N321 Care Plan #1

Lakeview College of Nursing

Matthew Catlett

Demographics (3 points)

Date of Admission 09/01/20	Patient Initials J.S.	Age 68	Gender 68
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Single	Allergies N.K.A.
Code Status Full Code	Height 5'6"	Weight 160 lbs	

Medical History (5 Points)

Past Medical History: Type 1 diabetes

Past Surgical History: N/A

Family History: N/A

Social History (tobacco/alcohol/drugs): Heavy alcohol intake, ~12-15 drinks/ day; smokes 2 packs/day, has smoked for 45 years.

Assistive Devices: N/A

Living Situation: Lives with others in multi-level home.

Education Level: Completed high school, no secondary education.

Admission Assessment

Chief Complaint (2 points): Possible seizure

History of present Illness (10 points): 61 y/o male brought to emergency department by medics after being found unresponsive by housemates on 9/1/20. Patient was unresponsive for ~8 minutes until medics arrived. After receiving information about social history, patient was found to be in alcohol withdrawal which likely caused the seizure.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):. Atrial fibrillation

Secondary Diagnosis (if applicable):.COPD, alcoholism

Pathophysiology of the Disease, APA format (20 points):

Atrial fibrillation is a heart arrhythmia. Atrial fibrillation causes interruption of the blood flow, creating an increased risk for blood clots and/or stroke. Atrial fibrillation is the arrhythmia of the atrium of the heart, which causes blood to not flow into the ventricles correctly, causing the blood to pool within the atrium. This causes the blood to coagulate within the atrium, forming a clot. This clot can then move into the body, potentially causing a pulmonary embolism.

Atrial fibrillation is most common in adults over the age of 65, although any person can suffer from atrial fibrillation. Symptoms include shortness of breath, chest pain, heart palpitations (fluttering), dizziness, and fainting. Treatments for atrial fibrillation include beta blockers, blood thinners, or calcium channel blockers. Atrial fibrillation is typically caused by high blood pressure, congestive heart failure, coronary artery disease, heavy drinking, or a combination of all of these things. Mr. Stearn's atrial fibrillation was most likely caused by his excessive alcohol use along with a poor diet, as well as his diabetes.

Risk factors for atrial fibrillation include increased age, being a male, heart disease, obesity, lung disease, and diabetes. To diagnose atrial fibrillation, the easiest way to find if someone is experiencing this is to perform an electrocardiogram, which is a test that records the electrical activity within the heart.

To prevent further complications with atrial fibrillation, an appropriate diet can provide major improvements to a client's heart health. This include cutting alcohol, caffeine, and salty foods out of the diet.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

Cherney, K. (2020, April 30). Atrial Fibrillation: Causes, Symptoms, Treatment, and More. Retrieved September 07, 2020, from https://www.healthline.com/health/living-with-atrial-fibrillation

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**4.5-6 mil**	**4.75 mil**		
Hgb	**14-16 g/dL**	**11.6**		**Low hemoglobin caused by potential acute infection.**
Hct	**35%-47%**	**39.6%**		
Platelets	**150-400 c/mm3**	**65**		**Low platelet count caused by decreased platelet production due to heavy alcohol consumption.**
WBC	**4.5-11 c/mm3**	**8.8 c/mm3**		
Neutrophils	**1.7-7.0 x 109/L**	**6.1**		
Lymphocytes	**0.9-2.9 x 109/L**	**1.25**		
Monocytes	**0.3-0.9 x 109/L**	**0.78**		
Eosinophils	**0.05-0.5 x 109/L**	**0.5**		
Bands	**0-0.5 x 109/L**	**N/A**		

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145 mEq/L	138 mEq/L		
K+	3.5-5.0 mEq/L	3.3 mEq/L		Low potassium caused by excessive alcohol use.
Cl-	98-107 mEq/L	107 mEq/L		
CO2	23-28 mEq/L	24 mEq/L		
Glucose	70-100 mg/dL	86 mg/dL		
BUN	8-25 mg/dL	11 mg/dL		
Creatinine	0.7-1.3 mg/dL	0.77 mg/dL		
Albumin	3.5-5.2 mg/dL	2.9 mg/dL		Decreased albumin caused by decreased kidney function.
Calcium	8.6-10 mg/dL	7.5 mg/dL		Decreased calcium caused by kidney dysfunction.
Mag	1.5-2.4 mg/dL	1.8 mg/dL		
Phosphate	3.0-4.5 mg/dL	N/A		
Bilirubin	0-0.3 mg/dL	N/A		
Alk Phos	36-92 u/L	91 u/L		
AST	0-35 u/L	56 u/L		Elevated AST caused by decreased liver function.
ALT	0-35 u/L	24 u/L		
Amylase	0-130 u/L	N/A		
Lipase	<95 u/L	N/A		
Lactic Acid	0.4-2.3 mEq/L	1.53 mEq/L		

