

N311 Care Plan #3

Lakeview College of Nursing

Bailey Pierce

Demographics (5 points)

Date of Admission 12.29.20	Patient Initials R.K.	Age 80	Gender F
Race/Ethnicity Caucasian	Occupation No known occupation	Marital Status Married	Allergies No known allergies
Code Status DNR, comfort focused care. In the event of Covid-19, pt is to remain comfort care focused.	Height 4'5"	Weight 127.2 lbs.	

Medical History (5 Points)

Past Medical History: Unspecified dementia w/o behavioral disturbance, adult failure to thrive, unspecified abnormalities of gait or mobility, right lower quadrant Pain, unsteadiness on feet, muscle weakness (generalized), unspecified urinary incontinence, Essential (primary) hypertension, Mixed hyperlipidemia

Past Surgical History: Cholecystectomy, hysterectomy, shoulder surgery (2008)

Family History: Father- Congenital heart disease (CVD), Mother- Hepatitis

Social History (tobacco/alcohol/drugs): Pt reports no usage of tobacco, recreational drugs, or alcohol.

Admission Assessment

Chief Complaint (2 points): Confusion

History of present Illness (10 points): Pt was previously living at home before being admitted with her husband in December of 2020 by her family. In the last 3 months, she has become increasingly more confused and actively seeks ways to exit the facility. With reassurance, she remains pleasant. Pt likes to keep bags packed in the room so they will be ready for her to

“leave”. Pt has also lost the ability to recognize her husband as her husband. She now identifies him as her father. Pt responds well to consistency and is expected to stay in long term care.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Unspecified dementia w/o behavioral disturbance

Secondary Diagnosis (if applicable): Adult failure to thrive

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

Dementia is the deterioration of one’s memory, reasoning, and other cognitive functions. Dementia is the leading reason patients are admitted into long-term care (Capriotti, 2020, pp. 905). Nearly 4-5 million people in the United States have been diagnosed with dementia (Capriotti, 2020, pp. 905). Of those affected, 1% are age 60-64 and 30%-50% are age 85 and older (Capriotti, 2020, pp. 905). Although dementia is more common in older generations, is not part of the normal aging process.

Dementia is caused by damage to nerve cells and their connections in the brain. These causes can be reversible or irreversible. Types of dementia that are related to irreversible causes include Alzheimer’s disease, Vascular dementia, and Lewy body dementia. Each type has different causes for its onset. Alzheimer’s disease is a form of progressive degenerative disease and is the most common type of dementia. Patients develop plaques made of beta-amyloid and tangles of tau proteins in the brain (*Dementia - Symptoms and Causes*, 2019). Genetics are believed to play a large role in the development of Alzheimer’s. Vascular dementia is the second most common and is related to prior stroke damage. Lewy body dementia is characterized by accumulation of proteins found in the brain. Reversible dementia includes infection and immune disorders, metabolic problems, endocrine abnormalities, nutritional deficiencies, medication side

effects, subdural hematomas, poisoning, brain tumors, anoxia, and normal-pressure hydrocephalus (*Dementia - Symptoms and Causes*, 2019).

The presentation of dementia can be very subtle and is usually noticed by friends and family members first. Personality changes, perceptual skills, and reasoning are typically the first changes noticed. Anomia is the inability to identify people and things by their name (Capriotti, 2020, pp. 906). Even with being reminded, individuals with dementia will repeatedly forget the simplest of information. Early on, dementia patients may become disoriented to their surroundings and forget their way home. These patients typically progress to loss of ability to perform familiar task such as getting dressed, self-hygiene, and preparing meals. Quick onsets of mood swings and personality changes are also observed. Sundowning occurs when these symptoms become enhanced in the evening hours and behaviors become erratic. In end stages of dementia, patients are often incomprehensible and will cease speaking all together.

