

# Nursing care study assignment

[Business](#), [Management](#)



Nursing care study In this assignment I will document and reflect on the care that I gave to one of the patients I was looking after while on clinical placement. I will be referring to the patient as ' Mr x' for confidentiality reasons. ' Mr x' was 69 years old. He initially presented with left sided unilateral weakness, expressive and receptive dysphasia, slurred speech and he suffered from nocturnal incontinence. He had been transferred from A&E to the ward. He had a provisional diagnosis of a right middle cerebral artery (MCA) infarct. A CT brain was performed which showed loss of grey and white matter differentiation and acute infarct in the right middle cerebral artery territory. He was assessed under the Roper, Logan and Tierney model of nursing. ' Mr x' required full nursing care. This focused on his 12 activities of daily living. The care he received was planned and based on this assessment. As discussed by Heath (1998) activities of daily living scales usually focus on basic activities such as eating and washing. This assessment highlighted areas of care that ' Mr x' required assistance with. As highlighted by Kozier et al. (2008) each activity is linked closely with either biological, social or psychological needs required for health. It enabled needs and strengths to be identified. According to Heath (1998) there may be times when older people are unable to express or make choices, and it is important that nurses facilitate that persons control as much as possible. He needed complete assistance with all of his activities of daily living. He was nil by mouth and had a peg tube inserted. I flushed his peg tube with sterile water every four hours to prevent it from becoming blocked. The peg was inserted as a direct result of his current health condition.

He was unable to swallow and he was at high risk of aspiration on oral intake. Speech and language assessed his swallow reflex. Regular oral care was performed due to the fact that he was nil by mouth. All of the patients medication was administered via the peg tube. I flushed the tube with sterile water after the medication had been administered to prevent it from becoming blocked. He had a urinary catheter in situ. The bag from the catheter had to be emptied everyday so that we could record his urinary output. The patient was on input and output monitoring and I was involved in documenting this.

Everything administered throughout the day via the peg tube was recorded. He was doubly incontinent and he had a pad in situ. ‘ Mr x’ had problems communicating due to dysphasia. He received full assistance with his personal hygiene. He was charted for combivent nebs PRN as he occasionally experienced respiratory distress. A care plan on breathing was developed. (See appendix) Combivent nebs are effective in cases of respiratory distress as they dilate the bronchioles in the lungs and increase the surface area for gas exchange. The care given to ‘ Mr x’ was evaluated under the patients nursing notes.

Health concerns were identified as a result of assessing the patient under the Roper, Logan and Tierney model of nursing. ‘ Mr x’ had a waterlow score of 15 therefore he was at risk of pressure ulcer development. A pressure ulcer prevention and immobility care plan were developed. (See appendix) Pressure ulcers can develop within a matter of hours therefore pressure ulcer care needs to be performed regularly. As mentioned by Walsh (2002) one of

the main purposes of setting a goal is to set a standard by which we can measure care. The short term goal in relation to pressure ulcer care was to minimise known predisposing factors which lead to the development of pressure ulcers. The long term goal was to try and reduce 'Mr Smith's' waterlow score by getting him onto a normal diet and free fluids and by improving the condition of his skin. A number of nursing interventions were put in place to allow these goals to be achieved. 'Mr x' was repositioned regularly throughout the day. As highlighted by Roper, Logan and Tierney (2004) the most important nursing activity in the prevention of pressure sores is the relief of pressure and minor changes of position should be incorporated into the nursing care plan as well as the familiar intervention of regular turning. According to Kozier et al. (2004) the client should be assisted to be as mobile as possible as activity enhances circulation. He was nursed on a pressure relieving mattress. Jackson (2003) stated that it is appropriate for patients to be nursed on an alternating pressure overlay or mattress, which ensures that no part of their skin is subjected to constant pressure. Pillows were placed under the patient's heels, behind his legs and underneath his buttock. Roper, Logan and Tierney (2004) argued that careful positioning and intelligent use of pillows can help to minimise tissue compression.

