

N321 Care Plan #3

Lakeview College of Nursing

Matthew Catlett

Demographics (3 points)

Date of Admission 10/8/20	Patient Initials M. B.	Age 57	Gender Female
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Married	Allergies Norco
Code Status Full Code	Height 5'4"	Weight 319 lbs	

Medical History (5 Points)

Past Medical History: Hypothyroidism (2018), Cutaneous lymphorrhea (2019),

Hypertension (2018).

Past Surgical History: C-section

Family History: Mother-Lung cancer/carcinoma (cause of death), Father- aneurism, diabetes mellitus.

Social History (tobacco/alcohol/drugs): Former smoker of 16 years, occasional alcohol intake. No drug use.

Assistive Devices: None

Living Situation: Lives with significant other in single-level home.

Education Level: Completed high school, no secondary education.

Admission Assessment

Chief Complaint (2 points): Leg swelling

History of present Illness (10 points): 57 y/o client presented to emergency department one week prior to admission on floor with erythema and pain in lower right leg that presented two days prior. Client states that she had a fever accompanied with fatigue. Client claims pain is moderate and radiating throughout entire leg, up to back. Client states that keeping pressure off the leg and laying down alleviates pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cellulitis

Secondary Diagnosis (if applicable): Sepsis, morbid obesity, lymphedema, macrocytic anemia, edema, ulcer of lower extremity

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

Cellulitis is a bacterial infection of the skin that can be potentially serious. Cellulitis occurs when streptococcus or staphylococcus bacteria enter the skin through a crack, break, or cut. This infection can occur anywhere in the body, but it is mostly found in the lower extremities of the body.

Symptoms of cellulitis include redness, swelling, tenderness, pain, fever, blisters, and skin dimpling. It is important that cellulitis gets treated early. The earlier a patient sees a doctor concerning their cellulitis, the easier it is to treat. Doctors can usually diagnose cellulitis just by looking at the affected area, but blood tests or other labs might be needed.

Those who are at risk for cellulitis include people with weakened immune systems, diabetes, skin conditions like eczema and psoriasis, lymphedema, and obesity. In this clients' case, her lymphedema along with her morbid obesity are likely factors that lead to her cellulitis. If left untreated, cellulitis can lead to sepsis and necrotizing fasciitis. This clients' sepsis is caused by her untreated and unmanaged cellulitis.

For treatment, a doctor will likely start the patient on a broad-spectrum antibiotic until lab results return which will determine the specific type of bacteria that has invaded the open tissue. Upon this result, the doctor will finish out treatment of antibiotic, re-examine the infected area, and then determine if further antibiotic is necessary. If further antibiotic treatment is necessary, a

narrow spectrum antibiotic will be given to the patient to receive to better treat the infection.

This client was placed on cefepime and vancomycin via IV to treat her cellulitis.

There are a few preventative measures that people who are at risk for cellulitis can take. If you currently have a wound, cleaning it properly with soap and water, applying appropriate protective creams/ointments, and covering your wounds after cleaning them can all reduce the chance of obtaining cellulitis.

It is also good practice to inspect your extremities often, moisturize your skin, and protect you skin if you are at risk for cellulitis.

Pathophysiology References (2) (APA):

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

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	2.45		Low RBC/Macrocytic anemia caused hypothyroidism.
Hgb	14-16 g/dL	7.7		Low Hgb caused by hypothyroidism
Hct	35%-47%	25.6		Low Hct caused by hypothyroidism
Platelets	150-400 c/mm ³	371		
WBC	4.5-11 c/mm ³	8.9		

