# N311 Care Plan 1

Lakeview College of Nursing

Happy Kalavadia

## Demographics (5 points)

| Date of Admission | Patient Initials | Age | Gender |
|---|---|---|---|
| 08/01/2020 | JJ | 78 | Female |
| **Race/Ethnicity** | **Occupation** | **Marital Status** | **Allergies** |
| White | Unable to obtain | Unable to obtain | None |
| **Code Status** | **Height** | **Weight** | |
| Full Code | 170 cm | 156 lb | |

## Medical History (5 Points)

**Past Medical History: Congestive Heart Failure , Diabetes and Urinary tract infection**

**Past Surgical History: None**

**Family History: Not mentioned in file.**

**Social History (tobacco/alcohol/drugs): No alcohol/tobacco/drugs**

## Admission Assessment

**Chief Complaint (2 points): Shortness of breath especially when lying down.**

**History of present Illness (10 points): Patient is 78 years old and is living in her home alone. The onset of pain was about 15 minutes after she had taken supper. She had severe shortness of breath and was immediately admitted to emergency department from her home. The location of the pain was in her chest area. The pain is severe in nature and constant. Patient had low BP and so she was given an IV bolus in ED. Her shortness of breath was very severe when she was lying down, and her condition improved when she was placed in fowler's position. The duration of pain was constant and sharp in nature. Patient was not able to describe characteristic or associated manifestations of the pain. She did not attempt any relieving medications nor any treatment due to severe intensity of the pain. The nurse measured her oxygen saturation and it was low. He sat the patient in head up position and the patient felt better. Her leucocyte count was elevated, and her urine was**

**cloudy with low urine output. She was diagnosed with urosepsis related to chronic urinary tract infection. After being admitted to hospital, her condition worsened, and she was having severe shortness of breath and mentally disoriented, so the nurse increased her oxygen supply from two liters to four liters. She received a large amount of IV fluid in hospital and condition improved . The patient was breathing hard but was stable. The patient's neighbor came to give her list of medications which were furosemide, glyburide, isosorbide dinitrate and digoxin. The medications list did not contain any instruction regarding when to take it. The nurse was not sure and decided to send to pharmacy for verification and did not give her any medications as the correct dose for medication was not mentioned . Since the patient did not take her cardiac medication , the nurse decided to give a call to provider as he thought that congestive heart failure would be causing her condition.**

## Primary Diagnosis

**Primary Diagnosis on Admission (3 points): Urosepsis due to UTI and shock**

**Secondary Diagnosis (if applicable): Congestive heart failure and Diabetes.**

**Pathophysiology of the Disease, APA format (20 points): Congestive heart failure is defined as chronic progressive condition which affects the pumping muscles of the heart. In congestive heart failure, there is fluid buildup in the heart which causes it to pump inefficiently (Capriotti and Frizzell, 2016). In the heart, ventricles pump the blood to the rest of our body but in congestive heart failure fluid backs up in lungs, abdomen and liver (Capriotti and Frizzell, 2016). Left sided CHF is the most common cause of heart failure since the left ventricle pumps to the rest of the body( Macon, 2019). There are two types of**

**congestive heart failure one is systolic and diastolic heart failure. Systolic heart failure can be defined as when the left ventricle cannot pump the blood to the rest of the body(Capriotti and Frizzell, 2016). In diastolic heart failure , the ventricles do not relax as it is very stiff and hence the heart cannot fill in between the beats ( Macon, 2019). The main difference between right and left sided failure is that in right side heart failure the fluid retention is in the lower extremities, abdomen and other large organs while in left sided failure , the fluid is backed up in the lungs (Capriotti and Frizzell, 2016). The main sign and symptom of CHF is shortness of breath especially when lying down. Other sign and symptoms are pitting edema in legs, anxiety, fatigue, wheezing and pulmonary edema. There are many causes of CHF, but the main ones are chronic hypertension, valve conditions such as stenosis or regurgitation and diabetes (Capriotti and Frizzell, 2016). To detect congestive heart failure, various diagnostic tests are performed like EKG and echocardiogram . Cardiac Catheterization can also reveal blockage of coronary arteries which allows the health care provider to view the extent of stenosis (Macon, 2019). Blood tests like BNP level in blood is done to estimate the extent of blockage in congestive heart failure. There are several medications used to treat congestive heart failure including ACE inhibitors like enalapril , captopril and ramipril. Beta blockers like atenolol and propranolol can reduce blood pressure and improve symptoms of congestive heart failure. Diuretics can reduce body's fluid content and hence decrease the mortality rates in congestive heart failure (Capriotti and Frizzell, 2016). Surgery like angioplasty which is a procedure to open blocked arteries is also performed to treat congestive heart failure.**