It was important that 'Mr Smith' was commenced on a normal diet as this would lower his waterlow score. Both the staff nurse and I worked closely with the dietician. As highlighted by Roper, Logan and Tierney (2004) the nurse often works in collaboration with other professionals to assist the patient to achieve their potential. 'Mr x' was nil by mouth and had a peg

tube in situ. This meant that he required regular oral care. A hygiene self care deficit care plan was developed. (See appendix) When a patient is NPO they should be given oral care hourly. There were both short and long term goals in place for this health concern. The short term goal in relation to oral care was to maintain a good standard of oral hygiene. The long term goal was to get ' Mr x' tolerating a normal diet so that he would not require regular oral care. There were planned nursing interventions put in place in relation to oral care. ' Mr x' received oral care every hour. According to Thurgood (1994 cited in Randall 2000) restricted oral intake such as ' nil by mouth' can result in dehydration and dry mouth. A soft toothbrush and toothpaste was used. Thurgood (1994 cited in Randall 2009) emphasises the fact that a soft bristled toothbrush is the most effective agent for removing plaque and debris from the mouth, teeth and tongue. The patient was unable to swallow and there was a risk of aspiration so we used suctioning. As discussed by Jones (1998 cited in Randall 2009) suction can be used to remove excess fluid from the mouth if the patient is unconscious or if they have a problem with swallowing as it is essential to prevent choking or aspiration of fluid. According to Green and Simpson (2007) patients may be unable to keep their mouth clean and moist without assistance when they receive their nutrients via a tube. Roper, Logan and Tierney (2004) stated that the objectives of mouth care procedures are comfort, cleanliness, moistness, prevention of infection and encouragement of appetite. Both the staff nurse and I worked closely with the speech and language therapist. Speech and language assessed the patients swallow reflex. It was important that ' Mr x' began eating a normal diet but this could only be achieved if the

aspiration risk was lowered. As argued by Roper, Logan and Tierney (2004) the problem with peg feeding for conscious people is that they are deprived of the smell, taste, temperature and texture of food which normally stimulates the flow of saliva and first stage of digestion as well as maintaining moistness of the mouth for comfort and for speaking and that without this mouth care is essential. Roper, Logan and Tierney (2004) stated that it is important for the nurse to work in conjunction with the speech therapist. Oral care and pressure ulcer care were equally prioritised in relation to this patient. Oral care had to be performed regularly because 'Mr x' was NPO and pressure ulcers can develop within a matter of hours therefore pressure ulcer care had to be performed on a continuous basis.

Both health concerns were of equal importance. I had a therapeutic relationship with this patient. Scandrett (2003) suggests that in therapeutic communication, the helper totally focuses on the client. 'Mr x' had difficulty speaking i. e. he was dysphasic. I listened to everything that he had to say and I gave him time to say what he wanted to say rather than interrupting him. According to Grieves, Steinparbury and Stevenson (2004) the art of listening involves knowing when not to interrupt a person in their discussion. If a person is interrupted while they are speaking they may not reveal what is bothering them.

I provided the patient with support by being informative and by displaying empathy. According to Grieves, Steinparbury and Stevenson (2004) the foundation skills of listening and understanding are the primary means of conveying a supportive attitude. All of the multi disciplinary team

contributed to the delivery of care. Speech and language worked with ' Mr x' in relation to his dysphasia. Their goal was to try and improve his speech clarity. ' Mr x' received communication therapy once a week. Speech and language also looked at the patients difficulty with swallowing and at his risk of aspiration on oral intake.

The dietician was responsible for choosing the most appropriate type of feed for ' Mr x'. He was on peg feeding and was NPO due to the high risk of aspiration on oral intake. The dietician also looked at the rate of the feed and how many hours per day that the feed was to be held for. The care plan was evaluated under the Roper, Logan and Tierney model of nursing. The care plan was amended based in accordance with any improvement or deterioration in ' Mr x's' condition. As discussed by Lincoln (1995) it is the right of older people to receive regular skilled and comprehensive assessment of their health needs and to receive care tailored to their individual needs. The planned nursing interventions were crossed out if they were no longer required. The main challenge that I encountered while looking after this patient was the barrier to communication. As highlighted by Dallas and Sully (2006) there are many potential barriers to communication that nurses will have to deal with on a regular basis e. g. deafness, language differences and speech impairment following a stroke. ' Mr x' had difficulty speaking following his stroke.

I took the time to listen to everything that he had to say. Dallas and Sully (2006) argued that when barriers to communication exist, working with people takes more time than if there are no difficulties therefore it is

important to make enough time to listen to your patients needs and explain the care they are receiving. I spoke slowly at all times. According to Tamparo and Lindh (2000) you should allow additional time for the elder adult to compensate for physiological changes. I made sure that ' Mr x' understood what I was saying by repeating myself several times and by rephrasing what I was saying in an attempt to make it easier for him to understand me. Reece (1995) highlights that the checking of understanding is essential and that the central skill of restating is required. I have a greater understanding about the needs of the older person as a result of caring for this patient. My communication skills have improved and I feel more confident about looking after people when barriers to communication exist. Mayeroff (1972 cited in Morrison and Burnard 1997) describes caring as a process which offers both the carer and the person being cared for an opportunity for personal growth.