N321 Care Plan # 2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 2/3/21	**Patient Initials** MR	**Age** 68	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired Bank Teller	**Marital Status** Widowed	**Allergies** Doxycycline (nausea, documented on 9/19/17)
Code Status Full Code	**Height** 168 cm	**Weight** 91.8 kg	

Medical History (5 Points)

Past Medical History:

- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- End Stage Renal Failure
- Iron deficiency anemia
- Atrial Fibrillation
- Diabetes Mellitus Type II
- Hyperlipidemia
- Hypertension
- Hypothyroid
- Breast Cancer
- Sleep Apnea

Past Surgical History:

- Corneal Transplant, 1998
- Caesarean Section
- Breast Biopsy (right side)

- Vascular Surgery (Arteriovenous fistula), 6/4/19
- Mastectomy, 10/10/19

Family History:

Patient's mother had a stroke that was the start of her decline as well as type II Diabetes which was diagnosed earlier in life. Patient's father had heart disease. Patient's sister had breast cancer and received a mastectomy as well.

Social History (tobacco/alcohol/drugs):

Patient is a retired bank teller. Patient quit smoking on April 3, 1993. She indicates she smoked a pack a day for approximately twenty years prior to quitting. Patient denies any current alcohol or drug use. Patient is unable to recall the date of her last alcoholic drink, but states it was years ago. Patient is widowed and lives two houses down from her only son.

Assistive Devices:

Patient uses a cane at home to get around her house. While in the hospital she indicates she hasn't been using the cane as the room is small enough, she never gets to far away from wall.

Living Situation:

Patient states she lives at home alone in the Danville area. Patient typically spends her day cooking, cleaning, reading books, and watching television. Patient's son arrived to hospital to bring patient her cell phone charger and stayed roughly 20 minutes.

Education Level:

Patient graduated high school and started College at The College of Lake County but moved to Danville after one year. She finished her associate degree in business at Danville Area Community College.

Admission Assessment

Chief Complaint (2 points):

- Patient became weak, short of breath, and was experiencing chest pain.

History of present Illness (10 points):.

- Patient reports she had similar symptoms three weeks ago and had to have a thoracentesis procedure to remove pleural effusion. Patient has chronic kidney disease and therefore retains excess fluid. Patient is supposed to go to dialysis three times a week but upon discussion with her son she has been missing appointments. When the patient does go to dialysis she has requested to only have one liter removed for fear taking more would trigger her into atrial fibrillation. The patient has been on three different anticoagulants but had gastrointestinal bleeds with all of them.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):.

- Chronic Kidney Disease

Secondary Diagnosis (if applicable):.

- Congestive Heart Failure
- Pleural Effusion

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

Chronic Kidney Disease (CKD) is an irreversible progressive disease process (Hinkle & Cheever, 2018, p. 1569). The progression of CKD occurs in five stages; kidney damage with normal or increased glomerular filtration rate (GFR) greater than 90ml/min, mild reduction in GFR 60-89 ml/min, moderate reduction in GFR 30-59 ml/min, severe reduction in GFR 15-29

ml/min, and kidney failure GFR lower than 15 ml/min. The patient today is in stage 4 with a GFR between 15-29 ml/min. The nephrons in stage 4 become overwhelmed and the GFR is lower than 20% of normal.

CKD causes accumulation of nitrogenous wastes which them causes multiple system symptoms. The patient may become confused, disorientated, or enter into a stupor or coma. Thrombocytopenia and anemia can occur due to platelets and red blood cells lyse because of the high nitrogen level within the blood. Thrombocytopenia can cause bruising and spontaneous bleeding while anemia can cause weakness, fatigue, and dyspnea. In this patient hyperkalemia is present which can lead to muscle weakness and life-threatening cardiac dysrhythmias.