**Pathophysiology References (2) (APA):**

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

**Macon, B. (2019, February 21). Congestive Heart Failure: Types, Causes, Stages, and Treatment. Retrieved November 10, 2020, from https://www.healthline.com/health/congestive-heart-failure**

## 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 | NA | 4.8 million/ mm3 | Within normal range. |
| Hgb | 12.0-16.0 g/dL | NA | 11.3 g/dl | Within normal range. |
| Hct | 37.0-48.0% | NA | 33% | Within normal range. |
| Platelets | 150-400 10^3/uL | NA | 220,000 | Within normal range. |
| WBC | 4.1-10.9 10^3/uL | NA | 13,000 | Elevated due to infection secondary to UTI (Capriotti and Frizzell, 2016). |
| Neutrophils | 1.50-7.70 10^3/uL | NA | NA | Within normal range. |
| Lymphocytes | 1.00-4.90 10^3/uL | NA | NA | Within normal range. |
| Monocytes | 0.00-0.80 10^3/uL | NA | NA | Within normal range. |
| Eosinophils | 0.00-0.50 10^3/uL | NA | NA | Within normal range. |
| Bands | | NA | NA | |

**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 | NA | 135 | Patient has abnormal value due to urosepsis related to UTI (Capriotti and Frizzell, 2016). |
| K+ | 3.5-5.1 mmol/L | NA | 4.4 | Within normal range. |
| Cl- | 98-107 mmol/L | NA | 100 | Within normal range. |
| CO2 | 21.0-32.0 mmol/L | NA | NA | |
| Glucose | 60-99 mg/dL | NA | 92 | Within normal range. |
| BUN | 5-20 mg/dL | NA | 21 | Patient has increased value due to diminished kidney function secondary to UTI and urosepsis(Capriotti and Frizzell, 2016). |
| Creatinine | 0.5-1.5 mg/ dL | NA | 1.0 | Within normal range |
| Albumin | 3.4-5.4 g/dL | NA | 3.2 | Patient has diminished kidney function due to urosepsis . Kidney cannot perform its normal function . (Capriotti and Frizzell, 2016). |
| Calcium | 8.5-10.1 mg/dL | NA | 9 | Within normal range. |
| Mag | 1.6-2.6 mg/ dL | NA | NA | |
| Phosphate | - | NA | 3.7 | |
| Bilirubin | Less than 0.3 | NA | NA | |
| Alk Phos | 44-147 U/L | NA | NA | |

**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 | Light yellow | NA | Slight amber | Patient has UTI , so urine cannot be eliminated easily.Retention of urine causes amber color.( Capriotti and Frizzell, 2016). |
| pH | 5.0-7.0 | NA | 5.6 | Within normal range. |
| Specific Gravity | 1.003-1.030 | NA | 1.039 | Specific gravity is high because of UTI infection .( Capriotti and Frizzell, 2016). |
| Glucose | negative | NA | negative | Within normal range. |
| Protein | negative | NA | negative | Within normal range. |
| Ketones | negative | NA | negative | Within normal range. |
| WBC | 0-25 /ul | NA | 10 | Within normal range. |
| RBC | 0-25/ul | NA | 4 | Within normal range. |
| Leukoesterase | negative | NA | positive | Leukoesterase is positive because patient has UTI. ( Capriotti and Frizzell, 2016). |

