HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT AND FAMILY CARE STUDY
ON
GASTROENTERITIS

BY

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

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PREFACE

The Patient/Family care study is a detailed write up of the care rendered to a patient and family by a final year student nurse. It entails a record of encounter between the patient, family and community on one hand and the healthcare team on the other hand, right from patient's admission until termination of care by the student nurse. The patient/family care study gives an opportunity to the student-nurse to interact with the patient in order to identify his strengths and health problems, and to put in measures to help the patient recover in good time. It exposes the student nurse to the real-world situation and experiences as he/she interact with the patient and relatives as well as with other health care providers. This prepares him/her for the professional practice ahead. The patient/family care study build on good communication skills, interpersonal relationship and research skills of the student nurse. My reason for carrying out this patient/family care study is that, as a final year student, it is a pre requisite by the Nursing and Midwifery Council that I achieve this objective in partial fulfilment for the award of licence to practice as a registered general nurse in Ghana. Also, this care study will enable me to translate my theoretical knowledge into practice in assessing, planning, implementing and evaluating nursing care. For the purpose of confidentiality, all persons referred to in this report will only be identified by their initials

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All praises and thanks be to the Almighty God, the sustainer of life who gave me the strength to start and complete this care study successfully.

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INTRODUCTION

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

The nursing process has five components. These are assessment, analysis, planning, implementation and evaluation.

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

This patient/family care study was carried out on a one year three-month-old boy who for the purpose of confidentiality, will be referred to as Master M.K.Y. The nursing care rendered to Master M.K.Y started on 8th December, 2022, when he was admitted to the Paediatric Ward of Holy Family Hospital, Berekum, with diagnosis of Gastroenteritis. Patient problems were identified such as abdominal pain, diarrhoea and vomiting, high body temperature, loss of appetite and body weakness and nursing diagnosis were formulated to help manage patient.

The following diagnostic test was carried out on client;

1. Full blood count
2. Malaria test

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

1. Intravenous paracetamol 10MG/KG (98mg) tid for 1 day

2. Oral rehydration salt powder (100ml after each stool)
3. Zinc Tablet 20mg daily for 10 days
4. Intravenous Ringers lactate 500ml Stat
5. Intravenous cefuroxime 30MG/KG (294mg) bid for 24 hours
6. Syrup paracetamol 5 mls tid for 5 days

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CHAPTER ONE

ASSESSMENT OF PATIENT /FAMILY

1.0 Introduction

According to McIntosh (2017), assessment is the act of judging or deciding the amount, value, quantity, or importance of something. It is the systematic collection of data to determine patient's current and past health status. The assessment gives the nurse more information about the patient, his family and the entire community.

This chapter is the first step of the nursing process which involves the collection of data concerning the patient, family and environment. This is done through interview, observation, examination and the use of medical records. This chapter also gives the general background information about the patient and family as well as the community in which they live. It comprises of the patient's particulars, the family medical and socioeconomic history, the patient's developmental history, his lifestyle and hobbies, patient past medical history, patient present medical history, admission of patient, patient's concept of illness, literature review and validation of data. All these pieces of information are gathered gradually starting from the day of admission. The information will be gathered from the patient, reports, relatives and friends as well as significant others.

1.1 Patient's Particulars.

According to McIntosh (2018), particulars are the details or information about a person or an event especially when officially recorded.

The name of my patient is Master. M.K.Y. He is a 15 months old child, born on 8th september, 2021, at Berekum in the Bono Region of Ghana to Mr. I.T and Mrs. S. M. both from Berekum in

the Bono Region of Ghana. Master M.K.Y. is the last born of the 2 children of his parents. Master M.K.Y resides at New Biadan in Berekum with the house number (NB02) with his parent and siblings. Master M.K.Y speaks Asante Twi fluently. He is fair in complexion, about 0.6cm tall and weighs 9.8 kg. Master M.K.Y family stayed at zabzugu in the northern region before coming to stay in Berekum which they leave currently. They are Christian and attends Roman catholic church. Master M.K.Y has not attended school yet. Master M.K.Y. is on valid National Health Insurance Scheme which help reduce his cost of his hospitalization.

1.2 Patient/Family Medical History

According to Master M.K.Y's mother, only their grandmother had hypertension. Apart from her, there is no other familiar history of chronic or hereditary diseases such as sickle cell disease, asthma and diabetes mellitus. The family has no history of mental illness and have no known allergies. His parents as well as his siblings are alive and in good state of health. The rest of the family members however suffer from minor illness like headache, cough, abdominal pains and fever and these are treated at the OPD and sometimes with the use of over the counter drugs. Based on this information, I educated patient and family on the dangers of over the counter medications. The family use both orthodox and herbal medicine. There have been several members of the family who have been hospitalized on several occasions but were successfully discharged from the hospital.

1.3 Patient/Family's Socio-Economic History

Socioeconomically, client's family belongs to the middleclass income group because his father been a civil servant and mother been a trader who earn adequate income for the upkeep of their children**.** Patient is fully dependent on his family for survival their source of finance for medical

care is the national health insurance scheme (NHIS). The family has a good relationship with everyone. There are no taboos governing the family but they cherish good moral values and also practice customary marriage.

1.4 Patient's Developmental History.

Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Taylor, 2019). Growth refers to an increase in amount of certain physical characteristics of human beings throughout life span (Taylor, 2019). Maturation refers to the acquisition of new characteristics or competencies that are genetically influenced (Taylor, 2019).

According to Master M.K.Y's mother, he was delivered safely at term through caesarian delivery without complications at Holy Family Hospital, Berekum, because of short interval between her first born and last born. According to Master M.K.Y's mother, he was breastfed for six months exclusively and together with other feeds (Complementary feeding) after the six months. According to the mother, Master M.K.Y was able to sit on the 5th month with support. He started crawling at the 7th month and talking in 12 months. He walked at age 10 months, He therefore developed motor and mental abilities normally Master M.K.Y has received all the immunization against the childhood vaccine preventable disease. Master M.K.Y has not started schooling according to her mother.

Erikson's theory of psychosocial development describes the human life cycle as a series of eight egos developmental stage from birth to death. Each stage is characterized by a distinct conflict, or crisis, relating to the person's physiologic maturation and to what society expects of a person at that age.

In respect to patient's age and psychosocial behavior, Master M.K.Y falls under the Trust versus Mistrust since he is 15 months old.

1.5 Patient's Lifestyle/Hobbies

According to the client's mother, Master M.K.Y's sleeps around 8:30pm and wakes up around 5:00am. Patient is found playing most at times when he wakes up every morning. He is bathed twice daily and empties the bowel and bladder when necessary. He had his breakfast as ear as 7 am in the morning and also sometimes takes some food at 10 am. Patient mother said he sometimes eat about four times a day. On Sundays too, they usually attend church after patient had finished taking his breakfast. He has not yet attended school. According to my Patient's mother, Master M.K.Y is not allergic to any food or drug as at his age. She also said that, her child tries beating his elder sister sometimes.

1.6 Patient's Past Medical/Surgical History

Information from the mother indicates that the client's had never been hospitalized before. However, he experiences some minor ailment like high body temperature which is been treated with drugs from the Over-the-counter. And also, client was brought to hospital with an eye problem in about three weeks ago. The mother said, Master M.K.Y had never experienced any childhood illness like poliomyelitis, measles, tetanus, tuberculosis, and diphtheria and has not identified any allergy to drugs, animals or insects. Information from the mother indicates that, Master M.K.Y. had never had any accident or injuries since he was born and therefore have no physical disabilities. Patient mother said, the last time patient came to the hospital was three weeks ago of which he came with an eye problem and was then given drug to take back home.

1.7 Patient's Present Medical History

Mrs. S.M. said that, her son was well until 7th December, 2022 evening, when she noticed that her son is vomiting with diarrhea. This was associated with pain because patient was often found holding stomach whilst crying, elevated temperature and general weakness. According to the mother, she rushed him to the under-five unit of Holy Family Hospital, Berekum around 6:30am where he was seen by Dr. Salamat and was diagnosed of Gastroenteritis. According the mother, the presenting signs and symptoms occurred suddenly. He was admitted to Pediatric Ward for the continuity of care.

1.8 Admission of the patient

On 8th December, 2022, the patient was brought to the pediatric ward 8:30am by the mother via under-five unit. She was warmly welcomed and was offered a seat. The child was immediately placed in a bed. The client's mother was however reassured and certain particulars such as name, age, sex, date of admission, residential address and the diagnosis were recorded in the admission and discharge book at the nurses' station. The client's mother was later introduced to the ward and reassured again by the nurses. Vital signs were checked and recorded as follows;

Temperature	38.0ºC
Pulse	175bpm
Respiration	42cpm
Oxygen saturation	99%

Physical examination on the patient was performed from head to toe and no abnormalities were seen. Assessment carried out on admission revealed that patient had a grimaced facial expression

depicting patient was in pain, the mother also complained of persistent high body temperature, diarrhoea, vomiting and often holds stomach when crying.

