

Adult holistic care across the age continuum nursing essay



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The patient that will be discussed within this care plan using a systematic approach using the ABCDE, is a female named Mrs J, aged 67 years old. Mrs J was brought to the hospital by her family, who informs the nursing staff of Mrs J past medical history of heart failure. In this instance there were no signs of any chest pain, Mrs J had sudden onset of dyspnoea with feelings of unable to swallow and coughing up frothy mucous. Mrs J also had a pale complexion and had dry skin, and was very tachycardia, hypertensive, respirations were over 20 and low saturation levels.

Respiratory failure is a condition in which the level of oxygen in the blood becomes low or the level of carbon dioxide in the blood becomes too high. Causing the inability to maintain adequate gaseous exchange and is a life threatening condition. It is important to do an accurate assessment so nurses and the multidisciplinary team can give the appropriate nursing care and treatment can be administered and the evaluated effectively (Higgins, 2008).

Patients shows signs of dyspnoea this may cause the patient to appear anxious or exhausted or they maybe unresponsive. Hypoxemia can alter a patient's mental state, and delirium or confusion might take place.

Hypoxemia can be caused by decreased oxygen content of inspired gas, hypoventilation, diffusion abnormalities (Lippincott Williams & Wilkins, 2007).

Dyspnea has been more specifically defined by as the " subjective experience of breathing discomfort that consists of qualitatively distinct sensations that vary in intensity. (Sharma, Mukul Agarwal, 2010)The patient's skin colour maybe pale and central cyanosis maybe present; which is a bluish discoloration of the skin. Central cyanosis (decreased oxygen

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saturation of haemoglobin in arterial blood) is best seen in buccal mucous membranes and lips. Peripheral cyanosis (slow blood circulation in fingers and toes) is best seen in nail beds. (Carpenito-Moyet, 2009). Mrs J's general presentation was showing signs of anxiousness, pale skin, but no late indicators of cyanosis, she also appeared to be confused.

Mrs J adopts a posture to make the most of lung expansion, Pursed lip helps Mrs J with her breathing so she can control shortness of breath. It is a quick and easy way to slow your pace of breathing, making each breath more effective. The accessory muscles as a compensatory mechanism to improve gas exchange; it is typically only used when the body needs to process energy quickly (Richardson, 2006). Mrs J appeared to be in respiratory distress as she was using her accessory muscles like her neck, shoulders and diaphragm and leaning forward with her shoulders hunched.

The respiration rate is measured when the patient is at rest and it simply involves counting the number of breaths for one minute by counting how many times the chest rises. Respiration rates can increase with fever, illness, or medical conditions. When checking respiration, it is also important to check whether the patient has any difficulty breathing likes of Mrs J. There are Electronic devices are available to perform this task of measuring the respiraroy rate but maybe unreliable so manual counting of the number of breaths is preferred (Timby, 2009). The patient will be observed for rate, depth and pattern on breathing. Respiratory rate in adults are between 12 - 20 breaths per minute. (Marieb & Hogan, 2007). Mrs J's respiratory rate was high at 25 breaths per minute and was showing signs of tachycardia which is increased pressure from the heart due to not enough oxygen to the tissues <https://assignbuster.com/adult-holistic-care-across-the-age-continuum-nursing-essay/>

and vital organs. This means the heart was pumping faster to compensate (Waugh & Grant, 2006). With Mrs J having respiratory disease she is likely to have an elevated respiratory rate to make it easier to gain the right amount of oxygenation air and ventilation of air (Brooker & Nicol, 2003).

Observations of the rhythm and depth of breathing indicate the quality of each breath. Mrs J's has a rapid irregular breathing pattern that does not allow expansion of the lower lobes of the lungs will also result in ventilatory failure (Brooker & Nicol, 2003). Changes in the pattern of respiration are often found in disorders, Mrs J was suffering from hyperventilation which will increase in both the rate and depth of respiration. This follows extreme exertion fear and anxiety which was in Daisy's circumstance (Dougherty & Lister, 2008).

Oxygen saturation is a percentage of haemoglobin molecules saturated with oxygen. The normal arterial oxygen saturation is approximately 95 - 100% (Harvard University, 2002). A pulse oximeter measures the oxygen saturation of a patient's. It will be attached to a monitor Mrs J so staff can see the her oxygenation at all times, it is a simple, non invasive way of measuring oxygen saturation of blood to see whether it is in normal range (95-100%). " In hypoxiaemia, the blueness of the blood will be measured by the pulse oximetry. This can be really useful but pulse oximetry has its limitations. It doesn't detect changes in carbon dioxide levels" (BMJ, 1998) Pulse oximetry should be available in all places where emergency oxygen is used (Dougherty & Lister, 2008).

