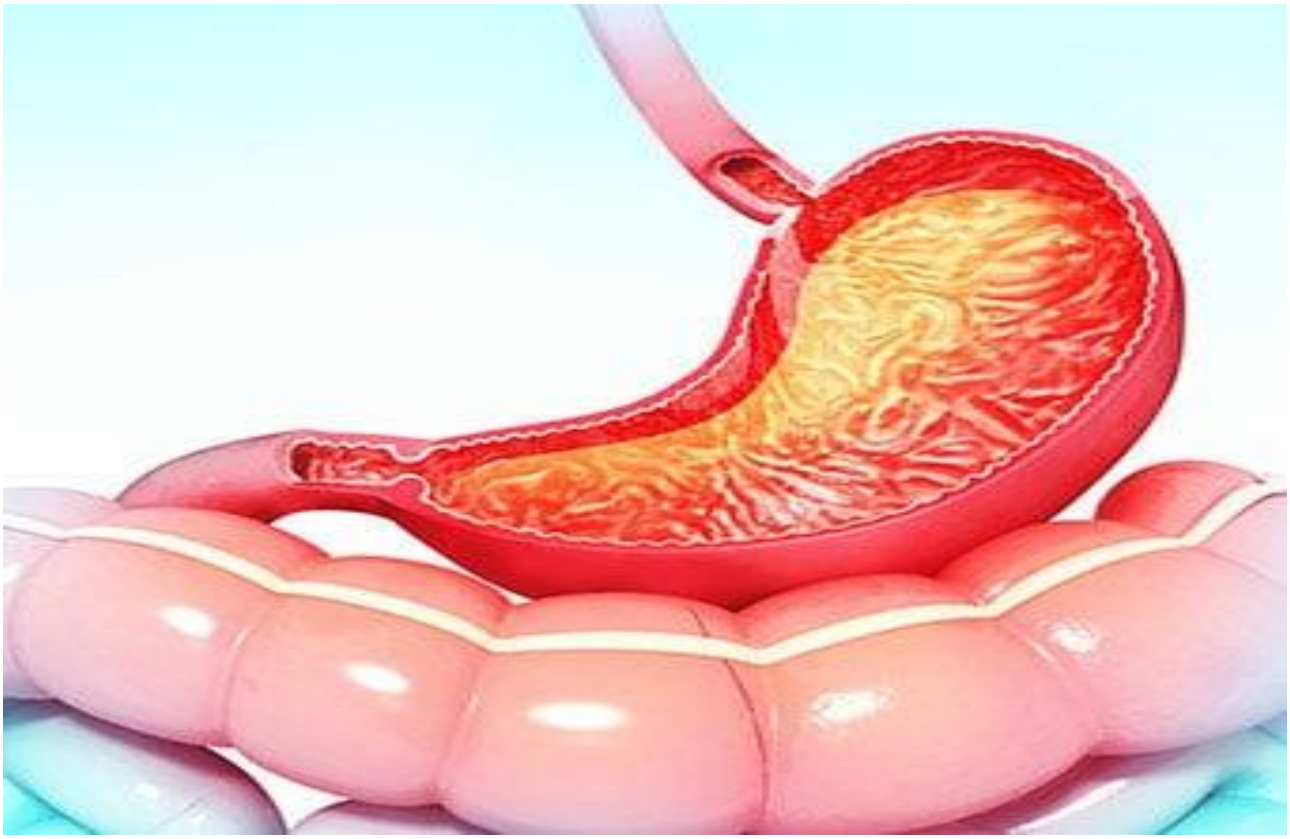
Gastritis

Cheever (2010) describes gastritis as the inflammation of the gastric or stomach mucosa. It is a common gastrointestinal problem. It may be acute or chronic.

Gastritis is an inflammatory process of the mucosal lining of the stomach. The inflammation may be contained within one region or be patchy in many areas.

Gastric structure and function are altered in either the epithelial or the glandular components of the gastric mucosa.

FIGURE 2: Diagram Showing the Inflamed Gastric Mucosa



Types

Gastritis can be classified into two major types:

1. Acute Gastritis

Acute gastritis: It is a term covering a broad spectrum of entities that induce inflammatory changes in the gastric mucosa (Ferris, 2017). The inflammation may involve the entire stomach or a region of the stomach. Acute gastritis is generally caused by Helicobacter pylori.

According to (Cheever, 2010), acute gastritis lasts for several hours to a few days and it is often caused by dietary indiscretion—a person eats food that is irritating, too highly seasoned, or with disease-causing microorganisms. Other causes of acute gastritis include overuse of aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs), excessive alcohol intake, bile reflux, and radiation therapy. A more severe form of acute gastritis is caused by the ingestion of strong acid

or alkali, which may cause the mucosa to become gangrenous or to perforate. Scarring can occur, resulting in pyloric stenosis or obstruction of the pylorus.

Acute gastritis also may develop in acute illnesses, especially when the patient has had major traumatic injuries; burns; severe infection; hepatic, renal, or respiratory failure; or major surgery. Gastritis may be the first sign of an acute systemic infection.

Causes

1. The cause of gastritis is Helicobacter pylori infection and is indicated in an average of 90% of gastritis cases.

2. Chronic ingestion of (or an allergic reaction to) irritating foods or beverages, such as hot pepper or alcohol.

3. Drugs, such as aspirin and other non-steroidal anti-inflammatory agents (in large doses), Cytotoxic agents, corticosteroids, antimetabolites, phenylbutazone, and indomethacin.

4. Ingestion of poisons, especially Dichloro Diphenyltrichloroethane (DDT), ammonia, mercury, carbon tetrachloride, and corrosive substances

5. Endotoxins released from infecting bacteria such as staphylococci, Escherichia coli, or Salmonella.

2. Chronic Gastritis

Chronic gastritis is sometimes associated with autoimmune diseases such as pernicious anaemia and gastrectomy. It is mostly determine base on the duration of the condition. When it persist for more than a six months then it is chronic. Pernicious anemia is commonly associated with atrophic gastritis, a chronic inflammation of the stomach resulting from degeneration of the gastric mucosa. In pernicious anemia, the stomach can no longer secrete intrinsic factor, which is needed for vitamin B12 absorption. Chronic gastritis caused by Helicobacter Pylori infection is implicated in

the development of peptic ulcers, gastric ulcers, and mucosa- associated lymphoid tissue lymphoma. It results from repeated exposure to irritating agents such as acid or alcohol and recurring episodes of acute gastritis. Prolonged inflammation of the stomach may be caused either by benign or malignant ulcers of the stomach or by the bacteria Helicobacter pylori.

Ferris (2017) describes three forms of chronic inflammation of the gastric mucosa as;

1. **Superficial chronic gastritis: i**s a term used to describe the initial stages of chronic gastritis, it means that the inflammation is mild and is taking place only at the very surface of the stomach lining, without affecting deeper layers. It is characterized by red, edematous surface epithelium, small erosions and decreased mucus content.

However, the gastric glands remain normal.

2. **Atrophic chronic gastritis:** It is the result of chronic gastritis which is leading to atrophy (thus, decrease in the thickness and wasting away) of the stomach lining. Inflammation extend deeper into the gland area of the mucosa with loss of parietal and chief cells. Atrophic gastritis further develops into the final stage of chronic gastritis.

3. **Gastric atrophy chronic gastritis:** It's the final stage of chronic gastritis and may lead to gastric cancer. According to Ferris (2017) other forms of gastritis include;

1. Erosive Gastritis: This type of gastritis involves an erosion of the mucus layer of the stomach and can lead to bleeding and ulcers in the stomach lining.

2. Superficial gastritis (or surface gastritis): is the inflammation of the superficial portion of the gastric mucosa.

3. Pan gastritis: "pan" meaning "whole" or "entire" is a term used to simply state the fact that the inflammation is found around all the stomach's lining.

4. Antral gastritis: It is a term used to describe inflammation in the mucosal lining of the antrum (the lower portion of the stomach which releases the contents of the stomach into the duodenum.

5. Bile gastritis: this is a stomach inflammation resulting from bile produced by the liver refluxing back into the stomach.

6. Phlegmonous gastritis: Is an uncommon form of gastritis caused by numerous bacterial agents including streptococci, staphylococci, Proteus species, Clostridium species and Escherichia coli. It usually occurs in individuals who are debilitated and it is associated with a recent large intake of alcohol, a concomitant upper respiratory tract infection and Acquired Immune Deficiency Syndrome. Phlegmonous means a diffuse spreading inflammatory of or within the connective tissue. In the stomach, it implies infection of the deeper layers of the stomach i.e. mucosa and sub-mucosa.

Risk Factors Gastritis

The risk factors of gastritis are described by Smeltzer and Bare (2010) to include;

1. Infection with Helicobacter pylori
2. Acquired immunodeficiency syndrome (AIDS)
3. Any condition that requires relief from chronic pain using NSAIDs, such as chronic back pain or arthritis
4. Alcoholism
5. Cigarette smoking
6. Older age
7. Herpes simplex virus or cytomegalovirus
8. Inflammatory bowel disease

Pathophysiology

The pathology as described by Smeltzers and Bare (2010) is that; normally, the gastrointestinal mucosa is protected by several distinct mechanisms:

(1) Mucosal production of mucus and bicarbonate (HCO3) which creates a pH gradient from the gastric lumen (low pH) to the mucosa (neutral pH) with the mucus serving as a barrier to the diffusion of acid and pepsin

(2) Epithelial cells remove excess hydrogen ions (H+) through membrane transport systems and have tight junctions, which prevent back diffusion of H+ ions.

