N301 Care Plan

Lakeview College of Nursing

Demographics (5 points)

Date of Admission 6/30/19	Patient Initials HD	Age 44 years old	Gender Male
Race/Ethnicity Caucasian	Occupation Tattoo Artist	Marital Status Single	Allergies NKA
CodeStatus Full Code	Height 187cm	Weight 70.3kg	

Medical History (5 Points)

Past Medical History: Chronic Pancreatitis, Diabetic Ketoacidosis, Osteoarthritis, Type 1 Diabetes Mellitus

Past Surgical History: Drainage of pseudocyst of pancreas by anastomosis

Social History (tobacco/alcohol/drugs, pertinent social factors): Smoker pack/day,

Admission Assessment

Chief Complaint (2 points): Right foot pain due to rock

History of present Illness (10 points):

A 44 year old Caucasian male presented the the ED after removing a rock from the bottom of his right foot that had been callused over. The patient has been a diagnosed type 1 diabetic for 15 years with a history of diabetic neuropathy. The patient did not know when the rock got into his foot however started noticing pain and redness within the last few weeks. The pain is only in his right foot and started at the bottom but is now spreading to the top. The patient states that the callus has been on his foot for 2-3 months meaning the rock could have been in his foot for that period of time. The patient could not feel any pain originally and only began to notice when his shoes were not fitting due to the swelling. Walking aggravated the pain and only morphine and elevation relieves it. The patient rates the pain after removing the rock a 10/10.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute diabetic foot ulcer; Diabetes

Secondary Diagnosis (if applicable): N/V due to uncontrolled hyperglycemia

Pathophysiology of the Disease, APA format (15 points):

Type 1 Diabetes

Type 1 diabetes is a chronic autoimmune condition in which the pancreas produces little to no insulin. The body mistakenly destroys islet cells (insulin producing cells) in the pancreas. Generally found in children, it is not uncommon for adult to develop type 1 diabetes. Genetics are the cause of type 1 diabetes and there is no cure. Insulin allows sugar to enter cells and regulating the amount of sugar in the bloodstream. Glucose/ sugar is the main source of energy for cells.

Signs of type 1 diabetes include increased thirst, increased urination, extreme hunger, unexplained weight loss, irritability, fatigue, weakness and blurred vision. The main risk factor for type 1 diabetes is family history and genetics. Since type 1 diabetes is an autoimmune disease, there is no way to prevent it. Diabetes complications can be disabling and eventually lead to death. These complications include heart and blood vessel disease, neuropathy, nephropathy, eye damage, foot damage and skin and mouth conditions.

Type 1 diabetes can be diagnosed with random and fasting blood sugar tests as well as an A1c blood test. Treatment includes insulin therapy, carb, fat and protein counting, frequent blood sugar monitoring, healthy diet and maintaining a healthy weight.Type 1 diabetics require life long insulin therapy. Treatment will not make Type 1 diabetes go away however managing diabetes well can prolong complications associated with the disease.

Type 1 diabetes. (2017, August 07). Retrieved from https://www.mayoclinic.org/diseases-conditions/type-1-diabetes/symptoms-causes/syc-20353011

Laboratory Data (15 points)

CBC: Highlight All Abnormal Labs, Explanations must contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**4.28-5.56**	**4.69**	**N/A**	**N/A**
Hgb	**13-17**	**14.9**	**N/A**	**N/A**
Hct	**38.1-48.9**	**42.7**	**N/A**	**N/A**
Platelets	**149-493**	**252**	**N/A**	**N/A**
WBC	**4.0-11.7**	**9.8**	**N/A**	**N/A**
Neutrophils	**45.3%-79.0%**	**77.8**	**N/A**	**N/A**
Lymphocytes	**11.8%-45.9%**	**13.4**	**N/A**	**N/A**
Monocytes	**4.4%-12.0%**	**5.9**	**N/A**	**N/A**
Eosinophils	**0.0%-6.3%**	**1.9**	**N/A**	**N/A**
Bands	**0.0-6.0**	**1.2**	**N/A**	**N/A**

Chemistry: Highlight Abnormal

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na+	**136-145**	**128**	**N/A**	**L**ow sodium levels can be caused by too many fluids, kidney or heart failure, cirrhosis nd use of diuretics
K+	**3.5-5.1**	**3.7**	**N/A**	**N/A**

