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Nursing Care: A Critical Analysis

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Abstract

Nowadays the challenges of Nursing Profession is to implement the independent and inter dependent nursing care with other health care profession .This nursing care explains the nurse has to assess and implement the nursing care n all the aspects of patient suffering with cancer stomach.

Keywords: Nursing Care; Ca Stomach; Nursing Diagnosis.

Demographic Data

Name	-	AXZ
Age	-	45year
Gender	-	female
Education	-	Un Educated
Occupation	-	housewife
Address	-	Roorkee
Marital status	-	married
Ward	-	General Surgery Ward
No of days in hospital	-	12 days
Provisional diagnosis	-	Ca . Stomach

- *Chief Complaints*

Pain in upper abdomen xo month fever x 8 month

- *History of Illness*

History of Present Medical Illness

Patient was apparentlyasymptomatic last 8 months She gradually developed pain in upper abdomen which is mild in intensity, on-off type non-radiating, no anointing factor relived by taking medication. She has a compliant of nausea which is relived by taking medication patient also undergoing treatmentfor fever since 8 months.

History of past medical illness patient took treatment for kock's disease before 25 years.

No H/O DM, HTN.

History of Present Surgical Illness

Patient has undergone total gastroectomy, cholecystectomy spleenotomy with D_2 lymph adenotomy, Roux-en-^{y} anastamosis.

History of Past Surgical Illness

Not significant

Personal History

Good Habits	–	All household activites
Bad Habits	-	Tobacco Chewing

Elimination Pattern

Bowel	–	Constipation
Bladder	–	Patient is kept on indwelling Cather with adequate intake and out put
Activity pattern	–	dull

Menstrual History

Menarche	–	18 years
Duration	-	5 days
Cycle	–	28 days

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Family History

In patient's family there are 9 Members. She is living in nuclear family and no history of consanguineous marriage. There is history evident in cancer in family.

Investigations

Biochemistry	Result	Normal Values	Remarks
Total Bilirubin	1.0 mg /dl	0.3-1.2 mg/dl	Normal
Direct Bilirubin	0.66 mg/dl	<0.20 mg/dl	increased
S.G. P.T.	19.0 U/l	M- <50; F- <35 U/L	normal
S.G.O.T.	17.0 U/L	M- <50; F- <35 U/L	normal
AL P	69.0 U/L	30-120 U/L	normal
Serum total protein	3.1 mg/dl	6.6 – 8.3 g/dl	decreased
Serum albumin	1.14 mg/dl	3.5 -5.2 g/dl	decreased
Serum Globulin	2.0	2.5 -3.2 g/dl	decreased
A.G ratio	1.0	1.4 -1.6	decreased
Serum Na+	135mmol/L	136-146 mmol/L	decreased
Serum K+	4.24 mmol/L	3.5- 5.1 mmol/L	normal
Serum Cl^-	107.0 mmol/L	101-109 mmol/L	normal
Serum Total Calcium	7.29 mg/dl	8.8- 10.6 mg/dl	decreased

Hematology Report

Hematologyreport	Result	Normal Values	Remarks
Hemoglobin	13.9 gm/dl	M: 13-17gm/dl;	Normal F: 12-15 gm/dl
RBC count	5.69 million/cumm	M: 4.5-5.5;	Normal F: 3.8-5.2 million/cumm
TLC	15,200 /cumm	4000-11000/cumm	Increased
DLC	Neutrophill - 89.7 %	40%-70%	Increased
	Easinophill – 0.1 %	1-6%	Decreased
	Basophill – 0.1 %	<2%	Normal
Platelet count	2.19 lakh/cumm	1.5-4.0 lakhs/cumm	Normal
Hematocrit	44.3%	M: 40-50%; F: 36-45%	Normal
MCV	77.8 fl	78-98 fl	Normal
MCH	24.5 pg	27-32 pg	Decreased
MCHC	31.4gm/dl	31-36 gm/dl	Normal
RDW	24.0	11-14	Increased

Urine Report

Routine examination	Result
Colour	pale yellow
Clarity	clear
Specific gravity	1.030
PH	6.0
Proteins	Negative
Glucose	Negative
Bilirubin	Negative
Urobilirogen	Normal
Blood	Negative
Leucocytes	Negative
Nitrite	Positive
Ketone	Negative

Microscopy Examination	Result
PNS cells	1-2/HDF
Epithelial cells	2-3/HPF
Red blood cells	nil
Casts	nil
Crystals	nil

Endoscopic Report	
Esophagus	normal
Funds	normal
Body	big mass seen
Autrum	Normal
Pylorus	Normal

Duodenum	
First Part	Normal
Second part	Normal

Surgical pathology cancer case summary

Specimen

- Stomach
- Spleen
- Separately sent Gall bladder

Procedure D2 Gastrectomy

Specimen size 30x23x5 cm

Tumor site: Gastric body- posterior wall

Tumor size: Greatest dimension-8.5 cm

Additional dimension: 6x2 cm

Impression

Big mass in stomach.