Patient and family were oriented to the ward and its environments and daily ward routines were adequately explained to them. Hospital policies regarding visiting periods were explained. Patient was also introduced to other patients and available staffs. Patient was placed in a private room. His treatment plan was as follows:

1. Intravenous Paracetamol 10MG/KG (98mg) tid for 1 day
2. Oral rehydration salt powder (100ml after each stool)
3. Zinc Tablet 20mg daily for 10 days
4. Intravenous Ringers lactate 500ml Stat
5. Intravenous cefuroxime 30MG/KG (294mg) bid for 24 hours
6. Syrup paracetamol 5 mls tid for 5 days

The following investigations had already been carried out:

1. Full blood count
2. Malaria test

I introduced myself to Master M.K.Y. and his mother as a final year student of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to seek his and her family's permission and to take him for my care study. Master M.K.Y. and his mother were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of license to practice as a Registered General Nurse. I explained to

the patient and his mother the concept of the patient/family care study and assured them of privacy and confidentiality. It was added that a report will be written after the entire event. I also explained to them how care is going to be rendered to the child from the time of admission until discharge and also visit her residence during his admission and after he has been discharged as well. They agreed to my request. I then expressed my gratitude to them. I decided to choose this patient for the study because I wanted to get a deeper understanding about the causes, signs and symptoms, prevention and treatment of gastroenteritis and to be able to differentiate it from other similar abdominal conditions. Patient was weighed and his weight was normal. Skin turgor was assessed by pinching him and was well hydrated and nourished.

1. 9 Patient and Family's Concept of the Illness.

Client had no idea about his condition. His mother said, she had little idea about the condition but was confident enough that her son will be well with the treatment given to her. The client and mother were reassured that the treatment he was given will result in his quick recovery and discharge home.

1.10 Literature Review on Gastroenteritis

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

According to Hinkle and Cheever (2018), the GI tract is a pathway 7 to 7.9 meters (23 to 26 feet) in length that extends from the mouth to the esophagus, stomach, small and large intestines, and rectum, to the terminal structure, the anus.

The Oesophagus

According to Tortora and Derrickson (2017), once food has been chewed and mixed with saliva in the mouth, it is swallowed and passes down the oesophagus. The oesophagus has a stratified squamous epithelial lining which protects the oesophagus from trauma; the sub mucosa secretes mucus from mucous glands which aid the passage of food down the oesophagus. The lumen of the oesophagus is surrounded by layers of muscle - voluntary in the top third, progressing to involuntary in the bottom third and food is propelled into the stomach by waves of peristalsis.

The Stomach

The stomach is situated in the left upper portion of the abdomen under the left lobe of the liver and the diaphragm, overlaying most of the pancreas. A hollow muscular organ with a capacity of 1,500 ml, which stores food during eating, secretes digestive fluids and propels food or chime, into the small intestine (Hinkle & Cheever, Brunner & Suddarth's textbook of medical-surgical nursing, 2018). The stomach is a 'j'-shaped organ, with two openings- the esophageal and the duodenal- and four regions- the cardiac, fundus, body and pylorus. Each region performs different functions; the fundus collects digestive gases, the body secretes pepsinogen and hydrochloric acid, and the pylorus is responsible for mucus, gastrin and pepsinogen secretion (Tortora & Derrickson, Principles of anatomy and physiology, 2017). According to Waugh and Grant (2018), The stomach is continuous with the oesophagus at the cardiac sphincter and with the duodenum at the pyloric sphincter. It has two curvatures; the lesser curvature and the greater curvature. When the stomach is empty, the mucosa appears wrinkled or folded. These folds are called rugae.

Functions of the Stomach

As specified in Tortora and Derrickson (2017) the stomach performs the following functions:

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

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

1. Parietal cells which secrete hydrochloric acid.
2. Chief cells which secrete pepsin.
3. Entero-endocrine cells which secrete regulatory hormones (Tortora & Derrickson, 2019).

The Small Intestine

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

The Duodenum

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

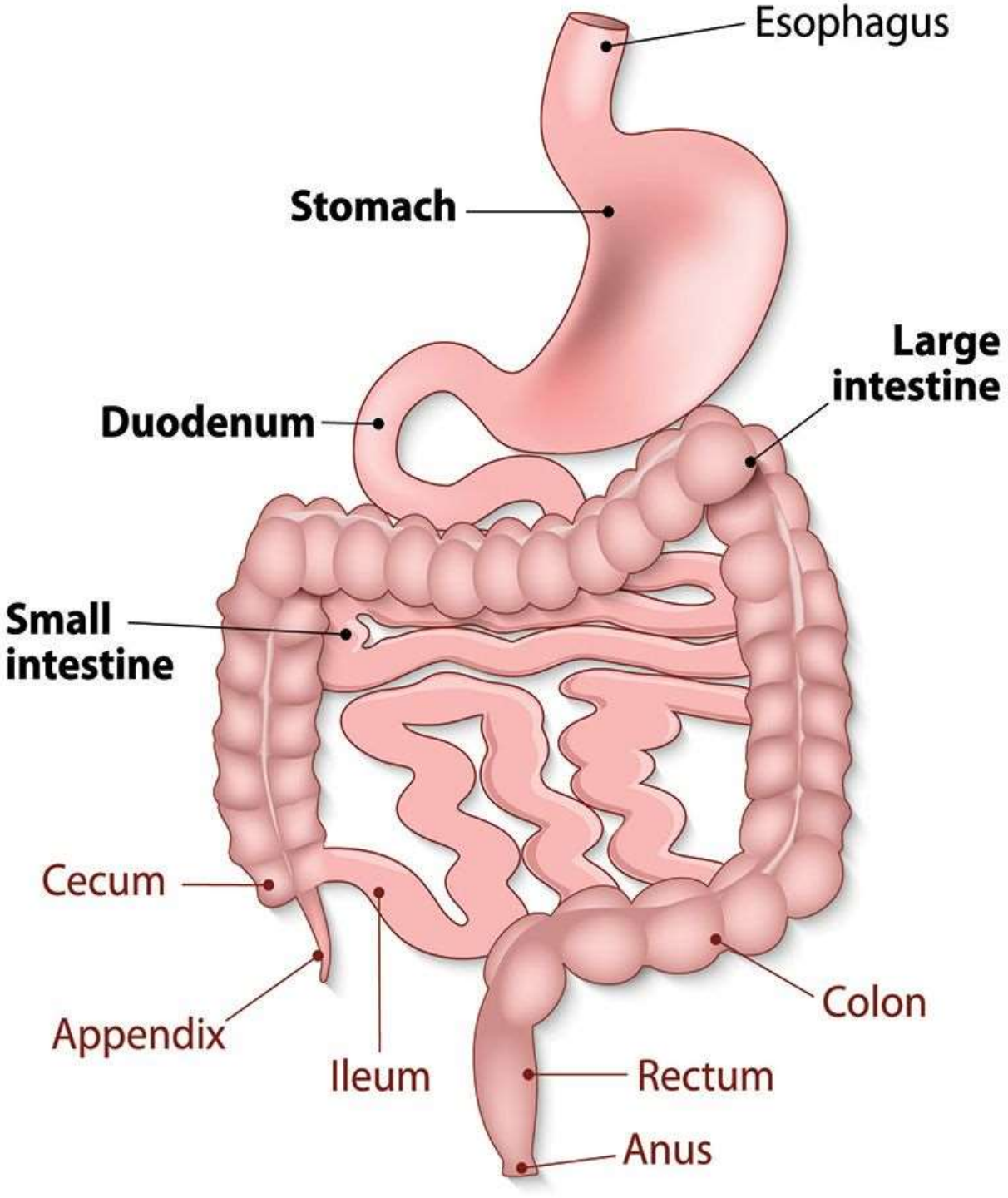

Figure 2: *Diagram of Gastrointestinal Tract*

(Fremont, 2019).

Definition

Gastroenteritis is an inflammation of the stomach and intestines that accompanies numerous gastrointestinal (GI) disorders. It is one of the main causes of dehydration and can cause life-threatening complications.

