

Functional Health Patterns

STUDENT NAME: Nicole Perretta

DATE 11-20-10

*Include client's admission date, occupation, diet, religion, activity, allergies, current meds, treatments, surgery, and diagnostic test results under the appropriate functional health pattern.

Client Profile (summarize events leading to day you cared for client): **DATABASE**

AREA OF HEALTH	SUBJECTIVE DATA	OBJECTIVE DATA	INDIRECT DATA	INTERPRETATION (effective patterns or barriers/potential barriers)
<p>HEALTH-PERCEPTION HEALTH-MANAGEMENT (general survey, perceived health and well-being, self-management strategies, utilization of preventative health behaviors and/or services.</p>	<p>Patient described his health as poor. He feels that he is slowly just getting worse. He does not exercise on a regular basis as he is in his wheelchair daily. Patient has stated he never used tobacco, alcohol or recreational drugs. Patient did not state the last time he went to the doctors (dentist, eye, or physical) Patient stated he had regular testicular self exams but would not disclose anything else. Patient is allergic to aspirin, Pyrazoles, and NSAIDs. Patient states he does use seatbelts but rarely leaves "his home".</p>	<p>The patient seems to be very weak, never seeing him get out of his wheelchair. Patient states he didn't need any help with transferring but I noticed in his chart that he needed assistance. Top rails are up on his bed Braden scale assessment was 19 which does not make the patient a wound care referral need. ** See attached braden scale in paper</p>	<p>Pt has an allergy to aspirin, pyrazoles, and NSAIDs (CHART) Meds that may increase fall risk includes: Metoprolol Tartrate, Omeprazole, Pletal (Cilostazol), Sertraline, Tramadol, Aricept (Donepezil), Cyanocobalamin, Digoxin, Enbrel (Etanercept), Ferrous Sulfate and Lasix (Furosemide) (CHART) Hemat: 31.3 Hemo: 10.2 Plat: 111,000 BUN: 25 CO2: 26 (CHART)</p>	<p>My patient did not seem satisfied with his life even though with the depression scale short form he said he was happy most of the time. My patient does have a history of depression. Risk for falls r/t medication: Metoprolol Tartrate, Omeprazole, Pletal (Cilostazol), Sertraline, Tramadol, Aricept (Donepezil), Cyanocobalamin, Digoxin, Enbrel (Etanercept), Ferrous Sulfate and Lasix (Furosemide) d/t dizziness or weakness</p>

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<p>NUTRITIONAL –METABOLIC (patterns of food and fluid consumption, weight, skin turgor, nails, hair, etc.)</p>	<p>When I arrived patient was being brought down to the dining room for dinner.</p> <p>Patient couldn't decide what he wanted to eat and ended up deciding a turkey sandwich and some coleslaw.</p> <p>Patient ate half the sandwich and all the coleslaw.</p> <p>Patient stated no problem with chewing, swallowing, or tasting. But did state he had a decreased appetite.</p> <p>Patient does feed self.</p> <p>Patient stated that he does get vomiting sometimes at night.</p> <p>Dentures are the top and are full.</p>	<p>I could tell the patient didn't have an appetite because nothing seemed to appeal to him.</p> <p>His nails and hair were in good condition, hair was white.</p> <p>Skin turgor was >2 tenting present.</p> <p>Patient can eat independently.</p>	<p>Patient on regular diet (CHART)</p> <p>Patient's weight is 167 and height is 6 foot 3 inches. (CHART)</p>	<p>I believe my patient is at risk for imbalanced nutrition: less than body requirements r/t inadequate intake of nutrients</p> <p>His decreased appetite could be due to certain drugs causing nausea/vomiting such as: Metoprolol Tartrate, Omeprazole, Prednisone, Sertraline, Tramadol, Aricept (Donepezil), Calcium Carbonate, Cyanocobalamin, Digoxin, Ferrous Sulfate, Lasix (Furosemide) and Dulcolax (Bisacodyl)</p>