(3) Mucosal blood flow removes excess acid that has diffused across the epithelial layer. In the presence of factors like stress, chemical substances, like drugs and alcohol, spicy foods, hot or sour foods, etc., there is sympathetic nerve stimulation, particularly that of the valgus nerve. The stimulation leads to increased production of hydrochloric acid in the stomach causing nausea, vomiting and anorexia. There is gastric mucosal cell exfoliation leading to erosion causing the gastric mucosa to lose its protective property. There is invasion of gastric mucosa and inflammatory reaction occurs. Mucosal cell loss cause bleeding (Myers, 2003). With constant irritation tissues become inflamed. The gastric mucous membrane becomes edematous and hyperemic. (Congested with fluid and blood) and begin to undergo superficial erosion. It secretes scanty amount of gastric juice with very little acid but much mucous.

Signs and Symptoms

According to Smeltzers and Bare (2010), Signs and symptoms may include;

1. Epigastric discomfort
2. Headache
3. Nausea

4. Anorexia

5. Vomiting

6. Hiccupping, which can last from few hours to few days.

While some patients remain asymptomatic, the symptoms if present may last from a few hours few days. The patient with chronic gastritis may describe similar symptoms as acute gastritis or may have;

1. Pyrosis (heartburn) mostly after meals

2. Belching or bloating

3. A sour taste in the mouth

4. Some patients may have only mild epigastric discomfort or report intolerance to spicy or fatty foods or slight pain that is relieved by eating.

5. Patients with chronic gastritis from vitamin deficiency usually have evidence of malabsorption of vitamin B12 caused by the production of antibodies that interfere with the binding of vitamin B12 to intrinsic factor.

6. Discomfort after eating (heart burns).

7. Epigastria heaviness after eating.

9. Hypochlorhydria (decrease hydrochloric acid secretion)

Assessment and Diagnostic Finding

According to (Cheever, 2010), gastritis is sometimes associated with Achlorhydria or Hypochlorhydria (absence or low levels of hydrochloric acid) or with hyperchlorhydria (high levels of hydrochloric acid). Diagnosis can be determined by;

- Clinical manifestation/ history taking to confirm condition
- Upper gastro-intestinal radiography to look for the state of stomach walls.

- Endoscopy of the gastric mucosa (Gastroscopy) for eroded mucosa.
- Histologic examination of a tissue specimen obtained by biopsy.
- Serum vitamin B12 assessment to ensure patient is safe from pernicious anaemia.
- Serology testing for antibody of Helicobacter pylori and to check for anaemia
- Culture and sensitivity of gastric secretions.
- Occult stool/ stool for routine examination
- One-minute ultra-rapid urease test

Treatment/Management

Goals of treatment: Grant and Anne (2010) describes the aims of treating gastritis to include;

1. Reduce the amount of acid in the stomach and allow the stomach lining to heal

2. To relieve symptoms such as abdominal pains and reduce complications

3. To treat the underlying cause of the condition

4. To promote comfort

Medical Management

According to Longe (2010), there are both over the counter and prescription medications for gastritis.

The "eradication therapy" is mostly used in treatment of Helicobacter pylori-related gastritis which involves the combination of three drugs; a proton-pump inhibitor to reduce acid production and two antibiotics. Bismuth salicylate (Pepto-Bismol) may be used instead of the second antibiotic. This drug, available over the counter, coats and soothes the stomach, protecting it from the damaging effects of acid. Some of the same drugs used for non-Helicobacter pylori gastritis are used for symptoms (like indigestion) due to ulcers:

- Antacids which may relieve heartburn or indigestion. They include;

- Aluminum hydroxide (Asphodel, AlternaGEL)
- Magnesium hydroxide (Philips' Milk of Magnesia)
- Aluminum hydroxide and magnesium hydroxide (Maalox, Mylanta)

2. Histamine 2 (H2) Blockers which reduce gastric acid secretion. They include;

- Cimetidine (Tagamet)
- Ranitidine (Zantac)

3. Proton pumps inhibitors which decrease gastric acid production. They include;

- Esomeprazole (Nexium)
- Lanzoprazole (Prevacid)
- Omeprazole(Prilosec)

4. Prostaglandin E1 Analogue examples are Sulcrafate, Misoprostol (Cytotec) protects gastric mucosa against actions of gastric juice by acting as a barrier.

The medical management is further described by Smeltzers and Bare (2008) to include;

5. Intravenous (IV) fluids like Dextrose Normal Saline (DNS) may need to be administered to correct electrolyte imbalance.

6. If gastritis is caused by ingestion of strong acids or alkalis, emergency treatment consists of diluting and neutralizing the offending agent. To neutralize acids, common antacids e.g. aluminum hydroxide are used; to neutralize an alkali, diluted lemon juice or diluted vinegar is used (Smeltzer, 2008).

7. If corrosion is extensive or severe, emetics and lavage are avoided because of the danger of perforation and damage to the oesophagus.

8. Anti- emetics e.g. Phenergan to reduce vomiting.

9. Analgesics and antipyretics e.g. tramadol to relieve pain and Paracetamol for pyrexia respectively.

10. Antibiotics like Amoxicillin+ Clavulinic acid (Amoksiclav) to help eliminate the bacteria causing the inflammation.

11. Gastric lavage.

12. Nasogastric intubation to decompress the stomach

According to Smeltzers and Bare (2010), in extreme cases, emergency surgery may be required to remove gangrenous or perforated tissue. A gastric resection or a gastrojejunostomy/ Billroth II (anastomosis of jejunum to stomach to detour around the pylorus) may be necessary to treat pyloric obstruction (a narrowing of the pyloric orifice, which cannot be relieved by medical management) or Phlegmonous gastritis (gangrene of the stomach).

Chronic gastritis is managed by modifying the patient's diet, promoting rest, reducing stress, recommending avoidance of alcohol and NSAIDs, and initiating pharmacotherapy. For chronic gastritis, occurring as a result of excessive gastric acid secretion, vagotomy may be necessary to decrease parasympathetic secretion of gastric acid.

Nursing Management

Nursing management of gastritis is described by Smeltzers and Bare (2008) to include the following interventions;

Psychological Care

- There is the need for continuous reassurance of patient and family about readiness of health care team to aid in treatment and the effectiveness of available medications and other supportive treatment modalities in bringing about speedy recovery and remission.

- If the patient has ingested acids or alkali, emergency measures may be necessary example gastric lavage.
- Prepare the patient for additional diagnostic studies (endoscopies) or surgery.
- The patient may be anxious because of pain and planned treatment modalities.
- The nurse uses a calm approach to assess the patient and to answer questions asked.
- It is important to explain all procedures and treatments base on the patient's level of understanding.
- The nurse offers supportive therapy to the patient/family during treatment and after ingested acid or alkali has been neutralized or diluted. In some cases, the nurse may need to prepare the patient for additional diagnostic studies (endoscopy) or surgery.

Observation and Monitoring

1. Continuously monitor vital signs including temperature, pulse, respiration, Oxygen saturation and blood pressure and intervene when appropriate

2. Monitor strict intake and output especially when vomiting persists

3. Monitor patient for therapeutic and adverse effects of administered medications

4. Assess and monitor patient for signs and symptoms of dehydration including, loss of skin turgor, dry mouth and persistent complaint of thirst.

Rest and Sleep

The following measures should be implemented to ensure good rest and comfortable sleep to promote recovery;

- Restrict or limit visitors when necessary and explain to the patient the need for rest and sleep.

- The environment should be properly ventilated and noise minimized to promote rest and sleep.
- Put patient in well prepared, comfortable bed and make sure bed is free from creases and cramps.
- If patient has pain-related insomnia, administer prescribed analgesics to relieve pain and prescribed hypnotics and monitor for therapeutic and adverse effects of the drug.

Elimination

- Elimination needs in the patient with gastritis is equally important as is medications in recovery and remission of signs and symptoms.
- Assess patients' elimination pattern.
- Monitor intake and output of patient.
- Monitor vomiting and observe vomitus for color, consistency and content of the vomitus.
- If vomiting is persistent, prevent dehydration of patient by rehydrating with prescribed intravenous infusions.

Personal Hygiene

Ensure patients hygienic needs are equally met as other medical needs of the patient are established.

- Ensure patient takes his/her bath twice a day. Assist or carry out bed bath when necessary
- Encourage patient to maintain adequate mouth care by brushing his/her teeth at least twice in a day.
- Teach and encourage patient and relatives to observe hand washing techniques after visiting the toilet or coming into contact with patient fluids such as vomitus to prevent spread of Helicobacter pylori bacteria.

- Ensure patient keeps a short and well-kept nails, carry out hand and feet care when necessary.

Pain Management

- Measures to help relieve pain include instructing the patient to avoid foods and beverages that may be irritating to the gastric mucosa.
- Instructing the patient about the correct use of medications to relieve chronic gastritis.
- The nurse must regularly assess the patient's level of pain
- Monitor the extent of comfort achieved through the use of medications and avoidance of irritating substances.

Fluid and Electrolyte Imbalance

- Daily fluid intake and output are monitored to detect early signs of dehydration.
- Electrolyte values (sodium, potassium, chloride) are assessed every 24 hours to detect any imbalance.
- Assessment for any indicators of hemorrhagic gastritis, which include hematemesis (vomiting of blood), tachycardia, and hypotension.

Nutrition

- For acute gastritis, provides physical and emotional support and helps the patient manage the symptoms, which may include nausea, vomiting, heartburn, and fatigue.
- Encourage intake of bland diet.
- If intravenous therapy is necessary, the nurse monitors fluid intake and output along with serum electrolyte values.
- After the symptoms subside, offer the patient ice cubes followed by clear liquids.