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Neutrophils	1.7-7.0 x 10 ⁹ /L	6.5		
Lymphocytes	0.9-2.9 x 10 ⁹ /L	1.28		
Monocytes	0.3-0.9 x 10 ⁹ /L	0.63		
Eosinophils	0.05-0.5 x 10 ⁹ /L	0.47		
Bands	0-0.5 x 10 ⁹ /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	139	-	-
K+	3.5-5.0 mEq/L	4.2	-	-
Cl-	98-107 mEq/L	112	-	High Cl caused by high salt intake or renal disease.
CO2	23-28 mEq/L	16	-	Low CO2 caused by kidney disorders or hormonal disorders.
Glucose	70-100 mg/dL	96	-	
BUN	8-25 mg/dL	25	-	-
Creatinine	0.7-1.3 mg/dL	1.96	-	High creatinine caused by poor kidney function and hypertension.
Albumin	3.5-5.2 mg/dL	3.2	-	Low albumin caused by sepsis and poor diet.
Calcium	8.4-10 mg/dL	8.4	-	-
Mag	1.5-2.4 mg/dL	1.8	-	-
Phosphate	3.0-4.5 mg/dL	8.5	-	Increase in phosphate caused by severe infection.
Bilirubin	0-0.3 mg/dL	0.2	-	-
Alk Phos	36-92 u/L	53	-	-

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AST	0-35 u/L	12	-	-
ALT	0-35 u/L	9	-	-
Amylase	0-130 u/L	N/A	-	-
Lipase	<95 u/L	N/A	-	-
Lactic Acid	0.4-2.3 mEq/L	1.23	-	-

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	N/A	-	-
PT	11-13 sec.	N/A	-	-
PTT	25-35 sec.	N/A	-	-
D-Dimer	≤ 300 ng/mL	N/A	-	-
BNP	<100 pg/mL	N/A	-	-
HDL	≥40 mg/dL	N/A	-	-
LDL	≤ 130 mg/dL	N/A	-	-
Cholesterol	150-199 mg/dL	N/A	-	-
Triglycerides	≤ 150 mg/dL	N/A	-	-
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	Value on	Today's	Reason for Abnormal
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	Range	Admission	Value	
Color & Clarity	Clear to slightly hazy	Yellow/clear	N/A	N/A
pH	4.5-8	N/A	N/A	N/A
Specific Gravity	1.005-1.035	N/A	N/A	N/A
Glucose	None	N/A	N/A	N/A
Protein	None	N/A	N/A	N/A
Ketones	None	N/A	N/A	N/A
WBC	None or rare	N/A	N/A	N/A
RBC	None or rare	N/A	N/A	N/A
Leukoesterase	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	N/A	N/A
Blood Culture	None present	N/A	N/A	N/A
Sputum Culture	None present	N/A	N/A	N/A
Stool Culture	None present	N/A	N/A	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): Chest x-ray

Diagnostic Test Correlation (5 points): Client was given chest x-ray to determine if any fluids present in the lungs, chest x-ray positive for fluid in lower lobes bilaterally.

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

**Current Medications (10 points, 1 point per completed med)
*10 different medications must be completed***

Home Medications (5 required)

Brand/Generic	Aspirin	bisoprolol	Microzide (hydrochlorothiazide)	Lasix (furosemide)	Azulfidine (sulfasalazine)
Dose	81 mg	10 mg	6.25 mg	40 mg	500
Frequency	1/day	1/day	1/day	1/day	2/day
Route	PO	PO	PO	PO	PO
Classification	NSAID	Antihypertensive	Diuretic	Diuretic	Anti-inflammatory
Mechanism of	Blocks the	Inhibits	Promotes movement	Inhibits	Delivers