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<p>ELIMINATION (patterns of excretory function and elimination of waste; relevant labs, medications, impacting, etc.</p>	<p>Patient has an indwelling catheter. Peri-area clear and skin intact with no redness or irritation. Patient states he had a BM the day I came to talk to him and that it was normal and didn't seem to have any abnormal odor. Patient states he has trouble with constipation sometimes but that he gets a medication to help him out. Patient stated he had no problem with diarrhea. No changes in bowel pattern with patient having a BM once or twice a day.</p>	<p>Patient's foley had yellow clear urine with no odor present. Patient did not have a bowel movement during the time I was there. The patient's bowel sounds were in all 4 quadrants during my assessment.</p>	<p>Dulcolax (Bisacodyl) and Magnesium Gluconate (CHART) BUN: 25 (CHART) Increased d/t congestive heart failure as a result of poor renal function</p>	<p>Patient may have bouts of diarrhea due to side effects of medication such as: Metoprolol Tartrate, Omeprazole, Pletal (Cilostazol), Sertraline, Tramadol, Aricept (Donepezil), Cyanocobalamin, Digoxin, Ferrous Sulfate, Lasix (Furosemide), Magnesium Gluconate and Dulcolax (Bisacodyl) Patient does has incontinence of bladder but has an indwelling catheter.</p>

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<p>ACTIVITY-EXERCISE (patterns of exercise and daily living, self-care activities include major body systems involved such as cardio, respiratory, musculoskeletal)</p>	<p>Patient stated that he usually gets up in the morning and has breakfast then he sits in his room and watches TV till lunch and then after lunch he either takes a nap or watches more TV till dinner and then after dinner he just relaxes.</p> <p>Patient at first told me his only limitation was with transferring and that he only need slight help.</p> <p>Later on in my questions however he rated his eating, dressing, toileting, bed mobility, bathing, and transferring all a 3 which is Assistance from person and equipment, while 4 is dependent/unable.</p> <p>Shopping, cooking, stairs, and home maintenance were unable to be scored because patient stated he did barely any of “that stuff”</p> <p>He does consider himself a fall risk.</p> <p>Patient also stated at one time he had 6 different canes.</p>	<p>My patient said he was very independent but when I read his chart he was listed as dependent in everything but feeding.</p> <p>Patient had very weak hand grasps but they were equal.</p> <p>Patient had weak but equal leg lifts and pedal pushes.</p> <p>Patient needs help transferring</p> <p>V/S: T: 98.9 P: 68 R: 18 B/P: 136/84 O2: 97%RA Pain: 7-8/10 HR: 73 irregular</p> <p>Capillary refill >3</p> <p>T:98.9 R:18 P: 68 B/P:136/84</p> <p>Pain: 7-8 relieved with medication O2: 97% RA</p>	<p>Patient can feed own self w/o assistance (CHART)</p> <p>Patient is in a wheelchair on a daily basis (CHART)</p>	<p>I believe my patient is at risk for injury r/t muscle weakness and fatigue</p> <p>Impaired mobility d/t generalized weakness</p>

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<p>SLEEP-REST (patterns of sleep, rest, relaxation, fatigue)</p>	<p>Patient had stated he usually goes to bed around 8:30 pm. And that he usually gets up around 6:30 am however he has sometimes only gotten 3-6 hours of sleep He stated he does sometime wake up throughout the night once or twice. Patient states he has no trouble falling asleep at night and no troubles getting up in the morning saying that he feels awake and alert but not always full of energy. Patient stated he sleeps on his back because it's the most comfortable for him.</p>	<p>May patient seemed very sleepy when I was there. I could also tell he was very tired and wanted to get into bed because he kept asking me if we were done with these silly questions and when I would be leaving.</p>	<p>There was nothing stated in the chart about when the patient wakes up or when he goes to bed Patient did say he's up at 6:30 am and asleep usually by 8:30 pm Nurse on duty told me that my patient usually takes nap at least once a day Patient is on no medication to assist with sleep.</p>	<p>Patient doesn't seem to have any trouble with sleep. Patient may have bouts of drowsiness due to some medications such as: Metoprolol Tartrate and Omeprazole Aricept (Donepezil) and Sertraline which may cause drowsiness but may also cause insomnia</p>

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<p>COGNITIVE-PERCEPTUAL (patterns of thinking and ways of perceiving environment, orientation, mentation, neuro status, glasses, hearing aids, etc.)</p>	<p>He stated he knows his memory is crappy. Stating he doesn't have any recent memory and that he doesn't have any remote memory.</p> <p>He said the days all seem to blur together and that they all seem the same.</p> <p>No problems with speaking, writing, or reading.</p> <p>Patient stated he did not have contacts or glasses, but did have hearing aids and dentures.</p>	<p>His long term memory and short term memory don't seem to be very good.</p> <p>Patient has a history of dementia.</p> <p>Patient did repeat things over and over again as if he was telling them for the first time</p>	<p>Chart has patient having hearing aids but patient stated he doesn't wear them anymore (CHART)</p> <p>Patient is A & O X 3 (Person, place, time, not situation) (CHART)</p>	<p>I believe the patient's history of dementia limits him and that's why he would be happy one moment and sad the next and other times confused with what I was asking.</p>

