Nursing Care Plan For Ms. Taylor, An 85-year-old Woman

Ms. Taylor, an 85-year-old women who lives in a religious care home and used do most activities of daily living my herself was transitioned to a palliative approach after a fall. Her health history includes being diagnosed with Parkinson's, aplastic anemia, postural hypotension, and depression. In mid-October Ms. Taylor had a fall while in the gift shop which was unwitnessed. During an assessment post-fall, she became a lot more confused, she complained of more pain than normal, and had a hard time forming sentences. Ms. Taylor used to be able to ambulate by herself with a walker, however, was needing more help with activities of daily living. Near the end of October, it became harder for Ms. Taylor to swallow and she wasn't able to take her oral medications. She received a doctor's order to hold all oral medications due to transitioning to a palliative approach. As a result, she took hydromorphone subcutaneously and became sedated a lot of the time. Due to her Parkinson's medication being held, this caused her tremors to increase and cause more pain associated with Parkinson's to emerge. Ms. Taylor, now on a palliative approach has family visiting from out of the country to support her through her last couple weeks.

Assessment

Upon assessment, Ms. Taylor appears restless, agitated and in pain while lying in bed. Her skin is slightly pale, warm to the touch and dry. Ms. Taylor is able to open her eyes when asked multiple times, however, closes her eyes immediately after. She is able to identify her name and location of where she is with slurred speech. Ms. Taylor's vitals are stable for her baseline (BP-106/70, RR-16, HR-64, O2- 98% on RA, Temp- 36.5?). While assessing oral temperature, Ms. Taylor's lips appeared very dry, and she states she is very thirsty. Ms. Taylor reports 8/10 aching and dull pain in her hip, shoulder, and back. Ms. Taylor yelled in pain when asked to raise her arms. Her right arm was able to raise 45 degrees while she was unable to move her left arm. When asked about her strength, patient stated that she felt very weak and unable to move herself in bed. Colour, warmth, movement, and sensation (CWMS) were adequate other than previously stated about movement in Ms. Taylor's upper extremities. Ms. Taylor's respiratory sounds are clear but decreased entry was heard in anterior left lobe, and apical pulse palpated at 64 bpm. Auscultation of posterior lung fields was not possible due to considerable discomfort during movements. Ms. Taylor's bowel sounds were present and hyperactive in all quadrants. She states that she has bowel movements one to three times a day and they are very loose in consistency. Ms. Taylor states this is very normal for her and she experiences no pain or blood with the bowel movements. She states that it has always been embarrassing for her as she always has an urgency to use the bathroom. She grimaced slightly when abdomen was palpated and stated a pain level of 3/10, however, no mass or distension were felt. Patient was incontinent of urine and slight redness was noted on her inner thighs. Ms. Taylor states no pain or blood with voiding. Patient denies pain or discomfort in her chest and notes no history of chest pain. No abnormal heart sounds were auscultated, and S1 and S2 were audible on assessment. Radial pulses were felt bilaterally, and capillary refill was three seconds. No edema present in lower extremities, pedal pulses were audible via doppler, capillary refill four seconds, and both legs were very pale in color. Four bruises located on her upper right thigh and right hip approximately 4-6 cm in length. Patient stated she didn't know where they came from and she felt slight pain when the bruises were touched. A full mobility

assessment was unable to be completed as patient was in too much pain. Ms. Taylor noted feeling dizzy and having a headache that she states has been around for four days.

Due to Ms. Taylor's Parkinson's, she is hard to understand at times, and especially in the mornings due to slurred speech. Previously the care aids and nurses were usually able to figure out what she wanted, however, after her fall, she became much harder to understand. Ms. Taylor states feeling very confused, not knowing where she is a lot of the time and sometimes forgets her name. Communication with others became harder for Ms. Taylor as she would forget what she was saying, or others didn't know what she was saying. She has a companion that visits her most days for an hour, however, when asked two hours after the companion had left, Ms. Taylor states that no one had visited her that day. Ms. Taylor normally sat in the dining room with two other women who she became close with, however, hasn't been able to get out of bed recently and has eaten meals in bed. Due to this, she has lost her social connection to these women. Ms. Taylor is widowed, has one son that lives in town and one daughter that lives abroad. When the family was notified about Ms. Taylor being transitioned to a palliative care approach, the daughter and her husband flew out. Her family started coming in for most hours of the day to be with her but noted that they don't understand what she was saying most of the time.

