

Case Study: Assessment and SWOB Activity 5

Focus: To apply aspects of the assessment and complete a SWOB

Directions:

1. Within your group identify a scribe and a person who will report out.
2. *Referring to information gained from Mr. B and Mrs. A. from the assessment process, complete a SWOB for each of them.*

MR. B

- Age 83
- Increasing symptoms of fatigue, weakness, SOB
- Hospitalized 3 months ago, HF exacerbation
- History of HTN, CAD, MI
- Temporarily living with daughter (only 2 more weeks)
- Unsure about his medications
- Feeling low
- High salt diet
- Worried about living arrangements
- Wants to be in own home
- Trouble sleeping
- Requires assistance with ADLs
- SDOH – positive screen, (transportation and home environment)

<p>Strengths Such as support systems, Resilience</p>	<p>Weaknesses Such as pt. likes hot dogs and finds cooking to be hard</p>
<p>Opportunities What does the patient want?</p>	<p>Barriers SDOH, Social, PHQ-9</p>

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MRS. A

- Age 70
- Has type II diabetes for last 10 years without complication
 - Recently started on insulin
 - Blood sugar recently out of control
 - HTN –BP controlled with medication
- SDOH – no needs

<p>Strengths Such as support systems, Resilience</p>	<p>Weaknesses Such as pt. likes hot dogs and finds cooking to be hard</p>
<p>Opportunities What does the patient want?</p>	<p>Barriers SDOH, Social, PHQ-9</p>

1. Given the information from the SWOB, answer the following questions:

- How might the information from the SWOB help you in creating a Plan of Care for each patient?
- How can the strengths and opportunities of each patient be utilized as you think about your work with each patient?
- What are some things to start thinking about related to the weaknesses and barriers of each patient as you begin your involvement?