Incidence

Gastroenteritis is one of the most common infectious diseases seen in children (Swearingen, 2019). Rotavirus infection is the most common cause of severe diarrhea in infants and young children worldwide. Before the rotavirus vaccine program started in 2006, rotavirus led to the hospitalization of 55,000 U.S. infants and children each year. Worldwide, rotavirus is estimated to cause 527,000 deaths in children annually. Because the rotavirus vaccines have been so effective against severe rotavirus disease, noroviruses are the leading cause of epidemic gastroenteritis now, detected in about 50% of acute gastroenteritis (AGE) outbreaks in Europe and the United States(Centers for Disease Control and Prevention, 2018)

Aetiology

According to Swearingen (2019), the following are the causes of gastroenteritis;

1. Infections
    a. Viral such as Rotavirus and norovirus
    b. Bacterial such as Escherichia coli, Salmonella, Shigella, and Campylobacter
    c. Parasites such as Giardia and Cryptosporidium
2. Drug induced: Clostridium difficile is the most common nosocomial source, and it occurs after antibiotic use. Example: Penicillin

The Ministry of Health (2017) added the following;

3. Chronic infections: e.g., amoebiasis, tuberculosis, opportunistic infections with HIV
4. Functional: e.g., irritable bowel syndrome
5. Inflammatory: e.g., ulcerative colitis, Crohn's disease

Pathophysiology

Adequate fluid balance in humans depends on the secretion and reabsorption of fluid and electrolytes in the intestinal tract; diarrhea occurs when intestinal fluid output overwhelms the absorptive capacity of the gastrointestinal tract. The 2 primary mechanisms responsible for acute gastroenteritis are (1) damage to the villous brush border of the intestine, causing malabsorption of intestinal contents and leading to an osmotic diarrhea, and (2) the release of toxins that bind to specific enterocyte receptors and cause the release of chloride ions into the intestinal lumen, leading to secretory diarrhea. (Prescilla, 2018)

Clinical Manifestation

According to Swearingen (2019), the following are the signs and symptoms of gastroenteritis;

1. Fever
2. Vomiting
3. Diarrhea: Wide range of frequency and character (e.g., watery, bloody)
4. Abdominal pain

MoH (2017) added the following:

5. Dry mucous membranes
6. Reduction in skin turgor
7. Weight loss

8. Anorexia
9. Headache
10. Muscle aches

Assessment/ Diagnostic Findings

Swearingen (2019), mentioned the following;

1. Patient history: History is important in determining the source of gastroenteritis and if there is a need for any tests.
2. Serum electrolytes: Determine severity of electrolyte imbalance and type of fluid replacement necessary
3. Complete blood count: Hematocrit is often elevated in dehydration. The differential will determine whether viral or bacterial infection is present. In a bacterial infection, the white blood cell (WBC) count is elevated with increased polymorphonuclear leukocytes or neutrophils. In a viral infection, the WBC count is slightly elevated with increased lymphocytes.
4. Blood urea nitrogen: Elevated with dehydration but should return to normal with rehydration.
5. Blood culture: Obtained if the child is acutely ill to help determine cause of illness. Stool specimen: Examined if diarrhea lasts more than a few days to help determine cause.
6. Rotazyme: Rapid test to see if rotavirus is present in stool. A positive test negates need for a stool culture.
7. Stool culture: Obtained if blood or mucus is present in stool, when symptoms are severe, or if there is history of travel to a developing country.

Specific Medical Intervention

According to MoH (2017), the following are the treatment objectives;

1. To prevent dehydration
2. To replace lost fluid
3. To maintain nutrition by ensuring adequate dietary intake during illness
4. To maintain personal hygiene
5. To eliminate infecting organisms where appropriate

Pharmacologic treatment

1. Antibiotics such as Gentamicin and Cefuroxime

   Note: No antibiotics are required for suspected viral gastroenteritis. Adequate rehydration is the main requirement.
2. Zinc supplementation
3. Analgesics such as Paracetamol
4. Fluid management such as ORS and intravenous fluids example ringers lactate

Non-pharmacologic treatment

1. Keep surroundings clean
2. Improve personal hygiene e.g. hand washing after toilet
3. Adequate fluid intake: oral and intravenous as necessary
4. Maintain adequate nutrition as can be tolerated

Nursing Management

Reassurance

1. Patient is reassured that diarrhea and abdominal pain will be resolved throughout the period of hospitalization
2. Client is also introduced to other patients who have similar conditions as him/her and has had their treatment waiting to be discharged.
3. Relatives are also reassured that all necessary procedures will be done for client.
4. Diversional therapy such as watching of televisions and the use of slide pictures are provided to divert patients mind from their condition.

Reliving pain and improving nutrition

1. Give prescribed medication.
2. Avoid aspirin, (anticoagulants and caffeinated foods).
3. Patient to eats at regular intervals in relaxed atmosphere.
4. Encourage relaxation techniques.

Monitoring complications

1. If hemorrhage is present, assess faintness or dizziness and nausea.
2. Insert indwelling catheter to monitor intake and output.
3. Monitor laboratory values, RBCs.
4. Insert NG tube, give lavage as ordered.

5. Give and Monitor oxygen administration.
6. Place patient in recumbent position.

Position

1. Patient is made comfortable on a well-prepared admission bed with enough pillows for comfort.
2. Patient is made to assume a normal position which was not contrary to client's health example supine or prone position. This helps the patient to relax and reduce pain.
3. The patient is positioned to avoid neck pain and joint stiffness

Rest and sleep and stress reduction

1. A quiet environment is provided by reducing noise to allow patient to get enough rest.
2. Windows were opened to allow ventilation.
3. Visitors are also restricted to allow patient gets enough rest and sleep.
4. All nauseating materials such as bedpans and dirty linens are removed.
5. Bed is been made free from creases and cramps by straighten the bed linen.
6. Warm beverages are served.
7. Warm bath is given with warm water, soap, sponge and towel in order to relax patient and to induce sleep.

Observation

1. Patient's level of consciousness is observed to know whether client was unconscious, semiconscious, or fully conscious.
2. Vital signs were also checked and recorded which comprises of temperature, pulse, respiration and blood pressure.

3. Intake and output chart are also monitored by observing intake and output chart to know patient's fluid and electrolyte balance. Intravenous infusion is also monitored by observing the site of intravenous cannula for abnormalities such as swelling or pain at the site. The intravenous flow rate is also observed for the normal flow rate with respect to the total volume and duration of administration. The intravenous given set were also observed for clinging which will cause obstruction to the flow of the infusion.
4. The desired effect and side effect of drugs served were also observed.
5. Side effects of drugs should be observed and reported if any, as well as for signs of dehydration.
6. Patient's response to medication therapy, nutritional therapy and emotional rest was observed.

Personal Hygiene

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

Nutrition / Diet

1. Balance diet.
2. Eliminate food that causes pain and stress.
3. To avoid coffee and other caffeinated foods alcohol and carbonated drinks.
4. Spicy foods to be avoided.
5. Low fibre diet should be served.
6. Food should be attractive to induce appetite, remove nauseating items around patient.
7. Provide food on time regularly served but in bits.
8. Avoid extremely hot or cold food.
9. Take time to chew and swallow to avoid indigestion.

Patient / family education.

1. Plan for rest periods.
2. Chew food thoroughly and eat in leisurely manner.
3. Eat meals in regular schedule.
4. Adhere to prescribed treatment.
5. Educate patient to report on signs and symptoms.
6. Educate patient that antacids cause changes in bowel movement.
7. Avoid over – the counter drugs unless prescribed by doctor.
8. Explain pathophysiology of Gastroenteritis to patient and family.
9. Encourage stress-reducing activities
10. Educate patient on medication to be taken home, its doses, frequency, therapeutic effects and possible side effects and explain compliance.
11. Educate patient to come for regular check-ups.

12. Educate patient to avoid irritating substances such as caffeine, carbonated drinks, alcohol, and extremely spiced foods.
13. Patient should identify and avoid foods that cause distress and pain**.**

Prevention

1. Washing hands often, especially after using the bathroom and before food preparation. If necessary, use hand sanitizer until one can access soap and water.
2. Don't share kitchen utensils, plates, or towels if someone in the household is sick.
3. Wash fruits and vegetables thoroughly.
4. Take special precautions to avoid contaminated water and food when traveling. Avoid ice cubes and use bottled water whenever possible.
5. Infant vaccination against rotavirus.

Complication

1. Dehydration
2. Malabsorption
3. Transient lactose intolerance
4. Chronic diarrhea
5. Sepsis

1.11 Validation of Data

According to McIntosh (2018), validation is the process of making something officially accepted or approved, especially after examining it. **Master M.K.Y mother** provided the necessary information needed of which some were crosschecked from patient Child Records. What was in the Child Records was not different from what **Master M.K.Y mother** said. The information

gathered during my home visits before and after discharge confirmed that, what the mother said was true. To clarify the information collected, I kept asking patient and his mother the same questions concerning the data collected initially and they gave me the same answers.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

According to McIntosh (2018), analysis is a careful examination of something in order to understand it better or find out what it consists of. Analysis is the detailed study or examination of something in order to understand the result of the study. This is the second stage of the nursing process. This stage covers the comparison of collected data with standards. The patient and family strengths, health problems are identified and nursing diagnosis developed. The data collected during the assessment phase are analyzed and interpreted at this stage.

2.1 Comparison of Data with Standard.

This is where the data collected on the health of the patient is compared with those in the literature review. This includes diagnostic investigations, causes, signs and symptoms, treatments and complications found in the literature review.

2.1 A. Diagnostic Investigations/Test

Diagnosis is the determination of the nature of a disease (Taylor, 2019). Investigation refers to procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatment (Taylor, 2019). The following are list of investigations which were carried out on Master M.K.Y. during his period of hospitalization

The following diagnostic test was carried out on client;

1. Full blood count
2. Malaria test

Table 1: Diagnostic tests/investigation in literature review compared with those carried out on patient.