Signs and symptoms of CKD will develop over time as the kidney damage progresses slowly. A patient could present with shortness of breath from fluid building up in lungs, chest pain, high blood pressure, nausea, vomiting, loss of appetite, sleep problems, fatigue and weakness, and changes in urination. The signs and symptoms are nonspecific as they can be caused by other diseases. The kidneys are adaptable and able to compensate for loss of function in the beginning but as the disease progresses the damage becomes irreversible.

Lab abnormalities of kidney disease would include complete blood count (CBC) with differential, serum electrolytes, serum creatinine, total albumin, blood urea nitrogen (BUN) and a urinalysis. The sodium, potassium, and bicarbonate will all by elevated. Hyperkalemia can lead to cardiac dysrhythmias which would require an electrocardiogram monitoring. BUN and creatinine levels will be elevated due to the nitrogenous waste accumulating in the bloodstream. The total albumin will be elevated due to glomerular damage which will lead to loss of protein in the urine.

Diagnostic tests for diagnosing CKD would include an x-ray, ultrasound, CT and/or MRI. These tests can locate any intrarenal masses, cysts, or calcium stones (Capriotti, 2020, p.540). It is important to not use the intravenous contrast as it can cause a decrease in renal function. CKD causes a decrease in renal function so adding the contrast will cause further damage.

Treatment for CKD includes managing fluid and electrolyte balances as they are critical. Blood pressure medication will also be used to help maintain a normal level for the patient. Dialysis is also started on patients who have a GFR between 10-20 ml/min. A patient may also be elevated for a kidney transplant.

My patient presented to the emergency room with shortness of breath and chest pain. A heart attack was ruled out. Her labs were drawn, and her admission creatinine value was 2.3 and on the day of clinical was 2.93. The doctor then ordered an ultrasound as the patient had been at dialysis and had 1 liter taken off. Pleural effusion was diagnosed, and plan of care was updated to be dialysis more frequently. On the day of clinical the patient went for another round of dialysis and allowed them to take 3 liters off. Upon a new ultrasound she still had a large quantity of fluid and a thoracentesis was performed. Patient was advised of needing to continue dialysis four times a week or she will likely get a chest tube to constantly drain the excess fluid off.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2020). *Pathophysiology Introductory Concepts and Clinical Perspectives* (2nd ed.). F.A. Davis Company.

Hinkle, J. & Cheever, K. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Wolters Kluwer.

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	3.8 - 5.3	3.92	3.58	Red blood cells are decreased in patients with kidney disease. This patient has chronic kidney disease which is the cause. (Pagana & Pagana, 2017, p.720)
Hgb	12.0 – 15.8	12.8	11.6	Hemoglobin are decreased in patients that are anemic. This patient has iron deficiency anemia. (Pagana & Pagana, 2017, p. 420)
Hct	36 -47	37.9	34.8	Hematocrit are decreased in patients that are anemic. This patient has iron deficiency anemia. (Pagana & Pagana, 2017, p. 422)
Platelets	140 – 440	225	207	Within Normal Limits
WBC	4 – 12	6.8	5.3	Within Normal Limits
Neutrophils	47 – 73	72.6	68.8	Within Normal Limits
Lymphocytes	18 – 42	7.5	8	Lymphocytes are decreased in patients with kidney disease. This patient has chronic kidney disease. (Pagana & Pagana, 2017, p. 724)
Monocytes	4 – 12	13	14.4	Monocytes are increased in patients with kidney disease. This patient has chronic kidney disease. (Pagana & Pagana, 2017, p. 725)
Eosinophils	0 – 5	6.1	7.3	Eosinophils are increased in patients with kidney disease. This patient has chronic kidney disease. (Pagana & Pagana, 2017, p. 726)
Bands	N/A	N/A	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-	133 – 144	136	137	Within Normal Limits
K+	3.5 – 5.1	4.0	4.0	Within Normal Limits
Cl-	98 – 107	100	100	Within Normal Limits
CO2	21 – 31	29	28	Within Normal Limits
Glucose	70 – 99	117	120	Glucose is elevated in patients with diabetes. This patient has type II diabetes mellitus (Pagana & Pagana, 2017, p.640)
BUN	7 – 25	17	25	Within Normal Limits
Creatinine	0.5 – 1	2.3	2.93	Creatine is elevated in patients with kidney disease. This patient has chronic kidney disease. (Pagana & Pagana, 2017, p.730)
Albumin	3.5 – 5	N/A	N/A	-
Calcium	8.8 – 10.2	10.2	10.8	Calcium is elevated in patients with kidney disease. This patient has chronic kidney disease. (Pagana & Pagana, 2017, p. 532)
Mag	1.6 – 2.6	1.9	1.9	Within Normal Limits
Phosphate	N/A	N/A	N/A	-
Bilirubin	0.2 – 1.3	N/A	N/A	-
Alk Phos	38 – 126	N/A	N/A	-
AST	14 – 36	N/A	N/A	-
ALT	0 – 34	N/A	N/A	-
Amylase	N/A	N/A	N/A	-

