Analysis of Geriatric Needs

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Abstract

The patient, a 77 year old woman, reported a long history of adhering to numerous fad diets. She expressed unhappiness with her body suggesting low self-esteem. She also stated that she has lost interest in hobbies that she was interested in prior to retirement. Physical assessment was within normal limits. Principles of the immunity theory and the role theory were applied to this patient. The patient’s top three problems were identified and nursing diagnoses were selected. The patient’s nutrition was addressed through the nursing diagnosis imbalanced nutrition: less than body requirements. The patient’s self-esteem and body image was addressed through the nursing diagnosis risk for spiritual distress. Her difficulty transitioning into retirement was addressed through the nursing diagnosis ineffective coping. A plan of care for each diagnosis was developed. Nursing interventions involving the patient, nurse, and the patient’s support persons for each nursing diagnosis were created. Outcomes were designed to be measurable to evaluate the effectiveness of the plan of care.

Analysis of Geriatric Care Needs

 Helen, a 77 year old woman faced concerns about her weight much like many other women. She compared herself to others and desired an unrealistically thin physique. Helen was a self-proclaimed lifetime dieter, and her most recent diet ended in a trip to see her physician.

**Assessment**

**Data Reported by Patient**

 Patient reported that she had been attempting to lose thirty pounds on an all-liquid diet. After several days on the diet, she began to feel constipated, weak, irritable, and nauseous. She also began to have heart palpitations. At that time she discontinued the diet and made an appointment with her physician. Patient reported long history of dieting, and stated that she had tried numerous fad diets in the past. She stated that she has enough money for food and has no particular dietary restrictions. She is retired from a successful professional career and has no trouble getting to the store to buy food. She stated that she has “lost interest in her hobbies since retiring and knows that she needs to pull herself together and be grateful for her blessings” (Ebersole, Hess, Touhy, & Jett, 2012, p. 263).

**Nursing Assessment**

 Patient was alert and oriented x 3. Vital signs were within normal limits. Lips and mucous membranes were pink and moist. Patient appeared to be well nourished with no visible muscle wasting. Pulses were present. Respirations were even and un-labored. S1 and S2 were auscultated, and the heart rate was regular. Lungs were clear to auscultation bilaterally. Skin was pink, warm, with mild dryness noted. No edema or tenting. Cap refill was less than 3 seconds. The Fulmer SPICES assessment tool was used on patient. No evidence of sleep disorders, incontinence, confusion, falls, or skin breakdown were observed. The patient was noted to have problems with eating and feeding. To further assess this area the Mini Nutritional Assessment (MNA) was completed. As part of the MNA the patient’s BMI was calculated. The patient was found to have a BMI of 25.4. The MNA showed the patient to be at risk of malnutrition. When questioned about cultural considerations, the patient cited that her African American Christian church community is very important to her.

**Top Three Patient Problems**

 Based on the data reported by the patient and the data gained through the nursing assessment the patient’s top three problems were identified. The first and most pressing problem is improper nutrition. The next problem that needs to be addressed is the patient’s self-esteem and body image. The final problem is the patient’s difficulty with transitioning into retirement.

**Theories of Aging**

 The principles of the immunity theory can be applied to the patient. “The immunity theory presents aging as a programmed accumulation of damage and decline in the function of the immune system” (Ebersole, Hess, Touhy, & Jett, 2012, p. 35). The patient reports a history of adherence to fad diets which may have caused damage to her immune system. “Lifestyle choices such as nutrition affect the immune system’s ability to eliminate or control infections” (Rymkiewicz, Heng, Vasudev, & Larbi, 2012).

 Another theory that applies to the patient is the role theory. “The role theory proposes that the ability of an individual to adapt to changing roles over the life course is a predictor of adjustment to personal aging” (Ebersole, Hess, Touhy, & Jett, 2012, p. 37). This theory can be easily related to this patient because she has recently retired and is now facing an adjustment period.

**Diagnoses**

 Based on the patient’s top three problems NANDA nursing diagnoses were developed. The first diagnosis is imbalanced nutrition: less than body requirements: r/t inadequate food intake. The second diagnosis is risk for spiritual distress: risk factors low self-esteem and poor body image. The final diagnosis for Helen is ineffective coping r/t maturational crisis (Nanda International, 2014).

**Planning**

**Imbalanced Nutrition**

The patient reported following numerous fad diets. The most recent diet left her feeling ill and at that time she discontinued the diet. The goal of this nursing diagnosis is to promote positive nutrition in the patient. When the patient was asked basic questions about proper nutrition she was unable to answer. It was determined that the patient is in need of nutrition education. Lab results will be requested from provider to evaluate albumin. “A serum albumin level of less than 3.5 g/100 milliliters is considered an indicator of risk of poor nutritional status” (Ackley & Ladwig, 2008, p. 576). A calcium supplement along with adequate vitamin D needs to be encouraged for bone health. “Older adults need 1200 mg calcium daily and adequate vitamin D” (Ackley & Ladwig, 2008, p. 579). Patient reported that when she was working she enjoyed having meals with her co-workers and she misses that experience since having retired. Patient will be provided information on congregate meals for seniors.

