Community Health Family Assessment

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Assessment

Family Demographics

The family that was seen had a son, R.K and daughter in law, K.K. who both were middle-aged. S.K. is a 73-year-old female who was diagnosed with chronic obstructive pulmonary disease (COPD). The entire family identifies as Caucasian. R.K. and K.K. have children of their own who had already moved out of the house. One of their daughters had a son of her own. The son was a one-year old boy who would be babysat every weekday by K.K. The client's family identified as being Christian. The client had multiple crosses in her room and also around the house. R.K.'s workplace was unknown. He was the only person in the household that worked. The client and her family were of a lower socioeconomic status.

Physical Environment

It was observed that the home was one story with three-bedrooms and two bathrooms. The client S.K. lives in her son's home. She occupies one of the rooms in the house and uses one of the bathrooms. The home was surrounded by almond trees that were not owned by the family. There were a few homes near by one of which was a relative's home. There were also chickens and horses outside of the family's home that they owned. The outside of the house had a metal gate surrounding it. They had a built-in trampoline and a playground. The family also had two dogs that were outside. The dogs were behind a fence while the home visits occurred. The also had a cat that lived inside. There was always plenty of misfit items outside in the front yard. For example, it was observed that there were empty cardboard boxes, a microwave, and a bedframe. The house was located on a ranch in Denair about 10 miles away from any grocery stores or gas stations. This made it an inconvenience for the family to go grocery shopping. Since the primary caregiver for the client is K.K. it is difficult for her to go grocery shopping and keep up with the

household duties. During a majority of the home visits the client stated that she had pancakes for breakfast and some sort of fast food lunch such as Burger King. The client also had a mini fridge in her room. The fridge contained snacks such as pudding and Coca-Cola.

Psychological and Spiritual Environment

It was viewed that there was mutual respect between K.K. and S.K. R.K. was at work during all of the home visits. S.K. had her sisters come over for a few days to visit her. K.K. mentioned that the company helped with S.K.'s wellbeing. S.K. would also occasionally visit her sister at her home. K.K. stated that any time S.K. was out of the house or with family members she would have her "better days". S.K. defines her better days as the days that she is able to breathe more easily while using her oxygen machine. Her oxygen machine is usually at 3 liters however, some days she has it at 2.5 liters.

Family Structure and Roles

K.K. is the primary care giver for S.K. She takes her to all of her appointments and tends to her daily needs. Some of her daily tasks are taking S.K.'S vital signs every single morning, assisting her with her medications, and scheduling and taking her to her appointments. K.K. stated that she did feel overworked certain days. She takes care of her mother-in-law S.K. and her grandson during the weekdays. At one-point K.K. also had to take care of her nephew for a few days after his hip replacement surgery. There was an apparent lack of division of labor within the family.

Family Functions

Many of S.K.'s needs were met by her caregiver. In addition to K.K. caring for S.K. she had nurses who made home visits at least once a week to check up on her and assist her. S.K. also had a tablet where all of her vital signs were recorded. She would have a video chat with the

nurses on the hotline as needed. As mentioned earlier, S.K. also has relatives who live near her such as her sisters, her granddaughter and her nephews and nieces. During one of home visits it was noted that S.K. had her haircut. The haircut helped with her self-esteem. Later it was mentioned that the client had her hair cut at a barber shop which took place hours before she visited her sister's home. On the contrary K.K. claimed that she never had much time for herself. She felt as though she was the caretaker for not only for her mother-in-law, she was also the babysitter for her grandson. Her own needs were rarely met due to the fact that she has always been busy tending to her family's needs.

Family Values and Beliefs

Although K.K. was no longer raising her own children, she did babysit her grandson on a daily basis. K.K. was not getting paid for any of her daily tasks of caring for her family members. The author of the paper was able to provide information and refer her to In-Home Supportive Services (IHSS). The only person who was working in the household was R.K. It was evident that the family was not able to spend money for their own needs. For example, S.K. was in need of a spacer for her inhaler. The author of the paper was able to find out that she had a prescription for the spacer however, K.K. stated that twenty dollars was not affordable. The family was unable to purchase an item that would have been very beneficial for S.K.'s health. R.K. also recently was also diagnosed with COPD. This meant that there was an additional member in the household that had a chronic health issue.

The family identified with being Christian however, they did not mention if they attended weekly church mass. There was no evidence or mention that the client or the family had any community involvement. S.K. is unable to be outside of the house for long due to the fact that she needs an oxygen tank with her. K.K. is also not able to be involved in the community due to

her being the primary caregiver at home. The only involvement with other people who were not a part of the household was known when S.K.'s sister came over and when S.K. and K.K. would go over to other relatives' homes. K.K. also mentioned that she would take S.K. to the grocery stores with her or to the pharmacy. She would take S.K. with her so that they can both be out of the house for a while. They would not be able to leave the house for long periods of time due to S.K.'s health condition.