Lipase	N/A	N/A	N/A	-
Lactic Acid	N/A	N/A	N/A	-

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	N/A	N/A	N/A	-
PT	N/A	N/A	N/A	-
PTT	N/A	N/A	N/A	-
D-Dimer	>600	N/A	N/A	-
BNP	N/A	N/A	N/A	-
HDL	>40	N/A	N/A	-
LDL	<130	N/A	N/A	-
Cholesterol	<200	N/A	N/A	-
Triglycerides	<150	N/A	N/A	-
Hgb A1c	4 – 6	N/A	N/A	-
TSH	0.27 – 4.2	N/A	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	N/A	N/A	-	N/A
pH	N/A	N/A	-	N/A

Specific Gravity	N/A	N/A	-	N/A
Glucose	N/A	N/A	-	N/A
Protein	N/A	N/A	-	N/A
Ketones	N/A	N/A	-	N/A
WBC	N/A	N/A	-	N/A
RBC	N/A	N/A	-	N/A
Leukocyte esterase	N/A	N/A	-	N/A

Lab Correlations Reference (APA): .

Pagana, K. D., & Pagana, T. J. (2017). *Mosby's Manual of Diagnostic and Laboratory Tests.* (6th ed.). Elsevier.

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	N/A	N/A	N/A	
Blood Culture	N/A	N/A	N/A	
Sputum Culture	N/A	N/A	N/A	
Stool Culture	N/A	N/A	N/A	

Lab Correlations Reference (APA): N/A

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- Electrocardiogram (ECG) on 2/3/21
    - The patient presented to the emergency room with chest pain, shortness of breath and overall weak feeling. A 12 lead ECG was then performed for patient's chest pain in the emergency room upon arrival to provide a view of the heart's electrical forces from a different position (Capriotti, 2020, p. 372). The cardiologist's note indicates normal sinus rhythm with possible left atrial enlargement. They could not rule out anterior infarct as age undetermined. No significant change was found since the previous ECG on 6/5/20.

- Chest X-Ray on 2/3/21
    - Lungs bilateral pulmonary vascular congestion with bibasilar pleural effusion with more showing on the right side than left. Underlying consolidation or atelectasis cannot be excluded. Mediastinum and bones both normal. The cardiologist's note indicates cardiomegaly pulmonary vascular congestion with congestive heart failure bilaterally. Bibasilar increased opacity right base underlying pleural effusion infiltrate or atelectasis cannot be ruled out. Findings are considered worse since the last study done post thoracentesis on 1/14/21.

Diagnostic Test Correlation & References (5 points):

Capriotti, T., & Frizzell, J. P. (2020). *Pathophysiology Introductory Concepts and Clinical Perspectives* (2nd ed.). F.A. Davis Company.

