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REVIEW ARTICLE

Nursing Process: Functional Health Pattern

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Abstract

The nurse assess the patient s' functional health pattern to identify patients strengths in function and to determine if dysfunctional health patterns and/or potential dysfunctional pattern exist. A days functional health pattern results in nursing diagnoses and potential dysfunctional patterns identify risk conditions for problems.

Keywords: Dysfunctional Health Patterns ; Diagnoses.

Demographic Data

- Name – xyz.
- Age- 60 year.
- Address- rishikesh.
- Occupation-housewife.
- Culture- Hindu.

Important Health Information

- Past health history- diabetes since 3 years.
- Medications- metformin DSR 500mg.
- Surgery or other treatments- cholecystectomy 6-year back.

Health Management Pattern

- Reason for visit- bilateral pedal edema and abdominal distension since 2 weeks.
- General state of health- fair.
- Any colds in past year- none.
- Most important things done to keep healthy- anulomvilom pranayama.
- Health compliance problem- none.
- Cause of illness? Action taken? Results? - cause of illness is fatty and spicy food. Patient got treatment from the local hospital but she didn't get any relief.
- Things important to you while here- to improve appetite and to lose weight.
- Family health history- no one in her family suffering from any kind of illness.

Illness and Injury Risk Pattern

- Use of cigarettes, alcohol, and drugs- none.
- Allergies (immunization) – immunization done.

Nutritional- Metabolic Pattern

- Typical daily food intake (supplements)- normal diet with no supplements.
- Weight loss or gain- weight gain since 2 months.
- Desired weight- 65 kg.
- Appetite- no appetite but now improved.

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- Diet restrictions- fatty and spicy food.
- Heal well or poorly- heal well.
- Skin problems- pruritus 6-month back.
- Dental problems- no any type of dental problem.
- Changes in appetite with anxiety – yes there was decreased appetite past 15 days.
- Food preferences- spicy food.
- Food allergies- no any kind of food allergies.

Elimination Pattern

- Bowel elimination pattern- regular.
- Urinary elimination pattern- increased frequency.
- Excess perspiration? Odor problem? Itching? - no excess perspiration, no any type of itching now a day.

Activity Exercises Pattern

- Sufficient energy for desired or required activities- now a days patient feels fatigue. She got easily tired.
- Exercise pattern- before admission in the hospital, patient used to do some yoga and pranayama.
- Leisure activities- patient likes to watch television.
- Perceived ability for- patient is able to do self-care and daily routine activities.

Sleep Rest Pattern

- Usual sleep rituals- patient believes that we should take 8-hour sleep per day to remove tiredness.
- Usual sleep pattern- sleep pattern is disturbed due to pain, but before the onset of the illness patient used to take 7 to 8 hours of sleep.

Cognitive Perceptual Pattern

- Hearing difficulty – hearing aids- no any type of hearing problem.
- Vision (wear glasses) last checked – patient wears lenses. Last checkup done 4 months before.
- Any change in taste and smell-no any change in taste and smell.
- Any recent change in memory – memory is intact.
- Easiest way to learn things- patient believes learning by doing.
- Any discomfort- patient is having abdominal pain now days.
- Ability to communicate-patient's communication skill is good.
- Understanding of illness- she understands about her illness very well.
- Understanding of treatment- she understands the treatment regimen very well.

Self-Perception- Self-Concept Pattern

- Effect of illness on self-image- self-image disturbed. Sometime patient become sad.
- Relieving factors- her son and hospital environment.

Role - Relationship Pattern

- Live alone? family- she live with her family.
- Family problem solving- she always discuss her problems with her family members especially son.
- Family and others feelings about her illness- her son is very anxious and fearful about her mother illness.
- Work satisfaction (school)- she was quiet and doing all work sincerely.

Reproductive Pattern

- Effect of illness- there is loss of interest in sexual activity.
- Use of contraceptives-she is not using any contraceptive but previously she used to take oral contraceptive pills.
- Menarche- 16 years.
- Menopause- 48 years.