- As food is introduced, evaluates and reports any symptoms that suggest a repeat episode of gastritis.
- Discourage the intake of caffeinated beverages, because caffeine is a central nervous system stimulant that increases gastric activity and pepsin secretion.
- It is also important to discourage alcohol intake.
- Discouraging cigarette smoking is important because nicotine reduces the secretion of pancreatic bicarbonate, which inhibits the neutralization of gastric acid in the duodenum.

Nutrition and Dietary Supplement

Following these nutritional tips may help reduce symptoms:

- Eating antioxidant foods, including fruits (such as blueberries, cherries and tomatoes), and vegetables (such as garden eggs and cucumber)
- Intake of foods high in B vitamins and calcium, such as almonds, beans, whole grains (if non-allergic), dark leafy greens (such as spinach and kale) and sea vegetables
- Avoid refined foods such as white breads, pastas, and sugar
- Use healthy oils, such as olive oil
- Reduce or eliminate trans-fatty acids, found in commercially-baked goods, such as cookies, crackers, cakes, onion rings, donuts and margarine.
- Avoid beverages that may irritate the stomach lining or increase acid production including coffee (with or without caffeine), alcohol and carbonated beverages.
- Drink 6 to 8 glasses of filtered water daily
- Identify and eliminate food allergies

The following supplements may help with digestive health:

A multivitamin daily, containing the antioxidant vitamins A, C, E, the B vitamins, and trace mineral, such as magnesium, calcium, zinc and selenium. Omega-3 fatty acids, such as fish oil, may help decrease inflammation. Fish oil may increase the risk of bleeding. Probiotic supplement (containing Lactobacillus acidophilus). Probiotics or friendly bacteria may help maintain a balance in the digestive system between good and harmful bacteria, such as Helicobacter pylori.

Probiotics may help suppress Helicobacter pylori infection, and may also help reduce side effects of taking antibiotics, the treatment for a Helicobacter pylori infection. People who have weakened immune systems, or who are taking immune-suppressive drugs, should take probiotics only under the direction of their physician.

Education

- Educate patient/family about the condition
- Educate patient/family on the need to take prescribed medications
- Educate patient/family on the restriction of offending agents like alcohol or highly seasoned foods
- Educate patient on the need to ensure rest
- Educate patient/family on the need for follow-up

Promoting Home and Community-Based Care: Teaching Patient Self-Care

According to Smeltzers and Bare (2010), the nurse evaluates the patient's knowledge about gastritis and develops an individualized teaching plan that includes information about stress management, diet, and medications.

- Dietary instructions take into account the patient's daily caloric needs, food preferences, pattern of eating.

- The nurse and patient review foods and other substances to be avoided (e.g. Spicy, irritating, or highly seasoned foods; caffeine; nicotine; alcohol).
- Consultation with a dietician may be recommended. Providing information about prescribed antibiotics, bismuth salts, medications to decrease gastric secretion, and medications to protect mucosal cells from gastric secretions may help the patient to better understand why it is important to follow information given (Platte, 2019).

Prevention

According to Ferris (2011), certain simple points can be followed to reduce the risk of developing gastritis. These include:

- Wash your hands with soap and water regularly and before meals. This can reduce the risk of being infected with helicobacter pylori
- Cook foods thoroughly. This also reduces the risk of infection
- Avoid alcohol or limit your alcohol intake
- Avoid NSAIDs or only use them infrequently. Consume NSAIDs with food and water to avoid symptoms.

Complication

The complications of gastritis were described by Smeltzers and Bare (2008) to include;

1. Stomach Ulcer mostly from chronic gastritis

2. Anaemia (Vitamin B12 deficiency anaemia): This occurs as a result of destruction of intrinsic factors.

3. Pyloric stenosis mostly occurs from malignant changes of gastric mucosa

4. Malignant changes of gastric mucosa

5. Hemorrhage or bleeding from an erosion or ulcer

6. Gastric Outlet Obstruction due to edema, limiting the adequate transfer of food from the stomach to the small intestine

7. Dehydration from vomiting.

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, 2014). 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. My visit to the patient house also confirmed most of what she told me, the house number of the patient is B-123/8 Boadwo. 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 the act of determining the component part of a substance (Weller, 2014). Data is a collection of facts (Weller, 2014). Analysis of data is the second stage of the nursing process, and it involves grouping the information collected at the assessment phase in simpler components. This allows an individual to come out with a conclusion about the patient health needs. The patient and family strengths are also identified and this forms a guide to arrive at a nursing diagnosis and to give appropriate care to the patient.

2.1 Comparison of Data with Standard

This involves the comparison of data collected and gathered from Madam N.G with standards. Both the objective and subjective data collected has been compared with accepted norms. The areas concerned are the diagnostic investigation, aetiology of the condition, clinical features, treatment and complications if any.

Diagnostic Investigations/Tests

The following diagnostic investigations were carried out on Madam N.G when she was on admission:

Table 1: Comparison of Test Carried out On Madam N.G to Literature.

Diagnostic tests from literature review	**Diagnostic tests carried out on patient**
Blood for full blood count	Full blood count was carried out on patient
Stool sample test	Stool test was not carried out on patient
Endoscopy	Endoscopy was not carried out on patient
Stomach biopsy	Stomach biopsy was not carried out on patient
Urine test	Urine was carried out on patient

Not all diagnostic tests from the literature review were carried out because the physical examination and the tests conducted were able to confirm his condition.

Malaria test was carried out for my patient because she presented some manifestations like vomiting, nausea and fever which are some of the clinical features of malaria.

The table below demonstrate the diagnostic investigations carried out on Madam N.G

Table 2: Diagnostic Investigations carried out on Madam N.G

Date	**Specimen**	**Investigations**	**Results**	**Normal Values**	**Interpretations**	**Remarks**
14/12/2022	Urine	Albumin	Negative	Less than 30mg/L	Within normal albumen level in urine.	No treatment given
14/12/2022	Urine	Sugar	Negative	0 to 0.8 mmol/L	Within normal sugar level in urine.	No treatment given
		Deposits of white blood cell	0 – 3/HPT	0 – 5/HPT	Within normal range.	No treatment given.
		Epithelial cells	3/High power field	1 – 5 squamous epithelial cells per high power field	Within normal range.	No treatment given.
14/12/2022	Blood	Malaria parasites	No parasites seen	Absence of malaria parasite	Specimen free from malaria parasites.	No treatment given
14/12/2022	Blood	Full blood count (FBC)	HB level:13.1 g/dl	Female:12-16g/dl Male: 14-18g/dl	Slightly below normal range	No treatment given
			WBC count: $6.14x10^3$/L	$2.60\text{-}8.50x10^3$/uL	WBC within normal range	Antibiotics was given IV Ciprofloxacin 400mg

Causes of the Condition

With reference to the literature and the signs and symptoms exhibited, Madam N.G condition was as a result of contaminated food (mashed kenkey), stress and fasting causing restrictions and excess HCL in contact with the epigastric or mucosal lining.

Clinical Manifestations

Table three below shows the Clinical Manifestation of Madam N.G on admission

Table 3: **Clinical Manifestations of Madam N.G Compared with Literature Review.**

Signs And Symptoms In Literature	**Signs And Symptoms Exhibited By Patient**
Abdominal pain	Abdominal pain was experienced
Headache	Patient complained of headache
Vomiting	Patient had vomiting
Fatigue	Patient complained of feeling tired (fatigue)
Nausea	Patient experienced nausea
Dehydration	Patient looked dehydrated
Anorexia	Patient experienced anorexia
Hiccups	Patient did not experience hiccup
Loss of weight	Patient exhibited weight loss
Diarrhoea	Patient experienced diarrhoea

Statement of Comparison: the features presented by Miss N.G have been compared to the accepted features of the condition and he exhibited more than half manifestations as stated above, which confirms her diagnosis.

2.4 Treatment

Treatment is defined as the mode of dealing with a patient or a disease (Weller, 2014).The treatment given to Miss N.G was medical treatment. The following were the drugs prescribed and given to her;

1) IV Omeprazole 80mg stat then 40mg
2) Syrup Aluminum hydroxide 15mls tds for 5day
3) Tablet Paracetamol 1g tid for 3days
4) IV ciprofloxacin 400mg bd for 24hours
5) IV metoclopramide 10mg tds for 24hours
6) Inj Hyoscine Butylbromide 40mg stat
7) IVF Ringers Lactate 2L for 24hours
8) IVF Normal Saline 1Lfof 24hours
9) IV Dextrose in Normal Saline 0.5L stat
10) Tablet Nefidepine 30mg bd for 30 days

Table 4: Comparison of Drugs Given to Madam N.G to that in the Literature

Drugs in the Literature review	**Drugs given to patient**
Antacids e.g.; Aluminium hydroxide	Syrup Nugel 15mls tdsx5days
Proton Pump Inhibitors e.g.: Omeprazole, Lanzoprazole	IV omeprazole 80mg stat, than 40mg bdx24hours was given
Antibiotics :e.g. Metronidazole, Ciprofloxacin	IV Ciprofloxacin 400mg bdx24hours
Intravenous fluids : e.g. Normal Saline, Ringers lactate , Dextrous saline	Normal saline 1L was given Ringers lactate 2L was given Dextrous saline was given
Anti-emetics(Metoclopramide)	Metoclopramide 10mg tdsx24hours was given
Antispasmodic: e.g. Inj Hyoscine Butylbromide	Inj Hyoscine Butylbromide was given
Antihypertensive: e.g. Nefidepine, Amlodipine	Tablet Nefidepine 30mg bdx30day
Analgesic agents : Paracetamol and diclofenac	Tablet Paracetamol 1g tidx3days

From comparison in the table 4, there is a clear indication that N.G. had the right treatment and the treatment given to her contributed to her recovery.