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

Home Medications (5 required)

Brand/Generic	Coreg Carvedilol (Jones & Bartlett, 2020, p. 186-188)	Cardizem Diltiazem (Jones & Bartlett, 2020, p. 345-347)	Feosol Ferrous Sulfate (Jones & Bartlett, 2020, p. 491-493)	Mucinex Guaifenesin (Jones & Bartlett, 2020, p. 572)	Letrozole Femara (Jones & Bartlett, 2020, p. 551)
Dose	12.5 mg	120 mg	325 mg	600 mg	2.5 mg
Frequency	BID	Daily	Daily	BID	Daily
Route	PO	PO	PO	PO	POC
Classification	Beta-blocker	Calcium channel blocker	Hematinic	Glyceryl guaiacolate	Non-steroidal aromatase inhibitor
Mechanism of Action	Reduces cardiac output and tachycardia, causes vasodilation and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload.	Inhibits calcium movement into coronary and vascular smooth-muscle cells by blocking slow calcium channels in cell membranes.	Acts to normalize red blood cell production by binding with hemoglobin	Increases fluid and mucus removal from the upper respiratory tract by increasing the volume of secretions.	Inhibits the aromatase enzyme by competitively binding to the heme of cytochrome P450 subunit of the enzyme
Reason Client Taking	Treat mild to severe chronic heart failure	Control hypertension	Treat iron deficiency	Promote a productive cough	Prevent cancer from returning
Contraindications (2)	Asthmas or related bronchospastic conditions Cardiogenic shock	Pulmonary edema Cardiogenic shock	Hemolytic anemias Hemosiderosis	Hypersensitivity No others listed	High cholesterol Severe liver disease
Side Effects/Adverse Reactions (2)	Hyperkalemia Hyponatremia	Bradycardia Heart failure	Hypotension Hemolysis	Dizziness Headache	Sweating Dizziness

Nursing Considerations (2)	Monitor patient's blood glucose level as ordered Avoid stopping drug abruptly	Monitor liver and renal function Assess patient for signs and symptoms of heart failure	Don't give antacids, coffee, dairy products, eggs, tea or whole grain breads or cereals within 1 hour before or 2 hours after iron Iron turns stool black or green and can mask blood in stool	Watch for evidence of more serious condition, such as cough that lasts longer than 1 week Don't break, chew, or crush E.R. tablets, swallow them whole.	Assess peripheral edema Assess dizziness, weakness, or vertigo that might affect gait or balance

Hospital Medications (5 required)

Brand / Generic	Cordarone Amiodarone	Cozaar Losartan	Duo-Neb Ipratropium Albuterol	Lasix Furosemide	Protonix Pantoprazole

	(Jones & Bartlett, 2020, p. 56-57)	(Jones & Bartlett, 2020, p. 730-731)	(Jones & Bartlett, 2020, p. 30-31)	(Jones & Bartlett, 2020, p. 538-539)	(Jones & Bartlett, 2020, p. 950-951)
Dose	100 mg	100 mg	3 ml	40 mg	40 mg
Frequency	BID	Nightly	QID	Daily	Daily
Route	PO	PO	Nebulization	PO	PO
Classification	Benzofuran derivative	Angiotensin II receptor blocker	Adrenergic	Loop diuretic	Proton pump inhibitor
Mechanism of Action	Acts on cardiac cell membranes, prolonging repolarization and the refractory period and raising ventricular fibrillation threshold.	Blocks binding of angiotensin II to receptor sites in many tissues, including adrenal glands and vascular smooth muscle	Blocks cholinergic receptors decrease the production of cyclic guanosine monophosphate and stimulates receptors on smooth muscle cells that line the airways causing muscle cells to relax and open airway	Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation.	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine-triphosphatase enzyme system or proton pump in gastric parietal cells.
Reason Client Taking	Treat irregular heartbeat	Manage hypertension	Treat wheezing and shortness of breath caused by COPD	Reduce edema caused by chronic kidney disease	Helps reduce difficulty swallowing and persistent cough
Contraindications (2)	Bradycardia Cardiogenic shock	Concurrent aliskiren therapy Hypersensitivity	Hypertension Hypersensitivity	Anuria Hypersensitivity	Concurrent therapy with rilpivirine containing products Hypersensitivity
Side Effects/ Adverse	Hypoxia	Hyperkalemia	Headache	Arrhythmias	Hypomagnesemia