Medications

FORM	DRUG	DOSE	FREQ.	ROUTE
Inj.	Tazact	4.5g	TDS	I/V
Inj.	Metrogyl	100 mg	TDS	I/V
Inj.	Amikacin	500 mg	OD	I/V
Inj.	Pantop	40 mg	BD	I/V
Inj.	PCM	1g	TDS	I/V
Inj.	Ca. Glucanate	1 amp	BD	I/V

Nursing Diagnosis

1. Anticipatory Grieving
2. Situational Low Self-Esteem
3. Acute Pain
4. Altered Nutrition: Less Than Body Requirements
5. Risk for Fluid Volume Deficit
6. Fatigue
7. Risk for Infection
8. Risk for Altered Oral Mucous Membranes
9. Risk for Impaired Skin Integrity
10. Risk for Constipation/Diarrhea
11. Risk for Altered Sexuality Patterns
12. Risk for Altered Family Process
13. Fear/Anxiety
14. Nursing Diagnosis for Gastric Cancer on priority daily need /problem

Preoperative

1. Acutepain related to the growth of cancer cells
2. Anxiety related to plan surgery
3. Imbalanced Nutrition Less Than Body Requirements related to nausea, vomiting and no appetite
4. Activity intolerance related to physical weakness.

Postoperative

1. Ineffective breathing pattern related to the influence of anesthesia.
2. Acute pain related to interruption of the body secondary to invasive procedures or surgical intervention.
3. Imbalanced Nutrition Less Than Body Requirements related to fasting status.
4. Risk for infection related to an increased susceptibility secondary to the procedure.

Anticipatory Grievingrelated to Anticipated loss of physiological well-being (e.g., loss of body part; change in body function); change in lifestyle *related* **to** anticipated loss of physiological well-being (e.g., loss of body part; change in body function); change in lifestyle, Perceived potential death of patient, Changes in eating habits, alterations in sleep patterns, activity levels, libido, and communication patterns, denial of potential loss, choked feelings, anger.

Nursing Interventions

- Expect initial shock and disbelief following diagnosis of cancer and traumatizing procedures (disfiguring surgery, colostomy, amputation).
- Provide open, nonjudgmental environment.
- Use therapeutic communication skills of Active-Listening, acknowledgment, and so on.
- Encourage verbalization of thoughts or concerns and accept expressions of sadness, anger, rejection. Acknowledge normality of these feelings.
- Be aware of mood swings, hostility, and other

acting-out behavior.

- Be aware of debilitating depression.
- Ask patient direct questions about state of mind.
- Visit frequently and provide physical contact as appropriate, or provide frequent phone support as appropriate for setting.
- Arrange for care provider and support person to stay with patient as needed.
- Review past life experiences, role changes, and coping skills.
- Talk about things that interest the patient.
- Be honest; do not give false hope while providing emotional support.
- Reinforce teaching regarding disease process and treatments and provide information as appropriate about dying.

Situational Low Self-Esteemrelated to, chemotherapy or radiotherapy side effects, e.g., loss of hair, nausea/vomiting, weight loss, anorexia, impotence, sterility, overwhelming fatigue, uncontrolled pain, fear and anxiety, verbalization of change in lifestyle; fear of rejection/reaction of others; negative feelings about body; feelings of helplessness, hopelessness, powerlessness.

Nursing Interventions

- Review anticipated side effects associated with a particular treatment, including possible effects on sexual activity and sense of attractiveness and desirability.
- Tell patient that not all side effects occur, and others may be minimized or controlled.
- Encourage discussion of concerns about effects of cancer and treatments on role as homemaker, wage earner, parent, and so forth.
- Acknowledge difficulties patient may be experiencing.
- Provide emotional support for patient.
- Use touch during interactions, if acceptable to patient, and maintain eye contact.

Expected Outcomes

- Verbalize understanding of body changes, acceptance of self in situation.
- Begin to develop coping mechanisms to deal effectively with problems.
- Demonstrate adaptation to changes/events that have occurred as evidenced by setting of realistic goals and active participation in work/play/personal relationships as appropriate.

Acute Pain related to compression/destruction of nerve tissue, infiltration of nerves or their vascular supply, obstruction of a nerve pathway, inflammation, Side effects of various cancer therapy agents evidenced byReports of pain, guarding behaviors and restlessness.

Nursing Interventions

- Determine pain history (location of pain, frequency, duration, and intensity using numeric rating scale (0–10 scale), or verbal rating scale ("no pain" to "excruciating pain") and relief measures used.
- Determine timing or precipitants of "breakthrough" pain when using around-the-clock agents, whether oral, IV, or patch medications.
- Evaluate and be aware of painful effects of particular therapies .
- Provide non pharmacological comfort measures (massage, repositioning, backrub) and diversional activities.
- Encourage use of stress management skills or complementary therapies (relaxation techniques, visualization, guided imagery, biofeedback, laughter, music, aromatherapy, and therapeutic touch).
- Be aware of barriers to cancer pain management related to patient, as well as the healthcare system.
- Evaluate pain relief and control at regular intervals.
- Adjust medication regimen as necessary.
- Discuss use of additional alternative or complementary therapies (acupuncture and acupressure).
- Administer medications as prescribed and indicated.

