

N311 Care Plan # 1

Lakeview College of Nursing

Name

Richard Kumpi

Demographics (5 points)

Date of Admission 09/15/2020	Patient Initials SC	Age 84	Gender F
Race/Ethnicity White/caucasian	Occupation Retired	Marital Status Widowed	Allergies Amoxicillin-pot: nausea Bactrim: diarrhea, nausea Codeine Sulfate: diarrhea, nausea, vomiting
Code Status Full	Height 5'4"	Weight 135 lbs	

Medical History (5 Points)

Past Medical History: A-fib (HCC), Sinoatrial node dysfunctional (HCC), calculus of kidney, uncontrolled diabetes mellitus type 2 without complications, hyponatremia, Anemia, other retention of urine, hematuria, had a fall that caused closed fracture of left radius, hip fracture, C7 cervical fracture.

Past Surgical History: cardiac surgery, kidney surgery, ORIF left hip.

Family History: No family history noted in her medical chart, she reported that her parents (mother and father) died of aging. Pt has 3 married children, several grandchildren, and great-grandchildren.

Social History (tobacco/alcohol/drugs): Pt reported that she used to smoke occasionally, but she quit over twenty years ago. No alcohol or recreational drug use.

Admission Assessment

Chief Complaint (2 points):GI bleed

History of present Illness (10 points):Onset: About 7 days ago. Location: digestive tract.

Duration: level of bleeding ranged mild with no pain. Characteristics: blood in stool and in urine.

Associated manifestation: constipation, also Pt reported having fatigue. Relieving factors: None.

Therapeutic treatment: blood tests were done for blood clots, platelet, and liver function. Pt was given an IV drug proton pump inhibitor to suppress stomach acid production, takes senokot for her constipation.

Primary Diagnosis

Primary Diagnosis on Admission (3 points):Hyponatremia

Secondary Diagnosis (if applicable): n/a

Pathophysiology of the Disease, APA format (20 points): A sodium serum level low than the normal range of 135mEq/L is referred to hyponatremia. In some cases, dehydration is caused by the loss of fluid and sodium together, it is referred as hypovolemic hyponatremia, which mostly occurs due to kidney dysfunctional caused by adrenal insufficiency, salt losing nephritis, or osmotic diuresis. In the other cases, hyponatremia is referred as hypervolemia, a situation in which sodium is diluted in overload fluid (Capriotti, 2020). An elder patient with hyponatremia can develop health conditions such as neurological deficits, confusion, and changes in behaviors, which can cause a patient to fall as a first apparent sign imbalanced electrolyte (Capriotti, 2020). My patient fell recently causing a fracture of hip, C7, and left radius. She also has other urine retention. These symptoms are mostly related to the effects of hyponatremia.

Patients with a history of congestive heart failure, cirrhosis of liver, nephrotic syndromes and chronic kidney diseases are likely to develop hypervolemic hyponatremia. Hyponatremia frequently happens in both acute and chronic renal dysfunctional as the kidneys are unable to completely excrete the ingested excess water. In addition, athletes are predisposed to develop severe hyponatremia because of the excess intake of water related to assiduous ADH secretion in some of them (Sahay, 2014).

When diagnosing hyponatremia, patient's drug and diet history is relevant and should be noted. Patients presenting clinical signs such as orthostatic diminution in blood pressure and increased pulse rate, slow skin turgor, dry mucus membranes should be considered hypovolemic. Treatment depends on whether it is acute or chronic, etiology of hyponatremia, and the volume status. The goal is to regulate fluid excretion and sodium balance in the bloodstream (Sahay, 2014).

Pathophysiology References (2) (APA):

Capriotti, Theresa M, "Pathophysiology: Introductory Concepts and Clinical Perspectives" (2020). *F.A. Davis Company*. P120.

Sahay, M., & Sahay, R. (2014). Hyponatremia: A practical approach. *Indian journal of endocrinology and metabolism*, 18(6), 760–771. <https://doi.org/10.4103/2230-8210.141320>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4192979/>

Laboratory Data (20 points)

If laboratory data is unavailable, values will be assigned by the clinical instructor

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	4.0-4.9 10 ⁶ /uL	2.96	2.97	These values are reliable to blood loss due to anemia and GI bleeding (Capriotti, 2020)
Hgb	12.0-16.0 g/dL	9.8	9.8	These values are reliable to blood loss due to anemia and GI bleeding (Capriotti, 2020)
Hct	37.0-48.0 %	27.9	28.3	These values are reliable to blood loss due to anemia and GI bleeding (Capriotti, 2020)
Platelets	150-400 10 ³ uL	-	301	