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Action	activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis.	stimulation of beta₁ receptors in the heart.	of sodium, chloride, and water from blood into DCT of nephrons.	sodium and water reabsorption in the loop of Henle.	sulfapyridine and mesalamine to the colon.
Reason Client Taking	Manage signs and symptoms or rheumatoid arthritis; relieve mild to moderate pain.	Manage hypertension	Manage edema/hypertension	Manage edema	Manage arthritis
Contraindications (2)	Active bleeding or coagulation disorders; current or recent GI bleed or ulcers.	Cardiogenic shock, heart block	Anuria; hypersensitivity to the drug	Anuria; hypersensitivity to the drug	Porphyria; intestinal/urinary obstruction
Side Effects/Adverse Reactions (2)	CNS depression; hepatotoxicity	Bradycardia, heart failure	Renal failure, pancreatitis	Thromboembolism, hyponatremia	Leukopenia, nephritis
Nursing Considerations (2)	Do not crush timed-release or controlled release aspirin tablets unless directed; Ask about tinnitus. This reaction usually occurs when blood aspirin level reaches or exceeds maximum dosage for therapeutic effect.	Administer cautiously in patients with PAD. Monitor diabetic patients closely for hypoglycemia.	Give in the morning and early evening to avoid nocturia. Monitor blood pressure, daily weight, and I & O frequently.	Monitor for hypokalemia Obtain weight before and during therapy.	Use cautiously in patients with chronic infections Monitor BUN and creatinine levels.

Hospital Medications (5 required)

Brand/Generic	Maxipime (cefepime)	Lasix (furosemide)	Cozaar (losartan)	Vancocin (vancomycin)	Zofran (ondansetron)
)Dose	2 g/100 ml	40 mg	50 mg	500 mg	4 mg
Frequency	Q12h/5days	1/day	1/day	Q24h/3 days	Q6h
Route	IV	IV push	PO	IV	IV push
Classification	Antibiotic	Diuretic	Anti-hypertensive	Antibiotic	Antiemetic
Mechanism of Action	Interferes with bacterial cell wall synthesis.	Inhibits sodium and water reabsorption in the loop of Henle.	Blocks binding of angiotensin II to receptor sites.	Inhibits bacterial RNA and cell wall synthesis.	Blocks serotonin receptors in the chemoreceptor trigger zone at vagal nerve terminals.
Reason Client Taking	To treat infection	Manage edema	Hypertension	To treat infection	Nausea and vomiting
Contraindications (2)	Hypersensitivity	Anuria; hypersensitivity to the drug	Aliskiren therapy; Hypersensitivity	Hypersensitivity to corn/vancomycin	Congenital long QT syndrome; hypersensitivity
Side Effects/Adverse Reactions (2)	Hepatic failure; thrombocytopenia	Thromboembolism, hypo-natremia	Hypotension; Angioedema	Hypotension; Neutropenia	Laryngospasm; angioedema
Nursing Considerations (2)	Use cautiously in patients with impaired renal function.	Monitor for hypokalemia Obtain weight before and during	African Americans may not benefit from this	Not indicated for prophylaxis of	Monitor closely for serotonin syndrome

	Use cautiously in patients with hypersensitivity to other cephalosporins.	therapy.	drug. Monitor potassium levels.	endophthalmitis	Monitor ECG
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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 awake and alert but agitated. -Client poorly groomed. -Client in distress due to pain.
INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises:	Skin color normal Skin extremely warm near wounds, regular throughout other areas. Multiple wounds visible on lower extremities. Yellow tinged drainage present from wounds. Further skin breakdown likely. Skin turgor normal, no tenting present.

<p>Wounds: . Braden Score: 12 Drains present: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: Wounds on lower extremities</p>	<p>Bruises present on lateral side of right thigh.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>-symmetrical; without deviation -TM pearly, no drainage present -Sclera's are white, positive RLR, EOM's present, no drainage present -No septal deviation, turbinates moist and pink. -Dentition is poor.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema: Legs, bilateral</p>	<p>-Heart sounds quiet, S1 and S2 present. -Poor capillary refill >3 seconds -Pulses present bilaterally on upper and lower extremities. 2+ throughout. -Edema present in both lower extremities. -Client has PICC line present.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>Breath sounds present bilaterally, vesicular Client has trouble breathing</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: 5'4" Weight: 319 lbs Auscultation Bowel sounds: Last BM: Yesterday (10/14/20) 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:</p>	<p>-Client maintains poor diet at home. -GI sounds normoactive throughout. -No pain present upon palpation. -No masses present.</p>
<p>GENITOURINARY (2 Points):</p>	<p>-Intake greater than output.</p>