Coping Stress Tolerance Pattern

- Recent life changes- illness, ascites.
- Problem solving techniques- communicate with family member.
- Have someone to confide in – her son.

Value Belief Pattern

Satisfied with life- she is satisfied with her life.

Conflict between treatment and belief- she belief that avoidance of spicy and fatty food will not be able to relief the symptoms.

Physical Examination

General Status

- Well-nourished and well hydrated, speech clear and evenly paced.
- Patient is alert, oriented, cooperative and calm.

Skin

- Pedal edema is present.
- Abdominal scar is present due to surgery.
- Trunk warmer than extremities, turgor returns quickly.
- No increase vascularity, no varicose veins.
- No clubbing of fingers.
- No congenital abnormality.

Nails

- Well groomed, round 160-degree angle.
- Nail beds pink, nail flexible.

Hair

- Thick, brown and white in color .
- Normally distributed.
- No dandruff, no pediculosis.

Head

- Normocephalic, sinuses nontender.
- No any type of scar mark on head.

Eyes

- Visual fields intact on gross confrontation.
- Pupils- PERRLA, pupils equal, round, reactive to light and accommodation.
- No ptosis.
- Extraocular movements are normal.
- Red reflex present bilat no opacities.

Ears

- Pinna intact, in proper alignment; external canal patent; small amount cerumen present.
- Whisper heard at 3 feet.
- AC>BC.

Nose

- Patent bilaterally; turbinates' pink.
- No swelling.
- No deviated nasal septum.

Mouth

- Moist and pink.
- Soft and hard palates intact.
- Uvula rises midline on ahh.

Throat

- No redness.
- No inflammation.

Tongue

- Moist and pink.

Neck

- ROM full, intact strong.
- Lymph nodes no palpable and non-tender.
- Thyroid palpable smooth not enlarged.
- Trachea midline and non-tender.

Breasts

- Soft without inversion, areola dark and symmetric.
- No discharge, no masses, non-tender.

Axilla

- Hair present, no lesion, non-tender.

Lungs

- No increase in AP diameter.
- Respiratory rate 18/min.
- No increase in tactile fremitus, no tenderness.
- Lungs resonant throughout.
- Diaphragmatic excursion 4 cm bilaterally.
- Lung fields clear throughout.

Heart

- Heart rate 82 / min.
- No palpable thrills.
- S1 , s2 louder.
- No s3 , s4 and murmurs.
- Carotid, femoral, pedal, and radial pulses present.

Abdomen

- Rounded
- No pulsations visible
- Active bowel sounds
- No bruits
- No palpable masses
- Fluid thrill is present during percussion

Liver

- Lower border percussed at costal margin, smooth, nontender.
- Approx. 9 cm span.

Spleen

- Nonpalpable, nontender.

Neurological system

- Oriented.
- Sensation intact.
- Cranial nerves 1-xi intact.
- Coordination proper.
- Romberg test intact.
- Reflexes normal.

Musculoskeletal system

- Well developed, no muscle wasting.
- Swelling present.
- No crepitus, no nodules.
- ROM full, intact, and equal bilaterally; no scoliosis.
- Strength; equal, strong bilaterally.
- Gait; walks erect 2 footsteps, arms swinging at side without staggering.

Genitalia

- External genitalia: no swelling, no redness no cysts.
- Normal hair distribution.
- Vagina: no lesion, discharge, bulging.
- Cervix: os closed; pink, no lesions, erosions, non-tender.
- Uterus: small, firm, nontender.
- Rectovaginal: sphincter intact; confirms above findings.

Psychological Status

- Affect appropriate.
- Mood appropriate to condition.
- Thought content: coherent.
- Memory: remote and recent intact.
- Nursing management.