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	<1	1.22		Increased INR caused by decreased liver function.
PT	11-13 sec.	16 sec.		Increased PT caused by decreased liver function.
PTT	25-35 sec.	32 sec.		
D-Dimer	≤ 300 ng/mL	N/A		
BNP	<100 pg/mL	N/A		
HDL	≥40 mg/dL	35 mg/dL		Decreased HDL caused by diabetes.
LDL	≤ 130 mg/dL	57 mg/dL		
Cholesterol	150-199 mg/ dL	106 mg/dL		Low total cholesterol caused by decreased liver function and malnutrition.
Triglycerides	≤ 150 mg/dL	71 mg/dL		
Hgb A1c	<7% (diabetic)	N/A		
TSH	0.5-5.0 mU/ L	N/A		

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Clear to slightly hazy	Yellow colored; Clear		Color caused by decreased fluid evacuation.
pH	4.5-8	6.5		
Specific Gravity	1.005-1.035	1.025		
Glucose	None	None		
Protein	None	None		

Ketones	**None**	**None**		
WBC	**None or rare**	**None**		
RBC	**None or rare**	**None**		
Leukoesterase	**Negative**	**Negative**		

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**<100,000/ml**	**N/A**		
Blood Culture	**None present**	**N/A**		
Sputum Culture	**None present**	**N/A**		
Stool Culture	**None present**	**N/A**		

Lab Correlations Reference (APA): ATI. (2016). *RN Adult Medical Surgical Nursing* (10.0 ed., Content Mastery Series)

Diagnostic Imaging

All Other Diagnostic Tests (5 points): N/A

Diagnostic Test Correlation (5 points): N/A

Diagnostic Test Reference (APA):

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**budesonide (Symbicort)**	**diclofenac (Voltaren)**	**N/A**	**N/A**	**N/A**
Dose	**160 mcg**	**75 mg**	**-**	**-**	**-**
Frequency	**BID**	**BID**	**-**	**-**	**-**
Route	**Inhalation**	**PO**	**-**	**-**	**-**
Classification	**Antiasthmatic**	**Anti-inflammatory**	**-**	**-**	**-**
Mechanism of Action	**Inhibits inflammatory cells and mediators**	**Blocks the activity of cycloocygenase, the enzyme needed to synthesize prostaglandins**	**-**	**-**	**-**
Reason Client Taking	**Control COPD**	**Manage signs and symptoms of rheumatoid arthritis.**	**-**	**-**	**-**
Contraindications (2)	**Hypersensitivity to budesonide; septal ulcers**	**Active GI bleed or ulcers; history of asthma attacks,**	**-**	**-**	**-**

		rhinitis, or urticaria from aspirin or other NSAIDs			
Side Effects/Adverse Reactions (2)	**Pancreatitis; Rectal bleeding**	**Hypoglycemia; GI bleeding; leukopenia**	**-**	**-**	**-**
Nursing Considerations (2)	**Use cautiously if patient has ocular herpes simplex; Monitor patients with diabetes mellitus, glaucoma, or cataracts, as glucocorticosteroid therapy may increase adverse effects.**	**Be aware that NSAIDs like diclofenac should be avoided in patients with a recent MI because risk of infarction increases; Be aware that the risk of heart failure increases with the use of NSAIDs such as diclofenac.**	**-**	**-**	**-**

Hospital Medications (5 required)

Brand/ Generic	**lorazepam (Ativan)**	**acetylsalicyclic acid (Aspirin)**	**amiodarone hydrochloride (Nexterone)**	**N/A**	**N/A**

Dose	**1 mg**	**325 mg**	**400 mg**	**-**	**-**
Frequency	**Every 6 hrs**	**Every 4 hours, PRN**	**TID**	**-**	**-**
Route	**IV**	**PO**	**PO**	**-**	**-**
Classification	**Anxiolytic**	**NSAID**	**Class III antiarrhythmic**	**-**	**-**
Mechanism of Action	**May potentiate the effects of gamma-aminobutyric acid (GABA) and other inhibitory neurotransmitters. GABA inhibits excitatory stimulation.**	**Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis.**	**Acts on cardiac cell membranes, prolonging repolarization and the refractory period and raising ventricular fibrillation threshold.**	**-**	**-**
Reason Client Taking	**To reduce anxiety caused by alcohol withdrawal.**	**Manage signs and symptoms or rheumatoid arthritis; relieve mild to moderate pain.**	**To treat life-threatening, recurrent ventricular fibrillation.**	**-**	**-**
Contraindications (2)	**Acute angle-closure glaucoma; psychosis**	**Active bleeding or coagulation disorders; current or recent GI bleed or ulcers.**	**Bradycardia that causes syncope; cardiogenic shock.**	**-**	**-**
Side Effects/ Adverse Reactions (2)	**Seizures; respiratory depression**	**CNS depression; hepatotoxicity**	**Acute renal failure; respiratory arrest**	**-**	**-**
Nursing Considerations (2)	**Before starting lorazepam therapy in a patient with depression, make sure he/she already takes an antidepressant because of the increased risk of**	**Do not crush timed-release or controlled release aspirin tablets unless directed; Ask about tinnitus. This reaction usually occurs**	**Check patient's implantable cardiac device, as ordered, at the start of and during amiodarone**	**-**	**-**

	suicide in patients with untreated depression; Use extreme caution when giving lorazepam to elderly patients, especially those with compromised respiratory function.	**when blood aspirin level reaches or exceeds maximum dosage for therapeutic effect.**	**therapy because drug may affect pacing or defibrillating threshold; Use an in-line filter during I.V. administration of amiodarone.**		