Diagnostic tests carried out in literature review	Diagnostic tests carried out on client
1. Patient history	1. History was taken
2. Serum electrolytes	2. Serum electrolytes was not done
3. Complete blood count	3. Complete blood count was done
4. Blood urea nitrogen	4. BUN was not done
5. Blood culture	5. Blood culture was not done
6. Rotazyme	6. Rotazyme was not done
7. Stool culture	7. Stool culture was not done
8. Malaria test was not in literature review	8. Malaria test was done

With reference to table 1, serum electrolytes, blood urea nitrogen, blood culture, rotazyme and stool culture were not carried out because the diagnosis was confirmed by patient history and complete blood count. Malaria test also assisted in ruling out the possibility of the patient having malaria

Table 2: Results of Diagnostic Investigations Carried Out on Patient

Ordered Date	Specimen	Investigations	Results	Normal values	Interpretation	Remarks
8/12/22	Blood	**FULL BLOOD COUNT**				
		Haematocrit	41.4%	**40.0% – 50.0%**	Haematocrit count was normal	No treatment given
		Red Blood Cell	5.77 IUL	**4.10 IU/L – 5.80 IU/L**	RBC count was normal	No treatment given
		White Blood Cell	18.92 IU/L	**2.8 IU/L – 8.00 IU/L**	White blood cells were elevated indicating infection.	Intravenous cefuroxime 300mg tid for 24 hours
8/12/22	Blood	Malaria parasite	Negative	Negative	Patient was tested negative for malaria	No treatment was given

2.1 B. Causes of Patient's Condition

With references to the literature review on the causes, Master M.K.Y. condition was due to infection which eventually led him to Gastroenteritis

2.1 C. Clinical Features/ Signs and Symptoms

Table 3: Clinical Features of patient Compared with those in the Literature Review

Clinical Features in Literature Review	Clinical Features Exhibited by Patient
1. Fever	1. Patient had with fever
2. Vomiting	2. Patient was vomiting
3. Diarrhoea	3. Patient had diarrhoea
4. Abdominal pain	4. Patient showed signs of abdominal pain
5. Dry mucous membrane	5. Patient had dried mucus membrane
6. Reduction in skin turgor	6. Patient had reduced skin turgor
7. Weight loss	7. Patient had lost weight
8. Anorexia	8. Patient had poor dietary intake
9. Headache	9. Patient could not verbalize headache
10. Muscle aches	10. Patient could not verbalize muscle aches

With reference to table 3, patient was truly having gastroenteritis since he exhibited some of the cardinal clinical manifestations of the condition such as diarrhea and vomiting.

2.1 D. Specific Medical Treatment

Treatment refers to the mode of dealing with a patient or a disease (Taylor, 2019).

Master M.K.Y. was treated medically with the aim of correcting dehydration, replacing lost fluid, maintaining nutrition by ensuring adequate dietary intake during illness and eliminating the infecting organism.

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

1. Intravenous cefuroxime 30MG/KG (294mg) bid for 24 hours
2. Oral rehydration salt powder for 5 days (100ml after each stool)
3. Zinc Tablet 20mg daily for 10 days
4. Intravenous Ringers lactate 500ml Stat
5. IV paracetamol 10MG/KG (98mg) tid for 24 hours
6. Syrup paracetamol 5 mls tid for 5 days

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

Treatment as in literature review	Treatment given to patient
1. Antibiotics i. Cefuroxime ii. Gentamicin	**1. Antibiotics** i. Cefuroxime was administered ii. gentamicin was not served
2. Mineral and Supplement i. Zinc	**2. Mineral and Supplement** i. Zinc was administered
3. Crystalloids (Isotonic) i. Intravenous Ringers Lactate ii. ORS	**3. Crystalloids (Isotonic)** i. IV Ringers lactate was administered ii. ORS was administered
4 Antipyretic and analgesic Syrup Paracetamol IV Paracetamol	**4 Antipyretic and analgesic** Syrup paracetamol was administered IV paracetamol was administered

From the above table, comparison of drugs in the literature review with drugs given to patient, the treatments given to patient were in line with the literature.

Table 5: Pharmacology of Drugs Administered to Patient

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/ Remedies**
8/12/22	Cefuroxime	**Dosage** Depends on patient's weight **Adult**: 750mg **Child**: 12-150mg/kg **Route** IV	**Dosage** 30mg/kg bid for 24 hours **Route** Intravenously	Antibiotic drug which belongs to cephalosporin class	It acts by inhibition of bacterial cell wall synthesis	Patient condition improved	Chills, sweating, cough, shortness of breath, unusual bleeding. None of these side effects were observed.

Table 5: Pharmacology of Drugs Administered to Patient

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effect/ Remedies
9/12/22	Zinc supplementation	**Dosage** 20 milligrams per day Adult: 10-40mg Child: 4-23mg **Route** Oral, intravenous	**Dosage** 20mg daily for 10 days **Route** Orally	Dietary Supplement	Zinc restores mucosal barrier integrity and enterocyte brush-border enzyme activity, it promotes the production of antibodies and circulating lymphocytes against intestinal pathogens, and has a direct effect on ion channels	Patient's diarrhoea resolved	Metallic taste, kidney and gastritis None of these side effects were observed.

Table 5: Pharmacology of Drugs Administered to Patient

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/ Remedies**
8/12/22	Oral rehydration	**Dosage** Dependent of fluid loss and physician's prescription **Route** Oral	**Dosage** Oral rehydration salt powder (100ml after each stool) **Route** Orally	Fluid therapy (Oral hydration)	It uses the sodium-glucose cotransport mechanism to passively absorb water across the intestinal mucosa	Patients condition Improved	High blood sodium, high blood potassium None of these side effects were observed.

Table 5: Pharmacology of Drugs Administered to Patient

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/ Remedies**
9/12/22	Syrup paracetamol	**Dosage** 5mls TID Adult:7.5-10 mls Child: 2.5-5 mls **Route** Oral	**Dosage** 5mls daily for 5 days **Route** Orally	Analgesic and antipyretic	Paracetamol is a commonly used medicine that treat pain It's typically used to relieve mild or moderate pain	Patient pain was reduced	None of these side effects were observed.

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/ Remedies**
8/12/22	IV paracetamol	**Dosage** Depends on patient's weight **Route** Intravascular	**Dosage** 98mg tid for 24 hours **Route** intravascular	Analgesic and antipyretic	Paracetamol is a commonly used medicine that treat pain and reduce a high body temperature(fever) It's typically used to relieve mild or moderate pain	Patient pain was reduced	None of these side effects were observed.

Table 5: Pharmacology of Drugs Administered to Patient

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/ Remedies**
8/12/22	Ringers Lactate	Amount depends on patient's fluid and electrolyte level and age as well as by doctor's prescription.	**Dosage** 500ml **Route** Intravenously	Crystalloid (Isotonic solution)	It restores fluid and electrolyte balances, produce diuresis, and acts as alkalizing agent (reduces acidity)	Patient was provided with the needed body fluid and electrolyte	Over hydration, hypocalcaemia, alkalosis None of these side effects were observed.

2.1 E. Complications

With reference to Table 6, the complications listed in the literature review such as dehydration, malabsorption, Sepsis etc.

Table 6: Complications compared with those in Literature Review

Complications in Literature Review	Complications exhibited by patient
Dehydration	Not manifested in patient
Malabsorption	Not manifested in patient
Transient Lactose Intolerance	Not Manifested in patient
Chronic Diarrhea	Not manifested in patient
Sepsis	Not manifested in patient

2.2 Patient / Family Strengths

Strength refers to the ability to do things that need lot of physical or mental effort. The following strengths were observed in patient and family during their period of hospitalization.

1. Patient can tolerate tepid sponging.
2. Patient can tolerate pain medications
3. Patient can tolerate small amounts of liberal fluids without vomiting.
4. Patient can cope with nursing care.
5. Patient can eat three spoons of his usual meal served.
6. Mother seek clarification on disease condition of child.

2.3 Patient's Health Problems

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

1. Patient had high body temperature (38.0^0C) (08/12/22)
2. Patient mother complained of patient showing signs of abdominal pain (08/12/22)
3. Patient mother complained of patient having vomiting and diarrhoea (08/12/22)
4. Patient showed signs of weakness (08/12/22)
5. Patient mother complained of child having poor nutrition (09/12/22)
6. Patient' mother had inadequate information on about condition (09/12/22)

2.4 Nursing Diagnosis

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

1. Thermoregulation imbalances (38.0) related infections of the intestine (08/12/22)
2. Abdominal pain related to irritation and inflammation of the gastrointestinal tract (08/12/22)
3. Risk for deficient fluid volume related to fluid loss through vomiting, and diarrhea (08/12/22)
4. Activity intolerance related to weakness and inability to stand on his own secondary to infectious process (08/12/22)
5. Risk of nutritional imbalances (less than body requirement) related to poor dietary intake (09/12/22)
6. Deficient knowledge related to inadequate information on the causes, management and prevention of gastroenteritis (09/12/22)

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 Introduction

According to McIntosh (2018), planning is a stage of the nursing process in which the nurse and the patient consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan.

Planning for the care of patient and family is a process that involves formulation of nursing strategies that are required in reducing the actual and potential health problems of the patient and family, be it physical, social, emotional or even spiritual that were identified during the analysis phase. When the problems were identified, nursing diagnoses are formulated, priorities are set and expected outcomes designed. It also involves setting goals and objectives which are evaluated continuously until the patient is discharged.

Planning for patient and family care is the process of designing nursing strategies required to reduce, eliminate or prevent patient's health problems that have been diagnosed.