WBC	4.1-10.9 10 ³ /uL	9.20	9.90	
Neutrophils	1.50-7.70 10 ³ /uL	68.4	66.0	Neutrophils are elevated in response to the presence of clostridium difficile. (Capriotti, 2020)
Lymphocytes	1.00-4.90 10 ³ /uL	15.5	17.3	Lymphocytes are elevated in response to the presence of clostridium difficile. (Capriotti, 2020)
Monocytes	0.00-0.80 10 ³ /uL	11.6	11.3	Monocytes are elevated in response to the presence of clostridium difficile. (Capriotti, 2020)
Eosinophils	0.00-0.50 10 ³ /uL	3.7	4.1	Eosinophils are elevated in response to the presence of clostridium difficile. (Capriotti, 2020)
Bands			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 Mmol/L	128	131	The findings are consistent with sodium diminution due to hyponatremia. (Capriotti, 2020)
K+	3.5-5.1 Mmol/L	3.9	4.1	
Cl-				
CO2	21.0-32.0 mmol/L	28	28	
Glucose	60-99 Mg/dL	-	124	Blood sugar elevated due to uncontrolled type diabetes mellitus. (Capriotti, 2020)
BUN				
Creatinine	0.5-1.5 Mg/dL	-	0.60	
Albumin				

Calcium	8.5-10.1 Mg/dL	-	9.6	
Mag	1.6-2.6 Mg/dL		N/A	
Phosphate	-			
Bilirubin	-			
Alk Phos	-			

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	Colorless- yellow, clear		Brownish- red	The results are reliable due to the hematuria. (Capriotti, 2020)
pH	5.0-7.0			
Specific Gravity	1.003-1.005			
Glucose	negative			
Protein	negative			
Ketones	negative			
WBC	0-25/uL			
RBC	0-20/uL			
Leukoesterase	negative			

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

Test	Normal	Value on	Today's	Explanation of Findings
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	Range	Admission	Value	
Urine Culture		N/A	N/A	
Blood Culture		N/A	N/A	
Sputum Culture		N/A	N/A	
Stool Culture	Negative	Positive		The result explains the presence of the bacteria clostridium difficile. (Capriotti, 2020).

Lab Correlations Reference (APA):

Capriotti, Theresa M, "Pathophysiology: Introductory Concepts and Clinical Perspectives" (2020). *F.A. Davis Company*. Pp 271-277, 127-128,

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

X-ray left Hip, left radius, and C7: positive for fracture of left Hip, left Radius and C7 cervical.

EIA/stool test: positive for toxins produced by *C. difficile* bacteria.

Cystoscopy: negative

Current Medications (10 points, 2 points per completed med) *5 different medications must be completed*

Medications (5 required)

Brand/ Generic	Lorazepam/ Ativan tablet	Acetamino phen/ Tylenol	Calcium carbonate/ Tums	Dextrose/	Glucagon/
Dose	0.5 mg	650 mg	1.5g	12.5g	1mg

Frequency	Once at night	Every 4 hrs	As needed	As needed	As needed
Route	Oral	Oral	Oral	IV	IM
Classification	Benzodiazepine	Analgesics and antipyretics	Mineral and electrolyte replacement/antacid	Carbohydrate caloric agent	Hyperglycemic agent Insulin antagonist
Mechanism of Action	Short/intermediate acting, sedative, anticonvulsant.	Inhibit the production of prostaglandins in the brain	Essential for blood coagulation, activator in transmission of nerve impulses.	Increases blood glucose concentration, provides calories.	Essential for glycogenesis and gluconeogenesis. Only effective in treating hypoglycemia if glycogen is available.
Reason Client Taking	Anxiety	Pain and fever	Heart burn, indigestion	Low blood sugar	Low blood sugar
Contraindications (2)	Acute narrow-angle glaucoma, coma	Active alcoholism, increase risk of hepatotoxicity	Hypercalcemia, Renal calculi, Constipation	Hypersensitivity to	Hyperglycemia Hypersensitivity to proteins
Side Effects/ Adverse Reactions (2)	Dizziness Headache	Nausea Stomach pain	Tingling Arrhythmia	Hypertension Osmotic diuresis.	Tachycardia Hypotension

Medications Reference (APA):