Diagnosis of dementia involves a complete history and physical exam. Ruling out physical illness contributing to patient's confusion should be ruled out before diagnosing as dementia. These factors include those of reversible dementia. Lab test including CBC, erythrocyte sedimentation rate, glucose level, renal and liver function tests, serologic test for syphilis, vitamin B12, thiamine level, and thyroid function test can be performed to rule out any other physical illnesses (Capriotti, 2020, pp. 907). Computed tomography (CT) and Magnetic resonance imaging (MRI) are used to diagnose Vascular dementia. Alzheimer's disease is diagnosed by positron emission tomography (PET) (Capriotti, 2020, pp. 907).

Treatment of dementia can be both pharmacological and nonpharmacological. Pharmacological approaches involve treatment with antipsychotics, mood stabilizers, serotonergic drugs, and stimulants (*Dementia - Symptoms and Causes*, 2019). Over 40% of

patients admitted into long term care are treated with antipsychotic drugs (Capriotti, 2020, pp. 908). Nonpharmacological approaches include consistency, validation, reorientation, physical activity, and nutrition. Reminding patients of facts about themselves and their environment is the most common form of management known as reality orientation (Capriotti, 2020, pp. 908). Validation involves the caregiver focusing on whichever time period the patient is “living in”. Caregivers avoid trying to reorient the patient as it can lead to behavioral disturbances.

R.K. is currently not being treated pharmacologically. A more nonpharmacological approach is being taken in her treatment. R.K. identifies in her past life and speaks frequently of working. She also believes that her husband is her father. Caregivers avoid trying to correct R.K. and instead practice validation therapy and consistency.

Pathophysiology References (2) (APA):

Dementia - Symptoms and causes. (2019, April 19). Mayo Clinic.

<https://www.mayoclinic.org/diseases-conditions/dementia/symptoms-causes/syc-20352013>

Capriotti, T. (2020). *Davis Advantage for Pathophysiology* (second ed.). F. A. Davis Company.

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	Male: 4.7-6.1 Female: 4.2-5.4	3.23	**	Low RBC levels can be linked to anemia (Conor, 2021).
Hgb	Male:14-18 g/dL Female:	9.7	**	Low Hgb levels are low which can be indicative of anemia (Conor, 2021).

	12-16 g/dL			
Hct	Male: 40-52% Female: 36-47%	31.7	**	Low Hct Levels can be indicative of anemia (Conor, 2021). Pt also has low levels of Hgb and RBC with also correlate with anemia.
Platelets	150-400 x 10⁹/L	376	**	
WBC	5-10 x 10⁹/ L	10.1	**	
Neutrophils	55-70	59	**	
Lymphocytes	20-40	24	**	
Monocytes	2-8	11	**	Increased monocytes can indicate a viral infection (Conor, 2021).
Eosinophils	1-4	6	**	Increased Eosinophils can indicate an allergic response (Conor, 2021).
Bands	0.5-1	**	**	

****Labs not completed**

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	142	**	
K+	3.5-5 mEq/L	4.1	**	
Cl-	99-111 mEq/L	108	**	
CO2	23-30 mEq/L	**	**	
Glucose	74-106 mg/dL	81	**	
BUN	10-20 mg/dL	29	**	Elevated BUN level can occur with pyelonephritis or a kidney infection (Conor, 2021).
Creatinine	0.5-1.1 mg/dL	1.0	**	
Albumin	3.5-5 g/dL	**	**	

Calcium	9-10.5 mg/dL	9.3	**	
Mag	1.3-2.1 mEq/L	**	**	
Phosphate	3-4.5 mg/dL	**	**	
Bilirubin	0.3-1 mg/dL	**	**	
Alk Phos	30-120 U/L	**	**	