Table 5: Shows the details of the pharmacology of drugs administered to N.G. during hospitalization

Date	Name of drug	Standard Dosage and Rout of Administration	Dosage and route of administration for the patient	Classification of drug	Desired effect	Actual effect of the drug observed	Side effect/ Remarks
14/12/22	Intravenous Ciprofloxacin	**Dosage** 400 mg every 12 hours **Route** Oral, IV	400mg bd x 24hours. Intravenously	Antibiotic (Fluoroquinolone)	Treatment of susceptible infection due to; Helicobacter, salmonella, Shigella.	Patient's infection resolved as evidence by relieve of symptoms such as normal white blood cell count	Nauseas and vomiting, constipation, rash, flatulence. Headache, abdominal pain. No side effect was observed on patient.
14/12/22	Intravenous Omeprazole	**Dosage:** 40mg twice daily for 24 hours. **Route:** IV, Oral	80mg start, then 40mg bd x 24 hours 20mg bd x 14days	Proton pump inhibitor	To Inhibit gastric acid by blocking the hydrogen potassium adenosine triphosphate enzyme system at the gastric parietal cells.	The final transport of hydrogen ions into the gastric lumen was inhibited and epigastric pain subsided	Nausea, Vomiting, flatulence, headache. None occurred.

14/12/22	Syrup Nugel O	**Dosage** 15mls two times daily for adults, **Route** Oral	15mls tds x 5	Antacid	For the neutralization of hydrochloric acid secreted by gastric parietal cells	Symptomatic relief of gastritis was achieved.	Diarrhoea, constipation, flatulence, stomach cramps, vomiting. None occurred.
14/12/22	Intravenous Normal Saline	**Dosage** Amount depends on hydration status of patient **Route** Intravenous	1 L X 24 hours Intravenously	Isotonic solution	To maintain fluid and electrolyte balance	N.G. fluid and electrolyte balance was maintained and was prevented from hypoglycaemia	Circulatory overload, oedema. No side effect occurred
14/12/22	Ringers lactate	**Dosage:** Amount depends on patient's fluid and electrolyte level and age as well as by doctors prescription **Route:** IV	2L X 24hours Intravenously	Intravenous fluid and electrolyte (isotonic solution)	To maintain fluid and electrolyte balance	Patient regained strength as normal fluid and electrolyte levels were restored.	Constipation, dry mouth None occurred

14/12/22	Intravenous Metoclopramide	**Dosage** Usual dose is 10 mg, repeated up to 3 times daily; max. daily dose is 500 micrograms/kg **Route** IV, IM, Oral	10mg tdsx24hours Intravenously	Antiemetic(dopamine antagonist)	For symptomatic treatment of nausea and vomiting in adults	Patient was relieved from nausea and vomiting after drug administration by not vomiting again.	Drowsiness, dizziness, confusion. None was observed
14/12/22	Injection Buscopan	**Dosage** 20 mg, then 20 mg after 30 minutes; maximum 100 mg per day **Route** Oral, IV, IM.	40mg stat Route: Intramuscular	Antispasmodics	Relieve spasm of the smooth muscles in the gastro-intestinal tract to resolve abdominal pains	Patient was relived of abdominal pain.	Constipation, dry mouth, flushing, dryness of the skin Non was observed

14/12/22	Dextrose in normal saline	**Dosage:** Adult/ children dose;- Dosage depends on the fluid and the electrolyte requirement **Route:** IV	5% Route: Intravenously	Intravenous fluid and electrolyte(iso tonic solution)	To restore fluid electrolytes balance and provide glucose for energy.	Patient was well hydrated. The patient skin turgor improved and gained energy.	Fluid overload, example pulmonary oedema. No side effect was observed
14/12/22	Nifedipine	Adult: Initially 30-60mg/day. Maintenance dose up to 120mg/day Rout: orally or sublingual	30mg bd for 30days Route: oral	Antihypertensive/ Anti angina drug	Decrease cardiac work and energy consumption	Blood pressure reduced gradually	Muscle cramps, light-headedness, constipation, joint stiffness, abdominal discomfort and nervousness. Constipation was observed in patient and roughage diet encouraged.
14/12/22	Paracetamol	**Dosage** 0.5–1 g every 4–6 hours; maximum 4g per day **Route** Oral, rectal and IV.	**Dosage** 1g tds x 3 days **Route** Orally	Anti-pyretic/ Analgesic	Has a central analgesic effect that is mediated through activation of descending serotonergic pathways.	Patient had a reduction in pain and temperature	Dark urine, skin reactions, liver damage following overdose. Patient experienced no side effects.

Complications

With reference to the complications stated in the literature review, N.G. did not develop any complication during the period of our interaction. This is because of the quality of care rendered.

2.2 Patient/ Family's Strengths

Strength refers to the ability, capability or resource that can aid the patient to cope with stress especially health problems thereby contributing to his or her speedy recovery. This could be physical, psychological, social and spiritual.

1. (14/12/2022) Patient was able to describe the intensity and the location of pain.
2. (14/12/2022) Patient was able to report when the skin was warm.
3. (15/12/2022) Patient could tolerate oral fluids
4. (16/12/2022) Patient could eat about 5 spoon full of rice and stew served.
5. (16/12/2022) Patient and family were ready to cooperate and learn about the disease condition.

2.3 Patient/Family's Health Problems

Health problems are matters that are difficult to solve. (Samjoi et al, 2017)

1. (14/12/2022) Patient complained of abdominal pain.
2. (14/12/2022) Patient has high body temperature (38.9℃).
3. (15/12/2022) Patient was vomiting and passing diarrhea stools.
4. (16/12/2022) Patient complained of loss of appetite.
5. (16/12/2022) Patient/family have inadequate knowledge about acute gastritis.

2.4 Nursing Diagnosis

A nursing diagnosis is a clear concise and definite statement of the patient health status that can be influenced by nursing interventions.

The following nursing diagnoses were made on Miss N.G during her period of

Hospitalization.

1. (14/12/2022) Altered body comfort (abdominal pain) related to inflammatory process of the stomach.
2. (14/12/2022) Hyperthermia (38.9^0 C) related to ongoing inflammatory reaction of the stomach.
3. (15/12/2022) Risk for fluid volume deficit related to excess loss of fluid through frequent diarrhoea and vomiting.
4. (16/12/2022) Imbalanced nutrition(less than body requirements) related to loss of appetite.
5. (16/122022) Knowledge deficit (patient and family) related to causes, the clinical manifestations, treatment and prevention of gastritis.

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is stage of nursing process in which the nurse and patient/family together consider the goals to achieve in meeting the patient's/family identified or potential problems in daily life and to produce an individual care plan (Weller, 2014). Planning is the third step which involves prioritization of patient's problems, setting of objectives and outcome criteria and outlining the methods of solving those problems. It also includes a statement of specification used to achieve goals specified and documentation of the care plan. It also aims towards designing measures or interventions required to prevent, reduce or eliminate the patient's health problems that were identified during the analysis.

3.1 Patient and Family Care Objectives/ Outcome Criteria

1. Patient would be relieved of abdominal pains within 24 hours as evidenced by:
    a. Patient reporting relief of abdominal pains.
    b. The nurse observing patient been calm and relaxed in bed.

2. Patient body temperature would fall to be within normal range (36.2^0C-37.2^0C) within 6 hours as evidenced by;
    a. The nurse observing a thermometer reading within normal range (36.2°C-37.2°C)
    b. Patient verbalizing that she is no more warm to touch.

3. Patient would maintain normal fluid and electrolyte volume throughout the period of hospitalization as evidenced by:
    a. The nurse recording a balanced intake and output of patient.

b. The nurse observing patient to have normal signs of hydration such as moist mucosa of the lips and the mouth as well as normal skin turgor.

4. Patient's nutritional status would be restored to normal within 48 hours as evidenced by;

a. Patient verbalizing she now have the appetite for food.

b. Nurse observing that patient's weight recording to be normal.

5. Patient and family would attain adequate knowledge on the cause clinical manifestations and prevention of gastritis within 24 hours as evidenced by:

a. Patient and family being able to give correct answers to questions posed on them with regards to the causes clinical manifestations and prevention of gastritis

b. Nurse observed that patient and family recognize the need for medications and understand treatment.

Table 6: Nursing Care Plan for Madam N.G and family

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
14/12/22 9:45 am	Altered body comfort (abdominal pain) related to inflammatory process of the mucosal lining of the stomach.	Patient would be relieved of abdominal pains within 24 hours as evidenced by: a. Patient reporting relief of abdominal pains. b. The nurse observing patient been calm and relaxed in bed.	1. Explain to patient/family the reasons for the pain and the available management. 2. Provide diversional therapy such as watching television and conversing with her. 3. Review factors that aggravate pain or alleviate pain. 4. Provide adequate rest. 5. Administer analgesics as prescribed. 6. Monitor effectiveness of pain medication. 7. Instruct patient to perform deep breathing exercise.	1. The reasons for pain and available management were explained to patient/family. 2. Diversional therapy such as watching of television and engaging patient in conversation was done. 3. Factors to aggravate or alleviate pain were reviewed. 4. Adequate rest was provided for patient. 5. Paracetamol 1g tid was administered. 6. Effectiveness of pain medication was monitored. 7. Patient was instructed to perform deep breathing exercise.	15/12/22 9:45 am	Goal was fully met as patient reported relieved of abdominal pains and nurse observing patient to be calm and relaxed in bed.	**V.A.K**

Nursing Care Plan for Madam N.G and family cont.

