

Community nursing: critical thinking case study

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Mrs.. MM is a 72 year old woman who has a primary diagnosis of Diabetes Mellitus Type II. Her secondary diagnosis and the reason why she was referred to Hackers home health agency was a non-healing wound on the second toe of her right foot.

Upon assessment of the patient, current health needs which were identified pertain to wound care, nutrition, and proper management of Diabetes through compliance with Insulin treatment, and knowledge on prevention of hypoglycemic and hyperglycemia episodes. The current plan of care for Mrs..

MM and the visit skill relate o wound care and Diabetes self-management. “ Diabetes Mellitus is a chronic multistage disease related to abnormal insulin production, impaired insulin utilization, or both” (Lewis, Hitchhiker, Drinkers, O’Brien, & Boucher, 2007, p. 1253).

According to Lewis, Hitchhiker, Drinkers, O’Brien, and Boucher (2007) some of the clinical manifestations of Type II Diabetes Involve fatigue, recurrent Infections, visual changes, and prolonged wound healing. As seen with Mrs.. MM prolonged wound healing could become a main concern given that it puts patients at increase risk for infection.

The desired goals in the treatment with Mrs.

. MM is to reduce symptoms of Diabetes, promoting healing and well-being, preventing acute complications of hyperglycemia, and delaying the onset and progression of long-term complications Lewis, Hitchhiker, Drinkers, O’Brien, and Boucher (2007). Standards of Care The ANA Scope and Standards of Diabetes nursing practice (2003) states that standards of care

describe a competent level of practice demonstrated through the nursing process. Starting from adequately collecting patient health data, identifying potential problems with the physical or spiritual being (e. Safety environment, oppression), to formulating realistic goals for improving overall health status (e.

G. Increasing physical activity), educating the patient of effective diabetes self- management (e. G. Insulin Injections, diabetic diet), planning and implementing interventions related to the current health needs, coordinating the care across all settings, and finally evaluating expected outcomes(e. G. Prevention of Infection, few or no hypo or hyperglycemia episodes), and effectiveness of interventions. Two disciplines that are a very important part of the healthcare team for Mrs..

MM are physical therapy and social services. Physical therapy is crucial for the rehabilitation of the patient given that mobility has been impaired by the non- healing wound on her foot. Social services are also a very important part of the care given that her support systems are very limited.

The current plan of care of Mrs.. MM is adequate given that all her health needs are being addressed and interventions are being implemented to assist those needs. These needs being related to wound care, diabetes self- management and patient education related to nutrition and insulin treatment, and safety amongst the home environment.

Support Systems Support systems Include people, groups, and organizations with which one escalates In order to accomplish goals or to conclave some purpose” (Roy & Andrews, 1999, p. 476).

Upon assessment of the support systems available to Mrs.. MM it was identified that she has very limited resources. She reported having a son who visits her once a week and does the grocery shopping for her. However the patient stated “ He is a very busy man and he does what he can for me, but he can’t always be there”.

Besides her son she did not identified any other source of support such as belonging to a church or having any friends.

She expressed “ Sometimes a neighbor would come by for minute to say hello, but otherwise I don’t socialize very much”. The patient also reported being a widower for four years now. Steps which could be considered in augmenting the support resources for Mrs.. MM are encouraging participation in senior activities within the community, and perhaps searching for arrangement of transportation due to her current impairment in ambulation.

Social services could also be involved for the possibility of assigning Mrs.

. MM a home health aide. The son could also be contacted and included in this plan of care; however he may be a less reliable resource. Environment The home environment assessed was to a great extent inadequate for the patient. The patient reported that during her last hospitalizing her house was robbed and everything was left in disorder since then.

The house was a one floor residence. Upon entering the home the clutter could be observed throughout the entire house.

There was only a path which went from the bedroom she used to the living room and to the kitchen. Although there were no rugs the clutter left very limited space for moving around. The lighting was very dim.

