Scenario: sylvester charles

*mr sylvester charles is a 58-year-old gentleman who lives with his wife susie in a bungalow on the outskirts of a busy costal town. they have one daughter who lives 20 miles away with her family, they are very close and she phones her parents every evening and visits them twice a week. up until 3 months ago he was a senior manager of a well-known insurance company but he was becoming increasingly stressed due changes in the company that may have resulted in him being made redundant. he therefore took early retirement so he could enjoy a better quality of life with his susie, who works as a nurse part-time at the local district hospital. sylvester was determined to be more physically active in his retirement by tending to his garden, which had been neglected recently and was planning on playing golf more frequently. sylvester has a history of hypertension, diabetes type 2 and hypercholesterolaemia. he gave up smoking 12 months ago.*

*one morning, susie found sylvester collapsed in the garden, he was mumbling incoherently, unable to move the right side of his body and had vomited. she realised he had experienced a stroke and quickly called 999 and he was taken to hospital. sylvester was diagnosed with a left sided ischaemic stroke and given rtpa in the ed and admitted to the stroke unit.*

*6 weeks later, sylvester is at home, having made a good recovery from the left sided ischaemic stroke. he is experiencing some degree of anomia and aphasia, but can make himself understood. he is self-caring, but still has some residual weakness in the right side of his body which makes his mobility challenging at times. susie has taken time off work to be at home with him. as the weeks have progressed, she has noticed that he is becoming intermittently confused with a poor attention span, and he does not interact with her as well as he used to. he has no interest in his garden or meeting with friends and family. in addition, he is not sleeping very well at night which means he spends the daytime dozing in his chair. susie has talked to him to try and find out what is wrong as they were a very close couple, however he tells her "there is nothing wrong". she thinks that he may be depressed in addition to his intermittent confusion and she is very concerned about him. susie thought that when he was discharged and at home things would continue to progress positively and she is becoming more upset by the current situation.*

*medications:*

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*clopidigrel 75mg od*

*atorvastatin 40mg nocte*

*ramipril 5mgs od*

*metformin 500mg bd*

*aspirin 75mg od*

*omeprazole 20mg od*

*you have been asked to review mr charles at home by the gp and will be required to carry out an assessment using an appropriate framework and formulate a care plan identifying your prioritised choice of 2 nursing problems.*

Case study:

The care of patients with complex needs

## Introduction

The long term care of elderly patients is a very complex process that very often should take into consideration the many possible aspects of every different patient that may have several different co morbidities and who end up needing a treatment that naturally turns out to be complex (Ballantyne, 2016; Barrett, et al., 2009; Chrisp & Dillon, 2015; Manning & Gagnon, 2017; Sieben-Hein & Steinmiller, 2005). These needs and features usually result in a therapeutic process that requires long term planning and constant care of around the clock (Fulton, 2014; Wodchis, et al., 2015; Coyne, 2014).

The nursing care plan for a patient with complex needs is a process that will require first the nurse to determine accurately and correctly what those needs are while at the same time recognizing all the risks that could be uniquely and potentially involved with each different patient (Edwards, 2003; Coyne, 2014). It must also be noted that the care plan will also provide a means of

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communication between the healthcare providers (nurse and attending physician) and their patients (Chrisp & Dillon, 2015; Kuluski, et al., 2017), a system of communication that should remain effective and consistent besides achieving its main primary purpose which is of course to promote the health of the patient by healing existing illnesses plus preventing new ones, ensure his well being and relieve his suffering, all in a consistent and efficient manner (Latour, et al., 2007).

Other additional aspects of a long term and complex nursing care plan is that it should preferably support a holistic and comprehensive treatment process that should cover the physical, social, psychological and spiritual facets of the patient's life (Chrisp & Dillon, 2015; Bovend'Eerdt, et al., 2009; Barrett, et al., 2009). The nursing care plan will include the health assessment by the attending physician, extensive assessment of additional aspects of the patient (in the areas of physical, emotional, social, spiritual, cognitive, functional and financial), diagnostic reports, any related clinical tests, observations and notes by both the physicians and nurses, the outcome expectations from the patient, treatments (both past and present), medical history, therapeutic interventions plus their rationale (and other aspects such as their effectiveness or side effects) and the periodical evaluation of the patient in all aspects (Cornwell, 2012; Revello & Fields, 2015; Rich, et al., 2012; Wright, 2005; Edwards, 2003).