<p>Color: Yellow Character: Clear 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 type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>-No catheter present -Client has no issues with urination.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 85 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>-Limited range of motion -Client has poor strength due to lack of muscle use. -Client refuses help with ambulation. -Client refuses appropriate supportive devices to move around, instead uses furniture as a means of maintaining balance.</p>
<p>NEUROLOGICAL (2 points): 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>-Client alert and oriented x3 -Client strength equal bilaterally -No signs of impaired mental status or LOC.</p>
<p>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 available family support):</p>	<p>-Client uses excessive eating as coping mechanism. -Client does not identify with any religion. -Client states that she does not have contact with any family.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0630	71	117/69	20	97.5	93% room

					air
0730	69	127/72	18	97.0	100% room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	Right leg	7	Sharp, radiating	Pain medication
0830	Numeric	Right leg	5	Radiating	Pain medication

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22G Location of IV: Right antecubital Date on IV: 10/15/20 Patency of IV: Signs of erythema, drainage, etc.: N/A IV dressing assessment: Dressing intact, no drainage.	Normal saline @ 50 mL/hr at 0800 on 10/15/20

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1680 mL	1350 mL

Nursing Care

Summary of Care (2 points)

Overview of care: Client was given appropriate medications on time with nursing supervision. Client's call light was also answered by nursing student or CNA's that were present.

Procedures/testing done: Chest x-ray, PICC line.

Complaints/Issues: Client was unhappy with student checking on client at appropriate times and was displeased during students' assessment.

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Client was tolerating current diet. Client stayed in chair and refused any movement or switching to bed.

Physician notifications: N/A

Future plans for patient: Patient will be placed in nursing home for further treatment.

Discharge Planning (2 points)

Discharge location: Nursing home pending SARS CoV-2 results.

Home health needs (if applicable): N/A

Equipment needs (if applicable): Client should be moving with assistive device although refuses to use walker or cane.

Follow up plan: Client should present to clinic for check ups concerning skin integrity and diet.

Education needs: Education on proper diet (DASH), pathophysiology of cellulitis, hypertension, lymphedema.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	Rational <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Intervention (2 per dx)	Evaluation <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. Excess fluid volume related to renal insufficiency as evidenced by edema	This client shows signs of extreme edema in both lower extremities.	-Monitor I & O; daily weight -Restrict sodium intake	Patient’s fluid excretion did not increase. Patient’s intake greater than output.
2. Violation of the integrity of the skin related to cellulitis as evidenced by lower extremity wounds.	Client’s cellulitis caused by breaking of skin from poor maintenance.	-Provide proper dressings to promote wound healing -Provide antibiotics to stop further growth of infection and prevent further skin breakdown.	Patient’s infection clearing up slowly. Patient displeased with dressing changes according to staff.
3. Inability to adapt to a change in health status related to morbid obesity as evidenced	Client has suffered from obesity for more than 2 years and has not taken proper steps to reduce weight and treat health issues,	-Place client on strict diet intended for weight loss and reduction in sodium intake. -Place client on strict regimen of medications to treat current health issues or prevent further health issues	Patient displeased with physicians orders to be placed on specific diet.

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Other References (APA):

Concept Map (20 Points):

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Subjective Data

- Agitated
- Non-compliant when nurses are not present
- Client uninterested in help from nursing students.