Reactions (2)	Hemolytic anemia	Hyponatremia	Dizziness	Hyponatremia	Hyponatremia
Nursing Considerations (2)	Monitor vital signs and oxygen level often during and after giving therapy Monitor ECG while checking for increased PR and QRS intervals, arrhythmias, and heart rate below 60 beats/ min	Monitor blood pressure and renal function studies Monitor serum potassium level	Monitor lung sounds before, during and after treatment. Monitor blood pressure and heart rate before, during and after treatment.	Obtain patient weight prior to and during use of furosemide therapy Monitor blood pressure and renal function studies	Monitor patient's urine for urine output Monitor patient for bone fracture.

Medications Reference (APA):

Jones & Barlett (2020). *Nurse's Drug Handbook.* (19th ed.). Ascend Learning Company.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:**	Patient is alert and orientated to person, place and

Orientation: **Distress:** **Overall appearance:**	time. Pt appears in no acute distress and well groomed.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 18** **Drains present: Y☐ N ☒** **Type:**	Patient's skin is fair tone with normal elasticity and warm to touch. No abnormal texture. Normal quality, distribution, and texture of hair. Nails without clubbing or cyanosis. No bruises. Patient has an IV in left hand that is saline locked. Braden Score: 18
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head is symmetrical, trachea is midline with no deviations. Thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and strong. Hair is gray. Ears show no abnormal drainage. Bilateral sclera white, bilateral corneas clear, bilateral conjunctive pink, no visible drainage from eyes. Bilateral lids are moist and pink without lesions or discharge. PERRLA is noted bilaterally. Patient uses glasses regularly. Nose shows septum is midline. No visible bleeding or polyps. Bilateral frontal sinuses are nontender to palpation. Oral mucosa is pink and moist with no abnormalities. Uvula is midline, soft palate rises and falls symmetrically. Patient's teeth present and yellow to white in color.
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:** Bilateral lower legs	Patient was on telemetry monitor for 48 hours when admitted. Telemetry was started on 2/3 at 1900 and will remain on until 2/5 at 1900. At time of clinical telemetry reading is normal. Heart sound auscultated in 5 locations (APETM). S1, S2 heart sounds noted, no murmurs, rubs, or gallops. Radial and pedal pulses assessed. Pulses graded 2+ and present bilaterally. Capillary refill less than 3 seconds fingers and toes bilaterally. Negative for neck vein distention. Edema present bilaterally in lower legs.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒**	Respirations are regular and even nonlabored bilaterally. No accessory muscle used when

Breath Sounds: Location, character	breathing. Patient denies being short of breath while on oxygen off the wall. Patient will sleep with CPAP. Anterior and posterior lung sounds auscultated. Lungs sounds have crackles bilaterally. No wheezes or rhonchi noted bilaterally.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** 168 cm **Weight:** 91.8 kg **Auscultation Bowel sounds:** **Last BM:** 2/4/21 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** N/A **Incisions:** N/A **Scars:** On chest/abdomen from previous surgeries. **Drains:** N/A **Wounds:** N/A **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Patient is on a diabetic diet. Scars on right chest and in lower quadrants from previous surgeries. Right forearm has an arteriovenous fistula however patient's arm bandaged from dialysis, student did not unwrap and inspect (patient had recently returned from dialysis). Abdomen is soft, nontender, no masses upon palpation of all four quadrants. Bowel sounds present in all four quadrants. Patient denies pain on palpation. No masses present. No ostomy, nasogastric tubes, PEG tubes, or drains. Patient states last BM was this morning.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☒ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient able to ambulate to bathroom with student. No catheter present. No genital abnormalities noted. Urine is yellow and no abnormal odor. Patient denies pain, hesitancy or urgency on urination.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 20	Patient able to show range of motion bilaterally in upper and lower limbs. Patient shows no sign of neurovascular deficit. Patient is a fall risk and is up with one assist from staff/student. Patient uses a cane at home to get around. During this admission patient indicates she has not used cane to get from bed to bathroom as it's a short distance.

