Case Study – Nursing Care for a Patient Scenario (Mrs. Jones)

Customer's Name

Academic Institution

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Nursing Care Plan

Area(s): Nutrition and Hydration

Nursing diagnosis (1). Nutrition: Imbalanced, less than body requirements related to inability to ingest or digest food or absorb nutrients because of physiologic alterations secondary to medication regimen, as evidenced by weight loss of 10 kg in the past four months (or 14.3% weight loss from 70 kg in October 2009).

Goals/desired outcomes. Within the duration of care, Mrs. Jones will be able to:

- Demonstrate interest/behaviors to improve her nutrition, thereby paving the way towards proper nutrition and progressive regain of her previous weight (Doenges, Moorhouse and Geissler-Murr, 2004).

Nursing interventions based on Doenges, Moorhouse and Geissler-Murr (2004, pp. 347-352):

1. Determine the client's ability to chew, swallow, and taste or any dietary restrictions.

   Rationale: This determines the factors affecting ingestion, digestion, and food intake.
2. Encourage the client to verbalize her thoughts and feelings about her current situation, diet, and nutrition.

   Rationale: This facilitates assessment and identification of the client's very own needs and perceptions about her nutrition, thereby leading to individualized care.
3. Encourage the client to choose foods according to her own preferences or foods that are appealing to her, with due consideration to any prescribed diet.

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Rationale: This stimulates the client's interest and appetite, at the same time, considering the recommended diet for the client.

4. Promote pleasant and relaxing environment as well as socialization.

   Rationale: Utilization of the environment to enhance food intake.

5. Consult a dietician or nutritionist to cater for the client's nutritional needs.

   Rationale: This facilitates experts' advice and tailoring of a nutritional plan suited for Mrs. Jones's unique nutritional needs, as well as facilitating collaborative care.

Nursing diagnosis (2). Failure to thrive, adult related to major disease(s) (uterine cancer and fracture of left neck of femur), as evidenced by apparent unintentional weight loss of 14.3% for the past 4 months.

Goals/desired outcomes. Within the duration of care, Mrs. Jones will be able to:

- Demonstrate interest/behaviors and lifestyle changes to improve her well-being and nutrition.

Nursing interventions according to doenges, moorhouse and geissler-murr (2004, pp. 214-216):

1. Perform physical and psychosocial assessment.

   Rationale: This is to determine the extent of limitations affecting Mrs. Jones's ability to thrive.

2. Explore Mrs. Jones's previously used coping mechanisms that may be applied to her current situation.

   Rationale: This refines or further develops the client's coping strategies.

3. Encourage the significant other's (SOs) to participate in the management/care of the client.

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Rationale: This strengthens the client's support system, thereby enabling her to cope and thrive.

Area: Skin Integrity

Nursing diagnosis (1). Skin integrity, risk for impaired (Mrs. Jones's risk factors: Fractured left neck of femur, old age, and altered nutrition, as well as braden pressure ulcer risk assessment tool score of 16 signifying mild risk).

Goals/desired outcomes. Within the duration of care, Mrs. Jones will be able to:

- Display interest/behaviors leading to reduced risks for impaired skin integrity.

Nursing interventions based on Doenges, Moorhouse and Geissler-Murr (2004, pp. 465-468):

1. Provide information to the client and SOs about the importance of regular observation and effective skin care as well as proper nutrition and hydration.

   Rationale: This promotes skin turgor and reduction of risks for impaired skin integrity.
2. Inspect skin routinely and observe for reddened/blanched areas and implement treatment promptly, if irregularities are evident.

   Rationale: This reduces the likelihood of progression to skin breakdown.
3. Keep the client's bed linen dry and free of wrinkles and crumbs.

   Rationale: This reduces the risks of skin injury by preventing pressure and possible friction.

Area: Continence

Nursing diagnosis (1). Urinary incontinence, urge related to irritation of bladder stretch receptors causing spasm secondary to Urinary Tract Infection (UTI).

Goals/desired outcomes. Within the duration of care, Mrs. Jones will be able to:

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- Display behaviors/techniques to control/correct situation (incontinence).

Nursing interventions:

1. Measure Mrs. Jones's amount of urine voided, especially noting amounts less than 100 cc or greater than 550 cc (Doenges, Moorhouse and Geissler-Murr, 2004, p.574).

   Rationale: This is to assess the degree of bladder disability to control urination.

2. Regulate Mrs. Jones's liquid intake at prescheduled times (with and between meals) and keep a continence record for 3 days (Berman, Snyder, Kozier, & Erb, 2008, p. 1296; Doenges, Moorhouse and Geissler-Murr, 2004, p. 574).

   Rationale: To promote a predictable voiding pattern.

3. Encourage Mrs. Jones to start and stop stream for two or more times during voiding (Doenges, Moorhouse and Geissler-Murr, 2004, p.574).

   Rationale: This isolates muscles involved in voiding process for exercise training.

4. Teach Mrs. Jones about Kegel exercises or the use of vaginal cones (Doenges, Moorhouse and Geissler-Murr, 2004, p.574).

   Rationale: This is to strengthen the pelvic floor and enhance bladder training exercises, thereby counteracting incontinence and promoting proper urinary elimination.

5. Encourage Mrs. Jones to consciously delay voiding (Doenges, Moorhouse and Geissler-Murr, 2004).

   Rationale: To gradually increase intervals between voiding to every 2 to 4 hours.

6. Suggest to Mrs. Jones's family to have an adequate lighting during nighttime as well as to install grab bars and elevated toilet seats as needed (Berman et al., 2008, p. 1298).

   Rationale: To promote comfort and safety.

