N301 Care Plan

Lakeview College of Nursing

Demographics (5 points)

Date of Admission 7/14/19	Patient Initials M.C	Age 81 years old	Gender Female
Race/Ethnicity Caucasian	Occupation Retired teacher	Marital Status Widowed	Allergies Penicillin
Code Status Full Code	Height 5’7	Weight 96.7kg	

Medical History (5 Points)

Past Medical History: Hx atrial fibrillation chronic GERD, CAD, Diabetes mellitus (type 2), left heart catheterization, hyperlipidemia, hypertension, obesity, osteoarthritis, asthma, COPD w/ asthma, moderate aortic stenosis, gout, neuropathy

Past Surgical History: Cardiac catheterization (5/9/19), dilation & curettage

Social History (tobacco/alcohol/drugs, pertinent social factors): Patient denies smoking, patient states she is a “social” drinker, patient denies drug use

Admission Assessment

Chief Complaint (2 points): Severe right knee and right hip pain

History of present Illness (10 points): 81-year-old Caucasian female patient presented to the ED with severe right knee and hip pain. Patient states the pain began Saturday morning and by the end of the day Sunday the pain was unbearable. Patient rates the pain a 8/10 and says that it feels like “a bundle of nerves being twisted and pulled apart.” She states that she cannot walk and there is pain when trying to wash. The only thing relieving the pain is morphine. Patient has a PMH of chronic GERD, CAD, Type 2 diabetes mellitus, hyperlipidemia, hypertension, obesity, moderate aortic stenosis, gout, neuropathy and wears 2L oxygen at home.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Febrile illness

Secondary Diagnosis (if applicable): Right knee pain/swelling, UTI

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

Sepsis is a bacterial infection that becomes life threatening. Sepsis is the immune systems response that ultimately ends with organ dysfunction or failure. The infection can begin in one area and then spill over into multiple systems of the body. Cytokines are released as an inflammatory response from neutrophils and macrophages. The cytokines inhibit fibrinolysis, resulting in microvascular thrombosis, a contributing factor to organ dysfunction. Sepsis is caused by infection and can happen to anyone. Sepsis is most common and most dangerous in older adults, pregnant women, children younger than 1, people with chronic conditions (diabetes, kidney disease, lung disease, cancer), people who have weakened immune systems

Some signs of sepsis include a respiratory rate of 22 breaths per minute or more, systolic blood pressure of 100 mm Hg or less, and altered level of consciousness. Systemic symptoms of sepsis are fever or hypothermia, tachycardia, tachypnea, and either leukocytosis or leukopenia (Jacobi 2002). Severe sepsis includes organ dysfunction and metabolic acidosis. The progression of organ dysfunction can be indicated by the inability to maintain homeostasis without intervention.

Early treatment of sepsis, usually with antibiotics and large amounts of intravenous fluids, improves chances for survival (2018). Blood tests, urine analysis, wound secretions and respiratory secretions can be used to diagnose sepsis. Blood samples are drawn from two different sites and are important for testing for evidence of infection, clotting problems, abnormal liver or kidney function, impaired oxygen and electrolyte imbalances.

This patient presented to the ED with a fever, localized inflammation, as well as multiple risk factors including age and chronic conditions Labs showed elevated white blood cells an indication of infection. The patient was diagnosed with an UTI. The patient was put on IV antibiotics and IV fluids. Inflammation in her knee increased throughout the night and the patient was then scheduled for a drainage and washout of her knee, to relieve inflammation, collect samples and stop the spread of the infection.

Jacobi, J. (2002, February 15). Pathophysiology of sepsis. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/11885412

Sepsis. (2018, November 16). Retrieved from https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214

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	3.99	N/A	N/A
Hgb	13-17	12.6	N/A	N/A
Hct	38.1-48.9	37.6	N/A	N/A
Platelets	149-493	232	N/A	N/A
WBC	4.0-11.7	12.5	N/A	Elevated WBC indicates infection
Neutrophils	45.3-79.0%	81.7	N/A	Elevated neutrophils indicate an infection, mostly commonly bacterial
Lymphocytes	11.8-45.9%	4.3	N/A	Decreased lymphocytes indicates a very high risk of infection, commonly viral infections
Monocytes	4.4-12.0%	13.5	N/A	Elevated monocytes indicate a

				presence of chronic infection, autoimmune or blood disorder. Normal immune response to infection, injury or inflammation
Eosinophils	0.0-6.3%	N/A	N/A	N/A
Bands	0.0-6.0	0.4	N/A	N/A

Chemistry: Highlight Abnormal

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na+	136-145	139	N/A	N/A
K+	3.5-5.1	4.0	N/A	N/A
Cl-	98-107	104	N/A	N/A
CO2	22-29	28	N/A	N/A
Glucose	70-99	114	N/A	Patient hx type 2 diabetes. Glucose high could indicate unmanaged DM
BUN	6-20	11	N/A	N/A
Creatinine	0.5-0.9	0.87	N/A	N/A
Albumin	3.5-5.2	3.8	N/A	N/A
Calcium	8.6-10.4	8.8	N/A	N/A
Mag	1.6-2.4	1.7	N/A	N/A
Phosphate	N/A	N/A	N/A	N/A
Bilirubin	0-1.2	0.6	N/A	N/A
Alk Phos	40-130	74	N/A	N/A
AST	0-40	23	N/A	N/A

ALT	0-41	19	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	N/A	N/A	N/A	N/A
PT	N/A	N/A	N/A	N/A
PTT	N/A	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.