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
14/12/22 10:00 am	Hyperthermia (38.9^0 C) related to ongoing inflammatory reaction of the stomach mucosa.	Patient's body temperature would fall within normal range (36.2^0C-37.2^0C) within 6 hours as evidence by; a. The nurse observing a thermometer reading within normal range (36.2°C-37.2°C) b. Patient verbalizing that she is no more warm to touch.	1. Tepid sponge patient 2. Undo heavy patient's clothing. 3. Provide adequate room ventilation. 4. Serve cold drinks. 5 Re-check temperature 15 minutes after tepid sponging. 6. Encourage patient to practice cold bath. 7. Serve prescribed anti-pyretic, antibiotics and observe for any side effects of drug served.	1. Patient was tepid sponged to bring temperature down by 1°C. 2. Pull over were removed and light clothing encouraged. 3. Nearby windows were opened and fans switch on to improve ventilation. 4. Cold drinks such as cold tea was served. 5. Temperature was checked 15 minutes after tepid sponging to determine any improvement in condition. 6. Patient was encouraged to take cold bath. 7. Tablet Paracetamol were served as analgesic for patient respectively.	14/12/22 4:00pm	Goal fully met as evidenced by the nurse recording a temperature value of 36.2^0C.	**V.A.K**

Nursing Care Plan for Madam N.G and family cont.

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
15/12/22 8:00am	Risk for fluid volume deficit related to excess loss of fluid through frequent diarrhoea and vomiting.	Patient would maintain normal fluid and electrolyte volume throughout the period of hospitalization as evidence by: a. The nurse recording a balanced intake and output of patient. b. The nurse observing patient to have good signs of hydration such as moist mucosa of the lips and the mouth, normal skin turgor.	1. Monitor patient's intake and output. 2. Administer Intravenous fluids such as, ringers lactate and dextrose normal saline as prescribed. 3. Assess vital signs, signs and symptoms of dehydration and the laboratory investigations. 4. Encourage patient to drink at least 2-3litres of fluid per day. 5. Collaborate with the nutrition team in the provision of low sodium diet. 6. Provide frequent oral care. 7. Serve prescribed medication (ORS).	1. Patient's intake and output was monitored. 2. Prescribed intravenous fluid such as, ringers lactate and dextrose normal saline was administered. 3. Vital signs, signs and symptoms of dehydration and the results of the laboratory investigation were assessed. 4. Patient was encouraged to drink at least 2-3litres of fluid per day. 5. Collaboration with nutritional team was done in the provision of low sodium diet. 6. Frequent oral care was provided. 7. ORS was served as prescribed.	18/12/22 8:00am	Goal was fully met as the nurse recorded balanced intake and output of patient and nurse observed patient having signs of hydration such as moist mucosa of the lips and mouth, normal skin turgor.	V.A.K.

Nursing Care Plan for Madam N.G and family cont.

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
16/12/22 @ 9:55 am	Imbalanced nutritional status(less than body requirements) related to loss of appetite.	Patient's nutritional status would be restored to normal within 48 hours as evidenced by; a. Patient verbalizing she now have the appetite for food. b. Nurse observing that patient's weight recordings to be normal.	1. Reassure patient and his family that patient will be able to eat normally 2. Plan diet taking into consideration patients likes and dislikes as well as culture. 3. Ensure proper care of the mouth at least twice daily to restore normal function of the taste buds. 4. Serve appetizers before meals. 5. Serve meals in small quantities, at frequent intervals and attractively. 6. Weight the patient daily.	1. Patient and the family members were reassured that madam N.G'S appetite will be restored and she can eat well soon. 2. Meals were planned and served according to the desires of patient and culture 3. Patient was encouraged to brush her teeth twice daily and rinse mouth before and after meals. 4. Fruit juice such as don Simon was served before meals to stimulate madam N.G's appetite. 5. Meals were served attractively, frequently and in small quantities 6. Patient was weight daily to check increment of weight.	18/12/22 9: 55am	Goal was fully met as patient was able to eat more than half of food served.	V.A.K.

Nursing Care Plan for Madam N.G and family cont.

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
16/12/22 10:30am	Knowledge deficit (patient and family) related to cusses, clinical manifestations, treatment and prevention of gastritis.	Patient and family would attain adequate knowledge on the clinical manifestations and prevention of gastritis within 24 hours as evidenced by: 1. Patient and family being able to give correct answers to questions posed on them with regards to the clinical manifestations and prevention of gastritis. 2. Nurse observed that patient and family recognize the need for medications and understand treatments.	1. Assess motivation and willingness of patient and family to learn. 2. Ensure a conducive environment for learning. 3. Establish good interpersonal relationship with patient and family. 4. Educate patient and family about the clinical manifestations and prevention of gastritis. 5. Encourage patient and family to ask questions bothering the mind. 6. Reassess the patient and family of what has been taught.	1. Patient's and family motivation and willingness to learn was assessed by observing his level of concentration. 2. A quiet – free environment was ensured to facilitate learning. 3. Good interpersonal relationship was established with patient and family to facilitate learning. 4. Patient and family were educated on the clinical manifestations and prevention of gastritis. 5. Patient and family were encouraged to ask questions bothering the mind and it was answered. 6. Patient and family were reassessed by asking them to verbalize in their own words what has been taught.	17/12/22 10:30am	Goal met as: 1. Patient and family verbalized correct answers to questions posed to them on the clinical manifestations and prevention of gastritis. 2. Nurse observed that patient and family recognized the need for medications and understand treatments.	**V.A.K**

CHAPTER FOUR

IMPLEMENTING OF PATIENT /FAMILY CARE PLAN

4.0. Introduction

Implementation is the fourth step of the nursing process which includes putting into action the actual nursing interventions mentioned in the care plan (Hornby, 2017). These are activities on the patient's physiological and spiritual needs. This section of the care study includes;

1. Summary of the actual nursing care rendered
2. Preparation of patient and family for discharge and rehabilitation.
3. Follow-ups, home visits and continuity of care.

4.1 Summary of Actual Nursing Care Rendered to Patient and Family

The nursing management of the patient started on the day of admission to the day of discharge. The management aimed at promoting speedy recovery as well as preventing further complications (Guigernsh, 2017). During the period of admission daily routine care was carried out such as bed making, maintaining the personal hygiene and feeding of patient and serving of prescribed medication to the patient. Patient's temperature, pulse and respiration were checked and recorded. Specific care was carried out according to patients need on particular days and is narrated as follows;

First Day of Admission :(14th December, 2022)

On the 14th December, 2022, around 9:30am Madam N.G was admitted through O.P.D to the Females ward of St. Mary's Hospital-Drobo per wheel chair accompanied by a student nurse and two relatives, with diagnosis of Acute Gastritis. She complained of fever, abdominal pain and headache. Vital signs were checked and recorded on arrival as indicated in the appendix.

Per the nursing assessment, three nursing diagnosis were made on the first day of admission:

At 9:45am, patient gave a verbal com]pliant of abdominal pain so a nursing diagnosis of altered body comfort (abdominal pain) related to related to inflammatory process of the mucosal lining of the stomach was made. A goal to help the patient be relieved of abdominal pains within 24 hours was set and the following interventions were carried out: pain and available management were explained to patient/family, diversional therapy such as watching of television and engaging patient in conversation was done, Factors to aggravate or alleviate pain were reviewed, adequate rest was provided for patient, Paracetamol 1g tid was administered, effectiveness of pain medication was monitored and patient was instructed to perform deep breathing exercise.

Assessment at 10:00am revealed that patient has high body temperature (38.9℃) so a diagnosis of Hyperthermia (38.9^0 C) related to ongoing inflammatory reaction of the stomach mucosa was formulated. An objective was set for Patient's body temperature to fall within normal range (36.2^0C-37.2^0C) within 6 hours. Patient was tepid sponged to bring temperature down by 1°C, Pull over was removed and light clothing encouraged, Nearby windows were opened and fans switch on to improve ventilation, Cold drinks such as cold tea was served, Temperature was checked 15 minutes after tepid sponging to determine any improvement in condition, Patient was encouraged to take cold bath and Tablet Paracetamol were served as analgesic and prescribed for patient respectively. At 10:00am, Madam N.G. vital signs were checked and recorded.

At 12:30 pm, patient had rice and stew as lunch. Vital signs were checked and due medications were served and recorded at 2:00pm. At 4:00 pm, objective set at 10:00am for Patient's body temperature to fall within normal range (36.2^0C-37.2^0C) within 6 hours was evaluated and goal was fully met as evidenced by the nurse recording a temperature value of 36.2^0C. She had banku with okro soup for supper and at 6:00pm, vital signs were checked and due medications served. Madam N.G took her evening bath, brushed her teeth and retired to bed at 8:30pm.

Second Day of Admission, (15th December, 2022.)

On the second day of admission, she woke up at 5:40am, according to the night nurses she was assisted in maintaining her personal hygiene that is brushing her teeth and taking her bath. Her bed linen and clothes were changed to make her comfortable. Her breakfast was porridge with bread and it was already taken and her morning medication were served. Her 60:00am, vital sings had already been checked and record.

At 8:00 am, assessment reveled that patient has diarrhoea and vomiting, so a nursing diagnosis of Risk for fluid volume deficit related to excess loss of fluid through frequent diarrhoea and vomiting was formulated. An objective was set to help the patient maintain normal fluid and electrolyte volume throughout the period of hospitalization. The following interventions were carried out: Monitor patient's intake and output, administer Intravenous fluids such as, ringers lactate and dextrose normal saline as prescribed, assess vital signs, signs and symptoms of dehydration and the laboratory investigations, encourage patient to drink at least 2-3litres of fluid per day, collaborate with the nutrition team in the provision of low sodium diet, Provide frequent oral care and Serve prescribed medication (ORS).