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Nursing Diagnosis (2). Urinary elimination, impaired related to urinary tact infection (uti), as evidenced by incontinence.

Goals/desired outcomes. Within the duration of care, Mrs. Jones will be able to:

- Display/verbalize understanding of the condition in order to achieve normal elimination pattern.
- Demonstrate behaviors/techniques to prevent the further complication and recurrence of urinary tract infection (Doenges, Moorhouse and Geissler-Murr, 2004, p.555).

Nursing interventions:

1. Inform the client that women are more susceptible to UTI because of the shorter size of the urethra (Berman et al., 2008, p. 1297; Doenges, Moorhouse and Geissler-Murr, 2004, p. 555).

   Rationale: To provide knowledge of the client's condition, thereby promoting utmost understanding.

2. Encourage Mrs. Jones and the SOs to drink adequate amount of fluids, that is, about eight to ten 8-ounce glasses of water or up to 3000 ml, with cardiac tolerance, daily (Berman et al., 2008, p. 1298; Doenges, Moorhouse and Geissler-Murr, 2004, p. 557).

   Rationale: To promote micturition (or urination), thereby flushing away the microorganisms from the urethra (Potter and Perry, 2001, p.1411). Including the family/SOs in the health teaching/education facilitates involvement in the care of the client. Nevertheless, cardio-clearance must also be taken into consideration to prevent fluid overload.

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3. Teach or instruct Mrs. Jones and female family members to wipe from front to back (from the urinary meatus toward the anus) every after voiding (Berman et al., 2008, p. 1298; Doenges, Moorhouse and Geissler-Murr, 2004, p. 557).

   Rationale: Cleaning from dirtiest to cleanest area promotes asepsis, thereby preventing UTI.

4. Encourage Mrs. Jones to complete the full course of the prescribed medication regimen for UTI and inform her about the actions, adverse effects and other pertinent information about the drugs (Berman et al., 2008, p. 1298).

   Rationale: This is to ensure effectiveness of the treatment. Educating the client about the actions and adverse effects of the medications enables the client to promptly report any untoward reactions that the client may be experiencing.

5. Monitor the effectiveness of the prescribed antibiotics and subsequently send the urine samples to the laboratory (Doenges, Moorhouse and Geissler-Murr, 2004, p.557).

   Rationale: This is to evaluate the effectiveness of the medication regimen.

Assessment Tool

Braden's Tool Score for Mrs. Jones – pre #NOF: 20 (See Appendix A for further details)

Braden's Tool Score for Mrs. Jones – post #NOF: 16 = Mild Risk

Differences between 2 Scores:

The difference between the above 2 scores signifies the apparent alteration of Mrs. Jones's mobility. Her fracture predisposes her to pressure ulcer formation, though it is of mild risk only (Braden's Tool score of 16).

Comment on Ease of Use (For Tool):

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The Braden Pressure Ulcer Risk Assessment Tool is somewhat easy to use because it provides choices that enable us to clearly picture-out or depict the scenario, thereby leading us to give the appropriate score suitable for the client.

Group Member Agreement/Disagreement of Assessment: The group was completely in consensus about the scoring and assessment done.

Any Problems with Tool Used:

So far, there are no problems encountered with the use of the tool.

Other Risk Assessment Tools Identified:

1. Norton scale/norton's pressure area risk assessment form scale was the first pressure ulcer risk assessment reported in the literature. It scores five risk factors namely, physical condition, mental condition, activity, mobility, and incontinence, wherein the total score ranges from 5 to 20 (Berman et al., p. 905; Potter and Perry, 2001, p. 1557).
2. Gosnell scale developed from a research on 30 clients in a nursing home, this scale scores five factors that include mental status, continence, mobility, activity, and nutrition (Potter and Perry, 2001, p.1557).

Frequency of Assessment:

Constantly (Potter and Perry, 2001, p.1557).

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Appendix A

PRE #LNOF

Braden Pressure Ulcer Risk Assessment

NOTE: Bed- and chair-bound individuals with impaired ability to reposition themselves should be assessed for risk developing pressure ulcers.
Patients with established pressure ulcers should be reassessed periodically.

Date of Assessment/Reassessment (day/month/year)							
SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited:** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	**2. Very Limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly Limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment:** Responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort.	4		
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist:** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist:** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist:** Skin is usually dry, linen only requires changing at routine intervals.	4		
ACTIVITY degree of physical activity	**1. Bedfast:** Confined to bed.	**2. Chairfast:** Ability to walk severely limited or non-existent. Cannot bear weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	3		
MOBILITY ability to change and control body position	**1. Completely Immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited:** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations:** Makes major and frequent changes in position without assistance.	3		
NUTRITION *usual* food intake pattern	**1. Very Poor:** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate:** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3		
FRICTION AND SHEAR	**1. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.	**2. Potential Problem:** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.				
NOTE: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers. (15 or 16 = mild risk. 13 or 14 = moderate risk. 12 or less = high risk)				TOTAL SCORE:	20		
				INITIALS:			

Highlight details specific to patient

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1. Braden B. Bergstrom N. Clinical utility of the Braden Scale for Predicting Pressure Sore Risk. *Decubitus*. 1989:2:44-51.

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POST #LNOF

Braden Pressure Ulcer Risk Assessment

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NOTE: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers. (15 or 16 = mild risk. 13 or 14 = moderate risk. 12 or less = high risk)				TOTAL SCORE:	16		
				INITIALS:			

Highlight details specific to patient

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Note: Image taken from "Government of Alberta – Seniors and Community Supports" (2010)

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