**Risk for Spiritual Distress**

The patient was determined to be at risk of spiritual distress because of statements made regarding her body image. Low self-esteem is a risk factor for this diagnosis. The goal of this nursing diagnosis is for the client to verbalize a connectedness with herself. The patient spoke about feeling like she had no one to talk to. It was determined that the patient may benefit from counseling potentially from a clergy member of her church. The foster grandparent program is suggested to the patient as an activity that might be helpful to the patient. “Meaningful experiences promote spiritual well-being” (Ackley & Ladwig, 2008, p. 779).

**Ineffective Coping**

The diagnosis of ineffective coping was given to the patient because of statements that she made regarding her recent transition into retirement. She stated that she has “lost interest in hobbies and needs to pull herself together” (Ebersole, Hess, Touhy, & Jett, 2012, p. 263). When questioned, the patient was unable to name any coping strategies. A need for education on coping strategies was identified. The patient was questioned about support resources. A knowledge deficit in this area was identified as well.

**Implementation**

**Imbalanced Nutrition**

 The nurse will provide the client with nutrition information handouts including MyPlate for Older Adults (Tufts University, 2014). The patient will be given a referral to see a dietician. Laboratory results will be reviewed with special attention to serum albumin level. The patient will be instructed to keep a food log recording all food and beverage intake. The patient has been referred to the Human Development Commission in Caro, Michigan for congregate meals. The patient is encouraged to take a Calcium and Vitamin D supplement as prescribed by physician.

**Risk for Spiritual Distress**

The nurse will encourage supportive social contacts. A suggestion will be made to the patient to seek potential support from the ladies group or minister of her church. The nurse will “be physically present and actively listen to the patient. Being present and actively listening to the patient promotes nurse-patient connectedness and helps the patient feel valued” (Ackley & Ladwig, 2008, p. 779). The nurse will help the client identify meaningful experiences. The patient will be encouraged to participate in the foster grandparent program mentoring at-risk youth.

**Ineffective Coping**

 Patient will be taught coping strategies such as physical activity, creating and using a support system, eating healthfully, avoiding known stressors, and getting plenty of rest (National Alliance on Mental Illness, 2013). The nurse will teach the patient about mental and physical activities that may interest her. The patient is given information about a senior exercise group and book club at her local senior center. The patient is encouraged to reconnect with family and friends that she did not have time for while working. The patient is encouraged to reminiscence. “Life review as an intervention had a significant effect of lowering depression” (Ackley & Ladwig, 2008, p. 276).

**Evaluation**

**Imbalanced Nutrition: Less than Body Requirements**

Three outcomes were decided upon for the nursing diagnosis imbalanced nutrition: less than body requirements. The first outcome is the patient will verbalize nutritional requirements at her follow-up appointment in two weeks. The second outcome is the patient will be free of signs of malnourishment at her two week follow-up appointment as well as at future appointments. This outcome will be measured through physical assessment and lab work done at the patients two week follow-up appointment. The last outcome for this diagnosis is the patient will consume adequate nourishment between now and two week follow-up appointment. This outcome will be measured by comparing the patient’s food log with the guidelines set forth by MyPlate for Older Adults (Tufts University, 2014).

**Risk for Spiritual Distress**

 The outcome chosen for the nursing diagnosis risk for spiritual distress is the patient will verbalize a sense of connectedness with herself at her two week follow-up appointment. This outcome is subjective and will be measured by the patient’s verbal response.

**Ineffective Coping**

The first outcome chosen for the nursing diagnosis ineffective coping is the patient will verbalize understanding and use of coping strategies at two week follow-up appointment. The second outcome chosen for this diagnosis is the patient will verbalize an increase in psychological comfort at two week follow-up appointment.

**Policy**

 Increasing the number of locations for congregate meal sites for seniors is a policy change that this particular patient would benefit from. The patient lives over thirty miles from the nearest meal site (Office of Services to the Aging, 2014). This could be particularly troublesome during Michigan’s harsh winter. Inclement weather could certainly prevent the patient from traveling such a long distance. There are only 3 meal sites within a 100 hundred mile radius of the patients home (Office of Services to the Aging, 2014). If more sites were available in more locations seniors all over Michigan would benefit.

**Conclusion**

 This case study has been a great example about the multi-faceted care that is required to best care for a patient. Many different individuals, organizations, and services were utilized to provide this patient with the best care possible.

References

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Appendix A

SPICES: Overall Assessment



Appendix B

Mini Nutritional Assessment