At 9:45am, an evaluation of the objective set on the 14th December, 2022 for patient to be relieved of abdominal pains within 24hours was done and goal was fully met as patient reported relieved of abdominal pains and nurse observing patient to be calm in bed.

At 10:00am Madam N.G's vital signs were checked and recorded and due medications were served Ward rounds was done by Doctor Essien and there was no new medication added to patient's drugs. The doctor ordered for continuity of care. She took yam whit kontomire stew for lunch. I used this opportunity to go for my first home visit after work with the help of the information I gathered during the admission process. The purpose was to know patient's residence and the

environment in which she lives to verify the information given to me and also to identify the risk factors such as poor sanitation that could lead to her condition. According to the afternoon nurses, visitors came to visit her and they had a long interaction with her. At 2:00pm vital signs were checked and recorded and patient was made comfortable in bed.

At 5:30pm in the evening supper was served and patient took her bath. Vital sign were checked and recorded at 6:00pm and due medication were served. She brushed her teeth and slept at 8:00pm.

Third Day of Admission, 16th December, 2022

On the third day of admissions, after a long sleep over night, Madam N.G woke up around 5:55am, according to the night nurses she maintain her personal hygiene that is bathing and mouth care. Her was bed linen were changed to make her comfortable. She was served with rice water and bread as breakfast at 6:15am. Patient's vital signs were checked and recorded at 6:00am.

The ward doctor came to review her condition and ordered that she should be monitored well and continued treatment.

At 9:55am, patient complained that she is was unable to eat well due of loss of appetite so a nursing diagnosis of imbalanced nutritional status(less than body requirements) related to loss of appetite was formulated. An objective was set to help the patient restore her normal nutritional status within 48 hours. The following intervention were carried out: Patient and the family members were reassured that madam N.G'S appetite will be restored and she can eat well soon., Meals were planned and served according to the desires of patient and culture, Patient was encouraged to brush her teeth twice daily and rinse mouth before and after meals, Fruit juice such as don Simon was served before meals to stimulate madam N.G's appetite, Meals were served attractively, frequently and in small quantities and Patient was weight daily to check increment of

weight. At 10:00am vital signs were checked and recorded and due medications were served as prescribed.

At 10:30am, patient and her relative were engaged in a conversation and it was realized that patient and her relative did not have adequate knowledge on her condition (gastritis).A nursing diagnosis of Knowledge deficit (patient and family) related to cusses, clinical manifestations, treatment and prevention of gastritis. Interventions carried out were: assess motivation and willingness of patient and family to learn, ensure a conducive environment for learning, establish good interpersonal relationship with patient and family, educate patient and family about the clinical manifestations and prevention of gastritis, encourage patient and family to ask questions bothering the mind and reassess the patient and family of what has been taught. At 2:00pm, Madam N.G vital signs were checked and recorded and due medication were served, she was served with banku with groundnut soup and was able to eat half of food served. After her lunch, she was made comfortable in bed. At 5:30pm her supper was served and was able to eat food been served. Patient vital signs were checked and recorded at 6:00pm.Patient had warm bath and brushed her teeth around 6:55pm and slept around 7:30pm.

Fourth day of Admission, 17th December, 2022.

Patient slept soundly during the night according to the night nurses and woke up at 6:00am and her vital signs were checked and recorded.

Patient was reviewed by the doctor at 8:00am and he ordered that her treatment should be continued. On examination patient looked cheerful and active. At 10:00am patient's vital signs were checked and recorded and due medication were served. At 10:30am, an evaluation of the objective set on the 16th December, 2022 that patient and family would attain adequate knowledge on the clinical manifestations and prevention of gastritis was done and goal was fully met as patient

and family verbalized correct answers to questions posed to them on the clinical manifestations and prevention of gastritis.

At 2:00pm, Madam N.G's vital signs were checked and recorded and due medications served, she was served with rice and beans stew and she was able to eat food served. After her lunch, she was made comfortable in bed. At 5:30 pm, in the evening supper was served and she had her bath and at 6:00pm vital signs were checked and recorded and due medication were served and she slept around 8:40pm.

Fifth Day of Admission, (18th December, 2022) Day of Discharge.

Madam N.G woke up happily this morning at 5:30am since she had a good night sleep as she told me, and also because she knew she could be possibly discharged home today. She took porridge with bread as breakfast.

Her 6:00am vital signs were checked by the night nurses and recorded.

At 8:00am, an evaluation of the objective set on the 15th December, 2022 for patient to maintain normal fluid and electrolyte volume throughout the period of hospitalization was done and goal was fully met as the nurse recorded a balanced intake and output of the patient and the nurse observed patient to have good signs of hydration such as moist mucosa of the lips and the mouth and normal skin turgor. At 8:30am during ward round, patient was discharged by the word Medical Officer since her condition was improved and she had no complains.

At 9:55am, an evaluation of the objective set on the 16th December, 2022 that patient's nutritional status would be restored to normal within 48 hours was done and goal fully met as patient verbalized she now have the appetite for food and nurse observed that patient ate more than half of every food served on normal sized plate. Her relative was informed and the bills were assessed to be paid and took the opportunity to educate patient on how to take the rest of her drugs and the

need to continue the drug treatment after discharge as well as maintaining personal hygiene and the need for follow ups and checkups. All discharged papers were duly signed by the discharging doctor. Syrup Aluminum hydroxide15ml three times a day for 14 days was prescribed for patient to take home. She was informed to come for review on 26th December, 2022.

I also reminded her on the education given on gastroenteritis with regards to the causes, mode of transmission, signs and symptoms, management and its prevention. Emphasis was again placed on good environmental hygiene such as proper refuse disposal and hand hygiene.

At 10:00am, her folder was sent to the billing officer for billing. Patient did not pay huge amount for the bills since she was having National Health Insurance Scheme. Her particulars were entered into the Admission and Discharge book and the daily ward state. The folder was later taken to the medical records and around 11:45am, patient was ready to go home so I helped them in packing their belongings. Bed linen used by the patient was sent to the sluice room and the mattress was well disinfected and remade with clean linen. Patient and family said goodbye to the other patients in the same cubical. She went to the ward in-charge to thank him and the rest of the staff on the ward. I accompanied the patient to the taxi rank opposite to the hospital gate. I promised to visit them in their home to know the state of their health. Finally, we bade each other goodbye.

4.2 Preparation of Patient/Family for Discharge and Rehabilitation

Preparation of patient/family for discharge started from day of admission when patient and relative were told that the hospital was not going to be her permanent living environment but she would be discharged home soon after competent care that would be rendered to her. This was done to help the patient to adjust to the hospital environment and live a healthy and normal life after hospitalization. Patient and her relative were educated on the main causes of gastroenteritis, the mode of transmission, signs and symptoms, complications and the preventive measures.

She was advised to avoid self-medication and to stop over the counter drugs sand the need to come to the hospital anytime for proper treatment and even if review date is not due. Education was made for my patient and family to put a stop to this by revealing the effect of such drugs to them and educated on the need to complete the rest of the treatment regimen and to follow the correct route, time, and dosage and the need for follow up or review. They were reassured that I would visit them at home.

Her name was entered into the admission and discharge book and also the ward daily state. Some of her bills were covered by National Health Insurance Authority.

I helped them to pack the rest of their things into their luggage. I accompanied them to the entrance of the hospital where they boarded a taxi. I bade them good-bye when the car set off. They left the entrance around 12:00pm on the day of discharge.

4.3 Follow-Up/ Home Visits/ Continuity of Care

Home visit is a visit to the home of the patient/family to assess the home and the family situation in order to provide the necessary nursing care and health related activities. Home visit could be routine or selective before or after the patient has been discharged. A routine home visit is a regular visit that the nurse makes to a patient's house to offer advice regarding how to cope with a situation. The selective home visit on the other hand deals with the nurse having a list of patients and their diagnosis and it may be a first time visit. The first home visit was on the 15th December, 2022, and the second one was on the 25th December, 2022 and the last one was on 28th December, 2022.

4.3.1 First Home Visit, (15th December, 2022.)

My first home visit to patient's house 'Boadwo'' Drobo was on the 15th December, 2022 at 10:30 am while she was still on admission. I was accompanied by a friend to the house, we board a taxi

at the taxi station and reached the town at 11:20am. This visit was to find out the environment in which the patient lives and help to identify problems that contributed to the patient's illness and find ways of solving them before the patient was discharged as well as factors that contribute to good health through health education. This was a selective home visit because it was the first time of visiting the patient's place of residence. When we alighted from the taxi: we walk for about 30minte and we got a 'motor king'' rider and we reached the patient's place within 20minutes. The house was situated few meters from a school called BOADOW L.A. When we got to the house, we met two people (one was a sibling of Madam N.G) We greeted and introduced ourselves to them as student nurses taking care of Madam N.G at the hospital for a study and they welcomed us. We were offered a seat and as well as water. I told them that I came to visit them in order to find out information that can help in the management of Madam N.G. My assessment of the house revealed that there were five bedroom building. With house number B123/8 Boadwo. The house was a compound house built with bricks, the front was plastered but the back was not .It was well roofed with aluminum iron sheets. Apparently they do not have a well-built kitchen. Their main source of fuel for cooking was firewood and charcoal. Their source of water is a borehole which was not far from their house and rain water which was stored in barrels without lids. The bathroom and toilet were temporal detached building at the back of the house. Even though the toilet was clean, container for collecting toilet papers was not covered. Their waste was kept in a dust bin which was covered and emptied every day. The surrounding was clean and tidy and this would promote faster and quick recovery of the patient but there were weeds at the back of the house. I then took advantage to educate them on the need to weed around the house and the need for personal and environmental hygiene like washing of hands with soap under running water before meals and after visiting the toilet, washing of utensils before using and

after eaten from it, the need to protect food from flies and covering of their water and frequent washing of the barrels and also educated them on the condition (gastritis); its causes, mode of transmission, signs and symptoms and prevention and to visit the hospital any time they are sick and put a stop to self-medication. There was a boy of four years old in the house I use the opportunity to study about his Road to Health Chart (RTHC) and discovered that he was fully immunized and also had growth pattern according to his age. The mother was encouraged to continue her care. We sought for permission to leave and they escorted us by taking us on a motor bike to the road side and waited till we had a taxi and said goodbye to them. There was no health facility in the community.

