

# Case study care plan

Business



This essay will include a case study about a patient nursed with the supervision of a registered nurse during a clinical placement.

It will demonstrate the ability to assess and develop a care plan for this patient. For this case study, the patient's name will be changed to Paul and confidentiality will be kept at all times. The nursing process will be described and used to develop a nursing care plan for the above patient. The setting is an integrated hospital service made up of Older Peoples health which provides services such as assessment, treatment and rehabilitation care for the over 65 years old population.

These services are provided by a team of professionals such as nurses, physiotherapists, occupational therapists, speech language therapists, dieticians, and social workers to name a few. They work in collaboration to care for patients who are ill and support them to be as independent as possible (Health Point corporation, 2013).

In order to plan care for a patient it is essential to understand the nursing process as it is a vital part of the care plan (Crisp & Taylor, 2010).

Potter and Perry describe the nursing process as a systematic way to collect client data, examine and analyse it in order to identify client's problems so individualized nursing care can be provided. The nursing process consists of five steps: assessment, diagnosis, planning, implementation and evaluation (Crisp & Taylor, 2010). Assessment is the first step in writing a care plan. It is a meticulous and systematic collection of data (Crisp & Taylor, 2010).

For this essay the functional health pattern format from Lexis's medical surgical will be used to collect client data (Grabber O'Brien & Thompson, 2010).

Paul is an 81 years old European male who lives alone in a private rest home. He was admitted due to an nuttiness fall which he has no recollection of. On admission he was diagnosed with multiple rib fractures on the left side ribs 4, 5 6 and on the right 5, 6, 7, head trauma with scalp swelling, and open wound on the chest and left knee. A rib fracture is a crack or a break of the rib bone. It can cause a lot of pain during breathing, coughing and movement.

Most rib fractures heal on its own and healing require about 6 weeks. However pain relief is essential to help manage pain during this process (WebMD, 2010).

Paul was chartered lag paramedical which is an analgesic to treat mild pain every four hours, and OMG oxymoron when needed, an podia analgesic to manage severe pain. In addition Paul stated that his mobility has decreased due to muscle weakness which has deteriorated in the past 3 months. Paul was diagnosed with type 2 diabetes 50 years ago. He says that his parents and grandparents had diabetes and that it runs in his family.

Paul suffers from left ventricular failure a condition where the left ventricle fails to contract enough to mammalian cardiac output and peripheral perfusion.

As a result, Pulmonary congestion occurs and edema develops from back pressure of blood in the left ventricle causing breathlessness, despite orthogonol and peripheral constriction (Craft, Gordon, Tasmania, Sue, Ms Cancel, Brash, Rot, 2011). On admission he had fluid overload and was given Transmuted. Loyal Paul continues taking Transmuted to Nell laminate excess water as well as regulate his high blood pressure. He also has a permanent indwelling catheter for energetic bladder. Energetic bladder is urinary tract condition where the bladder does not empty properly due to neurological condition.

As a result a catheter is inserted via the pubic area so the bladder can be emptied efficiently (MD guidelines, 2011). Paul doesn't drink alcohol and is an ex smoker. He enjoys the rest home which he has been living in for more than 10 years. He has a daughter and a granddaughter which he maintains a good relationship with. While visiting her dad in hospital, she brings unhealthy foods such as biscuits, and chocolate bars.

Paul is for Cardiopulmonary resuscitation status and has no known allergies.

Paul says that he is confused in regards to his diabetes because things changed so much over the years; he feels that he is healthy and is managing his diabetes well. However, while in hospital his draws were full of chocolate biscuits which he eats between meals, and before going to bed. As for Paul's nutritional pattern, he says that he eats prepared meals provided by the rest home. He usually has a good appetite.

Sometimes he asks his daughter to bring some snacks. He usually drinks well however while in hospital Paul needed to be reminded to drink during the day.

Paul is continent of faces and usually moves his bowel daily. He becomes anxious if he does not move his bowel daily. He says that in the rest home if this occurs he is given an enema which he finds helpful. His subtopic catheter is patent and he passes normal good amount of urine and needs help with emptying his catheter bag.

Before the incident Paul says that he was able to perform his activity of daily living ( Tall's) independently and mobiles with a low walking frame. While in hospital he finds it difficult to stand up and walk for a long period of time. He needs assistance to go to the toilet and shower.

He also needs help with setting up for showering. Paul spends lots of time in bed an sitting up in a chair as he is enable to mobiles independently.

Paul is aware that his mobility has decreased and he recognizes that he needs to do something about it. Paul has a good self esteem however since the incident, as he is unable to carry out his Tall's or mobiles, this has caused him to be anxious about returning to the rest home in such condition. Paul says that he usually sleeps well during the night at the rest home, unfortunately while in hospital he states that he has difficulty sleeping.

As a result, during the day he becomes tired. Paul lives alone in the rest home. He seems to have a close allegations with his daughter and granddaughter who visit him every day while he was in hospital.

