N311 Care Plan # late care plan

Lakeview College of Nursing

Ayeah Vivian Kuma-Biloh

Demographics (5 points)

Date of Admission **10/26/2020**	Patient Initials M.S	**Age** **88**	**Gender** **Female**
Race/Ethnicity **White**	**Occupation** **Retired**	**Marital Status** **widow**	**Allergies** **Demerol**
Code Status **No CPR**	**Height** **5'1**	**Weight** **98lbs**	

Medical History (5 Points)

Past Medical History: Arthritis, Asthma, C.difficile, Hypertension

Past Surgical History: AV node ablation, Cataract removal, Hysterectomy

Family History: Mother: Heart disease, Father: Hypertension

Social History (tobacco/alcohol/drugs): Pt reports that she has never smoked and does not drink alcohol.

Admission Assessment

Chief Complaint (2 points): Confusion

History of present Illness (10 points): M.S is a pleasant 88-year-old female patient who was brought to the emergency room by her daughter. She was not oriented to time and place. Daughter stated that her mother started acting weird 2 days ago, she could not tell what day it was or where she was. Daughter states that she thought it was due to lack of sleep, so she encouraged her mom to take frequent naps, but her mom's condition only got worse, so she decided to bring her to the hospital. Patient stated that she felt her muscle weakness and headache, no medication was given to relief her pain and headache.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Hyponatremia

Secondary Diagnosis (if applicable):N/a

Pathophysiology of the Disease, APA format (20 points): Hyponatremia is a sodium serum level of less than 135mEq/L (Capriotti 2020). The irrefutable picture of hyponatremia centers around water. When dehydration occurs due to the fact that the body has lost sodium and fluid is called Hypovolemic hyponatremia. Hyponatremia also occurs in the presence of hypervolemia (excess water). In this situation, hyponatremia develops because sodium is diluted within an excess of water which is one of the reasons why it is dilutional hyponatremia. Hyponatremia commonly occurs when water excretion is impaired, and sodium is diluted within the large volume of water in the blood stream. This is clinically significant when hyponatremia is part of a drop in the serum total osmolarity, which is measured by the calculation: 2(Na) mEq/L+ Serum glucose(mg/dL)/18 +BUN (mg/dL)/2.8. (Capriotti 2020). When there is an acute drop in the serum osmolarity, neuronal cell swelling occurs because of the water shift from the extracellular space to the intracellular space. Swelling of the brain cells occurs results in the following consequences; first, it inhibits the ADH secretion from the neurons in the hypothalamus and hypothalamic thirst center which leads to excess water elimination as dilute urine. Secondly, there is an immediate cellular adaptation with the loss of electrolytes and leads to a more gradual loss of organic intracellular solutes (Capriotti 2020).

Causes of Hyponatremia include: Adrenal insufficiency, Burns, cirrhosis, congestive heart failure, diaphoresis with more salt lost than water, diarrhea, Diuretic therapy, excess hypotonic fluid admistration, Hyperglycemia, hypoaldosteronism, Laxatives, Nasogastric suction, psychogenic polydipsia, renal disease. Severe hyponatremia can also cause coma, seizures and irreversible neurological damage due to pain and swelling(Capriotti 2020).

Signs and symptoms of hyponatremia may include: Nausea and vomiting, headache, confusion, loss of energy, fatigue, drowsiness, muscles weakness, spasms and cramps, seizures and coma.

Treatment of hyponatremia is based on its causes. In a dehydrated patient, slow replacement of sodium will with the right amount of fluid intake is the easiest method. Slow treatment is necessary, rapid correction of Serum Sodium can precipitate severe neurological complications (Capriotti 2020). Incase that does not help, aggressive measures will be needed such as the replacement with normal saline or hypertonic saline solution. If the cause of hyponatremia is Syndrome of Inappropriate ADH, its treatment requires restriction of water intake and investigating the source of ADH. If the cause is Fluid overload, diuretics will be used to remove excess water (Capriotti 2020).