4.3.2 Second Home Visit, (25th December, 2022.)

The second home visit was to assess the health of the patient and to know whether the education given to patient and family during the period of hospitalization and first home visit was adhered to. A day before the review date, I paid Madam N.G and her family a visit at their home as planned. I left from my house at 2:00pm and got to the road side around 2:15pm, boarded a taxi and arrived at Madam N.G's house at exactly 3:00pm.When I got to the house, I greeted them and I was offered a seat and water. I was very happy to see madam N.G doing well. I told them of my mission for coming to the house that was to know if Madam N.G was doing well.

Finally, I reminded them of the review date which was 26rd December, 2022 and its importance. After assessing the surrounding, I congratulated them for keeping to the health education. The barrels were covered with a lid, the weeds were also cleared. The causes, mode of transmission, signs and symptoms, ways of preventing gastritis could be repeated to me by patient and the relatives. I encourage them to keep on doing more and also ask them to ask if they have any question. In the absence of any questions or problems, I took the opportunity to ask about her

drugs and her daughter confirmed that patient had been taking her drugs as prescribed and when I inspected the drugs, it indicated that she had been taking them as prescribed. I told them I would be coming for another home visit but did not tell them the exact day. I sought permission from Madam N.G and her family to leave and it was granted so they escorted me to the road side where I boarded a taxi and came back to my house safely at 5:40pm.

Day of Review (26th December, 2022)

On Monday 26th December, 2022, at 9:00am Madam N.G came to the St. Mary's Hospital, Drobo for review. I went and met her at the Out-Patient department looking cheerful as noted from her facial expression and helped her to take her card to the records. Upon my interaction with patient, I observed that her condition had really improved. Her vital signs were checked and recorded as:

- Temperature: 36.6 degree Celsius
- Pulse Rate: 95 beats per minute
- Respiration: 20 cycles per minute
- Blood pressure: 130/70 millimeters of mercury
- SPO2: 97%

At the Out-Patient department, patient was seen by the medical officer at consulting room 2. Upon assessment by the doctor Madam N.G was healthy, she did not have any complaint and no medication was given to her. She was encouraged to practice personal and environmental hygiene to protect her from getting diseases. She thanked me for everything I did and asked me to visit them whenever I was free and I accompanied her to the entrance of the hospital gate and said goodbye to her.

4.3.3 Third Home Visit after Discharge (28th December, 2022)

My last home visit was made on the 28th December, 2022. The aim of the visit was basically to terminate care with my patient and family which were discussed on my previous visit. It was also to officially handover patient to the family for the continuity of care. I also aimed at finding out how the patient was doing after the review.

I set off around 9:15am and I arrived at around 10:20am. I was welcomed by my patient and family. They offered me a seat. My mission of the visit was asked and I told them that, I was there to terminate the care I had with them and also to handover Madam N.G to the family for the continuity of care. During a quick assessment, I found out that, Madam N.G was doing very well and they were also following the treatment regimen. I told patient's daughter that the care has officially ended, but she should not hesitate to call me anytime they needed my help. I used this opportunity to thank them for giving me the chance to use them for the patient and family care study. I told them that I was a student and I would have to go back to campus to continue my education, and for that reason I would not be able to visit them frequently, but I would pay them friendly visit when the opportunity comes. I therefore handed over patient to the family because there were no Health facility there. I bade them goodbye and they escorted me to the station to board a car at 3:00pm.

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, 2014). The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to patient and family.

5.1 Statement of Evaluation

According to Bare (2012), evaluation is defined as the final stage in the learning process and is a measure of the degree to which the patient has mastered the learning objective. Patient was admitted to the Females Ward with the diagnosis of Acute Gastritis. All goals and objectives were fully met. Below is the summary of the interventions carried out and to what extent the goals were met:

1. **Patient was relieved of abdominal pains.**

On 14th December, 2022 around 9:45am, patient gave a verbal complaint of abdominal pains so a nursing diagnosis of altered body comfort (abdominal pain) related to inflammatory process of the mucosa lining of the stomach was made. A goal was set to relieve patient of abdominal pains within 24 hours. The following interventions were carried out to meet the objective set; the reasons for pain and available management were explained to patient/family, diversional therapy such as watching of television and engaging patient in conversation was done, factors to aggravate or alleviate pain were reviewed, adequate rest was provided for patient, Paracetamol 1g tid was administered, effectiveness of pain medication was monitored and patient was instructed to perform deep breathing exercise. On the 15th December, 2022 at 9:45am the objective that was set

was evaluated and goal was fully met as patient reported relieved of abdominal pains and nurse observing patient to be calm in bed.

2. **Patient regained his normal body temperature (36.2℃-37.2℃)**

On the 14th December, 2022, around 10:00am patient had high body temperature so a nursing diagnosis of Hyperthermia (38.9^0 C) related to ongoing inflammatory reaction of the stomach was made. An objective was set for patient's body temperature to fall within normal range (36.2^0C-37.2^0C) within 6 hours. The following nursing intervention were carried out: patient was tepid sponged to bring temperature down by 1°C, pull over were removed and light clothing encouraged, nearby windows were opened and fans switch on to improve ventilation, Cold drinks such as cold tea was served, temperature was checked 15 minutes after tepid sponging to determine any improvement in condition, Patient was encouraged to take cold bath and Tablet Paracetamol was served as analgesic for patient respectively. On the 14th December, 2022 around 4:00pm, the objective for patient body temperature to fall within normal rang was evaluated and goal was fully met as evidenced by the nurse recording a temperature value of 36.2^0C.

3. **Patient maintained normal fluid and electrolyte volume throughout the period of hospitalization**

On 15th December, 2022 at 8:00am assessment revealed that patient had diarrhea and vomiting so a nursing diagnosis of Risk for fluid volume deficit related to excess loss of fluid through frequent diarrhoea and vomiting was made and goal to help patient maintain normal fluid and electrolyte volume throughout the period of hospitalization was set. The following nursing interventions were carried out: Patient's intake and output was monitored, prescribed intravenous fluid such as, ringers lactate and dextrose normal saline was administered, vital signs, signs and symptoms of dehydration and the results of the laboratory investigation were assessed, patient was encouraged

to drink at least 2-3litres of fluid per day, collaboration with nutritional team was done in the provision of low sodium diet, frequent oral care was provided and ORS was served as prescribed. On the 18th December, 2022 around 8:00am, the objective that was set on the 15th December, 2022 was fully met as the nurse recorded balanced intake and output of patient and nurse observed patient having signs of hydration such as moist mucosa of the lips and mouth, normal skin turgor.

4. **Patient's nutritional status was restored to normal.**

On the 16th December, 2022 around 9:55am patient complained that, she is unable to eat due to loss of appetite so a nursing diagnosis of Imbalanced nutrition(less than body requirements) related to loss of appetite. An objective was set to help patient restored her normal nutritional status within 48 hours. The following interventions were carried out; Patient and the family members were reassured that madam patient's appetite will be restored and she can eat well soon, meals were planned and served according to the desires of patient and culture, patient was encouraged to brush her teeth twice daily and rinse mouth before and after meals, fruit juice such as don Simon was served before meals to stimulate madam N.G's appetite and Meals were served attractively, frequently and in small quantities.

On the 18th December, 2022 at 9:55am, an evaluation of the objective set on the 16th December, 2022, that patient will restore her normal nutritional status within 48 hours was done and goal was fully met as patient was able to eat more than half of food served.

5. **Patient and family attained adequate knowledge on gastritis.**

On the 16th December, 2022 at 10:00am patient and family were engaged in an interaction and it was realized that patient and relative had less knowledge on gastritis. The nursing diagnosis formulated was; Knowledge deficit (patient and family) related to lack of adequate information on the clinical manifestations and prevention of gastritis. Intervention carried out were; Patient's and

family motivation and willingness to learn was assessed by observing his level of concentration, a quiet – free environment was ensured to facilitate learning, good interpersonal relationship was established with patient and family to facilitate learning, patient and family were educated on the clinical manifestations and prevention of gastritis, patient and family were encouraged to ask questions bothering the mind and it was answered and Patient and family were reassessed by asking them to verbalize in their own words what has been taught.

On the 17th December, 2022 at 10:30am the objective set for patient and family to attain adequate knowledge on the clinical manifestations and prevention of gastritis within 24 hours was evaluated and goal was fully met as patient and family were able to answer question on gastritis correctly.

5.2 Amendment of the Nursing Care Plan

Despite the numerous problems identified, with the nursing care rendered and support from the staff and co-operation of Madam N.G and her family, all of the goals set were fully met. The care plan was therefore not amended.

