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Daily self-care needs exceed current ability Home care for an older adult living alone

Community Health Nursing | Focused diagnosis-based template

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

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.

Medical / surgical management

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

Illustrative drug and treatment study

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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.

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Focused nursing-problem template

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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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 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: At the next patient-specific reassessment: 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. 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.

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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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: Daily self-care needs exceed current ability.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

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
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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

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