The reason my patient has Hyponatremia may be due to fluid overload(excess fluid in the body), risk of electrolyte imbalance or it may be due to some medications she is on like Polyethylene glycol 17g which helps relieving constipation and prompts my patient to have frequent bowel movements. This medication if taken frequently may cause my patient to have diarrhea which is one of the causes of Hyponatremia. My patient complained of lack of appetite which makes her not to eat all the nutrient needed by the body. This may be one of the reasons why she has hyponatremia.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (Second ed.). Philadelphia: F.A. Davis.

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	3.80-5.30	3.38	4.2	
Hgb	12-15.8	12.4	N/a	
Hct	36.0-47.0	36.4	N/a	
Platelets	140-440	322	N/a	
WBC	4.00-12.00	9.70	N/a	
Neutrophils				
Lymphocytes				
Monocytes				
Eosinophils				
Bands				

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-	133-144	111	128	**Due to deficient dietary intake(decrease sodium intake)**

K+	3.5-5.1	4.3	4.7	
Cl-	98-107	78	95	
CO2	21-31	25	28	
Glucose				
BUN	7-25	24	19	
Creatinine	0.50-1.20	0.48	0.58	
Albumin	N/a	N/a	N/a	
Calcium	8.6-10.3	9.3	8.4	
Mag				
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	Clear	Clear	cloudy	
pH	5.0-9.0	5.0	7.0	
Specific Gravity	1.003-1.030	1.020	1.012	
Glucose				
Protein	negative	negative	negative	
Ketones				

WBC	negative	negative	negative	
RBC				
Leukoesterase				

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				**No culture collected for this pt**
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

CT scan Brain: No acute intracranial abnormalities and no evidence of acute skull fracture.

CT C-Spine: No acute cervical spine fracture noted**.**

Current Medications (10 points, 2 points per completed med)
5 <u>different</u> medications must be completed

Medications (5 required)

Brand/Generic	Lasix/ Furosemide	Lisinopril	Panto Prazole	Melatonin tablet	Acetaminophen (Tylenol**)**
Dose	20g	5mg	40mg	3mg	650mg
Frequency	daily	daily	daily	Nightly prn	Q4hrs
Route	oral	oral	oral	oral	oral

Classification	Antihypertensive/ Diuretic	Antihypertensive	Antiulcer		analgesic
Mechanism of Action	Inhibits sodium and water reabsorption in the Loop of Henle and increases urine formation.	May reduce blood sugar by inhbiting conversion of angiotensin I to Angiotensin II. Angiotensin II is a potent vasoconstrictor that also stimulates adrenal cortex to secrete aldosterone.	Interferes with gastric acid secretion by inhibiting the hydrogen potassium - adenosine Triphosphatase enzyme system or proton pump, in gastric Parietal cells.	Melatonin is a derivative of tryptophan. It binds to melatonin receptor type 1A, which then acts on adenylate cylcase and the inhibition of a cAMP signal transduction pathway. Melatonin not only inhibits adenylate cyclase, but it also activates phosphilpase C.	Inhibits the enzyme cyclooxygenase Blocking prostaglandin production and inferring with pain impulse generation in peripheral Nervous system
Reason Client Taking	Prevents edema	Hypertension	Constipation	Insomnia	Pain
Contraindications (2)	Anuria unresponsive to furosemide; hypersensitivity to furosemide, sulfonamides, or their	Concurrent aliskiren use in patients with diabetes or patients with renal impairment, hereditary or	Concurrent therapy with rilpiviirine containing products. Hypersensitivity to pantoprazole.		Hypersensitivity To acetaminophen with any other medication. Diazepam

	components	idiopathic angioedema or history of angioedema related to previous treatment with an ACE inhibitor.			and chlorpromazine, severe hepatic impairment, severe active liver.
Side Effects/Adverse Reactions (2)	Dizziness, Blurred vision	Confusion Depression Fatigue	Anxiety, confusion	Dizziness Headache sleepiness	Hypersensitivity To acetaminophen

Medications Reference (APA):

Institute for Safe Medication Practices: ISMP Medication Safety Alert. http://www.ismp.org/.