Assessing which of all the aspects of life each patient has issues in is essential to the patient's well being and to preserve their good health as it is the first step in covering all their needs in all of these aspects; being comprehensive in this respect and providing all the care a patient needs is one of the most critical aspects in the care planning for a patient with complex needs and is one that is often overlooked making it one of the biggest therapeutic challenges for nurses and physicians; as such, it is something that must be always kept in mind at all moment (Coleman, 2003; Cornwell, 2012; Fulton, 2014; Coleman & Boult, 2003; Rich, et al., 2012); especially in a patient that will require around-the-clock care, those with cognitive deficits or intellectual disabilities (Pawlyn & Carnaby, 2009) and in the elderly (Wodchis, et al., 2015; Cornwell, 2012; Pawlyn & Carnaby, 2009).

Long term care nursing plans are both formal and informal, the last one being a plan that exists only in the nurse's mind and is directly shared with the patient while the first one involves a plan that is defined beforehand, extensively documented and set in writing (Howatson-Jones, et al., 2015). Because elderly patients with complex care needs will necessarily require nursing plans that are equally complex (Cornwell, 2012; Wodchis, et al., 2015), it is often that the nursing plans for these types of patients to be formal nursing plans too.

The realization of the nursing plan should be shared with the patient at all stages who must always remain involved (Bujold, et al., 2017; Bovend'Eerdt, et al., 2009; Manias, et al., 2017).

## The patient: Mr. Sylvester Charles

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Sylvester Charles is a 58 year old white mile who lives with his wife Susie Charles outside a touristic coastal city; his only other family is his daughter who is married and visits her parents twice a week and talks to them daily. Mr. Charles was employed as a senior manager in a big insurance company but retired early 3 months ago as a result of operational changes that made his role within the company increasingly redundant and the added high stress this situation was causing him. His wife is a part time nurse in a local hospital.

Ever since he retired Mr. Charles has quit smoking (12 months ago) and has tried to be more physically active, taking up gardening in his home and playing golf. Mr. Charles has a medical history that includes hypertension, diabetes type 2 and hypercholesterolemia.

One morning Mr. Charles' wife found him collapsed in his home garden: he was unable to speak (he could only mumble incoherently), there was vomit in his body and the right side of his body was paralyzed; he was thus displaying classic symptoms of a stroke and his wife took him to a hospital where he was diagnosed as having suffered a cerebrovascular accident (specifically an ischemic stroke) in the left hemisphere of his brain. In the emergency department, Mr. Charles was administered tissue plasminogen activator (a thrombolytic) and admitted to the stroke unit; from which he was discharged after 6 weeks and sent home after having made a good recovery and with an optimistic prognosis.

The patient has continued to experience residual symptoms which include slight aphasia and anomia, although this has not completely impaired his ability to communicate and the patient can still make himself understood. Additionally, the patient still experiences asthenia in the muscles of his left side of his body which has slightly impaired his mobility. The patient's wife has taken time off his job to be able to spend time with Mr. Charles; as more weeks passed, she started to notice worrying additional symptoms such as increased mental confusion (which presents itself only intermittently and which is minor when present), a considerable decreased attention span (he decides to do something or perform some action only to completely forget what it was after as little as 10 minutes and the same happens with conversations he is having as he cannot sustain long conversations since he loses his train of thought in these situations, something that did not happen before his cerebrovascular accident), anhedonia (he has completely lost interest in activities he found pleasurable and hobbies before his cerebrovascular accident and has, for example, stopped tending to his garden), social isolation (he interacts much less often with his wife and daughter than before his cerebrovascular accident) and insomnia (he sleeps less at night which has resulted in excessive daytime somnolence and when he does manages to sleep he only does so for an hour or two before suddenly awakening and staying awake for around 3 hours trying to sleep again, meaning he has middle-of-the-night insomnia and he also awakes very early when he does manages to sleep which means he has early-awakening insomnia).

The patient's wife Susie has tried to talk to the patient (Mr. Charles) about his current state of mind but he continually and consistently denies suffering from those symptoms, minimizes them when he is presented with irrefutable proof he has an issue for instance when he is awakened while nodding in midday, the patient also denies that anything is wrong or that he feels bad or

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distressed in any way; the patient's wife also suspects the patient might be suffering from depression as well.

The medications that the patient Mr. Charles is currently prescribed are clopidogrel 75 mg once a day (prescribed to prevent additional strokes), atorvastatin 40 mg once a day taken at night (prescribed for his high cholesterol), ramipril 5 mg once a day (prescribed to reduce his excessive blood pressure), metformin 500 mg twice a day (prescribed for his diabetes), aspirin 75 mg (prescribed to help prevent infarctions and additional strokes) once a day and omeprazole 20 mg once a day (prescribed for his heartburns and other related stomach discomfort, especially that caused by the aspirin, a prominent complaint from Mr. Sylvester).