Nursing Diagnosis

1. Imbalanced Nutrition Less Than Body Requirements related to anorexia.
2. Activity Intolerance related to muscle weakness.
3. Fluid and electrolyte imbalances related to portal hypertension.
4. Ineffective Tissue Perfusion related to hematemesis and melena.
5. Anxiety related to hematemesis and melena.
6. Ineffective Breathing Pattern related to decreased lung expansion.
7. Impaired Verbal Communication related to neurological disturbances talking.
8. Risk for injury related to uncontrolled movements.
9. Impaired Physical Mobility related to the effect of muscle stiffness.
10. Risk for Self-care deficit related to a state of coma.

Nursing Care

Nutrition: imbalanced, less than body requirements related to Inadequate diet; inability to process/digest nutrients, Anorexia, nausea/ vomiting, indigestion, early satiety (ascites), Abnormal bowel function as evidenced by Weight loss,Changes in bowel sounds and function, Poor muscle tone/wasting,Imbalances in nutritional studies.

Expected Outcomes

1. Demonstrate progressive weight gain toward goal with patient-appropriate normalization of laboratory values.
2. Experience no further signs of malnutrition.

Nursing Interventions

1. Measure dietary intake by calorie count.
2. Weigh as indicated. Compare changes in fluid

status, recent weight history, skinfold measurements.

3. Encourage patient to eat all meals including supplementary feedings.
4. Provide salt substitutes, if allowed; avoid those containing ammonium.
5. Restrict intake of caffeine, gas-producing or spicy and excessively hot or cold foods.
6. Suggest soft foods, avoiding roughage if indicated.
7. Encourage frequent mouth care, especially before meals.
8. Maintain NPO status when indicated.
9. Provide tube feedings, TPN, lipids if indicated.

Fluid Volume excess related to Compromised regulatory mechanism Edema, anasarca, weight gain,Intake greater than output, oliguria, changes in urine specific gravity, Dyspnea, adventitious breath sounds, pleural effusion,BP changes, altered CVP, JVD, positive hepatojugularreflex, Altered electrolyte levels, Change in mental status.

Expected Outcomes

- Demonstrate stabilized fluid volume, with balanced I&O, stable weight, vital signs within patient's normal range, and absence of edema.
- Nursing interventions.
- Measure I & O, weigh daily, and note gain of more than 0.5 kg/day.
- Monitor BP (and CVP if available). Note JVD and abdominal vein distension.
- Assess respiratory status, noting increased respiratory rate, dyspnea.
- Auscultate lungs, noting diminished breath sounds and developing adventitious sounds.
- Monitor for cardiac dysrhythmias. Auscultate heart sounds, noting development of S_3/S_4 gallop rhythm.
- Assess degree of peripheral edema.
- Measure abdominal girth.
- Encourage bedrest when ascites is present.
- Provide frequent mouth care; occasional ice chips (if NPO).
- Administer salt-free albumin/plasma expanders as indicated.
- Administer medications as prescribed.

Risk for impaired Skin Integrity due to Altered circulation/metabolic state, Accumulation of bile salts in skin, Poor skin turgor, skeletal prominence, presence of edema, ascites

Expected Outcomes

- Institute bed red or chair rest during toxic state. Provide quiet environment; limit visitors as needed.
- Recommend changing position frequently.
- Provide and instruct caregiver in good skin care.
- Inspect pressure points and skin surfaces closely and routinely.
- Use of emollient lotions and limiting use of soap for bathing may help.
- Gently massage bony prominences or areas of continued pressure.
- Encourage and assist patient with reposition on a regular schedule.
- Assist with active and passive ROM exercises as appropriate.
- Keep linens dry and free of wrinkles.
- Suggest clipping fingernails short; provide mittens/gloves if indicated.
- Use alternating pressure mattress, egg-crate mattress, waterbed, sheepskins, as indicated.
- Provide perineal care /catheter care (if catherazied) following urination and bowel movement.

Conclusion

Use of functional health pattern frame work for assessing and providing care assists nurse in differentiating between areas for independent nursing intervention and areas requiring collaboration or referral.

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