Nurses Content
Downloaded from nursescontent.com

Home care for an older adult living alone Transition & follow-up

Community Health Nursing | Transition & follow-up

For educational purposes only.

Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

79-year-old woman with declining mobility. Care stage: During planning for the next care setting after the team confirms clinical readiness.

Medical history: The patient lives alone and previously managed independently. Recent mobility limitations have affected shopping, personal care and medicine routines. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The next care setting needs a clear handover and the patient or caregiver wants to know when to seek urgent review.

Clinical assessment

Subjective: Difficulty shopping, taking medicines and reaching the bathroom.

Objective findings and required checks: Home hazards, nutrition and support needs are identified during assessment.

Physical examination and investigations: Assess daily activities, cognition, falls, nutrition, medicines, safeguarding and available services.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Home care for an older adult living alone: Functional limitations and limited support can increase falls, missed treatment and poor intake.

Nurses Content For educational purposes only. 1 / 8

Nurses Content
Downloaded from nursescontent.com

Medical / surgical management

Agree a person-centred support plan, improve practical access and coordinate appropriate community referrals.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Medication reconciliation	Identify duplication, missed treatment and high-risk medicines	Seek prescriber/pharmacist review
prescribed ongoing treatment	Continue an accessible plan	Confirm supply and ability to administer safely.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Difficulty shopping, taking medicines and reaching the bathroom. Home hazards, nutrition and support needs are identified during assessment. The next care setting needs a clear handover and the patient or caregiver wants to know when to seek urgent review.

Nursing diagnosis

Prioritize vulnerability to a fall or accidental injury; daily self-care needs exceed current ability; nutritional intake below current needs; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

Before any clinically approved transition: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Agree a person-centred support plan, improve practical access and coordinate appropriate community referrals. Check unresolved risks, medicine reconciliation, practical support and follow-up before transition. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This

Nurses Content For educational purposes only. 2 / 8

Nurses Content
Downloaded from nursescontent.com

vignette provides no completed patient outcome.

Nurses Content For educational purposes only. 3 / 8

Nurses Content
Downloaded from nursescontent.com

Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Check unresolved risks, medicine reconciliation, practical support and follow-up before transition.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about falls, dizziness, vision and usual walking aids. Assess: Assess gait, medicines, cognition and environmental risks.	Vulnerability to a fall or accidental injury. Possible factors: unsteady mobility, dizziness or environmental hazards. Validate against the patient's assessment.	Short-term: Before any clinically approved transition: Transfers and essential activity occur without a fall during the care period. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates safe use of assistance and identifies home hazards.	1. Individualize fall precautions and keep necessary items and the call bell accessible. Rationale: Accessible support reduces unsafe unassisted movement. 2. Supervise transfers according to assessed need and check footwear and aids. Rationale: Correct assistance and equipment improve stability. 3. Review reversible contributors with the team, including postural symptoms and medicines. Rationale: Addressing causes improves safety beyond environmental measures. 4. Agree a person-centred support plan, improve practical access and coordinate appropriate community referrals. Rationale: Functional limitations and limited support can increase falls, missed treatment and poor intake. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

Nurses Content For educational purposes only. 4 / 8

Nurses Content
Downloaded from nursescontent.com

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask which activities the person can do and where help is wanted. Assess: Assess personal-care tasks, cognition, mobility and available support.	Daily self-care needs exceed current ability. Possible factors: weakness, symptoms or reduced confidence. Validate against the patient's assessment.	Short-term: Before any clinically approved transition: Completes a chosen self-care activity with the agreed level of assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates essential care skills and knows support options.	1. Assess ability task by task and respect preferences and privacy. Rationale: Specific assessment prevents unnecessary dependence. 2. Provide only the assistance required and use suitable aids. Rationale: Supported participation protects dignity and builds independence. 3. Teach caregivers with consent and confirm realistic support at home. Rationale: Continuity depends on available skills and resources.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about usual diet, recent intake, weight change and food access. Assess: Assess growth or weight trends, intake record and relevant nutritional findings.	Nutritional intake below current needs. Possible factors: poor appetite, increased requirements or feeding difficulty. Validate against the patient's assessment.	Short-term: Before any clinically approved transition: Tolerates the agreed nutrition plan without new complications. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the individualized meal or feeding plan and follow-up arrangements.	1. Assess nutritional risk and confirm swallowing safety and any fasting order. Rationale: The appropriate feeding route depends on clinical safety. 2. Offer suitable small meals or prescribed feeds with dietitian input when indicated. Rationale: Individualized support improves intake and nutrient adequacy. 3. Monitor tolerance, weight or growth and metabolic findings where required. Rationale: Progress and complications guide adjustment of support.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: Before any clinically approved transition: Explains the most important immediate	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

Nurses Content For educational purposes only. 5 / 8

Nurses Content
Downloaded from nursescontent.com

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach safe medicine organization, emergency access and support arrangements with the person's consent. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

Nurses Content For educational purposes only. 6 / 8

Nurses Content
Downloaded from nursescontent.com

Health education and continuing care

Teach safe medicine organization, emergency access and support arrangements with the person's consent.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Acute confusion, injury, neglect, inability to eat/drink or immediate safeguarding concerns needs prompt escalation.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Functional limitations and limited support can increase falls, missed treatment and poor intake.

- Priority concerns: Vulnerability to a fall or accidental injury; Daily self-care needs exceed current ability; Nutritional intake below current needs; Learning needs about the condition and care plan.

- Acute confusion, injury, neglect, inability to eat/drink or immediate safeguarding concerns needs prompt escalation.

- Teach safe medicine organization, emergency access and support arrangements with the person's consent.

Exam / viva: Which unresolved problem would delay transition, and what information must reach the next care team?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Nursing Mental Health and Community Concepts, 2e - Open RN / WisTech Open, 2025
https://wtcs.pressbooks.pub/nursingmhcc/

Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

Original cases and care-plan wording by Nurses Content. Linked sources support further study; source terms and local clinical requirements apply. Prepared 23 November 2026. Not independently clinically peer reviewed.

Nurses Content For educational purposes only. 7 / 8

Nurses Content
Downloaded from nursescontent.com

Rights and reuse

Delivered by Nurses Content. Copyright claims apply only to original material owned by its authors. Medical facts, statutory exceptions and third-party/open licence rights remain unaffected. See the website's /policies/reuse/ page for terms.

Nurses Content For educational purposes only. 8 / 8