5.3 Termination of Care

Every nurse-patient relationship at the hospital needs to be terminated. However, this is a very difficult step to take after a good rapport has been established. Because of this, the reality of termination of care has to be made known to both patient and family from the day of admission.

The termination of Madam N.G's care started on the first day of interaction with her and her family. To avoid separation anxiety, they were told that, our relationship was a therapeutic one and would last for a reasonable period. They were informed that I would not be able to stay on the ward for 24 hours with them, hence the need for their co-operation with other nurses and paramedical staff on the wad. Therefore, they were not surprised when they were finally told about the termination of the care and my relationship with them on 28th December, 2022 when I went

for my third and final home visit. The aim of the visit was basically to terminate care with my patient and family which were discussed on my previous visit. It was also to officially handover patient to the family for the continuity of care. I also aimed at finding out how the patient was doing after the review.

I set off around 9:15am and I arrived at around 10:20am. I was welcomed by my patient and family. They offered me a seat. My mission of the visit was asked and I told them that, I was there to terminate the care I had with them and also to handover Madam N.G to the family for the continuity of care. During a quick assessment, I found out that, Madam N.G was doing very well and they were also following the treatment regimen. I told patient's daughter that the care has officially ended, but she should not hesitate to call me anytime they needed my help. I used this opportunity to thank them for giving me the chance to use them for the patient and family care study. I told them that I was a student and I would have to go back to campus to continue my education, and for that reason I would not be able to visit them frequently, but I would pay them friendly visit when the opportunity comes. I therefore handed over patient to the family because there was no Health facility there. I bade them goodbye and they escorted me to the station to board a car at 3:00pm.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

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

6.1 Summary of Care Rendered

Madam N.G a 51- year- old was admitted into the Female Ward of St. Mary's Hospital Drobo on the 14th December, 2022 with the diagnosis of Acute Gastritis. She complained of fever, abdominal pain, headache, vomiting and diarrhea. Her vital signs were checked and recorded as:

- Temperature: 37.5 degree Celsius
- Pulse Rate: 96 beats per minute
- Respiration: 21 cycles per minute
- Blood pressure: 150/90 millimeters of mercury
- SPO2: 98%

She spent a total of five days at the hospital. During her period of hospitalization five (5) health problems were identified. These were of fever, abdominal pain, headache, diarrhea, general body weakness, vomiting and anorexia and inadequate knowledge about diseases condition. Nursing diagnosis was formulated for each of the problems and in order to solve these problems, objective were set, nursing orders were given, orders were implemented and all the goals were fully met. The following investigation were carried out:

- Blood for full blood count
- Blood specimen for malaria parasite
- Urine for routine examination

She was managed with the following medications;

1) IV Omeprazole 80mg stat then 40mg bd for 24 hours
2) Syrup Aluminium hydroxide 15mls tds for 5day
3) Tablet Paracetamol tid for 3 days
4) IV ciprofloxacin 400mg bd for 24hours
5) IV metoclopramide 10mg tds for 24hours
6) Inj Hyoscine Butylbromide 40mg stat
7) IVF Ringers Lactate 2L for 24hours
8) IVF Normal Saline 1Lfof 24hours
9) IV Dextrose in Normal Saline 0.5L stat
10) Tb Nefidepine 30mg bd for 30days

On 26th of December 2022, patient and daughter reported for review as scheduled by the doctor and Madam N.G condition had improved. Three follow up visits were made to assess the home situation, to find out the actual and potential problems that contributed to the patient's illness and also to find ways of solving them, find out if patient was able to observe the drug regimen and to know her response to treatment after leaving the hospital. Moreover, to find out if patient/family is carrying out the advice and all education given to improve patient/family's health and standard of living. My first home visit was on 15th December, 2022, second home visit was on 25th December, 2022 and the third home visit was on 28th December, 2022. Patient care was terminated finally when she was handed over to her family for continuity of care.

6.2 Conclusion

In conclusion, the patient and family care study has helped me to know and understand comprehensive and holistic nursing care given to individual patient and family. Also, through this case study, I have really gained a lot of knowledge on gastritis after nursing Madam N.G and her family. It has enabled me to obtain much insight into her condition. It has given me an in depth knowledge on the causes, signs and symptoms, diagnosis, treatment, complications and possible prevention of the disease condition. This study has also enabled me put into practice all that I have learnt during my training as a nursing student. It has also enabled me understand a family's attitude towards illness and behaviours of individuals when they fall sick. Also, the patient/family care study can also serve as a source of reference for other students and hospital staffs who want to embark on same or similar studies.

My recommendation is that all patients should be given individualized, holistic, comprehensive and competent nursing care to help decrease re-occurrences of diseases in our hospitals as well as reducing mortality rate. I hope and believe that the additional knowledge and experience I have acquired while nursing Madam N.G and her family would help me offer expert and comprehensive nursing care to other patients in the health setting and community as a whole. Also, it is my recommendation that all students should be given the opportunity to embark on the patient/family care study in order to render individualized comprehensive care to patients/families.

APPENDIX

Date	Time	Temperature (℃)	Respiration (cpm)	Pulse (bpm)	Oxygen Saturation (%)	Blood Pressure (mmHg)
14/12/22	09:45am	37.5	21	96	98	150/90
	02:00pm	36.7	19	89	96	150/90
	06:00pm	37.8	20	101	90	130/90
	10:00pm	36.7	21	93	95	140/90
15/12/22	06:00am	36.5	22	100	95	155/90
	10:00am	36.8	20	95	97	140/90
	02:00pm	37.2	19	90	99	150/90
	06:00pm	36.2	18	95	98	130/70
	10:00pm	37.4	22	98	99	140/90
16/12/22	06:00am	36.6	21	93	90	130/90
	10:00am	36.2	22	89	95	140/90
	02:00pm	36.7	19	100	97	130/90
	06:00pm	37.4	20	95	96	140/90
	10:00pm	37.2	19	90	99	130/80
17/12/22	06:00am	36.6	21	93	95	130/90
	10:00am	36.8	18	96	66	150/90
	02:00pm	37.1	20	95	99	150/90
	06:00pm	36.6	22	93	100	140/90
	10:00pm	36.9	19	93	98	130/70
18/12/22	06:00am	36.7	21	93	98	140/90

BIBLIOGRAPHY

Cheever, J. L. (2010). Brunner and Suddarth Textbook Ofbu9d Medical- Surgical Nursing 13th ed. Philadelphia: Lippincott William & Wilkins.

Erickson, E. (2016, 07 09). Retrieved from Simple psychology : http// www.simplypsychology.org/@12 :36pm

Ferris, F. F. (2017, 05 02). Ferri's Netter Patient Advisor.). . . (2 ed.). China: Elsevier Science Ltd. Retrieved from Ferris, F. Fred. (2011). Ferri's Netter Patient Advisor. (2nd Ed). China. Elsevier Science Ltd.

Grant, A. W. (2014). Ross and Willson Anatomy and Physiology. New York: Elsevier Limited.

Janice L. Hinkle, K. H. (2014). In brunner & suddath's of medical-surgical nursing (pp. 792793). China: Lisa McAllister works press.

Karch, A. M. (2019). Lippincott's Nursing Drug Guide.

Lewis, H. D. (2016). Medical-Surgical Nursing (5th ed.). United State of America: A Harcourt Science Company.

Longe, S. (2019, 07 14). www.en.m.org/wiki/sickle cell diseasecauses. Retrieved from

McIntosh, C. (2017). Cambridge Advanced Learner's Dictionary (4th ed) .

Merriam-Webster. (2021). Merriam-Webster dIctionary.

Myers, G. (2003). Mosby's Nursing Care Plan (5th ed.). Philadelphia: Elsevier Mosby Company.

Platte, A. O. (2019, October 8). Medscape. Retrieved January 24, 2021, from http://WWW.medscape.com

Smeltzer, S. C. (2008). Brunner & Suddarth's Textbook of Medical and Surgical Nursing. (12th edition ed., Vol. I). Philadelphia: J.B Lippincott Company .

The nursing process, A practical guide for nursing & midwifery students. . (2016). Berekum – Ghana: Sir Ernesford Publications.

Weller, B. F. (2018). Nurses Dictionary. New york: Elsevier.

Weller, F. B. (2002). Balliere's Nurse's Dictionary (24th ed.). London : Royal College of Nursing.

Hornby, M., & Myers, J.L. (2017). Nursing care plans: Nursing diagnosis and Intervention (6th ed.). St. Louis, United States: Elsevier.

Med-ed. Virginia. education, P., & Burke M.K. (2010). Medical- surgical nursing: critical thinking in patient care (4th ed.).Pearson/P

Patient folder number : BR-A13-AAF0227 St. Mary's Hospital Drobo

SIGNATORIES

The Student Nurse

NAME: Konadu Vincentia Ataa

Signature: ……..

Date: ……...

The Nurse-In-Charge of Female's Ward (St. Mary's Hospital, Drobo)

Name……

Signature: ……..

Date: ……..

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

Name: Mr. Eric Obeng

Signature: ……..

Date: ……..

The Principal (Holy Family Nursing and Midwifery Training College, Berekum)

Name: Monica Nkrumah

Signature: …….

Date……

SIGNATORIES

The Student Nurse

Name: Konadu Vincentia Ataa

Signature: .....

Date: 07/07/2023

The Nurse-In-Charge of Female's Ward (St. Mary's Hospital, Drobo)

Name: Akoffu David

Signature: .....

Date: 10/07/2023

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

Name: Eric Obeng

Signature: .....

Date: 07/07/2023

The Principal (Holy Family Nursing and Midwifery Training College, Berekum)

Name: Monica Nkrumah

Signature: .....

Date: 10/07/2023

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM