# CASE ANALYSIS OF A PATIENTS WITH CHRONIC ILLNESS : NURSING INTERVENTIONS

**By..**

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# *CASE REPORT*

**An 80 –year-old woman , known case cerebral infarction for six months, she had head trauma due to falling down 3 days ago. Her family reported that she had small bruise in her scalp, refused food, restless, small & frequent voiding on diaper, she became with abdominal distention. When admitted, her B.P : 150/100 mmHg, P: 74/ min, R: 28/ min, O2 Sat : 90 % , GCS :12 score, WBC : 12,000 cell/ cumm, Hb: 9 mg%, Hct: 28 vol%**

**CT Brain: Old infarction of rt cerebral hemisphere**

**Impression: Cerebral concussion**

**R/O Abdominal mass**

# Rx

- **NPO, Record N/S, V/S q 1 hr**
- **5% D/1/2 NSS 1000 ml v drip 60 ml/ hr**
- **O2 bag with mask 10 lit/min**
- **Bed rest , elevated head 30 degree**
- **Schedule for ultrasound of abdomen at 2 PM**

# Nursing Assessment

## NANDA Assessment tool

## (13 Patterns)

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## Composed of:-

1. Activity/ Rest
2. Circulation
3. Ego integrity
4. Elimination
5. Food & Fluid
6. Hygiene
7. Neurosensory
8. Pain/Discomfort
9. Respiration
10. Safety
11. Sexuality
12. Social interaction
13. Teaching&Learning

# Results:-

## Pattern # 1. Activity/ Rest:

- Impaired activities: bathing, grooming and etc.
- Restless/ irritability

## Pattern # 2. Circulation

- B.P= 150/100 mmHg, P= 74/ min, R= 18/ min, GCS= 13 score, Hb= 9 mg%, Hct= 28 vol%

# Pattern # 3.Ego integrity

- No verbal communication
- Intense of facial expression

# Pattern # 4. Elimination

**Urination:**

- Frequent of voiding
- Abdominal distention
- The height of bladder detected
- Foul smell

→ Retention of urine??

**Bowel movement: Normal**

# Pattern # 5.Food & Fluid

- An 80 –year-old woman
- Weight : 42 kgs, Height: 152 cm
- Food & fluid intake very little
- Difficulty in swallowing

# Pattern # 6.Hygiene

- Poor hygiene
- Self care deficit
- Foul odor

# Pattern # 7. Neurosensory

**GCS: 12, CT Brain : Old infarction of rt hemisphere**

**Impaired cognitive functioning (memory & judgment)**

# Pattern # 8 Pain/Discomfort

- Restless/ irritabilty
- Tense facial expression
- Abdominal distention

# Pattern # 9. Respiration

- Respiration 28/min
- Decreased breathing sound
- O2 Sat= 90 %
- O2 mask with bag 10 lit/min

# Pattern # 10. Safety

-Falling down

-T 38.2 degree C

- Restlessness, may be falling off the bed

- WBC 12,000 cell/ cumm, Hb 9 mg%, Hct 28 vol%

- Genitalia: swelling due to fluid retention

# Pattern # 11. Sexuality

- Genitalia: swelling, no discharge

# Pattern # 12. Social interaction

- No interaction
- Patient showing no sign of any communication
- Patient’s family: Attentive ,providing care giver
- Good co-operation with health care team