3.1 Objective/Outcome Criteria for Patient and Family Care

A nursing outcome refers to a measurable behaviour or perception demonstrated by an individual, a family, a group, or a community that is responsive to nursing intervention (Herdman & Kamitsuru, 2018).

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

1. Patient's body temperature will be reduced to normal range (36.2^0C – 37.2^0C) within 24hours as evidenced by:

a). Nurse recording that patient's temperature is within the normal range (36.2^0C to 37.2^0C).

b). Mother verbalizing that patient not feverish

2. Patient abdominal pain will resolve within 24 hours as evidenced by;

a. Patient mother verbalizing child shows no signs of pain.

b. Nurse observing patient with a cheerful facial expression in bed and cooperate well with care.

3. Patient will maintain his normal fluid volume and electrolyte balance within 72 hours as evidenced by:

a. Patient's mother verbalizing that child no longer passes loose stools and also vomits no more.

b. Nurse observing an improvement in skin turgor upon assessment.

4. Patient will regain his strength for daily activities without assistance within 48 hours as evidenced by;

a) the nurse observing that patient is able to perform some activities of daily living

b) mother verbalizing that the patient can stand on his own without assistance

5. Patient will have good nutrition as required within period of hospitalization as evidenced by;

a. Patient's mother verbalizing child can eat well.

b. Nurse observing patient consume two thirds of his usual volume of meal served

6. Patient mother will have adequate information about the causes, management and prevention of the condition within 24hours as evidenced by:

a). patient's mother verbalizing that she has a basic understanding about the causes, management and prevention of the condition

b). nurse expecting positive feedback after giving enough information on the causes, management and prevention of the condition

Table 7: Nursing Care Plan for Patient

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation Statement	Sign
08/12/22 8:40am	Thermoregulation imbalance (fever, 38.0^{O}C) related to infection of the stomach and intestine.	Patient's temperature will fall within the normal range (36.2^{0}C to 37.2^{0}C) within 24hours as evidenced by; (a) Nurse recording that patient's temperature is within the normal range (36.2^{o}C to 37.2^{o}C). (b) Mother verbalizing that patient is not feverish.	1) Reassure patient mother 2)Tepid sponge the patient to reduce his body temperature 3) Changed heavy and tight clothing to light ones.	(1) Patient mother was reassured of being in the hands of competent nurses. (2) Patient was tepid sponged with warm water (3) Patient heavy clothing was changed to light ones to help reduce temperature	09/12/22 8:40am	Goal was fully met as -Patient 's temperature reduced to 36.6 ^{O}C and she was normal to touch.	A.F

			4) Ensure enough ventilation by opening windows and switching on the fans. (5) Serve prescribed antipyretic agents such as Paracetamol	(4) Windows were opened and the fans were switched on. (5) iv paracetamol 98mg was administered			

Table 7: Nursing Care Plan for Patient

Date/ Time	Nursing Diagnosis	Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
08/12/22 8:50am	Abdominal Pain related to irritation and inflammation of the gastrointestinal tract	Patient abdominal pain will resolve within 24 hours as evidenced by; a. Patient verbalizing child shows no signs of pain. b. Nurse observing patient with a cheerful facial expression in bed and cooperate well with care.	1. Reassure patient mother 2. Reduce noise and improve adequate ventilation at the ward. 3. Nurse patient in a comfortable position 4. Administer prescribed analgesic.	1. Patient mother was reassured that pain will subside because medications like analgesics will be given 2. Patient was nursed in a quite environment with adequate ventilation to have adequate rest. 3. Patient was nursed in prone position 4.iv paracetamol 98mg was serve	09/12/22 8:50am	Goals fully met as patient mother verbalized, he cries no more and nurse observed patient with a cheerful facial expression in bed.	AF

Table 7: Nursing Care Plan for Patient Continued

Date/ Time	Nursing Diagnosis	Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
08/12/22 5:00pm	Risk for deficient fluid volume evidence by fluid loss and electrolytes loss through vomiting, and diarrhea	Patient will maintain his normal fluid volume and electrolyte balance within 72 hours 1. Patient's mother verbalizing that child no longer passes loose stools and vomits no more 2. Nurse observing an improvement in skin	1. Reassure Patient mother 2. Assess the nature of the vomitus. 3. Remove all nauseating items from the patient's bedside 4. Maintain Patient's oral hygiene 5. check patients vital signs 6. Encourage oral fluid intake.	1. Patient mother was reassured that he is in the care of competent health nurses and that everything possible will be done to relieve him of the vomiting 2. Patient vomitus was assessed and was clear and non-offensive. 3. Nauseating items such as bedpan were emptied immediately after use to prevent nausea.	11/12/22 5:00pm	Goal fully met as Patient's mother verbalized child no longer passes loose stools and vomits no more and nurse observing an increase in skin turgor upon assessment.	AF

		turgor upon assessment.	7. Administer prescribed intravenous fluid.	4. Patient's oral hygiene was done twice daily to increase patient appetite 5. Patients vital signs was checked and recorded 6. Oral fluid intake of water and drinks were encouraged to replace lost fluid 7. ORS and IV R.L 500mg were administered			

Table 7: Nursing Care Plan for Patient continued

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation Statement	Sign
08/12/22 6:40pm	Activity intolerance (actual) related to weakness and inability to independently stand up secondary to infectious process	Patient will be able to perform activities of daily living within 48hours as evidenced by: a) the nurse observing that patient is able to perform some activities of daily living b) mother verbalizing that the patient can stand on his own without assistance	1. Reassure patient's mother 2. Assess patient's level of activity tolerance 3. Plan activity and rest periods with patient mother 4. Encourage patient mother to assist move out of bed	1. Patient's mother was reassured that he will be able to tolerate activities of daily living so far as treatment is continued 2. Patient's level of activity tolerance was assessed 3. Activity and rest periods of patient were planned with patient mother 4. Patient mother was encouraged to move out of bed with assistance	10/12/22 6:40pm	Goal fully met as client was able to perform some activities of daily living and her mother also stating that she could now stand on her own when assisted	A.F

			5. Encourage patient mother to assist patient stand 6. Serve prescribed antibiotics	5. Patient mother was encouraged to assist patient to stand 6. IV Cefuroxime 300mg was served as prescribed			

Table 7: Nursing Care Plan for Patient

Date/ Time	Nursing Diagnosis	Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
09/12/22 8:00am	Imbalanced nutrition: less than body requirement: related to loss of appetite	Patient will have good nutrition as required within 72 hours as evidenced by; 1. Patient's mother verbalizing child can eat well. 2. Nurse observing patient consume at least two/thirds of his meal served.	1. Reassure patient mother. 2. Assess the nutritional status of patient to serve as a baseline data. 3. Maintain patient's oral hygiene twice a day (morning and evening).	1. Patient mother was reassured that measures will be taken to restore adequate essential nutrients to balance his nutritional needs. 2. The nutritional status of patient was assessed to help plan diet for patient 3. Patient's oral cavity was cleaned using a tooth brush (morning and evening) to increase patients appetite.	12/12/22 8:00am	Goal fully met as patient's mother verbalized, child could eat well and nurse observed that patient was able to eat at least two thirds of his meal served.with 250ml bowl	AF

			4. Plan meals with patient, dietician and relative in order to provide patient with meals of his choice. 5. Serve food in bits but at frequent interval. 6. Educate patient mother on the need to serve patient nutritionally rich diets	4. Meals were planned with patient, dietician and relative to provide meals of his choice. 5. Patient was provided with rice and kontomire stew but served in small amount but frequent interval to help patient consume adequate meal. 6. Patient mother was educated on the need to maintain his nutritional status to encourage intake of nutritious diets			

Table 7: Nursing Care Plan for Patient Continued

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation Statement	Sign
09/12/22 6:30pm	Knowledge deficit related to inadequate information about the causes, management and prevention of the condition	Patient mother will have adequate information about the causes, management and prevention of the condition within 24hours as evidenced by: a). patient's mother verbalizing that she has a basic understanding about the causes,	1. Reassure patient relative 2. Assess her knowledge on patient condition 3. Inform patient relative about ways of preventing the symptoms and some management for the disease 4. Allow patient relative to ask questions for clarification	1. Patient relative was reassured and rapport established with them 2. Her knowledge on her condition was assessed 3. Patient relative was informed about ways of preventing the symptoms and some management for the disease 4. Patient relative was allowed to ask questions for	10/12/22 6:30pm	Goal fully met as patient's mother verbalized a basic understanding of the causes, management and prevention of the condition	A.F

		management and prevention of the condition b). nurse expecting positive feedback after giving enough information on the causes, management and prevention of the condition	5. Answer questions in simple understandable language without using professional jargons 6. Ask patient relative to summarize what she heard	clarifications on issues about the disease 5. All questions were answered in simple, and clear language without the use of professional jargons 6. Patient relative was asked to give feedback on what she heard			

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

Implementation is the process by which the nurse and the patient put into practice the planned care (Taylor, 2019). It involves putting into action the nursing and medical orders to meet the patient's needs. During the process of implementation, the patient is the central focus of activities. This chapter forms the fourth part of the patient/family care study. It entails carrying out medical interventions. The patient and relatives are encouraged to participate by playing their role in patient's recovery.