Nursing Diagnosis

Based on my assessments, Ms. Taylor's primary areas are related to her unmet needs including comfort, mobility, and adequate hydration (UBC School of Nursing, 2017). Due to Ms. Taylor being cared for on a palliative approach, her main priority is to provide a patient-centered approach by giving her comfort, relieve suffering, and providing a safe environment (Matzo & Sherman, 2018). As Ms. Taylor was struggling to swallow thickened fluids, she received a doctor's order to hold all oral meds. The medication for her Parkinson's which includes levo/carbidopa was no longer being administered which seemed to bring on more pain for her. As she had a very hard communicating, non-verbal cues such as her guarding behavior, grimacing and moans when being touched became more relied on. The combination of pain from her chronic back injury, her recent fall, and her Parkinson's disease provides the following primary nursing diagnosis:

Pain and discomfort related to chronic back injury secondary to Parkinson's disease as evidenced by patient rates pain 8 on 1-10 scale, expressive behavior of grimacing, guarding behavior, changes in eating habits, and decreased ability to ambulate.

Planning

Providing comfort care and symptom relief is the main goal for Ms. Taylor as stated in the nursing diagnosis. Providing her a safe and comfortable environment includes open communication with the patient with what she wants. This includes moving pillows to prop her up in bed, changing the music station to what she wants, identifying factors that makes her pain better or worse, and only providing the necessary care that is needed. With a palliative approach, the goal is to maintain the quality of life until death (Kozier, et al., 2018).

Continuing to assess Ms. Taylor's pain levels, perception of pain, and establishing a pain management plan is essential to keeping her comfortable. She has a PRN for hydromorphone

to keep her pain levels down, however, also working with other relaxation techniques such as breathing techniques will help provide her relief. Determining possible psychological causes of pain, such as her depression will also help in providing support to Ms. Taylor.

Communication with the family about effective comfort measures and education them will also provide a family-centered approach. As well, only giving the necessary care, speaking slowly, and only asking questions that support Ms. Taylor will help limit her confusion.

Implementation

Time Action/ Intervention Goal Supported / Fundamental of Care Addressed

- 0700 Arrive on unit and check on patient. Review Ms. Taylor's Kardex, medication administration record, nursing notes, physician's orders, and companion/family visit times.
- 0730 Greet Ms. Taylor, safety check, measure vitals, brief head to toe with a focus on pain, and check brief for incontinence. Encourage Ms. Taylor to take deep breathes to help with relaxation. Comfort
- 0800 Administered medication and chart on eMAR - 1 mg Hydromorphone subcutaneous (for pain management) Comfort
- 0830 Get breakfast from the dining hall, thicken water and fluids. Raise the head of the bed and encourage Ms. Taylor to drink and eat as much as she can while feeding her. Leave head of bed propped up to minimize risk of aspirating. Nutrition, Eating and Drinking
- 0900 Chart assessment findings in Ms. Taylor's file. Quality and Safety
- 0930 Provide a bed bath to Ms. Taylor with the assist of another nurse or care aid as this makes it more comfortable for her. Assess skin for signs of breakdown. Encourage Ms. Taylor to take deep breathes to help with relaxation. Personal Cleansing and Dressing
- 1000 Break My personal well-being.
- 1030 Greet family and communicate with them if they need anything. Reposition Ms. Taylor, check brief for incontinence, and assess pain to see how effective the medication was. Encourage Ms. Taylor to drink water. Communication
- 1100 Chart interventions in nursing notes. Quality and Safety
- 1200 Administer medication and chart on eMAR - 1 mg Hydromorphone subcutaneous (for pain management) Educate family on the use of opioids and the side effects. Encourage Ms. Taylor to take deep breathes to help with relaxation. Comfort
- 1230 Get lunch from the dining room. Raise the head of the bed. Give the family the option to stay or leave while feeding Ms. Taylor. Encouraging her to drink as many thickened fluids as tolerable. Nutrition, Eating and Drinking
- 1300 Lunch My personal well-being.
- 1400 Check Ms. Taylor's status and assess pain. Encourage Ms. Taylor to drink more water. Encourage Ms. Taylor to take deep breathes to help with relaxation. Quality and Safety Comfort Hydration
- 1500 Reposition Ms. Taylor. Use pillows to prop her how most comfortable. Inspect briefs for incontinence, clean as necessary. Check-in with Ms. Taylor and her family to see if they have any questions for me. Make sure chart is up to date. Report off to my primary nurse. Quality and Safety

The patient is absent of grimacing and guarding behaviors, the patient states that pain is below 4 on a 1-10 pain scale, patient shows improvement in mood, and both pharmacological and non-pharmacological pain-relief strategies have been used. Improved nutrition and hydration by giving fluids every hour will decrease Ms. Taylor’s dry lips and will be evidenced by pink and moist oral mucosa.

Conclusion

This care plan will not only support Ms. Taylor, but also her family by using a family-centered approach. Ms. Taylor was put on a palliative approach which focuses on providing comfort and symptom relief and that is exactly what this care plan focuses on. Continuality assessing Ms. Taylor’s pain, repositioning her in bed, keeping her hydrated, and working on relaxation techniques are a couple of the interventions. With all these combined, the goal is to provide Ms. Taylor the most comfort in her last couple days or weeks.