# Pattern # 13. Teaching & Learning

- No verbal response to conversation

- Able to give physical response to simple commands

# *During her admission :*

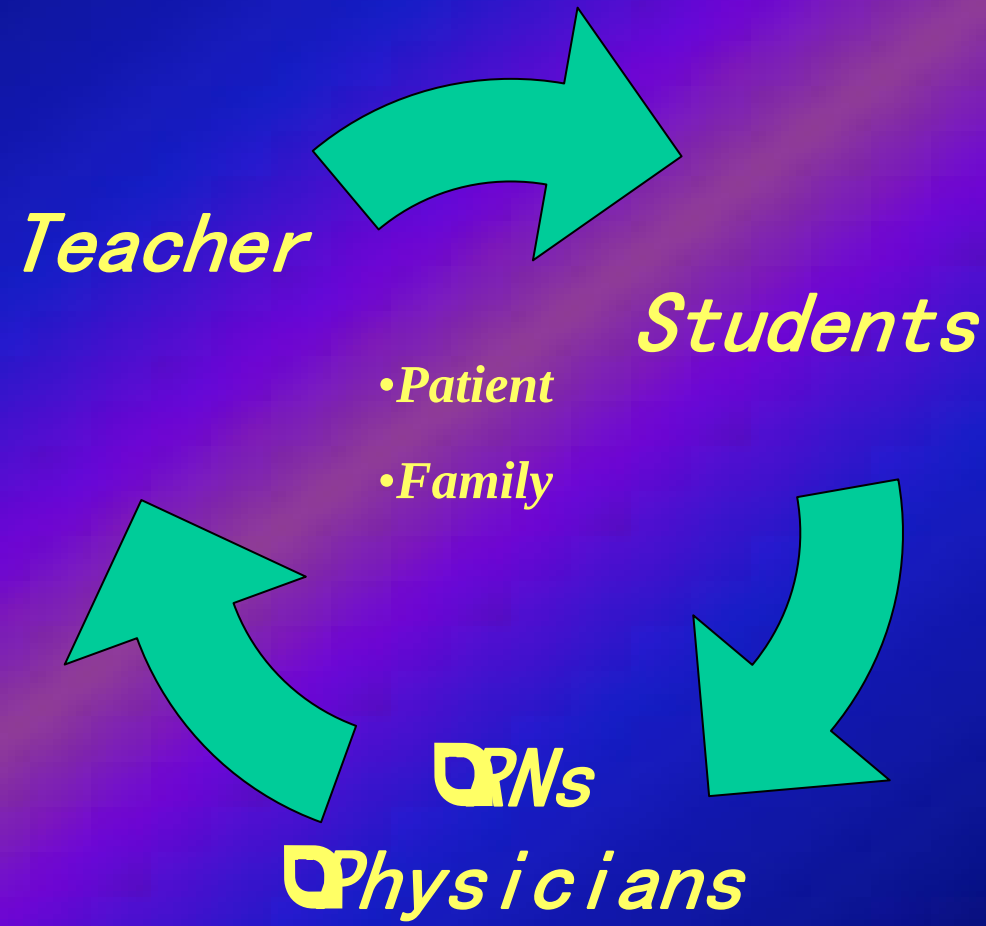
***Her abdominal distention has increased and resulted in her restlessness***