4.1 Summary of Actual Nursing Care Plan

The nursing management of the patient started on the day of admission thus from 8th December, 2022 to the day of discharge on 12th December, 2022. The management aimed at alleviating patient's abdominal pain and treating other presenting signs and symptoms of the condition, treating underlying cause and preventing complications. During the period of admission, daily routine care was carried out such as bed making, maintaining the personal hygiene, administering of prescribed medication to the patient and others.

First Day of Admission (8th December, 2022)

Master M.K.Y. was admitted to the Pediatric ward on 8th December, 2022 at 8:30am per mothers back on account of Gastroenteritis. She was accompanied by a staff nurse. On arrival patient was fully conscious and well oriented to time and place. I welcomed them and offered them a seat at the nurse's station. I collected the patient particulars from the relative and the accompanying staff nurse. The patient's identity was verified by mentioning his name for him to mother to respond. His particulars such as name, sex, age, and residential address were entered into the admission and

discharge book and the daily ward state. He was made comfortable into an already prepared admission bed. Vital signs were checked and recorded accurately as follows:

Temperature	38.0ºC
Pulse	175bpm
Respiration	27cpm
Oxygen saturation	99%

Physical examination on the patient was performed from head to toe and no abnormalities were seen. Assessment carried out on admission revealed that patient had a grimaced facial expression depicting presence of pain and mother also complained of child holding stomach whiles crying sometimes at home, there was also a complain of high body temperature and also persistent diarrhoea and vomiting.

Patient was orientated to the ward and its environments and daily ward routines were adequately explained to them. Hospital policies regarding visiting periods and payment of bills were explained. Patient mother was also introduced to the other patients on the cubicle.

His treatment plan was as follows:

1. Intravenous Paracetamol 10MG/KG (98mg) tid for 1 day
2. Oral rehydration salt powder for 5 days (100ml after each stool)
3. Zinc Tablet 20mg daily for 10 days
4. Intravenous Ringers lactate 500ml Stat
5. Intravenous cefuroxime 30MG/KG (294mg) bid for 24 hours
6. Syrup paracetamol 5 mls TID for 5 days

The following investigations had already been carried out:

1. Full blood count
2. Malaria test

On admission, Patient had fever (38.0 ^{0}C) so the nursing diagnoses of thermoregulation imbalance (fever) related to infection was made and a goal was set to bring patient temperature to normal (36.2^{0}C- 37.2^{0}C) within 24 hours at 8:40am. The following nursing interventions were carried out; patient was tepid sponged, adequate room ventilation was ensured by opening windows, iv paracetamol 98mg was administered as prescribed and temperature was checked 10 minutes afterwards and read 37.5^{0}C. Others to be carried out were; cold drinks(milk) and liberal fluids were to be served

Patient was seen to have abdominal pain during assessment hence the nursing diagnosis of abdominal pain related to irritation and inflammation of the gastrointestinal tract was formulated at 8:50am. An objective was set to help alleviate patient from abdominal pain within 24 hours. The following interventions were implemented: Patient mother were reassured that pain will subside because medications like analgesics will be given. Patient was nursed in a quite environment with adequate ventilation to have adequate rest, Patient was nursed in a comfortable position (prone), iv paracetamol 98mg was administered as prescribed

At 2pm, his vital signs were checked and recorded as indicated in the appendix

A nursing diagnosis for vomiting and diarrhea was formulated at 5:00pm as Risk for deficient fluid volume to fluid loss through vomiting and diarrhea. An objective was set to help restore patient's fluid and electrolyte level within 72 hours. The following interventions were implemented: Patient mother was reassured that he is in the care of competent health team and

that everything possible will be done to relieve him of vomiting, Patient vomitus was assessed and was clear and non-offensive, Nauseating items such as bedpan were emptied immediately after use to prevent nausea, Patient's oral hygiene was done twice daily to increase patient appetite , Oral fluid intake of water and drinks were encouraged to replace lost fluid, ORS and IV R.L 500mg were administered

At 6:00pm due medications were administered and, his vital signs were checked and recorded as indicated in the appendix.

At 6:40pm, per the interaction with the patient's mother the nursing diagnosis of activity intolerance (actual) related to weakness and inability to independently stand up secondary to infectious process was formulated. An objective was set to help patient regain his strength for daily activities without assistance within 48 hours. The following interventions were implemented: Patient mother was reassured that measures will be put in place to help him regain his strength, Patient's level of mobility was assessed prior to exercise to ensure that patient does not injure himself, Patient mother was encouraged to assist move patient out of bed. Patient was assisted in bathing, eating and supported to stand, Patient mother was encouraged to assist walk, and other activities, Patient/family were educated on the need to practice good personal hygiene such as oral hygiene and bathing. Patient was observed to show some level of exhaustion on activity but energy improved as time went on. IV Cefuroxime 300mg was administered as prescribed.

At 10:00pm, his vital signs were checked and recorded.

Second Day of Admission (9th December, 2022)

On the second day of admission patient woke up at 5:50am, patient looked cheerful that morning, mouth care was done, had his bath and emptied his bowel.

At 6:00am, his vital signs were checked and recorded as in appendix, due medications were administered. Patient had porridge as breakfast but could not eat all (about four table spoon).

Upon interaction with his mother, she complained of loss of appetite.

At 8:00am, the nursing diagnosis of imbalanced nutrition: less than body requirement: related to loss of appetite was formulated. An objective was set to help patient attain good nutrition within 72 hours. The following interventions were done: Patient and mother were reassured that measures will be taken to restore adequate essential nutrients to balance his nutritional needs, the nutritional status of patient was assessed to help plan diet for patient, Patient's oral hygiene was observed by assisting patient to clean oral cavity using a brush twice daily (morning and evening) to increase patients appetite, Meals were planned with patient, dietician and relative to provide meals of his choice, Patient was provided with rice and kontomire stew but was served in small amount but frequent interval to help patient consume adequate meal, Patient mother was educated on the need to maintain his nutritional status to encourage intake of nutritious diets.

At 8:40am the goal set on the 8th December, 2022 to enable Patient's temperature fall within the normal range (36.2^0C to 37.2^0C) within 24hours was fully met on 9th December, 2022 as evidenced by the nurse recording body temperature by checking with the thermometer and seeing temperature fell within the normal range 36.6ºC

At 8:50am evaluation of the set objective on 8th December, 2022 to resolve patient's abdominal pain within 24 hours was done; goal was fully met as patient mother verbalized he shows no signs of pain and nurse observing patient with a cheerful facial expression in bed and cooperate with care.

At 9:00am, doctors came for in-patient's review and added syrup paracetamol 5mls for 5 days and zinc 20mg daily for 10 days to his treatment plan

At 2:00pm, patient vital signs were checked and recorded as in appendix and due medications were served.

At 6:00pm vital signs were checked and recorded as in appendix.

He was served with rice and stew as super.

At 6:30pm, interaction with patient/mother revealed that they had little knowledge on causes of Gastroenteritis hence the nursing diagnosis of Deficient knowledge related to inadequate information on the causes, management and prevention of the condition. An objective was set to help patient mother gain adequate knowledge on patient disease condition within 24 hours. The following interventions were implemented: Patient mother was told that everything discussed was between them and that nobody will ever hear of it. This was to enhance learning and improve patient and family confidence in the nurse, Patient mother was reassured , her knowledge on her condition was assessed, patient relative was informed about ways of preventing the symptoms and some management for the disease, patient relative was allowed to ask questions for clarifications on issues about the disease bothering her mind, all questions were answered in simple and clear language without the use of professional jargons and also patient and family were asked to give a feedback on what she heard.

At 10:00pm, his vital signs were checked and recorded as in appendix.

Third Day of Admission (10th December, 2022)

I went to the ward to continue my nursing care for patient. Patient woke up at 5:40am, he was assisted to carry out his personal hygiene. His vital signs were checked and recorded at 6am as in appendix. Due medications were administered.

Patient took porridge as breakfast and he was able to eat 8 table spoons of porridge been served.

At 9:00am, doctors came for in-patient review and no new complains were made by the patient. So, the plan was to continue his treatment.

Master M.K.Y mother was informed about the Home Visit and she was really happy to hear that. She gave me directions to their house.

At 2pm his vital signs were checked and recorded as in appendix.

Patient had his supper around 5pm which was okro soup and Banku. He was then assisted to maintain his personal hygiene.

At 6pm, his vital signs were checked and recorded.

At 6:30pm evaluation of the set objective on 9th December, 2022 at 6:30pm to help patient and relative gain adequate knowledge on cause of Gastroenteritis within 24 hours was done; goal was fully met as patient/mother verbalized that she has understood what they were taught on Gastroenteritis and nurse observed that patient and relative practice what was taught.

At 6:40pm evaluation of the set objective on 8th December, 2022 that patient will regain his strength for daily activities without assistance within 48 hours was done; goal was fully met as nurse observed patient performing activities without assistance

At 10pm, his vital signs were checked and recorded, due medications were administered.

