

N321 Care Plan # 1

Lakeview College of Nursing

Jordan Helton

N321 CARE PLAN

Demographics (3 points)

| | | | |
|---------------------------------------|----------------------------------|----------------------------------|------------------------------|
| Date of Admission 2/23/2021 | Patient Initials C.A.D | Age 63 | Gender Female |
| Race/Ethnicity Caucasian | Occupation N/A | Marital Status Married | Allergies Levaquin |
| Code Status FULL | Height 167 cm | Weight 148 kg | |

Medical History (5 Points)

Past Medical History: Chronic venous insufficiency, CAD, hypercholesterolemia, hypertensive cardiovascular disease, left leg pain, morbidly obese, OSA, peripheral edema

Past Surgical History: C-sec (1999), cardiac catheterization

Family History: Mother/Father- CAD

Social History (tobacco/alcohol/drugs): Pt reports occasional drinking (1-3 a week). Pt reports no alcohol and recreational drug use.

Assistive Devices: Pt reports using glasses on a daily basis. She uses a walker when ambulating longer distances.

Living Situation: Lives at home with significant other and niece she has custody over.

Education Level: Pt stated having some college education.

Admission Assessment

Chief Complaint (2 points): Left leg pain

History of present Illness (10 points): A 63-year-old woman was presented to the ED with a chief complaint of lower leg extremity pain and swelling. Patient has stated she has increasing swelling and redness in her legs in the last month. Patient has noted that her swelling has gotten worse in the last six months. Weeping drainage has been noticeable in her left leg the last few

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weeks. In the same leg, on her heel, there has been a sore just accumulating. Patient is unable to ambulate with ease. Patient has a history of morbid obesity, obstructive sleep apnea, hypercholesterolemia, hypertension, chronic venous insufficiency, coronary artery disease, and diabetes. Patient denies any chest pain or shortness of breath.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Lower left leg cellulitis

Cellulitis is a common, serious bacterial skin infection. The affected skin appears swollen and red and is typically painful and warm to the touch. Cellulitis usually affects the skin on the lower legs, but it can occur in the face, arms and other areas. This occurs due to bacteria entering a wound or an area of no skin. *Streptococcus pneumoniae* is the cause of this infection. There is redness, rash with scabs and blisters, and feeling of warmth on the skin are some symptoms of cellulitis. With treatment, cellulitis can be healed within two weeks. An oral antibiotic is the best way to treat cellulitis.

Secondary Diagnosis (if applicable): N/A

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

Pathophysiology References (2) (APA):

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 |
|-----|--------------|-----------------|---------------|---------------------------|
| | | | | |

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|--------------------|------------------|--|-------------|--|
| RBC | 4.4-5.5 | | 2.92 | |
| Hgb | 13.1-16.0 | | 8.0 | |
| Hct | 39.0-48.5 | | 24.8 | |
| Platelets | 145-358 | | 306 | |
| WBC | 4.6-9.1 | | 11.0 | |
| Neutrophils | 2.3-5.7 | | 8.1 | |
| Lymphocytes | 1.1-3.3 | | 2.0 | |
| Monocytes | 0.3-0.8 | | 7.0 | |
| Eosinophils | 0.03-0.45 | | 0.9 | |
| 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 | | 140 | |
| K+ | 3.5-5 | | 3.7 | |
| Cl- | 96-107 | | 104 | |
| CO2 | 21-32 | | 28 | |
| Glucose | 74-106 | | 130 | |
| BUN | 7-18 | | 11 | |
| Creatinine | 0.7-1.3 | | 0.92 | |
| Albumin | 3.4-5.0 | | | |
| Calcium | 8.5-10.1 | | 7.3 | |
| Mag | 1.6-2.6 | | | |

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|--------------------|----------------|------------|--|--|
| Phosphate | N/A | | | |
| Bilirubin | 0.2-1.0 | | | |
| Alk Phos | 45-117 | | | |
| AST | | | | |
| ALT | | | | |
| Amylase | | | | |
| Lipase | | | | |
| Lactic Acid | | 2.2 | | |