***Suspected; Urinary retention***

***& Bladder overly full***

***Notifying physician for catheterized & indwelling***

# Key Concept



# *Factors to consider*

*1.Old cerebral infarction & concussion*

*2. Geriatric consideration*

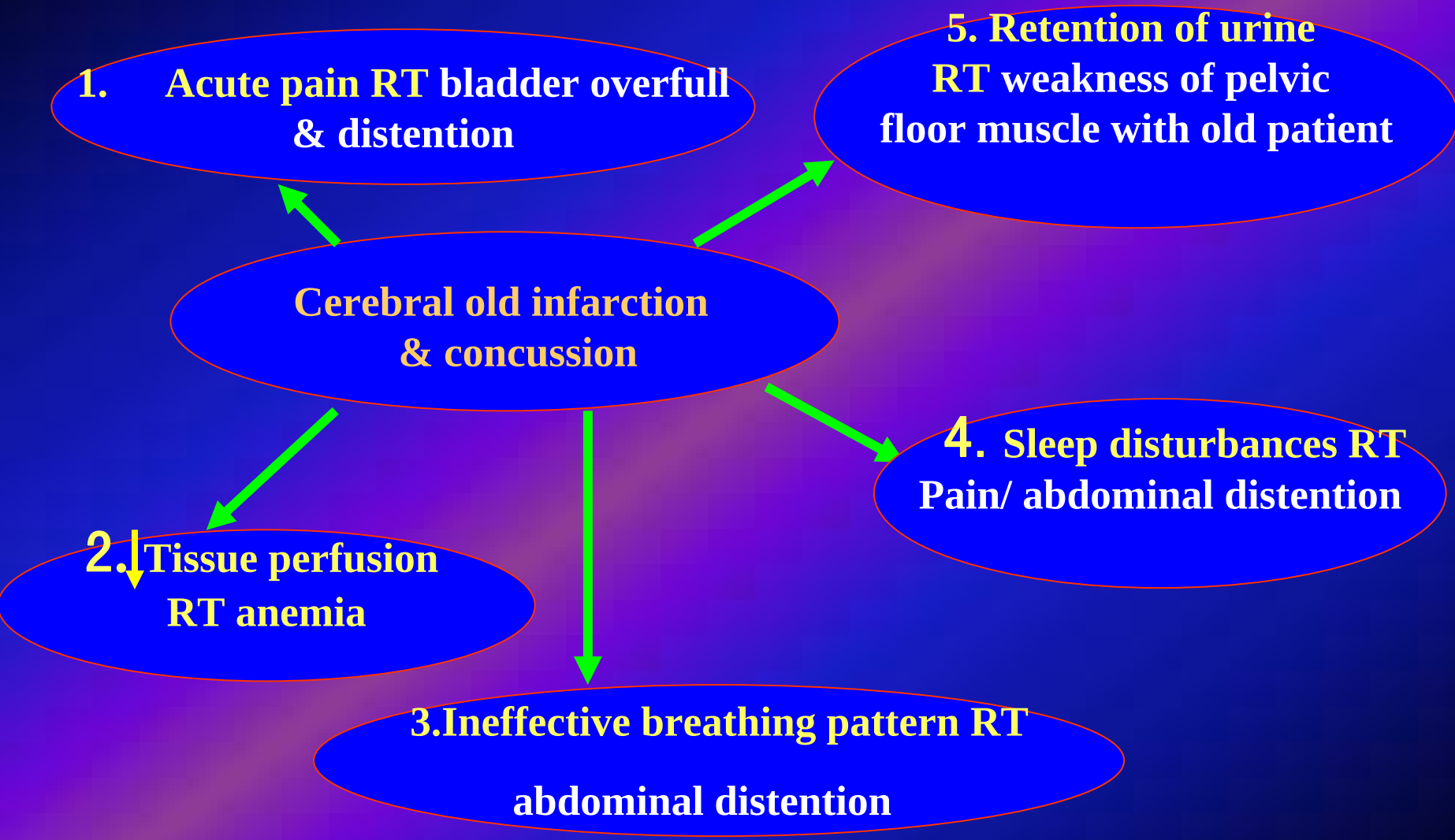
*3.Abdominal distention*

*3.Small & frequent voiding*

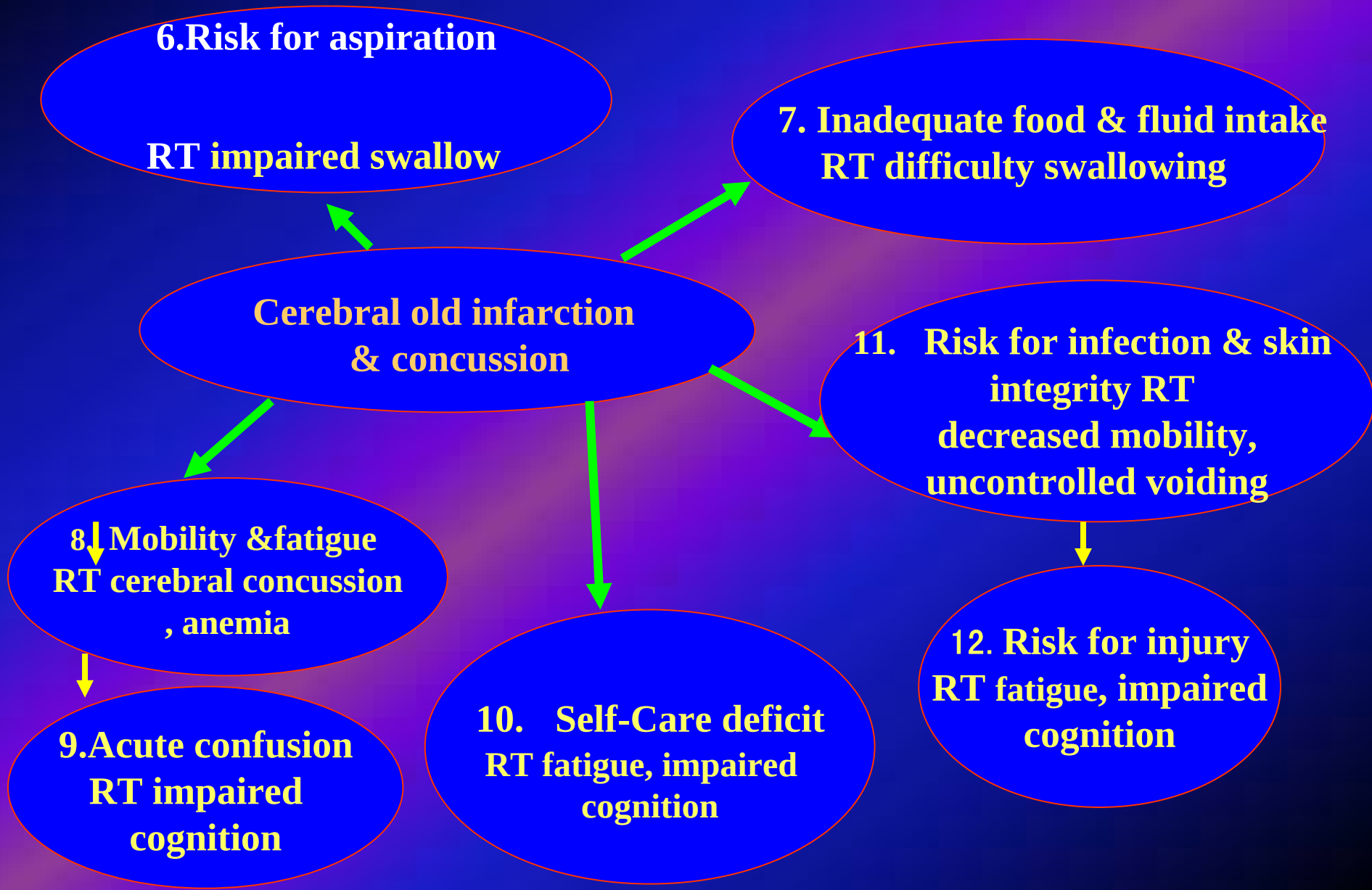
*4.Irritability/Restlessness*

*5.External genitalia swelling*

# *NANDA Nursing Dx*



# *NANDA Nursing Dx (cont.)*



## *NANDA –Approved Diagnosis*

- *This list would help nurses avoid using unknown & possibly confusing labels.*

# *Nursing intervention*

1. NPO, IV therapy
2. Monitored V/S, N/S , breathing sound O2 Sat
3. Indwelling catheter, I&O
4. Bed rest, head elevation
5. Positioning, hygiene care
6. Administered antibiotic as order
7. Psycho support

# *Immediate Outcome*

- *Urine drainage 1,600 ml (Bloody color)*

•Soft abdomen
•Patient became relaxed and more comfortable

→

•Ultrasound of suspected mass in the abdomen was cancelled.

# *Following outcome (one hour later)*

- Her face & lips look relaxed,  eyes were wide open
- Increased breathing sound 16 /min, chest expansion , O2 sat 95 %
- No signs of irritability
- BP 130/ 96 , P 82, R 16, GCS  13

# *One day later*

- *Inserting  N-G feeding tube*
- *Preparations to remove catheter*
- *Physical rehabilitation*
- *Ambulation  by wheelchair*

# Precaution

***There should be no recurrent of :***

**Urinary retention/ incontinence**

**Urinary tract infection**

# Conclusion

- *For the quality of nursing care*

- *Nurses should not follow doctor's order blindly . They should also assess the patients' condition and make useful recommendations to doctors in order to avoid any unnecessary investigation.*

# Thank You for Your Attention