Cl-	**98-107**	**94**	**N/A**	**L**ow chloride levels usually indicate dehydration. Low Cl occurs with any disorder that causes low blood sodium. Generally associated with electrolyte imbalances
CO2	**22-29**	**26**	**N/A**	**N/A**
Glucose	**70-99**	**450**	**325**	Glucose is elevated due to stress that the patient's body is going through. The increase in glucose levels is stimulated by the release of catecholamines and glucagon during times of stress. Elevated levels can also be caused by uncontrolled diabetes without proper care.
BUN	**6-20**	**10**	**N/A**	**N/A**
Creatinine	**0.5-0.9**	**0.60**	**N/A**	**N/A**
Albumin	**3.5-5.2**	**3.6**	**N/A**	**N/A**
Calcium	**8.6-10.4**	**8.7**	**N/A**	**N/A**
Mag	**1.6-2.4**	**N/A**	**N/A**	**N/A**
Phosphate	**N/A**	**N/A**	**N/A**	**N/A**
Bilirubin	**0-1.2**	**0.3**	**N/A**	**N/A**
Alk Phos	**40-130**	**76**	**N/A**	**N/A**
AST	**0-40**	**8**	**N/A**	**N/A**
ALT	**0-41**	**17**	**N/A**	**N/A**
Amylase	**N/A**	**N/A**	**N/A**	**N/A**
Lipase	**13-60**	**N/A**	**N/A**	**N/A**
Cholesterol	**N/A**	**N/A**	**N/A**	**N/A**

Triglycerides	**N/A**	**N/A**	**N/A**	**N/A**
Lactic Acid	**N/A**	**N/A**	**N/A**	**N/A**

Other Tests Highlight Abnormal

Lab Test	Normal Range	Value on Admission	Today's Value	Reason For Abnormal
INR	**0.86**	**N/A**	**N/A**	**N/A**
PT	**11.9-15.0**	**N/A**	**N/A**	**N/A**
PTT	**25-35**	**N/A**	**N/A**	**N/A**
D-Dimer	**N/A**	**N/A**	**N/A**	**N/A**
BNP	**N/A**	**N/A**	**N/A**	**N/A**

Urinalysis Highlight Abnormal

Lab Test	Normal Range	Value on Admission	Today's Value	Reason For Abnormal
Color & Clarity	**N/A**	**N/A**	**N/A**	**N/A**
pH	**N/A**	**N/A**	**N/A**	**N/A**
Specific Gravity	**N/A**	**N/A**	**N/A**	**N/A**
Glucose	**N/A**	**N/A**	**N/A**	**N/A**
Protein	**N.A**	**N/A**	**N/A**	**N/A**
Ketones	**N/A**	**N/A**	**N/A**	**N/A**
WBC	**N/A**	**N/A**	**N/A**	**N/A**
RBC	**N/A**	**N/A**	**N/A**	**N/A**
Leukoesterase	**N/A**	**N/A**	**N/A**	**N/A**

Cultures

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**N/A**	**N/A**	**N/A**	**N/A**
Blood Culture	**N/A**	**N/A**	**N/A**	**N/A**
Sputum Culture	**N/A**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications (7 ed.). Philadelphia, PA: F.A. Davis Company.

Barkas, F., Liberopoulos, E., Kei, A., & Elisaf, M. (2013). Electrolyte and acid-base disorders. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3959504/

Other Diagnostic Tests (EKG, Echocardiogram, Xrays, CT scan, etc) (5 points): Foot x-ray (negative for bone infection)

Diagnostic Test Correlation, APA Format & References (5 points):.

Current Medications (10 points, 1 per completed med))

Home Medications (5 required)

Brand/ Generic	Atorvastatin	Insulin Gargine	Cephalexin	Tramadol	Ondanstron
Dose	**20mg tab**	**30 units**	**500mg/cap**	**50mg/ tab**	**4mg/tab**
Route	**PO/ HS**	**SQ**	**PO/ BID**	**PO/ Q4H/ PRN pain**	**PO/ Q8H/ PRN n/v**
Classification	**Antihyperlipidemic, HMG-CoA reductase inhibitor**	**Long acting insulin**	**Antibiotic**	**Analgesic**	**Antiemtic**
Action	**Reduces plasma cholesterol and lipoprotein**	**Regulate blood**	**Treat skin infections**	**Relieve severe pain**	**Prevent nausea andvomittin**

	levels	**glucose**			**g**
Reason Client Taking	**Control lipid levels related to diet**	**Type 1 Diabetic**	**Cellulitis and diabetic foot ulcer due to rock**	**Pain with foot ulcer**	**Nausea and vomiting due to hyperglycemia**
Contraindications (2)	**-active hepatic disease -hypersensitivity**		**-Hypersensitivity**	**-alcohol intoxication -hypersensitivity**	**-long QT syndrome -hypersensitivity**
Side Effects/Adverse Reactions (2)	**-dry eyes -abdominal pain**		**-Fever -Dyspnea**	**-chest pain -blurred vision**	**-chest pain -abdominal pain**
Nursing Considerations (2)	**-liver function tests before therapy starts -used in patients without obvious CAD but with multiple risk factors**		**-caution with patients with penicillin allergy -obtain culture and sensitivity results**	**-avoid giving to patients with acute abdominal conditions -monitor respiratory status**	**-correct electrolyte imbalances before administering -monitor for signs of hypersensitivity**
Client Teaching needs (2)	**-not a substitute for a low cholesterol diet -monitor blood glucoses levels**		**-complete prescription -montior allergic reactions**	**-follow prescribed dose -do not crush or chew ER form**	**-use calibrated container or syringe to measure -seek immediate medical attention if symptoms worsen**