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<p>SELF-PERCEPTION SELF-CONCEPT (patterns of viewing and valuing self; body image and psychological state)</p>	<p>Patient stated his level of anxiety was a 4 on a scale of 1-10, 10 being the highest.</p> <p>Patient stated that he tries to make his body language so it's inviting so that people will want to come and talk to him.</p> <p>He said he usually views himself in a positive manner but there are times when he views himself in a negative manner.</p> <p>He said it all depends on what is going on that day.</p> <p>When asked if his current illness is going to result in a change in his body's structure or function he said yes because I feel like I'm just wasting away in this dang chair. I have noticed that I've lost weight over the past couple years.</p>	<p>Patient appeared to be nicely dressed with a suit and tie and dress shoes.</p> <p>Patient had good hygiene.</p> <p>His appearance was very calm when I walked in the room.</p> <p>Patient's face was not reddened with anxiety. He had no voice change and no hesitation when answering and all muscles were relaxed no teeth clenching or fist clenching.</p> <p>Patient did not turn however to make eye contact which I can only relate to him not having his hearing aids in and he wanted to be able to hear me the best he could.</p> <p>Patient answered questions readily unless he needed me to repeat the question slower and clearer.</p>	<p>Patient's weight is 167 (CHART)</p> <p>Patient's height is 6 foot 3 inches (CHART)</p> <p>Patient's BMI is 20.9 which is normal but on the low end of normal.</p>	<p>I think the patient sees himself losing weight and links that to him wasting away and he said, "...because I feel like I'm just wasting away in this dang chair."</p> <p>This patient already has a history of depression so I think keeping an eye on him would be best for his safety and health.</p>

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<p>ROLES-RELATIONSHIPS (patterns of engagement with others, ability to form and maintain meaningful relationships, assumed roles; family communication, response, visitation, occupation, community involvement)</p>	<p>The patient was married but is widowed now. Patient did not state if he had any children and if so how old they were or if they came to visit much</p>	<p>Patient seemed very sad when talking about his wife. Did not say what his wife's name was. He had visitors when I was there gathering information but I wasn't informed if that were his children or not.</p>	<p>Patient is widowed (CHART)</p>	<p>The patient didn't wish to talk about his wife very much or if he had any children.</p>

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<p>SEXUALITY-REPRODUCTIVE (testes, breasts, abdominal-genitourinary; satisfaction with present level of interaction with sexual partners)</p>	<p>Patient did not wish to talk to me about this section at all.</p> <p>Patient even stated that a young girl like me wouldn't want to know about a dirty old geezer like him and that it would be inappropriate to talk about those things with me.</p>	<p>Seemed very strong willed against talking about this.</p>	<p>Patient is widowed (CHART)</p> <p>Nothing in chart about his prostate or any sexual problems.</p> <p>Patient has history of BPH. (CHART)</p>	<p>Patient is on drugs that would decrease libido such as: Metoprolol Tartrate: erectile dysfunction, decreased libido, Sertraline: sexual dysfunction.</p>

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<p>COPING (stress tolerance, behaviors, patterns of coping with stressful events and level of effectiveness, depression, anxiety)</p>	<p>Patient stated he has stress but that it's a part of everyone's life.</p> <p>Also stated that he has nothing to deal with stress because he doesn't see it as necessary.</p>	<p>On this day I took care of my patient he seemed to get agitated the more questions I ask.</p> <p>I was told that he loved talking to students but it seemed like he couldn't get me out of the room fast enough.</p>	<p>There was nothing in the chart about how the patient copes.</p>	<p>I think the patient has only his children who he can talk to but I was told they don't visit on a regular basis.</p> <p>The patient seems to keep to himself and not talk to many people but just sit in his room and stare out the window.</p>

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<p>VALUES-BELIEF (patterns of belief, values, and perception of meaning of life that guide choices or decision; includes but is not limited to religious beliefs)</p>	<p>Patient did not want to discuss his beliefs with me.</p> <p>Only thing patient did state was that he was Baptist.</p>	<p>I considered my patient a very religious man just by talking to him.</p> <p>I really wish he wanted to discuss these things with me but towards the last couple of these his answers got shorter and he seemed agitated.</p>	<p>Nothing specified in the chart about the patient's belief's just his religion—Baptist. (CHART)</p>	<p>I don't fully understand why he did not wish to talk to me about these things. He seemed very open about everything else.</p>