Family Communication Patterns

The only two members that were seen at the household during the home visits were S.K., and K.K. and S.K.'s sisters when they were visiting her. The family had an open relationship and freely communicated with one another. S.K. would freely communicate any of her concerns about her health. K.K. would also chime in and add to her comments. They both had a mutual relationship with one another. As previously mentioned, the family only had a few neighbors since their house was out in the country in Denair. There was one house that was near their home which was owned by one of their relatives.

Family Decision-Making Patterns

Most of the decision making of the family was made by K.K. She was the one who was always home taking care of S.K. and doing the housework as well. For example, S.K.'s appointments would need to be around K.K.'s availability due to K.K. being the only one who takes care of S.K. A lot of the decision making is also in correlation to the family's financial status. For example, the family goes grocery shopping once a week and buys their absolute necessities. It was also apparent that K.K. does not have time to cook. Fast food was a quicker and cheaper option for the family.

Family Problem-Solving Patterns

Most of the family problems are dealt with and solved by K.K. For example, one of the issues that S.K. had was that she kept tripping and then falling. A main reason was due to their home being cluttered with various miscellaneous items. S.K. reported that she tripped twice over a plastic crate that was in her room. A suggestion that was made by the student nurse (SN) was to remove the crate from the room if she had no use for it. During the home visits S.K. and K.K. were both able to discuss any other problems that they were having. For example, S.K. was having pain due to her shingles diagnosis. K.K. mentioned that S.K. was out of her medication and that K.K. had contacted the physician for a refill. They were also reminded to write a list of problems that they had throughout the week. The problems list was then shared with the SN the following week at the home visit.

Family Coping Patterns

Stressors have always been a norm for the family. S.K.'s condition is a chronic condition. K.K. has been her primary caregiver for many years. The family is very patient and is able to go through the highs and lows of life together. Without the support of K.K. being at home caring for S.K. and R.K. working, S.K. would not have been able to receive the at home care that they have been providing for her. Although there are many difficulties the family endures, the family is still willing to provide the best care they can give to S.K. They respect and value her as a member in the family.

Family Health Behavior

It was evident that K.K. was not able to keep up with her own health. She was very involved with caring for the needs of her family members. She would always mention that taking care of others is not her job however, it felt like it was her job. As mentioned before, S.K. and her son R.K. were both diagnosed with COPD. S.K. stated that she smoked for 35 years. R.K.

also smoked as well. For the most part, S.K. was bed bound except when she needed to use the restroom or go grocery shopping and to her appointments. The at home tablet was an excellent resource for the family. The tablet had a video chat option where they could have immediate access to a healthcare provider. This was a convenient way to manage S.K.'s health at home. K.K. also had a medication organizer for S.K. where she organized S.K.'s weekly medication according to the appropriate day and hour. S.K. also had an oxygen machine that was running all of the time when she was at home. She also had a portable oxygen machine and an oxygen tank. She had several inhalers at her bedside and an incentive spirometer (IS) on her desk. S.K. admitted that she did not use her IS . The author of the paper taught her how to properly use the device and brought it closer to her bedside. The family tried their best to care for S.K. with the resources that they had.

Family Social and Cultural Patterns

It was not apparent that the family had very much of a social or cultural practice specific to them. They did appreciate one another and enjoyed family time. As previously stated, family time helped S.K. feel better by bringing up her morale. The lack of assistance from other family members when it came to caring for S.K.'s medical and physical needs was evident. K.K. felt an overload of responsibilities when it came to being S.K.'s at home care provider. There was little time to promote creativity within the household.

Diagnosis

As previously mentioned, client S.K. was diagnosed with COPD. She is heavily reliant on her oxygen machine that she uses. A nursing diagnosis for this client from the North American Nursing Diagnosis Association (NANDA) book would be ineffective breathing pattern. According to NANDA (2017), ineffective breathing pattern is when inspiration and

expiration does not provide adequate ventilation. The client's condition best fits this nursing diagnosis. Some of the defining factors that were seen while assessing the patient was abnormal breathing pattern and her fluctuating oxygen saturation (O2 sat) level. For example, the clients O2 sat level would be at % 96 when the SN would take it however, the client would be using 3 liters of oxygen. K.K. stated that there would be incidences where S.K.'s O2 sat levels would be at 70 to 80 percent. During those instances she would be taken to the Emergency room. The client's lung sound were of a regular rate however, coarse crackles were heard bilaterally. She took short shallow breaths. She also had difficulty speaking for long periods of time. The client stays in her bed for a majority of the day. She lays down flat on her back while she is watching television in her room.

A nursing diagnosis for a family member would be caregiver role strain. K.K. was the primary care giver for S.K. She did not get paid for this task. K.K. stated that caring for S.K. was similar to a full-time job. Some of the defining factors that best fit for K.K. was the fact that she is completely preoccupied with S.K.'s care routine. K.K. admitted that she is unable to care for herself at times due to her being attentive to S.K.'s schedule for appointments and care. In addition to caring for S.K., K.K. cares for her grandson on the weekdays. K.K. does not have time for any leisure activities such as being involved in the community.