****Labs not completed**

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, Amber/ Yellow	Yellow, Turbid	**	Turbid urine can be an indication of a urinary tract infection (UTI) (Conor, 2021).
pH	4.6-8 Average: 6	6.5	**	
Specific Gravity	1.005-1.03	1.017	**	
Glucose	50-300 mg/day	normal	**	
Protein	0-8 mg/dL	10mg/dL	**	Protein in urine can correlate with kidney stones (Conor, 2021).
Ketones	negative	neg	**	
WBC	0-4 per low- power field Negative for cast	100+	**	WBC present in the urine can be indicative of a UTI or kidney infection (Conor, 2021).
RBC	Less than or equal to 2 Negative for cast	11-25	**	RBC present in the urine can indicate a UTI (Conor, 2021).
Leukoesterase	negative	500	**	Leukoesterase in the urine correlates with a UTI (Conor, 2021)

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	Negative: less than 10,000 per mm of U Positive: greater than 100,000 per mm of U	**	**	
Blood Culture	Negative	**	**	
Sputum Culture	Normal Upper RT	**	**	
Stool Culture	Normal intestinal flora	**	**	

****Labs not completed**

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference*. St. Louis, MO: Elsevier.

Conor, J.G. (2021). *Lab Values for Nurses: Must Know Labs with Easy Memorization Tricks and Nursing Implications*. Independently published.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

1/11/21- Left knee, 2 views.

No acute fractures or dislocations. Intra-articular calcifications noted. Osteophyte formation present. Mild degenerative changes noted. No joint effusions.

Surrounding soft tissues are normal.

Reason: Pt presented shortly after admission with L knee pain and swelling.

Findings: Chronic and degenerative changes.

Treatment: L knee shows no signs of inflammation. Voltaren is applied 3x daily for pain.

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

Brand/Generic	Tylenol (Acetaminophen)	Colace Capsule (Docusate Sodium)	Voltaren (Diclofenac Sodium Gel 3%)	Esidrix (Hydrochlorothiazide tablet)	Myrbetria tablet ER 24 hr (mirabegron)
Dose	650 mg	100 mg	1 application	50 mg	25mg
Frequency	3 x Daily	Daily	3 x Daily	Daily	Daily
Route	po	po	Topical, L Knee	po	po
Classification	Analgesics-nonopioid	Laxative	Analgesics	Diuretic	Bladder antispasmodic
Mechanism of Action	Inhibits the enzyme cyclooxygenase which mediates inflammatory response causing pain, swelling, and vasodilation. (Jones & Bartlett Learning, 2020)	Acts as a surfactant that softens stool by reducing surface tension between oil and water in stool. (Jones & Bartlett Learning, 2020)	Blocks the function of cyclooxygenase which mediates inflammatory response causing pain, swelling, and vasodilation. (Jones & Bartlett Learning, 2020)	Inhibits sodium chloride transport in the distal convoluted tubule. (Jones & Bartlett Learning, 2020)	Relaxes the detrusor smooth muscle during the storage phase of the urinary bladder fill-void cycle by activating the beta 3 adrenergic receptor which increases bladder size. (Jones & Bartlett Learning, 2020)
Reason Client Taking	L knee pain	Bowel Management	L knee pain	Swelling	Urinary incontinence
Contraindications (2)	hepatic impairment, severe acute liver disease	Fecal impaction, undiagnosed abdominal pain	Active GI bleeding, history of asthma attacks	Hypertension, Sulfa or Penicillin allergy	hypersensitivity to mirabegron, renal impairment
Side Effects/Adverse Reactions (2)	constipation, stridor	Abdominal cramping, palpations	Cerebral hemorrhage, Anemia	Nausea, Dizziness	Atrial fibrillation, elevated LDH levels

Medications Reference (APA):

Jones & Bartlett Learning (2020). NURSE'S DRUG HANDBOOK 2021. S.l.: Jones & Bartlett learning.