He also receives several phone calls from his son who lives in Australia.

During this shift, his vital signs were : Blood pressure, 118/70, heart rate 64 beat per minute, respiration rate is 14 breath per minute, temperature: 36.3 degree Celsius, oxygen saturation 99%. His blood sugar levels (BBS) at 0200 was 16. Moll, pre-breakfast, 12.

4, and pre dinner 6.9, and weight is 75 kg.

His BBS has been fluctuating between 9- 16 mol in the past 2 weeks. In February he had a blood test to check the HIBACHI level. The result was 65 mol/mol. HIBACHI levels measure the average blood glucose over the past four to six weeks.

HIBACHI . During this shift he has passed small amount of urine and moved his bowel which was a formed medium size stool. He was also due for a dressing change. The wound on the chest and the left knee are sloughs in nature. The slough is yellow color and appears to be moist with serous exudates. The surrounding AT ten wound appears to be clean.

Paul is alert and oriented to person, place and time. His speech is understandable, he has an intact memory and his mood is appropriate to the situation. Paul denies chest pain with breathing; however he suffers from dyspnea on exertion which settles at rest. Vital signs are normal. He has a history of depression.

He has a scar on his scalp, an open wound on his chest and left knee which Paul denies pain. His skin is cold and dry. Paul has history of glaucoma and

wear glasses and denies any pain related to eyes. Paul does not wear hearing aids however he has total hearing loss in the left ear.

Paul denied trouble swallowing. Paul has full dentures and a history of seasonal allergies.

Radial pulse is strong. Paul denies any chest pain. He has regular rate and rhythm with no Edema. Respiration is unlabeled. Paul reports no cough. He is on regular diet and moves his bowel daily .

He has a subtopic catheter which is patent. Catheter bag was emptied numerous times, and output was small for the duration of this shift. Urine was clear, yellow, and odorless. He has an unsteady gait, due to decreased mobility in the past three months.

Paul uses a low walking frame for walking. Integrity versus despair is the final stage of psychosocial development from 65 years to death which is ego integrity versus despair.

In regards to Paul he feels that he has accomplished a happy life despite the difficulties he encountered. He feels happy about his children especially his daughter to whom he has a really good relationship with. Based on the assessment done earlier a nursing diagnosis, a patient outcome or goal, nurse's interventions, and evaluation of the care provided can be formulated.

A nursing diagnosis is a clinical judgment about actual or potential problems a patient may be facing (Crisp & Taylor, 2010). The first priority nursing diagnosis for Paul is impaired skin integrity related to impaired physical  
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mobility as stated by Paul “ my mobility has decreased in the past three months”, Paul needing assistance to move as manifested by the presence of grade 2 pressure ulcers on his sacral area.

Pressure ulcers also called distributed ulcers are injury to the skin or underlying tissue as a result of prolonged pressure in combination with shear or friction over a bony prominence.

The prolonged pressure causes blood vessel occlusion, as a result the tissue is deprived of oxygen and nutrients causing death of the tissue (Craft et al, 2011). Age, lack of mobility, and incontinence are some risk factors of developing pressure ulcers. Most common areas for pressure ulcers to develop are the sacrum, heel, and elbow (Craft et al, 2011). The goal for Paul is to experience healing of current pressure ulcers and his skin to be intact with no further pressure ulcers until discharge.

The interventions for Paul's diagnosis will be firstly, to apply a barrier cream twice daily as prescribed.

Barrier cream is a protection barrier cream which provides long lasting protection from body fluids, and moisturizes the skin at the same time (Barrier Durable Barrier Cream, 2013). Applying a permeable adhesive membrane such as barrier cream promotes wound healing (Contain, Lewis, & Yates, 2012). Secondly inspect the current pressure areas daily and document the skin condition. Regular inspection can provide evidence if the actual treatment is effective or not (Lynn, & Taylor, 2011).



Thirdly, encourage Paul to move, as walking and moving increases blood flow and keeps patient out of bed and chair (Crisp & Taylor, 2010).

Finally, encourage Paul to lie on his side when in EAL. D Alternating position removes pressure from sacral area and allows increase of blood flow (Crisp & Taylor, 2010). Paul's skin was checked on a daily basis. Emollient cream was applied as prescribed. Paul started to sit up more frequently in chair as well as ambulating. On the day of discharge no further pressure ulcers developed.

Current pressure ulcers are healing as evidenced by the decrease in size.

The goal was achieved. The second nursing diagnosis for Paul will be risk of infection related to skin disruption as manifested by the presence of wounds on his chest, knee and pressure ulcer grade 2 on sacral area. The goal will be that Paul will remain free from symptoms of infection throughout the duration of the week. Infection occurs when a host is invaded by pathogenic organism causing an increase of cytokines and lymphocytes resulting in an increase of body temperature. An open wound is a site of infection (Contain, Lewis, & Yates, 2012).

The most common cause of infection are bacterial infection.