Other Diagnostic Tests (EKG, Echocardiogram, Xrays, CT scan, etc) (5 points): .

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

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

Home Medications (5 required)

Brand/Generic	Albuterol	Aspirin	Gabapentin	Indomethacin	Losartan
Dose	2.5mg/3mL Q6H, PRN	3.25mg/tab Once, PRN	300mg/cap HS PRN	20mg/cap TID	50mg/tab
Route	Inhalation/ NEB	Oral	Oral	Oral	Oral
Classification	Selective beta2-adrene	Anti-inflammatory,	Anticonvulsant	Analgesic, antigout, anti	Angiotensin II receptor

	rgic agonist	antiplatelet, antipyretic		inflammatory, antirheumatic	antagonist
Action	Prevents exercise induced bronchospasm	Relieve mild pain or fever	Manage postherpetic neuralgia	Relieve symptoms of osteo and rheumatoid artritis	Manage hypertension
Reason Client Taking	Asthma	Osteoarthritis pain	Leg pain	Arthritis	hypertension
Contraindications (2)	-hypersensitivity -	-peptic ulcer disease -hypersensitivity	-hypersensitivity	-hypersensitivity to aspirin -hx proctitis or recent renal bleeding	-GFR less than 60ml -hypersensitivity
Side Effects/Adverse Reactions (2)	-anxiety -altered taste	-decreased blood iron -confusion	-abnormal vision -abdominal pain	-fluid retention -MI	-dizziness -hypotension
Nursing Considerations (2)	-monitor serum potassium -drug tolerance can develop	-Do not crush -Ask about tinnitus	-can mix with applesauce, juice or pudding -take as bedtime to reduce adverse reactions	-monitor for signs of cardiac ischemia -extreme caution if hx of GI bleeding	-may be used with other antihypertensives -monitor blood pressure
Client Teaching needs (2)	-shake before use -wait 1 minutes between inhalations	- do not take with ibuprofen -take with food	-do not take within 2 hours after taking an antacid -do not stop abruptly	-take with full glass of water -avoid lying 30 minutes afterwards	-take in the evening -important to have periodic eye exams

Hospital Medications (5 required)

Brand/Generic	Apixaban	Atorvastatin	Budesonide	Ceftriaxone	Diltiazem
Dose	5mg/tab BID	40mg/ 2 tab	0.25mg/2m	2,000mg/24	180mg/cap

		Daily	L BID	hrs	Daily
Route	PO	PO	NEB/soln-inhalation	IV PB	PO
Classification	Antithrombolytic	Antihyperlipidemic	Antiasthmatic, Anti-inflammatory	Antibiotic	Antianginal, antiarrhythmic, antihypertensive
Action	Reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation/ prevent DVT	Control lipid levels as adjunct to diet	Manage symptoms of seasonal or perennial allergic rhinitus	Treat infections and septicemia	Treat variant angina and improve exercise tolerance in patients with chronic stable angina
Reason Client Taking	Hx atrial fibrillation	High cholesterol	Asthma	UTI and sepsis criteria	Hypertension
Contraindications (2)	-Active pathological bleeding -hypersensitivity	-active hepatic disease -breastfeeding	-recent septal ulcers -recent nasal surgery	-calcium containing IV solutions -hypersensitivity	-acute MI -ventricular tachycardia
Side Effects/Adverse Reactions (2)	-hemorrhagic stroke -GI bleeding	-abnormal dreams -hyperglycemia	-bad taste -adrenal insufficiency	-chills -fever -acute renal failure	-abnormal gait -atrial flutter
Nursing Considerations (2)	-DC 24 hours before an invasive procedure -crush and mix if unable to swallow	-liver function test before starting -patients with multiple CAD risk factors	-assess effectiveness -determine milk allergy	-cautious with penicillin allergy -culture and sensitivity test	-caution with patients with impaired renal or hepatic function -assess for heart failure
Client Teaching needs (2)	-take as prescribed -report unusual bleeding	-not a substitute for a low cholesterol diet -consult PCP about OTC	-do not chew or crush -prime oral inhaler	-report superinfection -report watery, bloody stools	-must be swallowed whole -report chest pain or SOB

Lab Reference (APA Format):

2018 Nurses drug handbook (17th ed.). (2018). Burlington, MA: Jones & Bartlett Learning.

Assessment

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0740	87	150/85	20	37.6	91
1420	75	129/79	14	38.2	93