The windows were covered with dark drapes and lettered furniture did not allow access to the windows. The patient reported that her son was trying to find her a new apartment and that she felt very optimistic about it because she knew that her home wasn't a safe environment for her any longer especially after the recent robbery.

Taking in account the above description of the home it is evident that the environment was not interacting with her condition in any way. Due to the wound on her foot Mrs.. MM uses a walker to assist her ambulation.

The inadequate lighting, the cluttered areas and the narrow path leave very limited space for the free movement of the walker, thus bringing up serious safety issues and potential complications of her health. Potential economic issues may arise for Mrs.. MM given that she is a widower receiving only a social security pension, and has limited support systems. Behaviors Mrs..

MM displayed both behaviors of effective adaptation in certain aspects, and ineffective behaviors in others. Some of the behaviors which exhibited effective adaptation were her expressed knowledge and compliance with the insulin injections. She also stated " I check my blood sugar four times a day and I do the insulin injections in the morning and at night Just like the Doctor

said". Nonetheless, she reported losing the log of her glucose checks, consequently in order to verify her compliance and the effectiveness of the current insulin treatment a hemoglobin A1C test could be performed. The hemoglobin A1C test shows the average blood sugar for the past two to three months" (Belling, 1999, p. 77).

Another adaptive behavior displayed was her improving ambulation. She reported that upon discharge from the hospital she could barely take any steps, however, after noticing improvement later Pensacola tannery echelons seen Tell even stronger to continue. On the other hand Mrs.. MM also exhibited one very crucial ineffective behavior following a nutritional assessment as per the care plan. When asked about how many meals she ate per day she answered three meals and a couple of snacks in between.

However, when her refrigerator was looked into with the purpose of nutritional assessment there very few food products in it. The patient reported that her son had to come the following day to do grocery shopping, which meant that she relied solely on her son for her food. The chart also showed that the nurse who did the previous visit had also addressed the same issue and had informed the patient of the program " Meals on Wheels" but she reported that the patient refused it. In attempt to have the patient re-consider the program " Meals on Wheels" I explained to her how it worked and how this program would benefit her health.

I also assessed her perception of this program, however her main argument was that she felt well enough to cook her own food and refused it once again. According to Roy & Andrews (1999) this behavior displayed is

ineffective because her physiologic and physical integrity are at stake and basic needs are not being met.

This situation concerning Mrs.. MM nutrition relates directly to the plan of care involving social services and other possible available options for the patient. Patient Progress and/or Complications The absence of infection and the improved healing of Mrs..

M's wound could be evidence of progress in self-management of diabetes and complies with the expected outcomes in the plan of care. According to Belling (1999) when blood glucose levels are above normal the likelihood of an infection is increasingly higher. Therefore absence of infection may suggest controlled glucose levels. Few factors can serve as true evidence of progress in Mrs.. M's overall condition.

Nonetheless, in order to verify the adherence to the treatment and to what extent the diabetes is being controlled a log of the patient's glucose levels and/ or a hemoglobin AH C test would be ideal.

According to Belling (1999) the results of this test can help the patient and the healthcare provider tell how well the patient has been doing in controlling their diabetes over the last few months. As to what nutritional status concerns further re- assessment needs to be performed, and the patient's report on her son bringing the food should be verified. The patient currently does not present any signs of malnutrition. The possibility of increased loss of appetite should also be observed because it can be related to adverse effects of certain medications.

According to Lewis, Hitchhiker, Drinkers, O'Brien, & Boucher (2007) certain drugs often used in the treatment of chronic illnesses have an adverse effect on the appetite of older adults.

Acute complications which Mrs.. MM is at risk include: diabetic acidosis's, hyperbolas monotonic coma, and other illnesses such as pneumonia. Chronic conditions which the patient is at risk are: heart disease, stroke, high blood pressure, blindness, kidney disease, nervous system disease, and amputations.