Nursing History

J Halstead : Adapted from Nursing System Design for Client Care Plan, J Halstead.

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Client Profile

A. Personal characteristics:

Mrs. Smith is an 83-year old widowed female. Ethnic orientation and language information are not given but would be apparent when interviewing the patient. Religious orientation is not applicable but would probably be on admitting information. I assume that the patient is retired at 83, but I would ask if she had any previous occupation. She maintains an active social life with her friends and does volunteer work at a local nursing home. Educational level is not applicable unless severe knowledge deficit is detected.

B. Current Health Characteristics

Mrs. Smith has been in good health prior to admission with no chronic health problems. She has had repair of a fractured right hip which is healing slowly. From the information given she obviously enjoys good health and independence and would hope to return to that level of health.

C. Family characteristics:

Patient is widowed and has three grown children living in other states with their spouses and families. She lives alone. I would ask questions to obtain information about the relationship she has with her children and how often she communicates with them. Knowing she does not want to live with her children, I would ask her how she feels about her children assisting her in her home if that were necessary after discharge. I would also ask her questions to determine if her children kept in contact with her or visited her while she was in the hospital. I would obtain information about her economic status to know is she could meet her physical needs after discharge.

D. Environmental characteristics

Patient lives alone. I would ask questions about her physical setting and how large an area she takes care of for herself. Does she have stairs to climb? Are there other hazardous conditions in her physical environment? Does she cook her own meals? Might she need equipment when she is discharged? Does she have friends nearby to help? Information given indicates that she sees herself as a useful member of the community and she is proud of her ability to help others.

II. Universal Self-Care Requisites

AIR

1. Health habits:

I would ask patient if she was able to perform all of her own hygiene needs prior to admission and observe on admission if her hygiene appeared adequate. I would take into account her being alone for 2 days and unable to help herself. She has no chronic respiratory problems. I would ask about any breathing problems, and would observe for

any possible breathing problems. Inquire about a smoking history. Inquire about any cardiac or respiratory medications.

2. Review of systems

SKIN: Has bruising from her fall. I would observe for color, turgor, fragility, and ask her about any past problems with hair and skin

NAILS: I would note present appearance and check capillary refill.

RESPIRATORY**:** Apparently negative for chronic problems. Would assess respiratory sounds and ask if there are any other problems. Oxygen Saturation and use of oxygen at home should be assessed. Respiratory rate, rhythm and presence of sputum should be assessed.

CARDIOVASCULAR: heart sounds, presence of JVD, pedal and peripheral pulses, CSM and cap refills should be assessed. Blood pressure and BP trends should be assessed.

PERIPHERAL VASCULAR: CMS checks of all extremities and check the comparisons of extremities

Water

1. Health habits:

She was dehydrated on admission and then rehydrated. I would ask her about her patterns of intake at home to determine adequacy and would particularly want to know about her likes and dislikes to promote her maintenance or hydration.

2. Review of systems:

From information given assume patient is well hydrated at present. No intravenous fluids. I would look for any possible edema. Assess intake and output. Incorporate cardiovascular assessment, orthostatic blood pressure checks. Inquire about excess sweating.

Food

1. Health habits:

No information given on this but I would ask if she were on any particular kind of diet at home --evaluate her weight and determine any deviations from normal. What kind of food does she eat at home? Does she fix meals for herself? Does she take vitamins? Does she have adequate intake of calcium? Any recent weight loss or digestive problems? Does she take any GI specific medications?

2. Review of systems:

MOUTH: I would examine for condition of teeth, tongue, or gum.

THROAT: I would check for throat irritation and ask her if she has any difficulty swallowing.

GASTROINTESTINAL: Note weight gain or loss, level of present weight and ask about any history of G.I. problems. Assess abdomen

HAIR would note present characteristics and ask if there have been any recent changes.

Elimination:

1. Health habits:

I would ask patient what her normal pattern of elimination was and if she used any aids at home. I would keep in mind that her dehydration, decreased mobility, and possible intake of pain medications may tend to contribute to constipation.

2. Review of systems:

I would ask if she has any problems with urinating, incontinence, and/or bowel elimination. I would note characteristics of urine and stool

Activity and rest:

1. Health habits:

ACTIVITY LEVEL: Ambulating only short distances at present and sitting in a chair. What was her normal level or activity at home? Information indicates she is very active for her age. No assistive devices used prior to admission.
SLEEP/REST PATTERNS: How many hours of sleep per night? Does she use any sleep aids?

2. Review of systems:

RIGHT HIP FOCUSED EXAM: Does the incision line appear clean and well approximated? Assess mobility, strength, length, sensation and pain in the right leg
MUSCULOSKELETAL SYSTEM: Does she have any arthritis, muscle aches or pains, or discomfort from recent surgery that keeps her awake at night?
NEUROLOGICAL SYSTEM: I would want to know her tolerance for heat and cold, memory problems, history of headaches or dizziness.