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 | | | | ***Lab results not taken*** |
| PT | | | | |
| PTT | | | | |
| D-Dimer | | | | |
| BNP | | | | |
| HDL | | | | |
| LDL | | | | |
| Cholesterol | | | | |
| Triglycerides | | | | |
| Hgb A1c | | | | |
| TSH | | | | |

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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 | | | | **Lab results not taken** |
| pH | | | | |
| Specific Gravity | | | | |
| Glucose | | | | |
| Protein | | | | |
| Ketones | | | | |
| WBC | | | | |
| 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 | | | | ***Lab results not taken*** |
| Blood Culture | | | | |
| Sputum Culture | | | | |
| Stool Culture | | | | |

Lab Correlations Reference **(1)** (APA):

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Diagnostic Imaging**All Other Diagnostic Tests (5 points):**

CT abdomen and pelvis w/o Contrast

XR Ankle complete 3 or greater views Rt & Lt

XR tibia/Fibula

US ABI Doppler Complete Lower

US Venous Reflux Lower Ext Bilateral

Diagnostic Test Correlation (5 points):**Diagnostic Test Reference (1) (APA):****Current Medications (10 points, 1 point per completed med)*****10 different medications must be completed*****Home Medications (5 required)**

| Brand/Generic | Lasix/ Furosemide | Nitrostat/ Nitroglycerin | Pepcid/ Famotidine | Toprol-XL/ Metoprolol | Ecotrin/ Aspirin |
|----------------------|------------------------------|-------------------------------------|-------------------------------|----------------------------------|-----------------------------|
| Dose | 40 mg | 0.4 mg | 20 mg | 25 mg | 81 mg |
| Frequency | x1 daily | Q 5 min PRN | x1 daily | 1 tab x2 BID | x1 daily |
| Route | oral | sublingual | oral | oral | oral |

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| Classification | Diuretic | Antianginal , vasodilator | Antiulcer agent | Antihypertensive | NSAID |
|---|--|---|---|--|--|
| Mechanism of Action | Inhibits Na and water reabsorption in the loop of henle and increases urine formation | Reduces preload and afterload, which decreases myocardial workload and O2 demand. Dilates coronary arteries for better blood flow. | An inhibitor of histamine H2 receptors. Inhibits production of gastric juices. | Inhibits stimulation of beta 1-receptor sites in the heart, resulting in cardiac output, decreased cardiac excitability, and myocardial oxygen demand | Blocks the enzyme for prostaglandin synthesis. Causes inflammatory response. Pain signals to stop transmission. |
| Reason Client Taking | To help reduce edema in lower extremities | To treat acute angina attacks | To help treat heartburn and indigestion | To treat HTN and enlarged heart | To treat leg pain |
| Contraindications (2) | Anuria, hypersensitivity to drug | Acute MI, hypersensitivities to nitrates | Other H2 antagonists, hypersensitivity to drug | Second-or third-degree AV block | Current or recent GI bleed or ulcers, bled/coagulation disorders |
| Side Effects/Adverse Reactions (2) | Arrhythmias, thromboembolism | Arrhythmias, hypotension | thrombocytopenia, AV block | Abdominal cramps, diarrhea | GI bleeding, prolonged bleeding time |
| Nursing Considerations (2) | Assess fluid status, monitor daily weight | Monitor labs, treat if pain does not go away | Administer at bedtime, decrease dose with renal failure | Check vitals (BP and HR), client educate about not drinking alcohol | Check patient medical history, educate patient |

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Medications Reference (1) (APA):