An arterial blood gas (ABG) test measures the acidity (pH) and the levels of oxygen and carbon dioxide in the blood from an artery. This test is used to check how well your lungs are able to move oxygen into the blood and remove carbon dioxide from the blood. As blood passes through your lungs, oxygen moves into the blood while carbon dioxide moves out of the blood into the lungs. An ABG test uses blood drawn from an artery, where the oxygen and carbon dioxide levels can be measured before they enter body tissues. Only the doctor can do this test or people that are trained to do so (Timby, 2009). Mrs J's blood test was sent to microbiology to be tested, this is so it can help us to make a diagnosis and indicate the severity of Mrs J's affect of the her illness. ABG's provides the multidisciplinary team with information on the patient's oxygenation, adequacy of ventilation and acid base levels. These are some of the things that are looked at within the blood sample given; blood ph for acidosis, carbon dioxide levels for any signs of respiratory problems and it also looks at your oxygen levels (Timby, 2009).

There is also an orthopneic position which allows maximum vertical and lateral chest expansion, also provides comfort for resting and sleeping, however this was not appropriate for Mrs J condition (Timby, 2009).

Oxygen will be prescribed by a doctor for Mrs J and the prescription should include flow rate, concentration, delivery device, duration and method for monitoring treatment for Mrs J (Dodd, 2000). Oxygen therapy is for administrating more oxygen that is present within the environment around us to prevent or relieve hypoxemia (Carpenito-Moyet, 2009). Oxygen can be administered using a simple mask, partial or non re-breather masks, or a venturi mask. (Timby, 2008). The nasal cannula carries 1-6 litres of oxygen <https://assignbuster.com/adult-holistic-care-across-the-age-continuum-nursing-essay/>

per minute. The oxygen fraction provided to the patient ranges roughly from 24% to 35%, or the cannula may merely supply humidified air. Nasal cannula would be the best method to use for Mrs J as it is non invasive and promotes comfort and less likely to feel suffocated, as Mrs J is feeling very anxious with everything that is going on around her. The oxygen mask that was used for Mrs J with constant reassurance by using distraction or relaxation techniques by the nursing staff was a non - re-breather mask, which delivers 90% to 100% oxygen (Timby, 2009). Patients who use non-breather masks need high concentrations of oxygen. This mask has a one-way valve to allow only oxygen from its source as well as the reservoir bag, to be inhaled all exhaled air leaves the mask rather than entering the reservoir bag therefore supplying Mrs J with higher level of oxygen. (Timby, 2009).

Salbutamol is used for respiratory infections by acting on receptors in the lungs called beta 2 receptors. When salbutamol stimulates these receptors it causes the muscles in the airways to relax. This allows the airways to open (Science Direct, 2006) So salbutamol was prescribed by the doctor and was administered to Mrs J by an ultrasonic nebulizer and it usually takes 8 - 10 minutes to breathe in one complete treatment. Nebulizer is commonly used for treatment of COPD and other respiratory diseases. It is a type of inhaler that sprays a fine, liquid mist of medication, through the mask, using oxygen under pressure. (NHS, 2008). Bronchodilators such as salbutamol are used to open up the small airways of the lungs (bronchi) in order for Mrs J to breathe more easier, this was used short term to provide short term relief as Mrs J was experiencing an episode of breathlessness and showing signs of anxiety. (NHS, 2008).

Respiratory infections can be diagnosed by sending sputum samples. It is matter that is expelled from the respiratory tract, such as mucus or phlegm, mixed with saliva (Dougherty & Lister, 2008). It is usually associated with air passages in diseased lungs, bronchi, or upper respiratory tract to microbiology for testing. The observations for sputum are colour, viscosity, odour and the amount is vital. Thick viscous sputum that is coloured indicates infection; white frothy sputum indicates pulmonary oedema (Dougherty & Lister, 2008). Mrs J's sputum was white and frothy and was showing signs of oedema on both of her ankles. Suctioning was on standby as Mrs J was showing white frothy sputum and has difficulty in swallowing since being discharged six years ago due to cancer of the oesophagus, just to prevent any further obstruction. Routine of suctioning should be avoided and careful assessment of Mrs J respiratory function should be carried out instead (Pryor & Prasad, 2001). We should look for the location of secretions and whether this can be reached by catheter, each suctioning should last no longer than 10 - 15 seconds to decrease the risk of trauma, hypoxia and other side effects (Dougherty & : Lister, 2008)

By looking at Mrs J's respiratory status by doing observations, looking at her respirations to see if they have decreased, listening to her breath sounds to see if there is any wheezing noises or gurgling sounds. These observations will determine the effectiveness of mechanical ventilation of Mrs J also to see if her condition has improved (Carpenito-Moyet, 2009). As well as Monitoring Mrs J's oxygen saturation using the pulse oximetry, this was be monitored every 2 - 3 hours. Recordings will be documented on an assessment tool called the Modified Early Warning Score (MEWS) this provides a baseline for

future reference (Timby, 2009). Oxygen therapy should be titrated downwards and stopped when Mrs J is showing signs of being stable and the oxygen in the blood is stable (British Thoracic Society (BTS), 2009).