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:**	A& O x4. She 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 a fall risk. Patient is a 2+ assist due the pain in the right leg. Patient currently cannot bare weight on the leg. Patient denies use of walker, cane, or wheel chair at home but began using a cane to help her move with the leg pain. 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: 2+** **Capillary refill: < 3 seconds** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema_____**	Patient is currently being monitored by telemetry. Patient was noted to be in normal sinus rhythm on admission but night shift nurse reported a murmur (not noted in my assessment). Heart sound auscultated x5. Radial and pedal pulses assessed. Pulses graded 2+ and present bilaterally. Capillary refill average at <3 seconds. Patient shows no signs of edema. Negative for 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 is experiencing current shortness of breath. Anterior and posterior lung sounds auscultated. Lung sounds diminished bilaterally. Patient currently breathing 2L oxygen. Patient uses oxygen at home.
GASTROINTESTINAL (2 points): **Diet at home: regular** **Current Diet: NPO** **Height: 5'7** **Weight: 96.7kg** **Auscultation Bowel sounds:** . **Last BM: 7/14/19** **Palpation: Pain, Mass etc** **Inspection: distention, incisions, scars, drains, wounds** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:_____**	Patients current diet is NPO. Patient states at home her diet is regular or she "eats whatever". Patient denies current smoking and drug use. Bowel sounds present in all four quadrants. No scars noted. No masses present. No ostomy, nasogastric tubes, PEG tubes. No drains. Abdomen is soft and nondistended. Patients last BM was in the morning. Patient denies any rapid or current weight loss.
INTEGUMENTARY (2 points): **Skin color** **character, turgor, rashes, bruises:** **wounds:** . **Braden scale : _____** **Drains present: Y☐ N ☒** **Type_____**	Patient states she is Caucasian and presents with a fair skin tone. Skin warm to touch. No abnormal texture. No notable skin turgor. No rashes or bruises. Inflammation visible and warm to touch surround the right knee, patient extremely sensitive to touch in that region.
HEENT (2 points): **Head:** . **Ears:** **Eyes:** **Nose:** **Teeth**	Head is midline with no deviations. Hair is dark brown in color. Ears show no abnormal drainage, tympanic membrane visible, pearly grey. PEERLA is noted. Nose shows no deviated septum, turbinates equal bilaterally. Oral mucosa is pink and moist with no notable abnormalities. Patient's 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 ☒** **Type_____**	No dialysis, catheter. No genital abnormalities noted. Urine is yellow. Patient reports pain, hesitancy or urgency on urination. Patient is on I&O's. Patient confirmed dx UTI

PSYCHOSOCIAL/CULTURAL (2 points): **Coping methods,** **Educational level** **Developmental level,** **Ethnicity,** **Religion & what it means to pt.** **Occupation (previous if retired)** **Personal/Family Data (Think about home environment, family structure, and available family support)**	Patient identifies as a Caucasian woman. Reports being supported by family. Highest level of education is a college graduate. Patient is Presbyterian. Retired school teacher. Family is very close ad supportive. Developmental level appropriate.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1100	0-10	Right knee	8/10	“nerves pulling”	Procedure should help with swelling
1410	0-10	Right knee	0/10	No pain	Fentanyl given post op

IV Assesssment (2 Points)

Site Location, Patency/Condition & Date	Fluid Type/Rate or Saline Lock
Iv right antecubital, 20g, IV is patent, stable. No complications. Patient denies pain at site. No evidence of erythema, drainage or swelling. Flushes easily.	0.9% NS 1000mL 75ml/hr

Intake and Output during Your Shift (2 points)

Intake	Output
1840 mL	200 mL

Nursing Care

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

Patient scheduled for a drainage and washout at 1130. Morning medications and food held for surgery. Patient's family very concerned about her health status and continually checked up with her throughout the day. The morning care before the surgery consisted of making sure the patient and family was comfortable and understood what would be happening.

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

Patient will need education on the signs and symptoms of infection and when/how to intervene earlier. Patient will need education on appropriate ROM exercises. Consistent knee drainage post op, with assessment of quantity and quality of drainage. Patient education on appropriate wound healing.

***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. Alteration in comfort related to infection in right leg	Patient's pain began a day prior to hospitalization evolved to the point where patient is immobile	1. Obtain history about ongoing/previous experiences and pain control methods 2. Evaluate health history for alcohol and drug use
2. Risk for ineffective tissue perfusion related to interrupted venous flow secondary to prolonged immobility	Patient has been avoiding walking due to pain and has been on bedrest since the peak of inflammation	1. Perform passive ROM and encourage active ROM exercises 2.Encourage deep breathing
3. Risk for infection related to inadequate primary defenses	Patient's WBC elevated indicates infection in the body	1. Monitor vitals for evidence of further infection 2 Evaluate mental status,

		orientation and LOC
4. Fluid volume excess related to compromised regulatory mechanisms	Patient dx with urinary tract infection and therefore is not excreting fluids as she should	1. Assess for and report any indicators of fluid overload 2. Record I&O's and report significant imbalance
5. Impaired gas exchange related to hx of COPD and asthma	Patient has a PMH of COPD, asthma and wears 2L of oxygen throughout the day	1. Observe signs and symptoms of hypoxia 2. Monitor oximetry readings, auscultate breath sounds

Swearingen, P. L. (2016). All-In-One Nursing Care Planning Resource (4 ed.). St. Louis, Missouri: ELSEVIER.

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

Concept Map Attached (20 points):