**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 | NA | NA | NA | NA |
| Blood Culture | NA | NA | NA | NA |
| Sputum Culture | NA | NA | NA | NA |
| Stool Culture | NA | NA | NA | NA |

**Lab Correlations Reference (APA):**

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

**Diagnostic Imaging**

**All Other Diagnostic Tests (10 points):**

**Unable to obtain from the EMR.**

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

**Medications (5 required)**

| **Brand/Generic** | **Furosemide** | **Glyburide** | **Digoxin** | **Atenolol** | **Isosorbide** |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| | | | | | **dinitrate** |
| **Dose** | **40 mg** | **40 milli equivalent** | **40 milli equivalent** | **20 milli equivalent** | **10 milligrams** |
| **Frequency** | **Once a day** | **Once a day** | **Once a day** | **Once a day** | **Once a day** |
| **Route** | **Oral** | **Oral** | **Oral** | **Oral** | **Oral** |
| **Classification** | **Loop diuretics** | **Sulfonylureas** | **Digitalis glycosides** | **Beta Blocker** | **Nitrates** |
| **Mechanism of Action** | **It is a potent loop diuretic that works to increase the excretion of Na and water by kidneys their reabsorption from the proximal and distal as well as loop of Henle.** | **It increased the secretion of insulin in the beta cells of pancreas.** | **It induces an increase in intracellular sodium that drives an influx of calcium in the heart and causes increase in contractility.** | **It works by selectively binding to beta1 adrenergic receptors found in vascular smooth muscle and heart.** | **It is a vasodilator especially relaxation of vascular smooth muscle and dilation of arteries and vein.** |
| **Reason Client Taking** | **Due to congestive heart failure.** | **Due to type 2 diabetics.** | **Due to congestive heart failure** | **Due to congestive heart failure** | **Due to congestive heart failure.** |
| **Contraindications (2)** | **Diabetics Hyponatremia** | **Thyroid disease Diabetic ketoacidosis** | **Myocarditis Ventricular fibrillation** | **Complete heart block Sinus bradycardia** | **Heart attack Hypertrophic cardiomyopathy** |
| **Side Effects/Adverse Reactions (2)** | **Muscle cramps Thirst** | **Dizziness Diarrhea** | **Diarrhea Skin rash** | **Constipation diarrhea** | **Dizziness Headache** |

**Medications Reference (APA):**

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

## Assessment

**Physical Exam (18 points)**

| | |
|---|---|
| **GENERAL:**<br>**Alertness: Alert**<br>**Orientation: Disoriented**<br>**Distress: mental distress**<br>**Overall appearance:** | **Patient appears to be anxious, not alert and disoriented . She is aware of her surroundings, but she is in distress because she has dyspnea.** |
| **INTEGUMENTARY:**<br>**Skin color:**<br>**Character: dry**<br>**Temperature: warm**<br>**Turgor: normal( when pinched skin rebound normally)**<br>**Rashes: no**<br>**Bruises: no**<br>**Wounds: no**<br>**Braden Score: 12**<br>**Drains present: Y☒ N ☐**<br>**Type: Foley Catheter** | **Skin is dry and scaly and not pink. Skin is warm to touch . Skin turgor is normal. There is no ecchymosis or any rash present. Nailbed pink with no cyanosis or clubbing.** |