2020 Nurse's drug handbook. (2020). Jones & Bartlett Learning.

Assessment**Physical Exam (18 points)**

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|---|--|
| GENERAL (1 point): Alertness: Orientation: | A&O x3 No signs of acute distress Well oriented |
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|---|---|
| Distress: Overall appearance: | Well kept and groomed |
| INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type: N/A | pink Warm and intact Warm turgor is fine No rashes, bruises 9 No drains |
| HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth: | .Head is normocephalic, jugular veins not distended gray pearly TM , little cerumen PERRLA No sinus pain Moist oral mucosa |
| 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 type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema: | . NSR No murmurs, gallops, or rubs Strong, equal less than 3 seconds No None present Edema is present in lower extremities |
| RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character | .Clear to auscultation bilaterally in all lobes Rales, rhonchi, and wheezing are not present Accessory muscles are not used |
| GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: | . Normal diet at home and at hospital 167 cm 148 kg Bowel sounds present in all four quadrants; obese; soft and nondistended; Last BM- 2/24/21 Left heel wound open due to debridement done |

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| Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input type="checkbox"/> Type: | on 2/24/21 OSTomy, nasogastric, and feeding tubes not present |
| GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size: | Yellow/clear slight aroma 842.08 mL No pain on urination No dialysis Normal genatalia catheter not present |
| MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: 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"/> | . 5/5 strength in upper and lower extremities Uses glasses on daily basis; A walker used to ambulate far distances Yes Yes 55 Left leg with swelling, weeping, and erythema Diabetic foot ulcer on left heel (debridement done) |
| NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input 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: | Cranial nerves II and XII grossly intact No noted sensory deficits PERRLA Strength equal in lower and upper extremities A&O x3 Patient is conscious |
| PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Developmental level: Religion & what it means to pt.: | . Talk to her niece she has custody over Appropriate for age N/A |

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|---|--|
| Personal/Family Data (Think about home environment, family structure, and available family support): | |
|---|--|

Vital Signs, 2 sets (5 points)

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|-------------|--------------|------------|------------------|-------------|---------------|
| 0700 | 75 | 130/68 | 16 | 36.8 C | 94 |
| 1030 | 78 | 134/70 | 16 | 36.7 C | 95 |

Pain Assessment, 2 sets (2 points)

| Time | Scale | Location | Severity | Characteristics | Interventions |
|-------------|---------------|---------------------------------------|-----------------|--------------------------------|----------------------|
| 0700 | numeric scale | left lower leg | 6/10 | throbbing | pain medication |
| 1030 | numeric scale | left heel (debridement done recently) | 4/10 | throbbing; pain comes and goes | N/A |

IV Assessment (2 Points)

| IV Assessment | Fluid Type/Rate or Saline Lock |
|--|--|
| Size of IV: 18 gauge Location of IV: right forearm Date on IV: 2/23/2021 Patency of IV: No phlebitis; dry, intact Signs of erythema, drainage, etc.: N/A IV dressing assessment: Transparent; dry, intact | Saline Lock Vancomycin, pharmacy to dose, IV piggyback, As Directed |

Intake and Output (2 points)

| Intake (in mL) | Output (in mL) |
|-----------------------------|--------------------------|
| 2/23/21 | 2/23/21 |
| IV fluid: 1876.67 mL | Urine: 1576.67 mL |

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| | |
|----------------------------|---|
| 2/24/21 | 2/24/21 |
| IV fluid: 842.08 mL | Urine: not measured at this time |

Nursing Care

Summary of Care (2 points)

Overview of care:

Procedures/testing done:

Complaints/Issues:

Vital signs (stable/unstable):

Tolerating diet, activity, etc.:

Physician notifications:

Future plans for patient:

Discharge Planning (2 points)

Discharge location:

Home health needs (if applicable):

Equipment needs (if applicable):

Follow up plan:

Education needs:

Nursing Diagnosis (15 points)