Activity/Mobility Status: **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Fall Risk Score: 20
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is awake in bed. She is alert and orientated x4. Patient speaks English and at a normal pace and volume. Patient moves all extremities well and has good hand grip strength bilaterally. Patient shows no signs of neurological damage or deficit.
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):**	Patient is awake and watching the television upon student's entry to room. Patient denies drug and alcohol use. Patient quit smoking on 4/3/93, prior to quitting she smoked one pack a day for twenty years. Patient completed high school and college. Patient lives alone and has good family support in place (son lives two houses down). Patient is retired. When asked what a typical day is like for her, she replied, "I cook, clean, read book, and watch television." Her favorite tv show Law & Order Special Victims Unit was playing during clinical hours.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1525 (by student)	70	119/53	16	98.0 f	92%
1600 (by student)	76	114/57	14	97.9 f	94%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1430	Numeric Scale 0-10 8	Head	All over	Throbbing	Student provided Tylenol
1530	Numeric	Head	Severe	Throbbing	Cold wash cloth

	Scale 0-10 6 – Head 5 – Back	Back	Severe	Radiating from puncture site	provided Sat patient up to take pressure off of site

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: 20 g **Location of IV:** Left hand **Date on IV:** 2/3/21 **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Left hand IV placed on 2/3/21 in emergency room is stable, with no complications. Patient denies pain at site. No evidence of erythema, drainage or swelling. Dressing intact. IV flushes easily for RN prior to student arrival on unit.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
Total intake from 0000-1800 = 950 ml	Dialysis = 3,000 ml Procedure = 1,000 ml Urine Output (until 1800) = 500 ml Total = 4,500 ml

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was awake most of the afternoon and watching television. Patient was at dialysis when student arrived on floor but returned shortly after. Patient's lab

values are consistent with her diagnosis and past medical history. Patient complied with diabetic diet and fluid restriction guidelines. Patient allowed dialysis to take additional fluid off today as well as allowed a thoracentesis to drain additional fluid.

Procedures/testing done: Patient was at dialysis when I arrived on unit. Shortly after returning she underwent an ultrasound of her lungs and a thoracentesis procedure.

Complaints/Issues: Patient complained of headache and her back hurting where the puncture site from thoracentesis procedure occurred. Student gave Tylenol with Nurse for headache and followed up it was noted pain had decreased but not gone away completely.

Vital signs (stable/unstable): Vital signs are stable.

Tolerating diet, activity, etc.: Patient tolerating dietary restrictions.

Physician notifications: Doctor was notified of additional fluid prior to student arriving on floor. Doctor arrived on floor shortly after patient came back from dialysis for ultrasound to determine how much fluid was in pleural effusion. Thoracentesis procedure was performed at bedside.

Future plans for patient: Patient will remain inpatient with no discharge date set at time student left floor. Patient will receive dialysis four times a week to hopefully decrease the pleural effusion. The goal is for the patient to allow more than one liter be pulled off during dialysis however she has requested only one liter per dialysis visit.

Discharge Planning (2 points)

Discharge location: Patient will be discharged to her home.

Home health needs (if applicable): N/A

Equipment needs (if applicable): Patient indicates she has and uses a cane currently.

Follow up plan: Patient will continue to get outpatient dialysis, increasing from 3 to 4 times a week. If patient gets short of breath again due to pleural effusion, she will likely be admitted again and given a chest tube to continuously drain the excess fluid.

Education needs: Patient needs educated on importance of attending dialysis as the doctor orders to avoid having a chest tube placed.