| | |
|---|---|
| **HEENT:**<br>**Head/Neck:**<br>**Ears: Pinna of left and right ear appears symmetrical and it is nontender. Tympanic membrane white and pearly. Cerumen present in both ears. Slight loss of hearing in both ears.**<br>**Eyes:**<br>**Nose:**<br>**Teeth:** | **Head and neck symmetrical, trachea midline no deviation, thyroid palpable, no noted nodules. Bilateral carotid pulses palpable.**<br>**• Eyes bilateral sclera white, bilateral cornea foggy, conjunctive pink, slight drainage in left eye.**<br>**• Nose septum midline turbinate's moist and pink.**<br>**• Mouth pharynx moist and pink, dentition is good and has many cavities, mucosa pink and moist with lesion on upper right side** |
| **CARDIOVASCULAR:**<br>**Heart sounds:**<br>**S1, S2, S3, S4, murmur etc.**<br>**Cardiac rhythm (if applicable):**<br>**Peripheral Pulses: palpable**<br>**Capillary refill: 2 second**<br>**Neck Vein Distention: Y ☒ N ☐**<br>**Edema Y ☒ N ☐**<br>**Location of Edema:**<br>**Left leg** | **.Clear S1 and S2 heard without gallops or rubs. Pt in normal sinus rhythm with PVC'S, Peripheral pulses palpable. Capillary refill less then 3sec. Edema noted in left leg.** |
| **RESPIRATORY:**<br>**Accessory muscle use: Y☒ N ☐**<br>**Breath Sounds: Location, character**<br>**Anterior lung sounds have wheezing present.** | **Respiration irregular. When anterior lung sounds are auscultated , there is wheezing present in bilaterally. Mild crackles are heard because of congestive heart failure.** |
| **GASTROINTESTINAL:**<br>**Diet at home: Regular**<br>**Current Diet: Low sodium diet**<br>**Height: 170 cm**<br>**Weight: 196 lb**<br>**Auscultation Bowel sounds:**<br>**Last BM: Unable to obtain**<br>**Palpation: Pain, Mass etc.:**<br>**Inspection: Stomach an extra layer of adipose tissue**<br>**Distention: No**<br>**Incisions: NA**<br>**Scars: NA**<br>**Drains: NA**<br>**Wounds: NA**<br>**Ostomy: Y ☐ N ☒**<br>**Nasogastric: Y ☐ N ☒**<br>**Size:** | **Bowel sounds are present and normoactive in all four quadrants .Abdomen is soft, symmetric with no pain or tenderness. Aorta is midline with bruit or visible pulsation. No hepatomegaly or splenomegaly noted.** |

| | |
|---|---|
| **Feeding tubes/PEG tube Y ☐ N ☒**<br>**Type:** | |
| **GENITOURINARY:**<br>**Color: Light amber**<br>**Character: Cloudy**<br>**Quantity of urine: 100 ml**<br>**Pain with urination: Y ☐ N ☒**<br>**Dialysis: Y ☐ N ☒**<br>**Inspection of genitals:**<br>**Catheter: Y ☒ N ☐**<br>**Type: Foley catheter**<br>**Size: unable to obtain( not mentioned in EMR).** | **Patient does not have pain with urination. Urine is light amber color and is cloudy with leukocyte esterase positive.** |
| **MUSCULOSKELETAL:**<br>**Neurovascular status: stable**<br>**ROM:**<br>**Supportive devices: No**<br>**Strength:**<br>**ADL Assistance: Y☒ N ☐**<br>**Fall Risk: Y ☒ N☐**<br>**Fall Score: 8**<br>**Activity/Mobility Status:**<br>**Independent (up ad lib) ☐**<br>**Needs assistance with equipment ☒**<br>**Needs support to stand and walk☒** | **Patient is stable but not independent to walk. She requires support of assistive devices and assistance with equipment.** |
| **NEUROLOGICAL:**<br>**MAEW: Y ☐ N☒**<br>**PERLA: Y ☐ N☒**<br>**Strength Equal: Y ☐ N ☒ if no -**<br>**Legs ☒ Arms ☐ Both ☐**<br>**Orientation: Orientated**<br>**Mental Status: Alert to person, place and time**<br>**Speech: Understandable**<br>**Sensory: Able to feel sensation**<br>**LOC: Alert** | **Patient is alert, awake and oriented to place ,person and time. Motor function is normal with muscle strength 5/5 bilaterally. Reflexes 2+ bilaterally. No gait abnormalities are noted.** |
| **PSYCHOSOCIAL/CULTURAL:**<br>**Coping method(s):**<br>**Developmental level:**<br>**Religion & what it means to pt.:**<br>**Personal/Family Data (Think about home environment, family structure, and available family support):** | **Patient is living alone in her home by herself . She has a neighbor and her relationship is good with her as she came to give her medication to nurse.** |