Fourth Day of Admission (11th December, 2022)

Patient woke up exactly at 5:50am, He was assisted to maintain his personal hygiene. Patient looked really active. There were no complain from him and his mother in the morning. He took Tom Brown as breakfast.

At 9:15am, during review it was planned that patient would be discharged the next day as his condition had improved massively.

Patient mother was informed about their possible discharge the next day. Patient and mother were very excited to hear the news. Patient was assisted performed his personal hygiene in the evening. He took his supper and was made comfortable in bed.

At 10am, his vital signs were checked and recorded as in appendix, due medications were administered.

At 2:00pm, patient vital signs were checked and recorded as in appendix and due medications were served and recorded. Patient was served with TZ and okro soup as lunch. Patient had a rest after taking his lunch.

At 5:00pm evaluation of the set objective on 8th December, 2022 at 5:00pm to restore patients' normal fluid and electrolyte balance within 72 hours was done; goal was fully met as patient mother verbalized he no longer passes loose stools and vomits no more and nurse observing an increase in skin turgor upon assessment.

At 6:00pm, patient vital signs were checked and recorded. Patient supper which was Rice and Kontomire stew was ready after checking the vitals and he was able to eat more than half of the food served. He was assisted to maintain his personal hygiene.

Patient loss of appetite was assessed and he could eat half of his usual meal served.

Fifth Day of Admission (Day of Discharge) (12th December, 2022)

Patient woke up at 5:30am with a cheerful facial expression. His personal hygiene needs were ensured. At 6am, his vital signs were checked and recorded as in appendix, with his due medications also administered. Patient took in Hausa porridge for breakfast which he was able to consume almost everything.

At 8:00am evaluation of the set objective on 9th December, 2022 at 8:00am that patient will have good nutrition as required within 72 hours was done; goal was fully met as patient mother verbalized that child can eat well and nurse observing patient consume at least two/third of his meal served with 250mls bowl.

At 9am, patient made no complains on review, he was discharged to go home.

Patient and mother were informed that they have been discharged. I enquired whether they left any valuable items with any nurse and the response was no. Necessary documents were recorded into the admission and discharge book as well as the ward state. Assessment of patient bill were made and with the help of National health insurance scheme his bills were catered for. Patient and mother were reminded of the review date which was on 19th December, 2022. Patient was educated on the need of maintaining good personal hygiene. Patients used linen was removed and placed in the laundry basket. Bleach solution was used to disinfect the bed as well as the bed side locker.

4.2. Preparation of Patient/Family for Discharge and Rehabilitation

Preparation for discharge commenced from the time of admission at the hospital, at 8:30am on 8th December, 2022 till the last day of visit, 2nd January, 2022.The patient and family were informed that staying in the hospital was for a temporal period of time. Education of patient and family on gastroenteritis were reemphasized. Patient and mother were educated extensively on the causes, treatment and preventions of Gastroenteritis. Patient mother was advised to adhere to medication given and follow up visits to the health facility. This was aimed at helping the patient and relative

in the provision of adequate care. Patient and family were also educated on the need to maintain personal and environmental hygiene to help improve immunity. Education on the need to keep their environment clean and clear all stagnant waters around their environment to prevent breeding place for mosquitos were emphasized. They were advised to adhere to treatment given and also to report to the hospital immediately he experiences any abnormalities in his health so that early measure will be taken. Patient mother was asked to come for review on 19th December, 2022. The importance and necessity of the review was explained to the patient. I entered his name, date of discharge and receipt number into the Admission and Discharge book and daily ward state. They expressed their gratitude to the staff on the ward and bid the other patient's good bye. Patient belongings were packed and I accompanied them to the hospital entrance and bid them goodbye.

4.3 Follow Up/Home Visit/Continuity of Care

Follow-up visit is made to the patient at their homes to see to it that, the patient medication is properly taken as prescribed, progress of health and to discuss health matters related to the family members. This is also made to ensure that the patient really adhere to the planned care seriously, it was also aimed at assessing the patient's resources available to facilitate his recovery

4.3.1 First Home Visit (10th December, 2022

The first home visit was made on 10th December, 2022 whiles patient was still on admission. The purpose of this visit was for me to familiarize myself with the patient's home and find out how his home environment could have contributed to his present state of health. I left Holy Family Hospital, Berekum around 2:30pm and safely arrived at my patient's house at 2:50pm. I took a tricycle from the entrance of the hospital to New Biadan where patient stays.

They leave one store from the roadside. She stays with people known as friends and also she said she stays there with them and her kids and her sister's dauughter

When i went there, her sisters daughter was the only person found in the house. I greeted her and She welcomed me, offered me a seat and a glass of water.I told her i came for home visit to find out informations that can help in the treatment of my client. So i told her i will like to go round the house and she granted me the permission to do that.

They share the same kitchen with other house members, their main source of fuel for cooking is firewood and charcoal. They also have a wood made construction where they keep their sheeps which is near their kitchen. They also use one toilet building at one side of the house. At the back of the house, there are trees and some growing bushes around there, the smell near their toilet was not good, where their sheeps also sleeps also was not swept and the bushes at the back of the house can all contribute to the cause of gastroentritis. I explained all these to her and educate her on the need to clean the toilet very well and also sweeps where the sheep sleeps too. The need in bringing the bushes down. I also educaced her on the need for personal and enviromental hygiene such washing hands with soap and water after visiting the toilet and before meals, cutting of finger nails, washing of cooking utensils after eating and not leaving them overnight. . I told her i will take my leave, she gave me thank you and a good bye. So i came back to the hopital and continue my care.

4.3.2 Second Home Visit (15th December, 2022)

My second home visit was made on the 15th December 2022 in the morning at 11 o'clock I was happy to see master M.K.Y and family he was doing well. The purpose of the visit was to access the health of master M.K.Y to see whether education given during admission and first home visit were followed

A seat was given and a glass of water was offered. I asked about how master M.K.Y was doing and his mother said his condition was better and many improvements has taking place. I was very happy to see my client doing well.

There was also some improvement in on the environment. The smell near the toilet has changed, the weeds was brought down and also where the animals was sleeping was well swept and there was no littering around.

Their environment was clean. I told them to take good care of him, themselves and the environment also.

I reminded them of the review date which was on the 19th December 2022. I then ask permission and left there around 1;00 pm. I was then escorted by his mother.

4.3.3 Day of Review (19th December 2022)

On 19th December, 2022 Master M.K.Y. and Mrs. S.M. were met at the Out-Patient Department of Holy Family Hospital, Berekum at 8:30am looking cheerful and lovely as noted from facial expression. The Vital signs checked and recorded as

Temperature - 36.3°C

Pulse - 110bpm

Respiration - 22cpm

Upon assessment by the doctor, Master M.K.Y was healthy. Master. M.K.Y and mother did not make any complains. He was told not to hesitate to report to the hospital if he should encounter any health problem. No medication was given. He was also encouraged to practice personal hygiene to protect himself from getting diseases and injuries. Master M.K.Y was assured of a third home visit. I then accompanied them to the hospital gate where they bored a tricycle home

4.3.4 Third Home Visit (2nd January, 2023)

The main reasons for conducting the third home visit were to: Assess the general condition of patient and family, reinforce the need to comply with treatment given and finally terminate care. On 2nd January, 2023, I made preparation to go to patient's house at 12:30pm with a tricycle. I got to New Biadan around 12:40pm. I was welcomed and offered seat. Patient and family were doing well as they looked cheerful and had no complains. The environment was tidy as there were no rubbish nor stagnant water around. Patients' mother commended me for good work done and accepted to continue the care of her son at home. I however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick and rather than relying on self-medication. Patient and family was very happy with me and showered me with blessings After interacting with patient and family for a while, I reemphasized on health educations that had been given to them already. Since it happened to be my last day of therapeutic relationship with patient and family, I handed over patient to his parent to continue with care. I terminated my care and thanked them for their cooperation which made my study a success. Again, patient and his family expressed their gratitude by showing how grateful they were to me for the support and care given to them. I sought permission to leave around 1:20pm. They all escorted me to the roadside and I picked a tricycle.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT/FA MILY

5.0 Introduction

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

5.1 Statement of Evaluation

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

1. Patient's body temperature was reduced to normal (9th December, 2022)

It was found out on (08/12/22) at 8:40am, that patient had high temperature (38.0), an objective was set to enable patient reduce his body temperature to normal that is (36.2ºC/ 37.2ºC) within 24hours.The following nursing interventions were carried out; patient was tepid sponged, adequate room ventilation was ensured by opening windows, iv paracetamol 98mg was administered as prescribed and temperature was checked 10 minutes afterwards and read 37.5^0C. Others to be carried out were; cold drinks (such as milk) and liberal fluids were to be served, Goal was fully met on 9th December 2022 8:40am as evidenced by Nurse recording body temperature of 36.6º C

2. Patient was relieved from abdominal pain (9th December, 2022)

At 8:50am patient/relative complained of abdominal pain hence the nursing diagnosis of abdominal pain related to irritation and inflammation of the gastrointestinal tract was formulated. An objective was set to help alleviate patient from abdominal pain within 24 hours. The following interventions were implemented: Patient and mother were reassured that pain will subside because medications like analgesics will be given, Patient was nursed in a quite

environment with adequate ventilation to have adequate rest, Patient was nursed in a comfortable position (prone position), iv paracetamol 98mg was administered as prescribed

On 9th December, 2022 evaluation of the set objective on 8th December, 2022 at 8:50am to relieve patient of abdominal pain within 24 hours was done; goal was fully met as patient mother verbalized, he shows no signs of pain and nurse observed patient with a cheerful facial expression

3. Patient's fluid and electrolytes were restored (11th December, 2022)

On 8th December, 2022 at 5:00pm, per patients presenting complains, he was vomiting and also had diarrhea hence the nursing diagnosis of risk for deficient fluid volume evidence by fluid loss through vomiting, and diarrhea was formulated. An objective was set to help restore patient's fluid and electrolyte level within 72 hours. The following interventions were implemented: Patient and mother was reassured that he is in the care of competent health team and that everything possible will be done to relieve him of vomiting, Patient vomitus was assessed and was clear and non-offensive, Nauseating items such as bedpan were emptied immediately after use to prevent nausea, Patient's oral hygiene was done twice daily to increase patient appetite , Oral fluid intake and drinks were encouraged to replace lost fluid, ORS and IV R.L 500mg were administered.