MEWS charts, this is an assessment tool that records patients vital signs such as Blood pressure, pulse, respirations, oxygen saturation, temperature and urine input and output, it also measures the patients pain. Mews charts help nurses and people within the multidisciplinary team to do an evaluation of clinical interventions and nursing care, to improve the patients' quality of care (McArthur-Rouse, & Prosser, 2007). (As cited in: Dougherty., & Lister, S., 2008).

By using the Roper et al (1996, 2000) model for nursing based on a model of living will also provide the basis for a discharge plan and to facilitate safe discharge back into the community. Prior discharge Mrs J had surgery for a Percutaneous Endoscopic Gastrostomy tube (PEG). A PEG is placing a feeding tube directly into the stomach through a small incision in the abdominal walls using an instrument known as an endoscope (Tortora & Grabowski, 2003). This procedure is performed for providing nutrition to Mrs J who cannot have food by mouth, as Mrs J has had treatment for cancer of the oesophagus six years ago and has poor control over her swallowing ever since (Patient UK, 2010)). Oesophageal cancer the most common symptom is dysphasia (difficulty in swallowing) usually, there is a feeling that food is sticking on its way down to the stomach, liquids maybe swallowed easily at first, but in Mrs J's circumstances this was becoming a problem (Pryor & Prasad, 2001).

General Practitioners (GP) are responsible for co - coordinating community services, Therefore should inform Mrs J on discharge of any feeding regimen changes. Feed preparation and regimes are generally advised by dieticians and prescribed by the GP (Patient UK, 2010). General Practitioners provide a complete range of care in the local community A discharge letter will be posted to Mrs J's GP by nursing staff on the day she is going home and the Feeding regimes will be devised by a dietician. (British Dietetic Association, 2010)

There are a variety of different types of feed which the dietician may use. Standard feeds are generally 1kcal/ml. There are also fibre containing feeds which will help Mrs J with her constipation. Mrs J was put on a feed called jevity 1500ml which was administered to Mrs J as instructed by the dietician (Timby, 2009).

A dietician is an expert in food and nutrition. They help develop, modified diets, participate in research, and educate individuals and groups on good nutritional habits. Dietician may provide specific artificial nutritional needs to patients unable to consume food normally. Dietary modification to address medical issues involving dietary intake is also a major part of dietetics. (Timby, 2009). As Dietician instruction Mrs J was using an Abbott's pump, a feeding device widely used within hospital setting and home environment (Abbott Laboratories, 2010). As Mrs J was going to be on this feeding regime for a long period due to restriction of the oesophagus Mrs J felt this was suitable for her more than the bolus feed because of her dignity as she feels embarrassed on where the feeding tube was situated. The

dietician should be involved at the earliest stage of discharge planning (Bapen, 2009)

Mrs J will need to be referred to the district nurses, so a completed district nurses' referral form is needed, this will be accepted from any member of the multi disciplinary team. On the referral form you need to be clear on what you want the district nurse to do or the reason for the visit (NHS , 2006). District nurses provides care from General Practitioners, Health Centres, and in patients homes, the team provides a 24 hour access care, support and advice. The team also includes a community matron; who are nurses with additional skills to support people with health needs. They play a central role in the assessment of care planning, co ordination and evaluation of nursing care to ensure Mrs J gets all help and support she needs (NHS Careers, 2010) District nurses role would be to look after Mrs J's Feeding regime and any complications that may occur, such as toleration to the feed, Checking the stoma site for any infections that may occur or any signs of blockages within the tube it's self (NHS Westminster, 2008). The district nurse is also to administer Mrs J's medication most medications that come in tablet or pill form can be crushed and dissolved in water and passed through the feeding tube. District Nurses are there to also educate and advise with Mrs J and her family when needed; also they leave contact details as they provide 24 hours Care. The district nurse liaisons with the community dietician and documentation are filled out correctly (Timby, 2009)

COPD is characterized by airflow control. Air flow limitation is usually progressive and is due to inflammatory in the lungs encouraged by irritants.

The common cause of COPD is cigarette smokie, air pollution. The <https://assignbuster.com/adult-holistic-care-across-the-age-continuum-nursing-essay/>

community dietician will be visiting Mrs J at home weekly or fortnightly to do a review on Mrs J's weight to see if the feeding is working properly. The dietician will ensure that the feed is prescribed by the General practitioner and all equipment that needs will be ordered. Support and Advise is available at all times and the dietician will give all the necessary leaflets and contact numbers to Mrs J and her family in case of emergency. " The community dietician arranges necessary update training on enteral feeding for the multidisciplinary team as required Timby, (2009)", also the dietician liaison with the multidisciplinary team on Daisy's care.

A woman with fatigue, dyspnoea, and orthopnoea

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