Goals and Objectives

A goal for S.K.'s diagnosis would be for her to report that she is able to breathe comfortably. A measurable object would be for the client to use her IS 5 times a day and reach to a marked level on her IS. It is also a measurable objective because the client will be able to demonstrate improvement or the usage of the tool. A goal for K.K's nursing diagnosis will be for her to receive financial assistance from IHSS. A measurable goal would be for the client to

complete and submit her required paperwork what was sent from IHSS. This goal and objective assist K.K. to be employed. It will also help the family as a whole by having an additional person assisting with the financials in the home.

Interventions

The SN will need to ensure the client has proper equipment and education. The SN will first make sure that the client has an incentive spirometer at home. The student will next assess the knowledge base of the client on the IS. The client will then demonstrate how to use the device. If the client does not properly use the IS, the SN will instruct the client on how to use it. The SN will also instruct the client to use the IS five times a day. Each time she uses the IS she will move the marker to her highest level she was able to expire. The SN will also ensure that the device is near the clients reach. The progress and improvement will be reassessed each week.

The SN will speak with K.K. to see if she has heard of IHSS before. The SN will call the IHSS phone number and make a referral for the client. The student will inform K.K. that she will be receiving a phone call once the student has made the referral. K.K. will also be receiving paperwork through the mail. The SN will tell K.K. to check her mailbox. Once the client has received the paperwork, the SN will follow up with K.K. to see if she has any questions about the paperwork and submits it back to IHSS.

Evaluation

The SN will measure success by reassessing the client. The client will show the SN how she uses the IS. The client will also show her highest level she was able to achieve by using the IS marker. The client will report that she understands the reason why she uses the IS and that it is helping with her breathing pattern. To evaluate the effectiveness of the interventions for K.K., K.K. will state that she received a phone call from IHSS. She will state her understanding of how

IHSS will assist her and her family financially. K.K. will also submit her paperwork back to IHSS. The end goal of this intervention is to ensure K.K. feels like she is being paid for her caregiving role. The family will also feel more financially stable since there will be two family members brining in money to the home.

Reference

Ackley, B. J., Ladwig, G. B., & Makic, M. B. F. (2017). *Nursing diagnosis handbook: an evidence-based guide to planning care*. St. Louis, MO: Elsevier.

Family Assessment Tool*

Family Constellation

Member (initials)	**Birth Date**	**Sex**	**Marital Status**	**Education**	**Occupation**	**Community Involvement**
R.K.	9/04/ 1970		Married	High school level	Unknown	None
K.K.	4/15/ 1970	F	Married	High school level	Caregiver	None
S.K. (client)	1/31/ 1947	F	Widowed	High school level	Retired	None

Financial Status: Lower socioeconomic status

Using the following scale, score the family based on your professional observations and judgment:

0 = Never
1 = Seldom
2 = Occasionally
3 = Frequently
4 = Most of the time
N = Not observed

Facilitative Interaction among Members

a. __4__ Is there frequent communication among members?
b. __2__ Do conflicts get resolved?
c. __4__ Are relationships supportive?
d. __3__ Are love and caring shown among members?
e. __3__ Do members work collaboratively?
f. __16__ Total score

Enhancement of Individual Development

a. __3___ Does family respond appropriately to member's developmental needs?
b. ___3__ Does it tolerate disagreement?
c. ___4__ Does it accept members as they are?
d. __3___ Does it promote member autonomy?
e. ___13__ Total score

Effective Structuring of Relationships

a. __3___ Is decision making allocated to appropriate members?
b. ___2__ Do member roles meet family needs?
c. __1___ Is there flexible distribution of tasks?
d. ___2__ Are controls appropriate for family stage of development?
e. __8___Total score

Active Coping Effort

a. __3___ Is family aware when there is a need for change?
b. __2___ Is it receptive to new ideas?
c. __4___ Does it actively seek resources?
d. __3___ Does it make good use of resources?
e. __3___ Does it creatively solve problems?
f. __15___ Total score

Healthy Environment and Life-style

a. __1___ Is family life-style health promoting?
b. __2___ Are living conditions safe and hygienic?
c. __4___ Is emotional climate conducive to good health?
d. ___2__ Do members practice good health measures?
e. ___9__ Total score

Regular Links with Broader Community

a. _1____ Is family involved regularly in community?
b. __4___ Does it select and use external resources?
c. ___3__ Is it aware of external affairs?
d. ___2__ Does it attempt to understand external issues?
e. ___9__ Total score

Grading Rubric for Family Assessment

Category	**Element**	**Points**
Family Assessment Tool	•Addresses each category within the assessment •Comments are included and add to each category	/3
Diagnosis	•Uses NANDA when possible •Uses a family diagnoses when appropriate •Is derived from assessment	/1
Goal	•One long term goal for each diagnosis (> 6 months) •Family focused •Relates to the diagnosis •Does not have to measurable	/1
Objective	•At least one objective for each diagnosis (by the end of our time) •Family focused •Relates to the goal and diagnosis •Realistic •Measurable	/2
Interventions	•Interventions for each objective/goal/diagnosis •Nurse focused •Relates to objective/goal/diagnoses •Includes resources •Realistic	/2
Evaluation	•Address how you will measure success of the plan	/1
TOTAL		/10