**Vital Signs, 1 set (5 points)**

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| **0700** | **88**<br><br>**Radial pulse** | **128/84**<br><br>**Arm not**<br><br>**mentioned** | **22/min** | **99 F**<br><br>**Oral** | **91% oxygen** |

**Pain Assessment, 1 set (5 points)**

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| **Unable to obtain** | **8** | **Hip** | **Severe** | **Pain is sharp and dull in nature.** | **Acetaminophen to ease the pain.** |

**Intake and Output (2 points)**

| Intake (in mL) | Output (in mL) |
|---|---|
| **IV 2300 ml**<br><br>**IV PB- 30 ml**<br><br>**Total 2600 ml** | **Indwelling catheter – 100 ml**<br><br>**Total- 100 ml** |

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

| **Nursing Diagnosis**<br>• Include full nursing diagnosis with "related to" and "as evidenced by" components | **Rational**<br>• Explain why the nursing diagnosis was chosen | **Intervention (2 per dx)** | **Evaluation**<br>• How did the patient/family respond to the nurse's actions?<br>• Client response, status of goals and outcomes, modifications to plan. |
|---|---|---|---|
| **1. Ineffective breathing pattern related to congestive heart failure as evidenced by difficulty breathing and patient requiring supplemental oxygen by nasal canula.** | **Patient is in severe distress and unable to breath adequately due to failure to consume congestive heart failure medications .** | **1. Patient was positioned in high fowler's position to improve her airway problem.**<br><br>**2.Maintain 98% arterial oxygen saturation.**<br>**3. offered bed bath to improve blood circulation and improve in breathing pattern.** | **1.Patient revealed a great relief when she was positioned in fowler's position.**<br>**2. By maintaining O2 saturation , patient breathing improved and her shortness of breath decreased.**<br><br>**2. Patient liked the bed bath as she mentioned that her condition improved, and she had a good sleep after the bath.**<br><br>**Even though these are simple measures , goals are met.** |
| **3. Acute pain as related fall from home as evidenced by requirement of Buck's traction for hip fracture.** | **Patient has pain as she has history of fall in her home and injured her hip area severely.** | **1. Patient was offered icepacks to relieve the pain at the hip area.**<br><br>2.**Patient was given Buck's traction to relieve the pain instead of hip surgery due to her comorbities.** | **Patient refused to have icepacks and told that she will ask for it if she wants it.**<br><br>**2. Patient did not like to have buck's traction and wanted to have hip surgery.**<br><br>**Although patient refused intervention , goals were met because patient's pain decreased.** |

**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 presents with severe shortness of breath when she was at her home. She fell from her home and hence he was having severe pain at hip .**

**Nursing Diagnosis/Outcomes**

**Ineffective breathing pattern related to congestive heart failure as evidenced by difficulty breathing and requiring supplemental oxygen by nasal canula.**
Maintain 98% O2 saturation.
Patient should be placed in high fowler's position

**Acute pain as related fall from home as evidenced by requirement of Buck's traction for hip fracture.**
Offer ice pack or pain medications to relieve pain .
Buck's traction is less invasive than hip surgery so recommended to patient.

**Objective Data**

Patient looks very anxious as she cannot breathe normally and is in severe distress. Patient was given 2L oxygen as as her o2 stat was low. Patient had bed sores when examined during her bed bath.

**Patient Information**

Patient is 78 years old admitted on 08/01/2020 due to severe shortness of breath. Height is 170 cm and weight is 156 lb.

**Nursing Interventions**

Patient was positioned in high fowler's position to improve her airway problem.

Patient was also given bed bath to improve blood circulation and hence improve irregular breathing pattern.

Patient was offered icepacks to relieve the pain at the hip area.

Patient was given Buck's traction to relieve the pain instead of hip surgery due to her comorbities.