Assessment

Physical Exam (18 points)

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>A & O x1, Pt is only alert to person. Pt is generally in a pleasant state but does have periods of distress associated active exit seeking. Pt is well groomed and dressed suitably.</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: Drains present: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Type:</p>	<p>White Dry, normal, lentigo generalized. warm to touch Tenting 3+ No rashes present No bruises present No wounds present 18</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Symmetric Symmetric, difficulty hearing Symmetric, Glasses Symmetric Full upper denture, missing lower posterior dentition</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill:</p>	<p>. Clear s1 and s2 sounds w/o gallops or rubs. N/A Bilateral radial pulse 2+, Bilateral dorsalis pedis pulse +1 Capillary refill of fingers 4 seconds and toes 4 seconds.</p>

<p>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>No edema present.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Clear anterior and posterior lung sounds bilaterally. No wheezes, crackles, or rhonchi noted. Respirations unlabored and within normal limits (12-20) at 16 breaths per minute.</p>
<p>GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: 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>Regular Regular 4'5" 127.7 lbs Normoactive bowel sounds in all 4 quadrants. 2-28-21 Pt refused to lie down for abdominal assessment. Palpation and assessment completed in chair. Abdomen is soft with no signs of tenderness or mass present. No distention present No incisions present No scars observed on limited exam. Pt preferred to stay in wheelchair. No drains present No wounds present</p>
<p>GENITOURINARY: Color: Character: 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"/></p>	<p>Yellow Not observed Pt was heavily soiled 1x requiring a wardrobe change. Toileted 1x. Exact quantity not measured. Pt states no pain when urinating. No abnormalities observed while changing attend. Full genitals examination not performed.</p>

Type: Size:	
MUSCULOSKELETAL: 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"/>	.
NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" 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:	Pupils are equal, round, reactive to light, and able to accommodate.
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):	.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0722	75	146/74	16	97.5 temporal	94%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	1-10	Pt is not in any pain	0	Pt is not in any pain	No interventions

					needed
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Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL Milk 240 mL Water 120 mL Juice	Pt had one wet attend and able to urinate 1x on the toilet.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 		<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. Memory impaired related to dementia as evidence by active exit seeking.	Pt is consistently looking for ways to exit the building.	1. Provide pt with positive reassurance about where she is. 2. Approach pt in a caring and friendly manner.	Pt responded positively when reassured that her husband “father” was still there and where they were. Pt responds well to a soft and nurturing voice. Easily comforted.
2. Self-care deficit to toileting related to dementia as evidence by inability to state when needing to use the restroom.	Pt was unaware of need to use the restroom after repeatedly being asked if she need to. As a result, pt urinated through attend, pants, and onto wheelchair.	1. Encourage pt to try to use the restroom at more frequent intervals.	Not observed. Pt was described to have been able to state when she needed to use the restroom. After repeated attempts of asking if the pt need to use the restroom, it was observed that they pt had urinated in her attend. In caring for the client in the future, I would expect to observe less accidents as a result

		2.Dress pt in attire that is easy to remove to use the restroom and also remove in the event they become soiled.	of more frequent attempts to use the toilet. Pt was dressed in pants that were easy to pull up and down as well as remove after becoming soiled.
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Other References (APA):**Concept Map (20 Points):**

Subjective Data

Nursing Diagnosis/Outcomes

- 1. Memory impaired related to dementia, as evidenced by inactive day and night sleeping.
 - a. Goal: Pt will remain clothed like her husband, but he was my dad” and laughed.
- 2. Self-care deficit to toileting related to dementia, as evidenced by inability to state when she needs to use the restroom.”
 - a. Goal: Pt will use the toilet every 3 hrs to avoid soiling clothing.

Objective Data

Patient Information

Nursing Interventions

- 1. Provide pt with positive reassurance about where she is. HR: 75
- BP: 146/74
- 2. Approach pt in a caring and friendly manner. O2: 94
- RR: 16
- Temp: 97.5 Temporal
- 1. Encourage pt to try to use the restroom at more frequent intervals. Height: 5'4" Married
- Weight: 127.2 Caucasian
- 2. Dress pt in attire that is easy to remove to use the restroom and in the event they become soiled. Hysterectomy
- Cholecystectomy
- Shoulder surgery (2008)