## Assessment

Mr. Charles is clearly and evidently suffering from psychological symptoms (which are neuropsychiatric symptoms in the patient's case as these were almost certainly caused by his cerebrovascular accident as it will be explained below) and these neuropsychiatric symptoms are what are impairing the patient and reducing his quality of life more than anything else at this point; the rationale behind this conclusion is the fact that his physical ailments have been controlled reasonably well by the treatment that the patient is currently taking and which were instituted by his attending physician as the patient has had physiotherapy while in the hospital to recover most of his mobility (although physiotherapeutic exercises are still needed and have been prescribed for the patient at home) and also because the patient is also having a pretty comprehensive pharmacological treatment already; in addition to all of this, the patient is not currently complaining about any physical symptoms (although it must be mentioned that he is not very communicative right now which means he might be suffering from physical symptoms but has not communicated them).

The clinical problems that can be currently identified in Mr. Charles are all derived from his current state of mind, which presumably have been in turn caused (at least in huge part) by his cerebrovascular accident, as it is unlikely his neuropsychiatric issues appeared at the same time as his cerebrovascular episode (his stroke) and it is unlikely that these are just a coincidence; especially because the patient has no history of previous mental issues.

The second most important issue for this patient is the lack of physical activity which, again, is derived at least in a big part from his neuropsychiatric symptoms which have made him uncommunicative and prone to spend hours and even days in bed which obviously has diminished his level of physical activities and impacted in a negative way his compliance with the physiotherapeutic exercises that were prescribed for him. In specific terms, the neuropsychiatric symptoms that have been identified in the patient and which are the most prominent include the following: his lack of motivation (anhedonia), depression (major depressive disorder), insomnia,

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exhaustion (which is considered to be caused at least in a big part by the insomnia itself) and his social isolation (Holland, 2017; Pawlyn & Carnaby, 2009).

Given this assessment, the priority now for the nurse and attending physician is to treat the neuropsychiatric symptoms that are present in the patient and also, after this treatment has been instituted, to observe the patient to see if he shows any improvement by becoming more active physically, more communicative, more social and resumes his hobbies and other activities that used to bring him pleasure such as gardening (Coyne, 2014); it must be noted however, that these improvements, should they happen, will probably take weeks and possibly even months.

His neuropsychiatric-related issues are insomnia, depression, confusion (which is slight and is most likely caused by his depression plus his severe and chronic sleep deprivation) and possibly anxiety at a pathological degree (specifically generalized anxiety disorder).

These diagnoses that were made for this patient, Mr. Charles, were made and confirmed by the fact that his symptoms fulfill the ICD-10 criteria in its 11$^{th}$ version, which is its latest version (the International Classification of Diseases which is published and maintained by the World Health Organization).

Psychological therapy, consultation with a psychiatrist and consultation with a neurologist are thus indicated; the latter is indicated so that other neuropsychiatric diseases can be excluded or diagnosed, specifically Alzheimer's disease and Parkinson's disease; if Mr. Charles has a comorbid disease then the second of this possible diagnoses would more unlikely while the former would more likely.

In regards to the psychological therapy, it is considered that Mr. Charles would find much more benefit and a positive impact from cognitive behavioral therapy and the consultation from a psychologist will also be necessary so as to determine whether these emerging mental health problems are only transient and have happened as a natural result of just having a major health problem and being physically disabled or if they are pathological and chronic, although it should be noted that they will almost certainly require treatment regardless of their etiology since they are having a considerably big negative impact over the daily life, functionality, wellbeing, happiness and physical health of Mr. Charles.

In regards to psychiatric treatment, it is considered presently that Mr. Charles would be more benefited from an antidepressant (preferably one with a dual mechanism of action over two neurotransmitters: serotonin and norepinephrine) and a non-benzodiazepine should be considered to treat his insomnia, it should be noted however that a non-benzodiazepine would be much preferable to a benzodiazepine due to the fact that sedatives increase confusion and have increased effects in elderly patients, as such a sedative with a short half life would result a better alternative (just to induce sleep) and whatever sedative medication is chosen then it should be used in the short term, that is, 2 weeks at most, to avoid issues of rebound insomnia or physical dependence.