Hospital Medications (5 required)

Brand/Generic	**Atorvastatin**	**Enoxaparin (Lovenox)**	**Insulin detemir (Levemir)**	**Piperaclillin tazobactam**	**Insulin aspact (Novolog)**

Dose	**20mg/ tab**	**40mg=0.4mL Daily**	**28 units**	**3.375g=50mL Q6H**	**5 units TID**
Route	**PO/HS**	**SQ**	**SQ**	**IB PB**	**SQ**
Classification	**Antihyperlipidemic, HMG-CoA reductase inhibitor**	**Antithrombotic**	**Long acting insulin**		**Rapid acting insulin**
Action	**Reduces plasma cholesterol and lipoprotein levels**	**Prevent DVT**	**Regulate blood glucose**		**Regulate blood glucose**
Reason Client Taking	**Control lipid levels related to diet**	**Patient mostly stationary throughout day**	**Type 1 diabetic**		**Type 1 diabetic**
Contraindications (2)	**-active hepatic disease -hypersensitivity**	**-Active major bleeding -hypersensitivity**	**-roll vial -give at bedtime**		
Side Effects/Adverse Reactions (2)	**-dry eyes -abdominal pain**	**-bloody stools -hyperkalemia**			
Nursing Considerations (2)	**-liver function tests before therapy starts -used in patients without obvious CAD but with multiple risk factors**	**-extreme caution in patients with risk of hemorrhage -catiously with hepatic or renal impairment**			
Client Teaching needs (2)	**-not a substitute for a low cholesterol diet -monitor blood glucoses levels**	**-notify provider about adverse reactions -get immediate help if shortness of breath occurs**			

Lab Reference (APA Format):.

Assessment

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1130	**85**	**128/91**	**16**	**36.7**	**97**
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Physical Exam (18 points)

NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation, Mental Status, Speech, Sensory, LOC:**	Patient asleep on and off in bed with. Patient appears tired. A& O x4. He slept well but is still in pain. Patient speaks English well and at a normal pace. Patient MAEW for current age and condition. Patient's strength is bilaterally equal. Patient shows no signs of neurological damage or deficit. .
MUSCULOSKELETAL (2 points): **Neurovascular status, ROM, Supportive devices/strength** **ADL Assistance Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	Patient exhibits active range of motion bilaterally. Patient shows no sign of neurovascular deficit. Patient is independent in his room, to the bathroom, and walking in the hallway. Patient denies use of walker, cane, or wheel chair at home. Patient denies the use of any other assistive devices around her home.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable)** **Peripheral Pulses:** **Capillary refill: < 3 SECONDS** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒**	Patient is not currently being monitored by telemetry. Patient was noted to be in normal sinus rhythm on admission and this morning upon assessment. Heart sound auscultated x5. S1, S2 heart sounds noted. Radial and pedal pulses assessed. Pulses graded 2+ and present bilaterally. Capillary refill average at <2 seconds. Patient shows no signs of edema. Negative for

