Nursing: chronic health conditions critical thinking example

Business, Management

(Professional/nursing care plan)

Introduction

- A brief introduction to setting and the chronic health condition

Critical application of a chronic disease model of care used to inform self-management.

Articulation of short and long term goals.

Identification and critical examination of specific strategies/interventions to support self-management.

Identification of the tasks/actions necessary to complete each strategy, as well as who will

Conclusion

- Examination of the effectiveness of the self-management plan (i. e. how the achievement of goals will be evaluated)

Abstract

This report contains a self-management care plan for a diabetic patient with an associating chronic condition. A brief introduction to the setting and chronic health condition will be outlined. Critical application of the Stanford chronic disease model of care will be used to inform self-management. An articulation of short and long term goals will be undertaken as well as identification and critical examination of specific strategies/interventions to support self-management; tasks/actions necessary to complete each strategy, as well as who will execute them will be specified. Finally, an Examination of the effectiveness of the self-management plan (i. e. how the achievement of goals will be evaluated)

(Professional/nursing care plan)

Introduction

A brief introduction to setting and the chronic health condition

According to research the prognosis of people afflicted by Type 11 diabetes varies depending on how well they adhere to treatment, diet and exercise. Essentially, demands for insulin increases with age and the islets of Langerhans cells may wear out trying to keep up with high blood glucose levels. As such, complications of the disease may begin to take its toll on the body. These include heart attack, kidney disease, stroke, and poor circulation in low extremities as well retinal damage, which could lead to blindness (Feinglos, 2008).

Type 11Diabtes Mellitus is predicted to reduce life expectancy by 10 years. However, with careful management this has been reduced. Presently the case fatality rate reads 10. 8 to 6. 1 per 1, 000 person-years. In 2010 there has been an estimated 285 million people living with type 11 diabetes accounting for 6% of the world’s population. Annual mortality rates range from 0. 28 to 8. 24 per 100 patient-years (Halvorsen et. al, 2007).

Critical application of a chronic disease model of care

Used to inform self-management

The chronic disease model of sel-care that will be utilized in this self-care management plan is the Stanford Model. The model advances that during chronic illness the goal is function and comfort not cure (Ruggiero et. al, 2010). Consequently, the health care provider’s role changes from principle

care giver to teacher and partner. Also, the care environment is removed from a clinic or hospital to the community or person's home. As such, the patient's role changes into one of self-care (Alvarez 2009).

Importantly, this public health approach is a patient centered, participatory and culturally appropriate education program. It emphasizes that there is a distinct difference between self-management and disease (Rutten, 2005). Precisely, self –care focuses on improving quality of life for the individual and providing skills to manage life in the presence of the chronic condition. Further, the model advocates a program whereby preparation for individual patient teaching is undertaken through group education/ interaction of 10-15 people (Thomas-Hawkins & Zazworsky, 2005). Participants could have the same chronic condition or there could be a diversity of conditions. Sessions should not last longer than 2- 2 ½ hours with organized interaction and trained facilitators (Hertz, 2013).

THE STANFORD SELF-CARE MANAGEMENT MODEL

Better Functional and Clinical Outcomes (Alvarez, 2007)

In concluding this section relating the critical application of a chronic disease model of care informing self-management of this 68 year old woman with type 11diabetes mellitus it would be worthwhile offering a quick assessment of apparent self- management needs (Sullivan, 2012) Type 11 diabetes mellitus is a chronic condition with complications to be managed. Complications of diabetes are evident in the form of chronic renal failure; hypertension; myocardial infarction; leg ulcer; respiratory distress and bloated abdomen. Mrs. Johnson has shown signs of these complications

(Deakin et. al, 2006).

Articulation of short and long term goals.

Generally, self-care management for type 11 diabetes mellitus centers around seven main goals. They are healthy eating; keeping active; healthy coping; blood sugar monitoring; medication administration, reducing risks and problem solving. The rationale for eating healthy is to reduce saturated fats and maintain adequate carbohydrate intake. Keeping active increases circulation of blood; learning healthy coping reduces incidences of depression which is very common in patients with chronic illness (Colberg et. al, 2012).

The rationale for monitoring blood glucose levels is to limit incidences of hypoglycemia in the short term. In the long term it postpones complications of the disease while the use of medication is the long-term safe guard that complications of the disease will take a longer time to affect the body. Controlling risks of hypo as well hyperglycemia coma is essential self-care management since it is a short term complication frequently encountered by diabetics. Problem helps relieve stress which can elevate blood sugar levels even when taking medications (Bycroft & Tracey, 2006).

It must be noted that while these are the seven standard goals for self-management of a patient with type 11 diabetes it must be understood that. Mrs. Johnsons has complications, which must also be addressed individually in the management of a person with a chronic health . condition (Skinner et. al, 2006). From her profile they include chronic renal failure; hypertension, leg ulcer, myocardial infarction; respiratory distress and abdominal bloating. Then chart below highlights the condition needing self-care management;

the projected long and short terms goals along with ther rationale for each of them (Kralik et. al, 2012).

GOAL ARTICULATION CHART

Identification and critical examination of specific

Strategies/interventions to support self-management.