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Additionally, other possible add on agents to reinforce the treatment of Mr. Charles that should also be seriously considered include the following: a dopamine agonist (such as ropirinole, rotigotine or roxindole) which could potentially result helpful as it could aid in diminishing his physical weakness (which resulted from his cerebrovascular accident), his social isolation, his anxiety (at a minor level), his anhedonia and his depression. Secondly, the non-addictive stimulant modafinil should be considered if his excessive daytime somnolence continues; however, amphetamine salts could be considered as an option to modafinil (preferably Adderall due to its mixed composition of amphetamine salts which act both in the dopamine and norepinephrine receptors), but only if a diagnoses of Parkinson's disease is conclusively excluded.

The role of the nurse in the treatment of Mr. Charles will be supportive in his particular case and it will result especially crucial during at least the first 2 to 3 weeks as that is the period of time that would result necessary for the antidepressant medications to take full effect, during this time, the patient will especially need additional support in order to: stay compliant to his treatment (Revello & Fields, 2015), continue his physiotherapy routines, engage more with others in order to communicate with others (for reasons of his well being and also to allow him to communicate whatever needs and complaints he could have) and for his wife to be educated so she can understand the nature of her husband's ailments and also provide the emotional and practical support and care he needs and participate in his recovery (Malim-Robinson, et al., 2008).

## Conclusions

All patients are unique and different; this is a principle that remains especially true in the patients that require long term care to fulfill extensive and complex needs, but the case of the patient here analyzed presents other unique aspects and factors that complicate the treatment and care that should be provided by his nurse and physician. First is the fact that he has multiple comorbid chronic (but not degenerative) ailments, namely diabetes, hypertension and high cholesterol; additionally, new mental health issues are emerging which is especially worrying because of the fact that those are issues that were not present before and this patient has never had a history of mental illness. For these two different reasons, this patient will require his healthcare providers to pay attention to different health aspects and the quality of life of the patient will also be decreased and all this will make it especially necessary for everyone involved to give the patient extra support, both physical but also emotional, in this initial phase of his life and to plan carefully the care plan for the patient, as it will be especially comprehensive, complex, demanding (for both the healthcare providers and for the patient as well) and while, above all, remaining effective.

The patient has a long way ahead of him in order to achieve sufficient recovery so as to be functional on his own and happy again: however, it can be noted that he also has a rather good prognosis and a very strong personal support structure (which is strong and committed, even though this structure is composed of just of his wife and daughter) and, finally, while a complete

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cure will obviously not be possible for his ailments which are of a chronic nature, he will still have the potential for recovering sufficiently to become a fully functional, happy and stable man.

## Bibliography

Adiseshiah, M., 2005. Effective care of patients with type 2 diabetes and dyslipidemia: A nurse's perspective. *Diabetes Research and Clinical Practice,* 1 June, 68(Suppl 2), pp. S23-S27.

Ashelford, S., Raynsford, J. & Taylor, V., 2019. *Pathophysiology and Pharmacology in Nursing.* Second edition ed. London(England): Learning Matters.

Ballantyne, H., 2016. Developing nursing care plans. *Nursing Standard,* 1 February, 30(26), pp. 51-57.

Barrett, D., Wilson, B. & Quinn, T., 2009. *Care Planning: A Guide for Nurses.* First edition ed. London(England): Pearson Education.

Bovend'Eerdt, T. J., Botell, R. E. & Wade, D. T., 2009. Writing SMART rehabilitation goals and achieving goal attainment scaling: a practical guide. *Clinical Rehabilitation,* 23 February, 23(4), pp. 352-361.

Bujold, M. P. P. et al., 2017. Decisional needs assessment of patients with complex care needs in primary care: a participatory systematic mixed studies review protocol. *BJM Open,* 12 November, 7(11), p. e016400.

Chrisp, P. & Dillon, A., 2015. *Social care of older people with complex care needs and multiple long-term conditions,* London: Government of the United Kingdom.

Coleman, E. A., 2003. Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs. *Journal of the American Geriatrics Society,* 1 April, 51(4), pp. 549-555.

Coleman, E. A. & Boult, C., 2003. Improving the quality of transitional care for persons with complex care needs: Position statement of the American Geriatrics Society Health Care Systems Committee. *Journal of the American Geriatrics Society,* 1 April, 51(4), pp. 556-557.

Cornwell, J., 2012. *The care of frail older people with complex needs: time for a revolution,* Kent: Parliament of the United Kingdom of Great Britain and Northern Ireland.

Coyne, D., 2014. *Working with People with Chronic and Complex Health Care Needs Practice Package,* Strawberry Hills: New South Wales Government.

Edwards, S., 2003. Critical thinking at the bedside: a practical perspective. *British Journal of Nursing,* 23 October, 12(19), pp. 1142-1149.