Jones & Bartlett Learning. (2019). 2019 Nurse's Drug Handbook. Burlington, MA

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Pt appears alert and oriented x3. Pt is well groomed and no acute distress.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Pink Dry/Normal Warm Normal turgor 2+ No rashes No bruises
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck symmetrical Trachea midline with no deviation Thyroid is not palpable, no noted nodules. No Visible drainage from eyes No visible drainage in nose or polyps. Dentition is good. .
CARDIOVASCULAR: **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:**	Clear S1 and S2 without murmurs galops or rubs. Normal peripheral pulse.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular, even and unlabored. Lung sounds clear throughout bilaterally, no wheezes, no crackles or rhonchi noted
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:**	Regular diet at home High sodium diet 5’1 98lbs Normoactive bowel sounds

Auscultation Bowel sounds: **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	No B.M No mass Pain level 3/10
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	yellow urine Not cloudy but clear Patient has no indwelling catheter
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐X** **Needs assistance with equipment ☐X** **Needs support to stand and walk☐X**	Arms and legs are strong. Strength in both upper and lower extremities All extremities pink, warm and dry and symmetrical with full strength and range of motion None, gait belt and walker to move around Patient needs limited assistance with activities of daily living. She is able to perform most of the activities on her own Fall score is 8 Pt need gait belt and one-person assistance to stand ambulate.
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:**	. Strong legs, Arms strong, Cognitive of space, time, and location, No gross focal neurological deficits Patient Patient is oriented to person place and time Mental status good

Speech: **Sensory:** **LOC:**	Patient is coherent in speech No LOC
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):**	Pt has a daughter who is very supportive. Daughter comes to visit as often as she can. Patient is a Christian Patient lives in an assisted living facility. She misses her friends and she can't wait to be back.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:30	72 (radial)	127/66 (Right arm)	16	98.0(oral)	98% Room air

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8:00	0/10	Lower back pain	4/10	Sharp pain	Pain medication administered by nurse

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
180 mLOrange juice 90 ml Cranberry juice 40% Oatmeal 180ml Prune juice Oatmeal: 60%	Voided 1x No B.m during my shift

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

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. Risk for electrolyte imbalance related to low sodium level as evidenced by lab result revealing low sodium level of 128.	Fluid balance indicators are important since either fluid excess or deficit may occur with hyponatremia**.**	**1.** Encourage fluids high in sodium such as meat, milk, egg and carrots. Use fruits juices instead of water**.** 2.Monitor intake and output	Goal met. Patient was offered orange and cranberry juice all through my shift and she drank as much as she could. Patient voided one time during my shift.
2. Risk of injury related to confusion. Evidenced by patient stating that " I feel dizzy when I stand, I am scared I am going to fall	Patients is at risk of falling due to weakness. Patient is able to walk if assisted. Patient needs a walker to maintain her balance	1. keep bed in low position. And keep side rails up to prevent falls. 2.Place call light within reach and encourage the patient to use call light whenever she	Goal met. Patient bed remain in low position during my shift, patient used the call light when ever she needed help with anything. Patient was happy that her call lights was answered promptly and she more confident about wanting to get out

and get hurt”		needs something	of bed and move around.

Other References (APA):

Concept Map (20 Points)

Subjective Data

Headache
Muscle pain
confusion

Nursing Diagnosis/Outcomes

Risk for electrolyte imbalance related to low sodium level as evidenced by lab result revealing low sodium level of 128.

Goal met. Patient was offered orange and cranberry juice all through my shift and she drank as much as she could. Patient voided one time during my shift.

Risk of injury related to confusion. Evidenced by patient stating that " I feel dizzy when I stand, I am scared I am going to fall and get hurt"

Goal met. Patient bed remain in low position during my shift, patient used the call light when ever she needed help with anything. Patient was happy that her call lights was answered promptly and she more confident

Objective Data
Temp: 97.8 F
Pulse: 72
B/p:127/66
RR: 16
Oxygen sat: 98%
Weight: 98Lbs
Height: 5'1

Patient Information

CT scan Brain: No acute intracranial abnormalities and no evidence of acute skull fracture.

CT C-Spine: No acute cervical spine fracture noted.

Nursing Interventions

Encourage fluids high in sodium such as meat, milk, egg and carrots. Use fruits juices instead of water.
Monitor intake and output
Keep bed in low position. And keep side rails up to prevent falls.
Place call light within reach and encourage the patient to use call light whenever she needs something