Clinical manifestations are purulent discharge, redness, fever and elevated white blood cells (WBC) (Crisp, & Taylor, 2010). WBC are cells of the immune system involved in protecting the body against infectious diseases. A normal WBC level range between 4000- 10000 Mac (Pagan & Pagan, 2013). During dressing change signs such as redness surrounding the wound, discharge,

elevated temperature would be observed. Monitor elevated WEB at the end of the week.

These are indications of infection (Contain, Lewis, & Yates, 2012). If signs of infections are recognized early prompt treatment can be put in place.

Use appropriate aseptic technique before and during Pall's dressing change. Thorough infection control precautions are essential to prevent infection, specifically with hand hygiene. Meticulous hand washing before and after dressing change reduces the risk of spread of microorganisms from one area to another (Lynn, & Taylor, 2011). Inform the registered nurse about Pall's poor eating diet so he can be referred to dietician.

Dietician is able to educate patient about the importance of adequate diet and are able to adjust meals in accordance to patient nutritional preference.

Meanwhile, a brief education is given to Paul about the importance of adequate nutrition as well as encouragement for Paul to eat his meals. Calories and proteins are needed to meet the metabolic needs and to promote wound healing. Fluid also prevents dehydration ND promotes blood perfusion (Brown & Edwards, 2012). People with diabetes often have decrease blood flow to the extremities.

As a result, the body is less able to immobile normal immune defenses and nutrients that promote the body's ability to fight infection and promote healing (Dunning, 2009).

Paul was monitored throughout multiple shifts during the week, for signs of infection. Aseptic and hand washing technique were performed at each  
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dressing change. Paul was assessed by the dietician. At the end of the week Paul was free of sign of infection his temperature was 36. Degree Celsius.

The Doctor did not order a WEB at the end of the week. There was no purulent discharge, or redness from the wound. The goal was met. Although there was no presence of infection at the end of the week, Paul was still monitored for signs of infections and aseptic and hand washing methods were maintained.

Knowledge deficit related to dietary regimen as manifested by repeated inappropriately attack Detente Y to 15 mol/L Ana a HIBACHI AT 65 mol/mol.

Pall's glucose level will return too normal level by the end of the shift; he will understand the importance of healthy eating, his knowledge about healthy nutrition ill increase by the end of the shift. A long term goal for Paul would be for him to feel like he has continuous community support in regards to managing his condition with his diet. Diabetes is a condition where the pancreas is unable to produce insulin; produce little insulin or the cells become resistant to insulin.

Insulin is a protein that regulates the amount of glucose in the blood.

Without insulin, glucose is unable to enter the cell causing an increase in blood glucose level (hyperglycemia)( Craft et al, 2011).

Clinical manifestations are Polaris, Polynesia, and polyphonic. Complications f diabetes are macromolecular diseases such as coronary artery disease (CAD), stroke, hypertension and macromolecular diseases such as enumerator, reiteration neophyte (Robbins, Shaw, Lewis, & Davis, 2010). To

manage his glucose levels Paul is prescribed cataract 70/30 a short acting insulin.

The intervention for Paul is to administer insulin as prescribed as it will regulate his glucose level and prevent him from developing acidosis's and further macromolecular and macromolecular damage (Robbins et al, 2010). Assess Pall's readiness to learn as learning is most effective when patient is motivated (Dunning, 2009).

Asses Pall's level of knowledge in regards to nutrition. This will give an idea where his knowledge gap is so that appropriate interventions can be put in place. As mention in the assessment, Paul has a habit of snacking between meals which usually consist of biscuits and chocolate.

Therefore, in order for his blood glucose level to be managed, offering Paul brief advice during nursing cares on the effect of his unhealthy habits and how it affects him is necessary. Study shows that brief advice is more effective than a long teaching session (Mitchell, 2008). Inform the registered nurse (RAN) about Pall's diet gap knowledge deficiency so she can refer him to a dietician instructing her of where the knowledge gap exists.

Dietician can assess Pall's current diet habits and organism a personalized menu for him.

By doing this, there is a better chance that Paul will adhere to his new nutritional plan. As Paul is already under the care of the diabetes nurse, the registered nurse will inform her about his unmanaged blood glucose level in relation with his diet so she can work in collaboration with the dietician to

help Paul. Another intervention will be to encourage Pall's daughter to accompany him to see the diabetes nurse and the dietician so she could learn about diabetes, healthy eating choices which will help manage Pall's diabetes (Diabetes New Zealand, 2008).

Insulin was administered as charted. Pall's glucose level was managed during the entire shift as evidenced by blood sugar level readings being below 10.0 mmol/mol.

Brief advice was given however Paul was unwilling to cut down on his sugary treats. This also means that Paul is not ready to receive any further dietary education. Ongoing assessment of Paul readiness will be continued while in hospital. Paul will be referred to the diabetes nurse and a dietician once discharged. Conclusion The nursing process has four stages: assessment, diagnosis, planning, implementation, and evaluation.