Medications

- Aricept (Donepezil) 10 mg PO, QHS
- Calcium Carbonate 500mg PO, BID
- Cyanocobalamin 1,000mcg PO, QAM
- Digoxin 0.125mg PO, Once a Day
- Enbrel (etanercept) 25mg SUBQ, Once a day on Thursday
- Ferrous Sulfate 325 mg PO, QAM
- Folic Acid 1mg PO, QAM
- Lasix (Furosemide) 20mg PO, QAM
- Magnesium Gluconate 500mg PO, TID
- Megace Oral (Megestrol) 10mL PO, HS
- Metoprolol Tartrate 12.5mg PO, BID
- Multivitamin 1 TAB PO, QAM
- Omeprazole 20mg PO, BID
- Pletal (cilostazol) 100mg PO, BID
- Prednisone 7.5mg PO, QAM
- Sertaline 100 mg PO, QAM
- Tramadol 50 mg PO, QID

PRN:

- Dulcolax (bisacodyl) 10mg Rectal, Once a Day
- Tylenol (acetaminophen) 650mg PO, TID

IV Sites/Fluids/Rate

No IV

N20030 Concept Map
 Student Name Nicole Perretta Client Initials J.H. Date 10-05-10
 Age 89 Gender Male Room # 600-1 Admit Date 10-01-10
 CODE Status DNR-CC-ARREST Allergies Aspirin, NSAIDs, Pyrazoles
 Diet Regular, Thin Liquids Activity Up with assistance Braden Score 19/23

Admitting Diagnoses/Chief Complaint
Frequent Falls with pelvic, clavicle and rib fracture
Acute Kidney Failure

Assessment Data

89 y.o. male admitted for frequent falls resulting with pelvic, clavicle and rib fracture. T:98.9 R:18 P: 68 B/P:136/84 Pain: 7-8 relieved with medication O2: 97% RA A&OX3 person place and time not situation Responds to verbal stimuli appropriately; PERRLA-2mm; No slurring of speech; No JVD; Feeds self with no assistance; Grips equal and weak; Side rails X2; No IV. Lungs clear but diminished in all lung fields; No cough present; BSx4; Abd. Non-tender to palpitation

No nausea or vomiting; peri-area intermittent catheter, clean and intact without redness; Active ROM; Both extremities cool to touch, dry and intact; Facial expression WNL; Tongue/mucous membrane pink without lesions; Skin dry and intact; Tonsils removed; Neck ROM WNL, no tenderness in neck Trachea midline intact. No glasses present; Hearing Aids present but does not wear them; Dentures top fall; Hair white and intact; Muscles slightly atrophied; Eye lids sunken into skull; Slight numbness in hands

Chest and Abd symmetrical; No constipation or diarrhea; BM last night; right leg pedal pulses: dorsalis pedis +1, posterior tibial +1; left leg pedal pulses: dorsalis pedis +1, posterior tibial +1; leg strength equal and weak; No nasal or ear drainage

Patient states, "The pain is mainly in my back and legs due to this dang chair and being old"

Lab Values/Diagnostic Test Results

25	BUN	26	CO2
		10.2	HEMO
		31.3	HEMAT
			111
			PLT

- Hemo decreased d/t anemia
- BUN increased d/t congestive heart failure as a result of poor renal function
- PLAT decreased d/t autoimmune disorders (RA)
- Hemat decreased d/t anemia
- CO2 decreased d/t kidney disease

Treatments

- Bilateral ½ upper siderails
- Float heels in bed
- Reposition Q2H
- House barrier cream to buttocks after each incontinent period or PRN
- Pressure relieving mattress
- SBA to bed at all times
- SCA to chair at all times
- Skin assessment every week
- Occupational Therapy
- Physical Therapy
- Foley Catheter constant drain
- Cath care qshift and PRN
- Catheter bag change 1st of the month
- Change/flush cath PRN to maintain patency

Past Medical /Surgical History

- Right Knee Surgery
- Splenectomy
- FH: Noncontributory
- History: CHF
- hypertension
- BPH
- Venous insufficiency
- Paroxysmal Atrial Fibrillation
- Recurrent DVT
- Prostate Cancer
- GERD, with Barrett's esophagus
- Depression
- Dementia
- Osteoarthritis
- Rheumatoid Arthritis
- Acute Renal Failure
- Anemia