Nursing Diagnosis/Outcomes

Objective Data

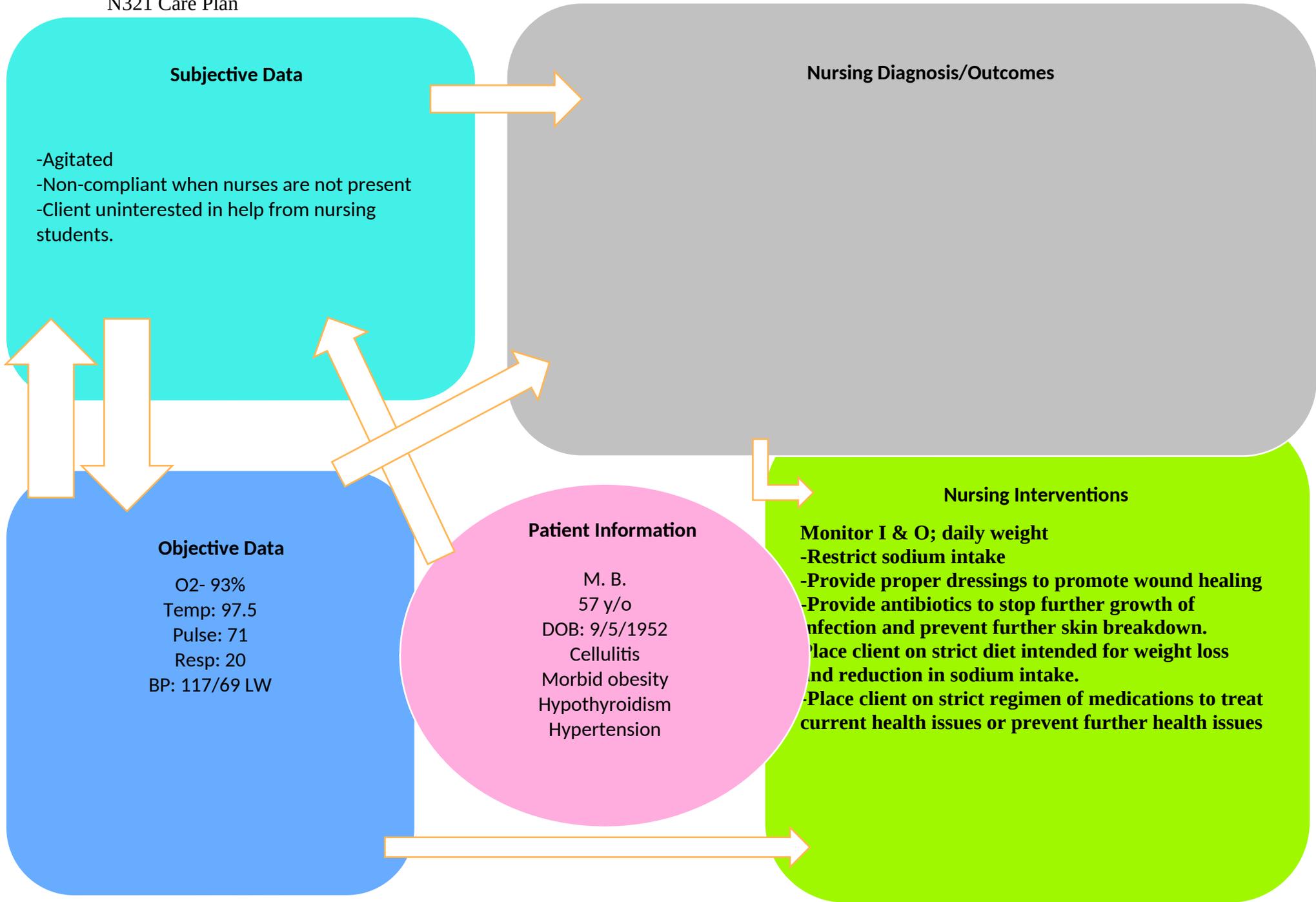
- O2- 93%
- Temp: 97.5
- Pulse: 71
- Resp: 20
- BP: 117/69 LW

Patient Information

- M. B.
- 57 y/o
- DOB: 9/5/1952
- Cellulitis
- Morbid obesity
- Hypothyroidism
- Hypertension

Nursing Interventions

- Monitor I & O; daily weight
- Restrict sodium intake
- Provide proper dressings to promote wound healing
- Provide antibiotics to stop further growth of infection and prevent further skin breakdown.
- Place client on strict diet intended for weight loss and reduction in sodium intake.
- Place client on strict regimen of medications to treat current health issues or prevent further health issues



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