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Elsherif, M. & Noble, H., 2011. Management of COPD using the Roper-Logan-Tierney framework. *British Journal of Nursing,* 13 January, 20(1), pp. 29-33.

Fulton, J. S., 2014. The future of complex care. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice,* 1 July, 28(4), pp. 195-196.

Goodell, S., Bodenheimer, T. & Berry-Millet, R., 2009. *Care management of patients with complex health care needs,* Princeton: Robert Wood Johnson Foundation.

Holland, K., 2017. *Cultural Awareness in Nursing and Health Care: An Introductory Text.* Third edition ed. Abingdon-on-Thames(England): Routledge.

Howatson-Jones, L., Standing, M. & Roberts, S., 2015. *Patient Assessment and Care Planning in Nursing.* Second edition ed. London(England): Learning Matters.

Kuluski, K., Ho, J. H., Hans, P. K. & Nelson, M. L., 2017. Community care for people with complex care needs: bridging the gap between health and social care. *International Journal of Integrated Care,* 1 July, 17(4), p. 2.

Latour, C. H. et al., 2007. Nurse-led case management for ambulatory complex patients in general health care: A systematic review. *Journal of Psychosomatic Research,* 1 March, 62(3), pp. 385-395.

Malim-Robinson, D., Jackson, D., Fleet, T. & Sta. Ana-Maniquiz, M. eds., 2008. Planning: A necessary step in clinical care. *Journal of Clinical Nursing,* 1 August, 17(13), pp. 1728-1734.

Manias, E. et al., 2017. *Improving documentation at transitions of care for complex patients,* Sydney: Australian Commission on Safety and Quality in Health Care.

Manning, E. & Gagnon, M., 2017. The complex patient: A concept clarification. *Nursing and Health Sciences,* 1 March, 19(1), pp. 13-21.

Matthews, E., 2010. *Nursing Care Planning Made Incredibly Easy!.* First edition ed. London(England): Lippincott Williams & Wilkins.

Parsonage, M., Hard, E. & Rock, B., 2018. *Managing patients with complex needs: Evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service,* London: National Health Service.

Pawlyn, J. & Carnaby, S., 2009. *Profound Intellectual and Multiple Disabilities: Nursing Complex Needs.* First edition ed. Hoboken(New Jersey): John Wiley & Sons.

Peate, I., 2018. *Fundamentals of Applied Pathophysiology: An essential guide for nursing and healthcare students.* Third edition ed. Chichester(England): Wiley-Blackwell.

Peate, I. & Nair, M., 2017. *Fundamentals of Anatomy and Physiology: For Nursing and Healthcare Students.* Second edition ed. Chichester(England): Wiley-Blackwell.

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Revello, K. & Fields, W., 2015. An Educational Intervention to Increase Nurse Adherence in Eliciting Patient Daily Goals. *Rehabilitation Nursing,* 1 September, 40(5), pp. 320-336.

Rich, E., Lipson, D., Libersky, J. & Parchman, M., 2012. *Coordinating care for adults with complex care needs in the patient-centered medical home: Challenges and solutions,* Rockville: Mathematica Policy Research.

Rudin, r. S. et al., 2016. *Identifying and Coordinating Care for Complex Patients: Findings from the Leading Edge of Analytics and Health Information Technology,* Santa Monica: Office of the Assistant Secretary for Planning and Evaluation of the United States Department of Health and Human Services.

Scott, W. N. & McGrath, D., 2009. *Nursing Pharmacology Made Incredibly Easy!.* First edition ed. London(England): Lippincott Williams & Wilkins.

Sieben-Hein, D. & Steinmiller, E. A., 2005. Working with complex care patients. *Jouirnal of Pediatric Nursing,* 1 October, 20(5), pp. 389-395.

Thomas, S., 2018. *Conceptualisation, development and validation of a community-based Patient Complexity Instrument (PCI) for district nurses.* Birmingham, Royal College of Nursing, pp. 30-31.

Toro, N. et al., 2018. *Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services,* Geneva: United Nations.

Waugh, A. & Grant, A., 2018. *Ross & Wilson Anatomy and Physiology in Health and Illness E-Book.* Thirteenth edition ed. London(England): Churchill Livingstone.

Wodchis, W. P., Dixon, A., Anderson, G. M. & Goodwin, N., 2015. Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *International Journal of Integrated Care,* 1 November, 15(6), p. e021.

Wright, K., 2005. Care planning: An easy guide for nurses. *Nursing and Residential Care,* 1 February, 7(2), pp. 71-73.

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