Medications Reference (APA): Jones & Bartlett Learning. (2020). *2020 Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**-Client was fatigued and agitated.** **-Client was in distress due to ETOH withdrawal.** **-Client poorly groomed.**

INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 16** **Drains present: Y☐ N ☒** **Type:**	**-Clients skin was dry, temperature warm upon palpation.** **-Client had multiple areas of ecchymosis on left and right forearms, along with right leg.** **-No other wounds or ulcers present.**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**-symmetrical; without deviation** **-TM pearly, no drainage present** **-Sclera's are slightly jaundiced, positive RLR, EOM's present, no drainage present** **-No septal deviation, turbinates moist and pink.** **-Dentition is fair, client does not use dentures.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**-Heart sounds clear, S1 and S2 present.** **-Arrhythmias present occasionally.** **-Capillary refill ~3 seconds** **-Pulses present bilaterally on upper and lower extremities. 2+ throughout.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**-Respirations are slightly increased** **-Lung sounds present without crackles or wheezes.** **-Breathing is slightly labored.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM: Three days ago, (9/1/20)** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	**-Bowel sounds present; normoactive** **-Regular diet** **-No pain or tenderness present.** **-Height: 5'6"** **-Weight: 160 lbs**

Ostomy: Y ☐ N ☐ **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**-Urine is yellow and clear.** **-Urine output is slightly decreased (500 mL in past 12 hours.)** **-No lesion or any discoloration in genital area.** **-Client experiencing urgency.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**-Client is independent.** **-Full ROM** **-Moves without any assistive devices.** **-Client is prone to LOC due to alcohol withdrawal.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**-Client was alert.** **-Speech was normal.** **-Client possibly susceptible to seizures.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and**	**-Client is Caucasian** **-Client does not identify with any religion** **-Uses alcohol and nicotine for coping** **-Client lives with other roommates** **-Client has no known children**

available family support):	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0630	**54**	**148/80**	**29**	**97.9**	**98%** **3.5L/O2/NC**
0730	**52**	**N/A**	**26**	**N/A**	**100%** **3L/O2/NC**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	**Numeric**	**N/A**	**0**	**N/A**	**N/A**
0900	**Numeric**	**N/A**	**0**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22G **Location of IV: Right antecubital** **Date on IV: 09/01/20** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Normal saline @ 150mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
2400 mL	**975mL**

Nursing Care

Summary of Care (2 points)

Overview of care: Client was given medications to control anxiety and atrial fibrillation. Client was also observed closely to prevent leaving his bed, due to safety concerns from increased fall risk. Linens changed frequently throughout the day due to incontinence**.**

Procedures/testing done: Client's blood drawn to check CBC, lipid panel, ABG's, mineral levels, INR, PT, and PTT.

Complaints/Issues: Client displeased with inability to leave bed. Client refused to keep leads attached from vital monitor**.**

Vital signs (stable/unstable): Vital signs mostly stable, increased RR.

Tolerating diet, activity, etc.: Client had no issues with diet. Client frequently upset that he was unable to get out of bed and walk around.

Physician notifications: N/A

Future plans for patient: Continue treatment to maintain healthy heart function. Continue treatment to ween patient away from alcohol in a safe and effective manner.

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Rehabilitation

Education needs: How to appropriately control heart rhythm and maintain a healthy diet. Also, help client find ways to cope other than alcohol use.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Altered urinary elimination related to decreased kidney function as evidenced by low urine output.	**Client was unable to urinate, input was greater than output.**	**1.** Provide the client with a bladder scan to find if their bladder is holding urine. **2.** Administer a diuretic to help client urinate and eliminate fluid from the body.	**Client's urination increased; no diuretic was given. Client then was unable to control bladder.**
2. Ineffective individual coping strategies related to alcoholism as evidenced by alcohol withdrawal.	**Client stated that he used alcohol as a coping strategy.**	**1.** Speak to client about safe and effective coping strategies. **2.** Manage withdrawal symptoms to assist the body to ween from alcohol.	**Client was not ready to speak about alternative coping strategies.** **Goal met: Client's body handled the assistance given by medications well.**
3. Disruption of gas exchange related to COPD as evidenced by need of	**The client is unable to inspire O2 and expire CO2 due to chronic obstructive pulmonary**	**1. Raise client's bed to semi-Fowlers or high-Fowlers to alleviate stress upon the lungs.** **2. Continue to**	**Client's breathing became less labored upon these interventions and was able to breathe easier.** **Goal met: Client**

nasal canula.	**disorder without the use of supplemental oxygen and Symbicort.**	**administer supplemental oxygen via nasal cannula.**	**maintained O2 saturation range of 98-100% on 3-3.5L**

Other References (APA):

Concept Map (20 Points):

N321 Care Plan

N321 Care Plan

N321 Care Plan