Nursing interventions could save lives

In this nursing care plan guide are nursing diagnosis for the care of the older adult, also known as gerontological nursing. Learn about the assessment, care plan goals, and nursing interventions for gerontology nursing in this post. This report by Paul Martin, BSN, R.N. appeared in NursesLabs.

Gerontology nursing specialises in the care of older or elderly adults. Geriatric nursing addresses the physiological, developmental, psychological, socio-economic, cultural, and spiritual needs of an ageing individual.

Since ageing is a normal and fundamental part of life. Providing nursing care for elderly clients should not only be isolated to one field but is best given through a collaborative effort which includes their family, community, and other health care team. Through this, nurses may be able to use the expertise and resources of each team to improve and maintain the quality of life of the elderly.

Geriatric nursing care planning centres on the ageing process, promotion, restoration, and optimisation of health and functions; increased safety; prevention of illness and injury; facilitation of healing.

1. Risk for falls

Nursing Diagnosis

Risk for Falls: Increased susceptibility to falling that may cause physical harm.

Risk Factors

Common risk factors for the nursing diagnosis risk for falls:

- Age (especially ≥ 65 years)
- Impaired physical mobility
- Loss of muscle strength
- Altered sensory perception
- Presence of illness (Alzheimer's disease, dementia, osteoporosis)
- Urinary incontinence
- Use of medications

- Disorientation
- Dizziness
- Lack of knowledge of environmental hazards secondary to confusion
- Improper use of aids (e.g., canes, walkers, wheelchair, crutches)

Nursing Interventions

Nursing Interventions: Identify factors that increase the level of fall risk.

Interventions: Assess the patient's environment for factors associated with an increased risk for fall. Rationale: A patient who is not familiar with the placement of furniture in an area or who has inadequate lighting in the house increases the risk for falls.

Therapeutic Interventions

1. Secure a wristband identification to warn healthcare providers to implement fall precaution on the patient. Healthcare providers need to recognise patients at high risk for falls to implement measures to promote patient safety and prevent falls.
2. Place assistive devices and commonly use items within reach. Provide easy access to assistive devices and personal care items. Items such as call bell, telephone, and water should be kept close to avoid frequent reaching.
3. Review protocols regarding transferring a patient. The facility should have clear policies and procedures during transfers that will ensure the patient's safety.
4. Always keep the patient's bed in the lowest position. Keeping the bed closer to the floor prevents injury and risk of falls.
5. Answer call light as soon as possible. This is to prevent an unstable patient from ambulating without any assistance.
6. Use side rails on bed as needed. Raising the side rails reduces the risk of patients falling out of bed during transport.
7. Advise the patient to wear shoes or slippers with non-slip soles when walking. Wearing non-slip footwear help prevents slips and falls.
8. Orient the patient to the surroundings. Avoid re-arranging the furniture in the room. The patient should be familiarised with the bed, location of the bathroom, furniture, and other environmental hazards that can cause older patients to trip or fall.
9. Ensure the patient's room is well-lit. Consider the use of a bedside lamp that is turned on at night. Providing lighting in key places can reduce fall risk and avoid obstacles during mobility.
10. Always encourage the family and other significant others to stay with the patient. This prevents the patient from accidentally falling or pulling out tubes.
11. Ensure the patient's eyesight is regularly checked and explain the importance of wearing eyeglasses if needed. Make sure glasses and hearing aids are always worn. This hazard can

be lessened if the patient utilises appropriate aids to improve visual and auditory orientation to the environment. Visually impaired patients are at high risk for falls.