Evaluation of the set objective on 8th December, 2022 at 5:00pm to restore patients' normal fluid and electrolyte within 72 hours was done; goal was fully met as patient mother verbalized patiet no longer passes loose stools and vomits no more on 11th December, 2022 at 5:00pm.

4. Patient regained his strength for daily activities (10th December, 2022)

At 6:40pm, per the interaction with the patient's mother in the morning the nursing diagnosis of Partial self-care deficit related to body weakness was formulated. An objective was set to help patient regain his strength for daily activities without assistance within 48 hours. The following interventions were implemented: Patient mother was reassured that measures will be put in place to help him regain his strength, Patient's level of mobility was assessed prior to exercise to ensure that patient does not injure himself, Patient was encouraged to move out of bed with assistance Patient was assisted in bathing, eating and supported to stand, Patient was encouraged to stand, and other activities, Patient/family were educated on the need to practice good personal hygiene such as oral hygiene, bathing, Patient was observed to show some level of exhaustion on activity but energy improved as time went on. IV Cefuroxime 300mg was served as prescribed

Evaluation of the set objective on 8th December, 2022 that patient will regain her strength for daily activities without assistance within 48 hours was done; goal was fully met as Patient's mother verbalizing that child has regained his strength and nurse observing patient performing some activities without assistance on the 10th December 2022.

5. Patient nutritional status was restored (12th December, 2022)

At 8:00am, the nursing diagnosis for imbalanced nutrition: less than body requirement: related to loss of appetite was formulated. An objective was set to help patient attain good nutrition within 72 hours. The following interventions were done: Patient mother was reassured that measures will be taken to restore adequate essential nutrients to balance his nutritional needs, the nutritional status of patient was assessed to help plan diet for patient, Patient's oral hygiene was observed by assisting patient to practice mouth care with the use of brush twice daily (morning and evening) to increase patients appetite, Meals were planned with patient, dietician and mother to provide meals of his choice, Patient was provided with rice with kontomire stew and was served small but

frequent interval to help patient consume adequate meal, Patient was educated on the need to maintain his nutritional status to encourage intake of nutritious diets.

Evaluation of the set objective on 9th December, 2022 at 8:00am was done; goal was fully met as patient mother verbalized, he could eat well and nurse observed that patient was able to eat at least two thirds of his meal served with 250mls bowl at 12th December 2022 at 8:00am.

6. Patient mother will gain adequate knowledge (10th December, 2022)

At 6:30pm, interaction with patient/mother revealed that they had little knowledge on causes of Gastroenteritis hence the nursing diagnosis of Deficient knowledge related to inadequate information on the causes, management and prevention of the condition. An objective was set to help patient mother gain adequate knowledge on his disease condition. The following interventions were implemented: Patient and mother were told that everything discussed was between them and that nobody will ever hear of it. This was to enhance learning and improve patient and family confidence in the nurse, Patient and family were reassured, their knowledge on her condition was assessed, patient relative was informed about ways of preventing the symptoms and some management for the disease, patient relative was allowed to ask questions for clarifications on issues about the disease bothering their minds, all questions were answered in simple, and clear language without the use of professional jargons and also patient and family were asked to give a feedback on what they heard.

Evaluation of the set objective on 9th December, 2022 at 6:30pm to help patient and relative gain adequate knowledge on cause of Gastroenteritis within 24 hours was done; goal was fully met as patient mother verbalized that they have understood what they were taught on Gastroenteritis and nurse observed that patient and relative practice what was taught on 10th December 2022.

5.2 Amendment of the Nursing Care Plan

Despite the numerous problems identified, with the individualized comprehensive nursing care and support from other members of the health team and co-operation of patient and relative, all of the goals set were fully met. The care plan was therefore not amended.

5.3 Termination of Care

Care of patient and family ended on the 2nd January, 2023 which was my last home visit. This ended the interaction between the health team and the patient and his family. The preparation for termination started on day of admission through discharge, review to the third home visit. During these periods, patient and family were educated on various topics. I congratulated the family for the care they had rendered to the patient. They were thanked for their co-operation and patient was handed over to his mother. They were told that now that Master. M.K. Y's. health had been restored, the care for him has officially ended. I informed them of my desire to visit them unofficially whenever I had the opportunity. They were happy and noted that they would miss my care and would strictly adhere to all instructions given to them. It was a moment to remember when I told them of my intention to leave.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation, or compendium of previously stated facts or statements. Conclusion is something that you decide when you have thought about all the information connected with the situation (Taylor, 2019). This is the last step of the patient/family care study which entails the student's personal appreciation of the therapeutic relationship with the patient as well as the use of the nursing process.

6.1 Summary

Master M.K.Y. was admitted to the Paediatric ward through the Under-five unit of Holy Family Hospital, Berekum on the 8th December, 2022 at 8:30am with the diagnosis of gastroenteritis. Patient presented with severe abdominal pains, vomiting and diarrhea, fever, knowledge deficit, loss of appetite and body weakness. Six Nursing diagnosis were formulated on problems identified and objectives set to help treat patient condition.

Laboratory investigations requested were

- Full Blood Count
- Malaria card test

Master M.K.Y. was managed on the following medications;

1. Intravenous Paracetamol 10MG/KG (98mg) tid for 1 day
2. Oral rehydration salt powder (100ml after each stool)
3. Zinc Tablet 20mg daily for 10days
4. Intravenous Ringers lactate 500ml Stat

5. Intravenous cefuroxime 30MG/KG (294mg) bid for 24 hours

6. Syrup paracetamol 5 mls TID for 5 days

Patient and relative were educated on gastroenteritis and its management. Patient was also assisted in maintaining personal hygiene, rest and sleep, nutrition, and exercises were also ensured.

Patient was discharged on 12th December, 2022. On the 19th December, 2022 patient reported for review as scheduled. It was to find out if patient was adhering to the advice and all the education given to improve his health and standard of living. Three home visits were embarked on. The first home visit was done while patient was still on admission on 10th December, 2022, second home visit was on the 15th December, 2022 and third home visit was on the 2nd January, 2022. The care of Master M.K.Y and his family care was terminated on 2nd January, 2022, during the third home visit when patient had fully recovered.

6.2 Conclusion/Recommendation

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

the community's wrong perceptions about staff nurses and also improve the people's attendance to the hospital.

Therefore, it is my recommendation that all students are given the opportunity to embark on the patient/family care study to implement the nursing process in order to render individualized comprehensive care to patients/families. This helps the patient and family to gain adequate information about gastroenteritis, causes, treatment and its preventions. In brief, I really enjoyed every bit of writing this script despite the challenges encountered.

APPENDIX

Table 8: Vital Signs of Master M.K.Y. throughout the period of hospitalization

Date	Time	Temperature (^{0}C)	Pulse (bpm)	Respiration (cpm)
08/12/22	8:30am	38.0	175	42
	10:00am	37.5	150	37
	2:00pm	37.3	140	26
	6:00pm	37.4	160	28
	10:00pm	37.3	137	23
09/12/22	06:00am	36.3	145	28
	10:00am	36.6	150	30
	02:00pm	37.0	140	27
	06:00pm	36.6	145	28
	10:00pm	36.6	130	32
10/12/22	06:00am	36.2	136	26
	10:00am	36.5	142	29
	02:00pm	37.1	152	27
	06:00pm	37.0	144	29
	10:00pm	36.8	151	28
11/12/22	06:00am	36.8	129	26
	10:00am	36.3	126	27
	02:00pm	36.5	132	26
	06:00pm	36.2	140	26
	10:00pm	36.4	145	29
12/12/23	06:00am	36.3	130	28
	10:00am	37.0	123	25

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THE STUDENT NURSE

NAME: AMOATENG FELIX

SIGNATURE.....

DATE.....12TH JULY 2023.....

NURSE IN-CHARGE OF PAEDIATRIC WARD, HOLY FAMILY HOSPITAL, BEREKUM

NAME: ESTHER DUODU EFFAH

SIGNATURE.....

DATE.....12-07-2023.....

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

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