Location of Edema_____	neck vein distention.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	No accessory muscle use when breathing. Trachea midline. No deviations. Patient denies current shortness of breath. Anterior and posterior lung sounds auscultated. Lung sounds clear bilaterally. Patient currently breathing room air. Patient denies the use of oxygen at home
GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current Diet: Carb Consistent Cardiac** **Height: 6'2** **Weight: 157 pounds** **Auscultation Bowel sounds: Active** **Last BM: 7/1** **Palpation: Pain, Mass etc: No Pain** **Inspection: distention, incisions, scars, drains, wounds** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:_____**	.Patients current diet is soft. Patient states at home diet is regular or he "eats whatever". Patient denies current alcohol use. Patient smoke on average one pack/day. Bowel sounds present in all four quadrants. No scars noted. No masses present. Patient covered with tattoos. No ostomy, nasogastric tubes, PEG tubes. No drains. Abdomen is soft and nondistended. Patients last BM was in the morning of 7/1. Patient denies any rapid or current weight loss.
INTEGUMENTARY (2 points): **Skin color** **character, turgor, rashes, bruises:** **wounds: Right Foot Ulcer** **Braden scale : _____** **Drains present: Y☐ N ☒** **Type_____**	.Patient states he is Caucasian and presents with a fair skin tone. Skin has normal elasticity, warm to touch. No abnormal texture. No notable skin turgor. No rashes or bruises. Patient has an incision sight on bottom right foot where rock was removed. Redness and pain at touch located at the top side of the right foot radiating to the heel/
HEENT (2 points): **Head:** . **Ears:** **Eyes: Reading glasses** **Nose:** **Teeth: No dentures**	.Head is midline with no deviations. Ears show no abnormal drainage, tympanic membrane visible, pearly grey. Left ear piercing. PEERLA is noted. Nose shows no deviated septum, turbinates equal bilaterally. Oral mucosa is pink and moist with no notable abnormalities. Patient's limited number of teeth present in yellow to white in color.
GENITOURINARY (2 Points): **Color, character, quantity of urine, pain,** **Dialysis Y ☐ N ☒** **Inspection of genitals** **Catheter: Y ☐ N ☒**	Patient is able to ambulate in his room and to the bathroom independently. No dialysis, catheter. No genital abnormalities noted. Urine is yellow. Patient denies pain, hesitancy or urgency on urination. No abnormal odor. Patient is on

Type_____	I&O's.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping methods: Family** **Educational level: Highschool** **Developmental level,** **Ethnicity: Caucasian** **Religion & what it means to pt: Catholic** **Occupation (previous if retired)** **Personal/Family Data (Think about home environment, family structure, and available family support)**	Patient presents fatigued. Patient goes in and out sleep. Current everyday cigarette smoker, about a pack per day for the past couple years. Patient denies current alcohol use. Patient states he complete high school. He lives in Mattoon, IL with his nephew, sister comes to check in on him. Patient appears to have good family support. Patient is Catholic. Patient is a tattoo artist.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1000	**0-10**	**Right Foot**	**10/10**	**Sharp**	**Morphine administered & wound care**
1130	**0-10**	**Right FooT**	**8.5/10**	**Sharp**	**Pain reduction after administration**

IV Assesssment (2 Points)

Site Location, Patency/Condition & Date	Fluid Type/Rate or Saline Lock
Right Forearm 20g IV/ 6/30/19	NS 75ml

Intake and Output during Your Shift (2 points)

Intake	Output
1938 ml	**1000ml**

Nursing Care

Summary of care- Narrative of Nursing care provided, patient status throughout the day, any major concerns, etc (2 points):

Upon arrival patient was walking on right foot with pain rated 10/10. Patient's incision site was inspected by wound nurses and started on IV antibiotics. Vitals came back within normal range. Blood glucose extremely elevated at 450, insulin was given and routine monitoring began. Patient given morphine for pain with the lowest rating reaching 8.5 out of 10. Patient able to ambulate to bathroom independently, however limits ambulation due to pain.

Discharge Planning- Identify discharge needs, education, home health services/equipment, family involved, etc (2 points):

Upon discharge patient will return to his home in Mattoon, Il. Patient will be educated on proper footwear for diabetic patients as well as how to inspect feet for wounds or infections regularly. Patient will also be reeducated on blood glucose monitoring as well as the importance of proper insulin use. Patient education will also cover appropriate eating and lifestyle habits. Patient will be referred to podiatrist for proper nail care.

***The following must be listed in order of priority and must be NANDA approved Diagnosis (18 points Total, 3 points for each complete diagnosis with 2 interventions & Rational, 3 points for correct prioritization)**

Nursing Diagnosis	Rational	Intervention (2 per dx)
1. Cellulitis	**Patient's right foot incision continues to be redden and increase in pain when touched**	**1.Assess pedal pulses regularly** **2.Administer IV antibiotics according to order**
2. Diabetic foot ulcer	**Patient's callus now open after removal of the rock, slow healing**	**1. Monitor incision sight for spread of infection**

		2.Assess patients pain post removal
3. Hyperglycemia	**Patient's blood glucose when presented to the ED was 450, since then has only fallen to around 325**	**1.Monitor pt's lab results for abnormalities** **2Monitor vitals as well as I&O's**
4. Elevated Carbon Monoxide	**Patient's lab value came back elevated, patient reports smoking 1 pack per day**	**1.Administer nicotine patch when asked** **2. Assess lifestyle modifications**
5. Foot pain/ swelling	**Patient's redness and swelling continues to travel beyond the wound nurse's outlined area**	**1.. Elevate right leg with pillows to decrease swelling** **2.. Assess foot for signs of healing**

Overall APA Format/Neatness/Grammar (5 point):

Concept Map Attached (20 points):