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

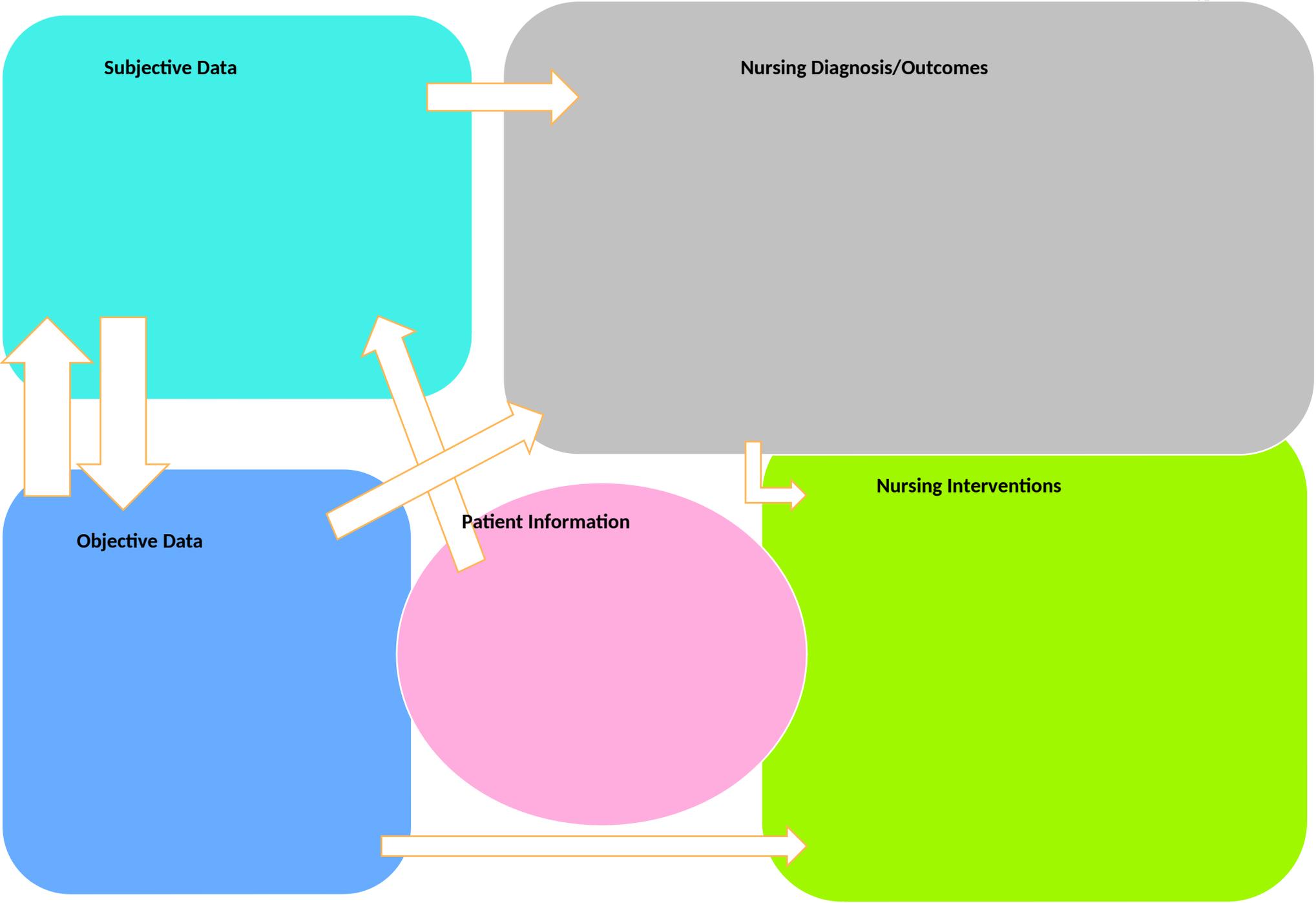
| Nursing Diagnosis | Rational | Intervention (2 per dx) | Evaluation |
|--------------------------|---------------------------|--------------------------------|--------------------------------------|
| ● Include full nursing | ● Explain why the nursing | | ● How did the patient/family respond |

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| diagnosis with “related to” and “as evidenced by” components | diagnosis was chosen | | to the nurse’s actions? ● Client response, status of goals and outcomes, modifications to plan. |
|---|-------------------------|----------|--|
| 1. | | 1. 2. | |
| 2. | | 1. 2. | |
| 3. | | 1. 2. | |

Other References (APA):

Concept Map (20 Points):



Subjective Data

Nursing Diagnosis/Outcomes

Objective Data

Patient Information

Nursing Interventions