12. Instruct the patient how to move about at home, including using safety measures such as handrails in the bathroom. This helps to relieve anxiety at home and eventually decreases the risk of falls during ambulation.
13. Encourage the patient to engage in a programme of regular exercise and gait training. Exercises can improve muscle strength, balance, coordination, and reaction time. Physical conditioning reduces the incidence of falls and avoids injury that is sustained when a fall happens.
14. Collaborate with other health care teams to assess and review patient's medications that can contribute to the risk for falls. Identify the peak effects of the medications that can alter the consciousness of the patient.
15. A review of the patient's prescribed medications will recognise side effects and drug interactions that may enhance fall injury risk. The more medications a patient takes, the greater the risk for side effects and interactions such as orthostatic hypotension, dizziness, confusion, urinary incontinence, and altered gait and balance. Polypharmacy (multiple medications) in older adults is a significant risk factor for falls.
16. Evaluate the need for physical and occupational therapy to assist patient with gait techniques and provide the patient with assistive devices for transfer and ambulation. Initiate a home safety evaluation as needed. The use of gait belts provides a more secure means to safely assist patients when transferring from bed to chair. Assistive aids such as wheelchairs, canes, and walkers allow the patient to have stability and balance during ambulation. High toilet seats can facilitate safe transfer on and off the toilet.

2. Impaired Gas Exchange

Impaired Gas Exchange: Excess or deficit in oxygenation and/or carbon dioxide elimination at the alveolar-capillary membrane. Conditions that cause changes or collapse of the alveoli (e.g., atelectasis, pneumonia, pulmonary oedema, and acute respiratory distress syndrome) impair ventilation.

Defining Characteristics

The following are the common subjective and objective data or nursing assessment cues (signs and symptoms) that could serve as your "as evidenced by" for this care plan:

- Dyspnoea
- Irritability; restlessness
- Lethargy
- Tachycardia
- Decreased mental acuity
- Abnormal ABGs

Desired outcomes

Below are the commonly used expected outcomes or patient goals for Impaired Gas Exchange nursing diagnosis:

- Patient's respiratory pattern and mental status will be normal for the client.
- Patient's pulse oximetry or arterial blood gas results will be within the patient's normal limits.

Nursing Interventions and Rationale

In this section are the nursing interventions and rationale (or scientific explanation) for the nursing diagnosis.

Monitor and record the following during admission and routinely thereafter: respiratory rate, depth, and pattern; breath sounds, cough, sputum, and mental status. This provides baseline data for subsequent assessments of the patient's respiratory system.

Assess subtle changes in patient's behaviour or mental status - e.g., anxiety, disorientation, hostility, and restlessness. Check oxygen levels using pulse oximetry (higher than 92%) or reviewing ABG values (optimally Pao2 80%-95% or higher). These changes in the sensorium can indicate decreasing oxygen levels.

To comprehensively monitor pulse oximetry, the haemoglobin (Hgb) must be determined. Patients with low haemoglobin levels can have a higher pulse oximetry level and still exhibit acute confusion or restlessness. This happens due to diminished haemoglobin to deliver oxygen through the body.

Auscultate the lungs for adventitious sounds. When people get older, lungs elasticity decreases. The lower portion of the lung is not sufficiently aerated resulting in the occurrence of crackles (usually heard in individuals 75 years of age and above). This sign alone does not imply the presence of a disease condition. Crackles (rales) that do not clear with coughing in an individual with no additional symptoms such as increased temperature, increasing anxiety, changes in sensorium, increasing respiratory depth are considered benign.

Therapeutic Interventions

1. Encourage breathing and coughing exercises. Instruct patient in use of incentive spirometry if applicable. These measures provide alveolar expansion and remove the secretions from the bronchial tree, resulting to optimal gas exchange.
2. Encourage increased fluid intake (greater than 2.5 litres daily) unless contraindicated by a renal or cardiac condition. Adequate hydration promotes mobilization of secretions.
3. Treat hyperthermia immediately, reduce pain, lessen pacing activity, and decrease anxiety. These measures decrease the demand for increased oxygen consumption.
4. Teach the patient in the use of support devices such as nasal cannulas or oxygen masks. Knowledge about equipment such as this promotes adherence to the treatment.