Expected Outcomes

- Report maximal pain relief/control with minimal interference with ADLs.
- Follow prescribed pharmacological regimen.
- Demonstrate use of relaxation skills and diversional activities as indicated for individual situation.

Altered Nutrition: Less Than Body Requirements related to Hypermetabolic state associated with cancer, surgery, e.g., anorexia, gastric irritation, taste

distortions, nausea, Emotional distress, fatigue, poorly controlled pain. Evidenced by Reported inadequate food intake, altered taste sensation, loss of interest in food, perceived/actual inability to ingest food, Body weight 20% or more under ideal for height and frame, decreased subcutaneous fat/muscle mass Sore, inflamed buccal cavity, diarrhea and/or constipation, abdominal cramping.

Nursing Interventions

- Monitor daily food intake; have patient keep food diary as indicated.
- Measure height, weight, and tricep skinfold thickness.
- Weigh daily or as indicated.
- Assess skin and mucous membranes for pallor, delayed wound healing, enlarged parotid glands.
- Encourage patient to eat high-calorie, nutrient-rich diet, with adequate fluid intake.
- Encourage use of supplements and frequent or smaller meals spaced throughout the day.
- Encourage open communication regarding anorexia.
- Adjust diet before and immediately after treatment (clear, cool liquids, light or bland foods, candied ginger, dry crackers, toast, carbonated drinks).
- Control environmental factors (strong or noxious odors or noise).
- Avoid overly sweet, fatty, or spicy foods.
- Identify the patient who experiences anticipatory nausea and vomiting and take appropriate measures.
- Insert and maintain NG or feeding tube for enteric feedings, or central line for total parenteral nutrition (TPN) if indicated.

Expected Outcomes

- Demonstrate stable weight/progressive weight gain toward goal with normalization of laboratory values and be free of signs of malnutrition.
- Verbalize understanding of individual interferences to adequate intake.

Participate in specific interventions to stimulate appetite/increase dietary intake.

Post operative nursing management

Risk for Fluid Volume Deficit may include Excessive losses through normal routes (e.g., vomiting, diarrhea) and/or abnormal routes (e.g., indwelling tubes, wounds), Hypermetabolic state, Impaired intake of fluids

Nursing Interventions

- Monitor I & O and specific gravity; include all output sources, (emesis, diarrhea, draining wounds. Calculate 24-hr balance).
- Monitor vital signs. Evaluate peripheral pulses, capillary refill.
- Weigh as indicated.
- Encourage increased fluid intake to 3000 mL per day as individually appropriate or tolerated.
- Observe for bleeding tendencies (oozing from mucous membranes, puncture sites); presence of ecchymosis or petechiae.
- Minimize venipunctures (combine IV starts with blood draws).
- Encourage patient to consider central venous catheter placement.
- Avoid trauma and apply pressure to puncture sites.
- Avoid trauma and apply pressure to puncture sites.
- Provide IV fluids as indicated.
- Monitor laboratory studies (CBC, electrolytes, serum albumin).

Expected Outcomes

- Display adequate fluid balance as evidenced by stable vital signs, moist mucous membranes, good skin turgor, prompt capillary refill, and individually adequate urinary output.

Anxiety May be related to Situational crisis, Threat to/change in health/socioeconomic status, role functioning, interaction patterns, threat of death *evidenced by* Increased tension, shakiness, apprehension, restlessness, insomnia, expressed concerns regarding changes in life events, feelings of helplessness, hopelessness, inadequacy

Expected Outcomes

Outcomes

- Display appropriate range of feelings and lessened fear.
- Appear relaxed and report anxiety is reduced to a manageable level.

- Demonstrate use of effective coping mechanisms and active participation in treatment regimen.

Nursing Interventions

- Determine what the doctor has told patient and what conclusion patient has reached.
- Encourage patient to share thoughts and feelings.
- Maintain frequent contact with patient.
- Talk with and touch patient as appropriate.
- Be aware of effects of isolation on patient when required by immunosuppression or radiation implant.
- Limit use of isolation clothing and masks as possible.
- Avoid arguing about patient's perceptions of situation.
- Permit expressions of anger, fear, despair without confrontation.
- Help patient prepare for treatments.
- Provide primary and consistent caregivers whenever possible.
- Promote calm, quiet environment.

Conclusion

Nursre who are providing Nursing care 24 hours understands the holistic approach and implement all the aspects while delivering care to the patient. This makes the patient very comfortable and co-operate them to accept all the care providing to him/her.

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