In the preceding pages of this document Stanford Chronic Disease Self-Management Model was identified as the pattern for Mrs. Johnson’s care plan. Essentially, this model entails holding generic group workshops weekly for the most six weeks. Non-medically trained volunteers facilitate discussions, which are conducted in community settings such as churches, community centers, libraries or hospitals. Subjects discussed at each session include:-

- techniques to deal with problems such as frustration, fatigue, pain and isolation
- appropriate exercise for maintaining and improving strength, flexibility, and endurance
- appropriate use of medications
- communicating effectively with family, friends, and health professionals
- nutrition, and
- How to evaluate new treatment (Alvarez, 2009).

In this specific case Mrs. Johnson is to be trained in self-management of her health challenges before leaving hospital. A limitation of the Stanford model was identified as some people being very uncomfortable in group settings. Since this is a community based intervention, a six week training session

could begin in the hospital setting before her discharge. According to the model patients do not necessarily have to be suffering from the same health condition, but the common element is that all health conditions must be chronic (Kralik et. al 2010).

Implementation agency for this program is the public health department within the participating community. This agency forms the Health System Organization managing interventions and strategies designed for each workshop. Stanford University provides the content by linking relevant community resources to the program (Krishna, & Boren, 2008).

They include churches, non- medical volunteers, hospitals and stakeholders. Integrated elements of the project/program are the delivery system design embodying workshops style, self-management support process; decision support derived from planned interactions at workshops and a clinical information system, which stores relevant workshop/patient data for easy access to health care providers within the Health System Organization (Alvarez 2009) (See the diagram of the Stanford Self-Care chronic illness diagram).

The model while teaching self-management skills could be limited in designing specific interventions and strategies for distinct health complications as those challenging Mrs. Johnson. Therefore, in my health care plan Mrs. Johnson’s needs ought to be address from an individual level within and without of the six the week two hourly teaching workshop. Consequently, my nursing care plan would encompass a workshop component as well as an individual interactive teaching segment (Khunti et. ai, 2012).

SPECIFIC STRATEGIES/ INTERVENTIONS TO SUPPORT SELF MANAGEMENT

SELF- MANAGEMENT

Self-management strategies and interventions will focus on meeting goals of each complication to produce improved functional and clinical outcomes. Even though Stanford model is used as the guide adjustments for addressing Mrs. Johnson's specific health challenges will be made since according to Langford (2007) and colleagues patient-centered goal setting is a useful tool in improving diabetes self-management (Langford et. al, 2007).

WORK-SHOP STANFORD SELF-CARE MODEL

(Group sessions)

Identification of the tasks/actions necessary to complete

Each strategy, as well as who will

Conclusion

This report contained a self-management care plan for a diabetic patient with an associating chronic condition. A brief introduction to the setting and chronic health condition was outlined. Critical application of the Stanford chronic disease model of care was used to inform self-management. An articulation of short and long term goals was undertaken as well as identification and critical examination of specific strategies/interventions to support self-management; tasks/actions necessary to complete each strategy, as well as who is expected execute them was specified. Finally, an Examination of the effectiveness of the self-management plan (i. e. how the achievement of goals were evaluated) was given.

Examination of the effectiveness of the self-management plan

(i. e. how the achievement of goals will be evaluated)

The following goal evaluation score sheet will be filled out monitoring Mrs. Johnson achievement after each weekly workshop session conducted prior to leaving hospital in preparation for self-management at home after discharge

ACHIEVENT SCORE SHEET

Appendix A: Extended Patient Profile

Subjective data

- Had a myocardial infarction at 62 years of age
- Has experienced increasing dyspnoea, frequent cough, and oedema in legs over the last 3 weeks
- Has to sleep with head elevated on three pillows

Objective data

- In respiratory distress, use of accessory muscles, respiratory rate 36 breaths/min
- Heart murmur
- Skin cool and diaphoretic
- Venous leg ulcer on left ankle
- Bloated abdomen

Physical examination

- Pulse full and bounding: 92 bpm, blood pressure: 162/106 mmHg, O2 saturation: 88% (room air)
- Temperature: 37. 1oC
- Urinalysis: protein++++; pH 6. 8; SG 1. 020; blood, glucose & ketones -

nil

Diagnostic studies

- Serum: K 5. 9 mmol/L; HCO3 14 mmol/L; Urea 13. 7 mmol/L; Creatinine 238 µmmol/L; eGFR 17 mL/min/1. 73m2; Hb 98 g/L; HbA1C 7. 2%.
- Chest X-ray result: left ventricular hypertrophy; fluid in lower lung fields
- ECG: normal sinus rhythm

Collaborative care

- Frusemide 80 mg BD
- Peridopril 8 mg daily
- Lercanidipine 10mg daily
- Atorvastatin 10mg daily
- Calcium carbonate 600mg TDS
- Calcitriol 0. 5µg daily
- Lispro 25% 12 units BD
- Oxygen 6 L/min via Hudson mask
- Daily weight
- Renal diabetic diet
- Referral to renal team (nephrologist & CKD nurse practitioner

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