Solitude and social interaction:

1. Health habits:

Patient maintains social interaction with friends and gets out in the community for volunteer work --she is obviously a young 83. I would ask about hobbies such as reading or sewing she might do in alone time. Sexuality is probably not important in this situation. I would want to know her interests to possibly provide diversional activity while hospitalized.

2. Review of systems:

EAR: Does she have any hearing problems?
EYES: Eyesight is well enough to drive. Does she use any medication in her eyes since her cataract surgery? Information indicates she reads and writes letters. Assume there is no vision problem.

Hazards to human life. human functioning and human well-being:

Patient now has limited mobility and uses a walker for ambulation. She has the potential for falling, she has risk for infection, and she is unable to care for all of her own self needs at this time

Normalcy: Promotion of human functioning and development within social groups in accord with human potential, known limitations, and the human desire to be normal:

1. Health Habits

Patient had a very active social life for a person her age prior to her injury. She is in good health for her age. It is known she sought the proper health resources in the past for her cataract problems. I would want to know if she had a family physician and if she saw him on a regular basis to assure she could maintain her health and prevent future problems.

2. Self concept/image:

From information given, patient sees herself as a very independent person capable of caring for all other own needs. She is very coherent and seems to know what she wants. Self-image may be altered at present because she has lost some of that independence and still needs to depend on nursing agency for some of her self-care requisites.

Developmental Self-Care Requisites

According to Erikson's theory of psychosocial development, the patient is in the developmental stage of maturity where she is reaching the end of her life span. She has a need to feel a sense of ego, integrity, and wisdom. According to Sullivan's interpersonal theory, this patient would be in the stage of mature adulthood characterized by self-respect and a feeling of dignity. At the age of83 and being in good health, this patient would derive a great deal of accomplishment and self- worth from still being able to be independent and maintain her own home. From information in the case study it is obvious that she wants to keep it that way.

BREASI'S: Ask if she performs monthly breast exams and if any changes have been noted.

PAST HEALTH DEVIATION SELF-CARE REQUISITES

1. Seeking appropriate medical assistance

Due to patient's age and the fact that she was in good health prior to her injury, I would assume that she had appropriate medical assistance in the past to maintain her health. Information given does state that she sought medical assistance to correct her cataract problems.

2. Attending to pathological states:

As above, sought treatments or cataracts. I would ask if she had any past medical problems, such as surgeries, that she might have sought help to correct.

3. Carrying out medically prescribed measures:

She did consent to have surgical treatment for her cataracts and agreed to surgical intervention for her hip injury.

4. Attending to deleterious effects of medical care measures:

No information given here except that she apparently had no problem adjusting after her cataract surgery and no other health problems are listed or indicated.

5. Modifying one's self-concept:

Her past self-concept is one of being independent and capable of caring for herself. Up to this point she apparently had no need to modify that.

6. Learning to live with the effects of pathological conditions:

She has apparently adjusted well to her past resolution of cataract problems

PRESENT HEALTH DEVIATION SELF-CARE REQUISITES

1. Seeking appropriate medical assistance:

Patient was unable to seek help herself when she fell and injured herself. Neighbors needed to intervene for her. She then consented to have surgical repair for her hip.

2. Attending to pathological states:

She consented to having surgery on her hip and to participating in recovery process.

3. Carrying out medically prescribed measures:

She appears to be cooperative with prescribed measures to regain her health and mobility. She has agreed to be transferred to an E.C.F. to complete her recovery.

4. Attending to deleterious effects of medical care measures:

She is participating in efforts to regain her mobility and independence after her injury and subsequent surgery.

5. Modifying one's self-concept:

Her self-concept of being independent has necessarily been modified by limitations imposed on her by her surgery and needed time to recover She has to adjust to the fact that she is now partially dependent on others and it will be some time before she returns back to her normal state of independence.

6. Learning to live with the effects of pathological conditions:

Patient appears to be accepting of her situation in that she has agreed to further time and effort for recovery. She will need to be aware of safety precautions and avoid hazardous conditions to prevent further injury to herself.

NURSING DIAGNOSES

Impaired physical mobility related to injury and subsequent surgical procedure of the right hip as evidenced by ability to ambulate only short distances with assistive device.

Potential for injury related to surgical procedure of the right hip, resulting instability in ambulation, and need for use of assistive device.

Self-care deficit: Bathing/Hygiene, dressing/grooming, and toileting related to surgical procedure of the right hip as evidenced by needing assistance in these areas of personal care.

Potential for infection related to surgical procedure of the right hip.

Impaired home maintenance management related to patient's inability to care for self independently as evidenced by needed improvement in ambulation and