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.
Excess Fluid Volume related to compromised regulatory mechanism occurring with renal dysfunction as evidenced by the patient gaining weight over the past few months and edema present in her lower legs. (Swearingen, 2016, p. 190-191)	My patient has edema in lower limbs and limits her dialysis to only 1 liter per trip. Not allowing the dialysis to take additional fluid means the fluid will continue to build up in excess.	Assess intake and output (I&O). Monitor results of serum creatinine (creatinine is the better indicator of renal function because it is not affected by diet, hydration, or tissue catabolism).	Patient understands the need for keeping strict intake and output. Patient receptive to writing down all intake and output post discharge. Patient understands while inpatient labs will continue to be drawn daily. Once discharged she will need to continue to have lab work drawn per the doctor's order.
Risk for imbalanced fluid volume related to excessive fluid removal from dialysis as evidenced by the patient having 3 liters taken off on clinical	My patient has stated numerous times she only wants 1 liter taken off during dialysis but today	After dialysis assess patient for hypotension, tachycardia and complaints of dizzy or lightheadedness.	Patient understands the volume taken off today could cause fluid volume deficit which comes from the rapid fluid loss during dialysis.

day (Swearingen, 2016, p. 208-209)	allowed them to take 3 liters. Once complete with dialysis she then had another liter removed via thoracentesis.	Weigh the patient daily at same time each day using same scale and wearing same amount of clothing.	Patient is being weighed in hospital gown while inpatient at 0700. Patient understands once discharged she will continue to weigh herself first thing in the morning and record the value.
Deficient Knowledge related to information misinterpretation as evidenced by inaccurate follow through of instructions. (Swearingen, 2016, p. 206-207)	My patient has continued to miss dialysis appointments which result in hospital admissions.	Assess patient's current level of knowledge about her therapy and health care literacy. Review disease process, prognosis, and future expectations.	Patient agreeable to discussing her current understanding of her disease and ways to help avoid hospitalization. Patient acknowledges the need for dialysis on a more frequent basis. She understands she needs to allow more than one liter but raises concerns as she as experienced side effects after allowing them to take additional fluid off.

Other References (APA):

Swearingen, P. (2016). *All-In-One Nursing Care Planning Resource* (4th ed.). Elsevier

Concept Map (20 Points)

Subjective Data

Patient arrived to emergency room with symptoms of being weak, short of breath, and chest pain.

Patient states "I don't want them taking more than 1 liter at a time in dialysis as I don't like how I feel afterwards."

Nursing Diagnosis/Outcomes

Patient is diagnosed with pleural effusion which was causing the shortness of breath and weakness.

Patient acknowledges she has excess fluid volume related to her chronic kidney disease and will limit her fluid intake as instructed.

Patient understands she is at risk for imbalanced fluid volume related to excessive fluid removal during dialysis and thoracentesis. Patient will report any side effects not limited to dizziness, headache, or weak feeling.

Patient has a knowledge deficient when it comes to her follow up care when discharged and will consistently asking questions as they come up.

Objective Data

Patient was off the floor receiving dialysis when student arrived on floor. Patient had three liters removed.

Patient's ultrasound of lungs at bedside showed pleural effusion on the right side. A thoracentesis was performed and drained one liter off.

Patient's lab values are consistent with her chronic kidney disease and continue to deteriorate.

Patient Information

MR is a 68-year-old female who presented to the emergency room with weakness, shortness of breath, and chest pain. She has a past medical history that includes chronic kidney disease, diabetes mellitus type II, iron deficiency anemia, hypertension, COPD and sleep apnea.

Nursing Interventions

Patient will monitor her input and output daily as well as keep all lab draw appointments.

Patient will weigh herself daily first thing in the morning wearing the same amount of clothing and using the same scale. Patient understanding of possible side effects of fluid volume being imbalanced due to excess fluid pulled out.

Patient was agreeable to discussing her diagnosis and the ways she can prevent readmission, including attending her dialysis appointments as instructed. Patient will continue to ask questions and seek answers to any questions related to her disease.