Jones & Bartless Learning. (2020). 2020 Nurse's drug handbook (19th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>Pt appears pleasant A&O x 4 Oriented to person, time, place, and current event No acute distress well groomed</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: 10 Drains present: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: Urethral Catheter 100% silicone 16</p>	<p>Pink Moist/ normal Warm Normal turgor 2+ None Bruise on Lt arm and Lt hip Tailbone sore stage 1, wound on Lt hip covered with 4x4 gauze dressing and Ace bandage.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck symmetrical, has CT tissue neck w/o contrast, normal cephalic. Ears are symmetrical and free of discharge, no hearing aids. Eyes are symmetrical, no eyeglasses. Nose: septum midline, no drainage or bleeding noted. Pt has dentures on top and bottom, in good shape overall.</p>
<p>CARDIOVASCULAR:</p>	<p>.</p>

Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: 85 Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:	Pulse 85 Capillary refill > 3 seconds because she has anemia.
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	Non labored breathing, no wheezes, or crackles noted.
GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Regular Fluid restriction 5'4" 135Lb 1015 No pain or masses noted on palpation. No rashes No distension No incisions No scars
GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: urethral silicone Size: Fr 16	Brownish-red Cloudy 200 mL
MUSCULOSKELETAL: Neurovascular status: ROM:	Strength in both upper and lower extremities. Normal ROM except on fractured Lt leg and

<p>Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 10 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Lt arm. None high Not able to move body up towards head of bed or walk because of fracture on Lt hip and Rt arm. Use of repositioning sling with total lift.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Oriented to time, date, location Has no issue on speech, good articulation on speech. Mature and cognitive Alert</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>Family, friends Mature Christian The patient is receiving good support from friends and family. They come to visit her and or talk over the phone.</p>

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1120	85	118/51	20	97.5 F oral	96

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions

1130	0-10	none	none	none	none
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Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Total intake 50 apple sauce. The patient is on fluid restriction due to urinary retention.	The output 200: urine (catheter) 50-200 = - 150mL

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 		<ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
1. Immobility with impaired walking due to	Patient is unable to move body up towards head of	1.Patient will be checked and repositioned every	The patient is making some coordinated movements on her bed ,

<p>recent fall causing multiple fracture (left hip, C7, and left radius) as evidenced by the patient admitting to stay in bed to minimize pain and any recurrent fall.</p>	<p>bed, cannot stand up and walk. She cannot bear full body weight on left leg, she is at high risk of fall.</p>	<p>2 hours to avoid or minimize the impact of bedsores on patient's skin. The use of sling with total lift to prevent friction and shear.</p> <p>2.ROM is done regularly and encourage the patient to do so in order to avoid muscle and joints atrophy</p>	<p>she is helping on repositioning which is good for function of muscles and joints.</p>
<p>2. Constipation due to the use of medications calcium carbonate for her heartburn as evidenced by no bowel movement in the past 48 hours.</p>	<p>This was a concern for the patient and the care givers for not having bowel movements after many hours. This could lead the patient to</p>	<p>1. Initiate orders of laxatives to help her have bowel movement at least one a day and have some backup interventions in place to solve the problem.</p> <p>2.Assess for abdominal discomfort, distension, tenderness and advise the patient not to have Valsalva maneuver as this may drop her PB to drop and the heart rate to go up.</p>	<p>No Valsalva maneuver by the patient, no abdominal distension or tenderness. Patient had bowel movement before the end of the shift. The goals were met.</p>

Other References (APA):

Swearingen, P.L., & Wright, J.D. (2019). All-in -one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health. St. Louis, MO: Elsevier.

Concept Map (20 Points):

Subjective Data

Patient reports that she has a GI bleeding. Also complains about constipation and fatigue.

Nursing Diagnosis/Outcomes

Impaired mobility due to multiple fractures
High risk for bedsores

Constipation due the use of calcium carbonate:
patient to have bowel movement to
ease the discomfort

Goals met : patient had bowel movement
Treatment available

Objective Data

Na- level low due to urine retention
Glucose elevated due to uncontrolled
type 2 mellitus diabetes.
Neutrophils, lymphocytes, Monocytes,
Eosinophils were high due to the
presence of bacteria C. Diff

Patient Information

A 84 year-old female with
many underlying medical
conditions was admitted for GI
bleeding.

Nursing Interventions

P patient assessed for abdominal discomfort
Patient repositioned every 2 hours
Skin assessed for bedsores

ROMs regularly done to prevent
joints and muscles atrophy



