N311 Care Plan #4

Lakeview College of Nursing

Bailey Pierce

Demographics (5 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
11.30.20	R.P.	90+	M
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	No known occupation	Married	No known allergies
Code Status	**Height**	**Weight**	
DNR, no medically administered means of nutrition. In the event of Covid-19, pt is to remain comfort care focused.	No Height Listed	125.5 lbs.	

Medical History (5 Points)

Past Medical History: Metabolic encephalopathy, Pneumonia (unspecified organism), Sepsis (unspecified organism), Bacteremia, Unspecified dementia w/ behavioral disturbances, Essential (primary) hypertension, Urinary tract infection (site not specified), Muscle weakness (generalized), Reduced mobility, Dysphagia (oropharyngeal phase), Fever (unspecified), Gross hematuria, Supraventricular tachycardia, Acidosis, Frequency of micturition, Benign prostatic hyperplasia w/ lower urinary tract symptoms, Other obstructive and reflux uropathy, Urge incontinence, Atherosclerosis of native arteries of extremities w/ intermittent claudication (bilateral legs), Major depressive disorder (single episode, mild), Unspecified osteoarthritis (unspecified site), Generalized anxiety disorder, Personal history of other malignant neoplasm of Lg. Intestine, Mental disorder (not otherwise specified), Malignant melanoma of the skin (unspecified), Colon cancer

Past Surgical History: Colon resection, Skin cancer excision, Hernia repair

Family History: **Reviewed by facility, no contributing family history patient's current presentation.

Social History (tobacco/alcohol/drugs): Pt reports former usage of tobacco “maybe a pack a day”. “Hardly ever” used alcohol, and no usage of recreational drugs.

Admission Assessment

Chief Complaint (2 points): Pressure Ulcer Right Hip

History of present Illness (10 points): Pt presents with a pressure ulcer on the Right hip beginning Jan. 19th, 2021 while under the care of Pleasant Meadows. Wound has worsened since original onset and has now progressed to a Stage 4 ulcer measuring 1.5”x1.5” w/ pink borders extending 0.5” around the wound and serous drainage. Pt reports no pain but lying on his side is bothersome to the area. Pt is most comfortable sitting in his recliner. Current treatment includes consulting with a wound Dr, low air loss mattress w/ 15 minute alternating pressure, Thera honey sheets, silicone foam, transparent film 3x a week (M, W, F) (PRN), and turning pt every 2 hrs.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Metabolic encephalopathy

Secondary Diagnosis (if applicable): Not listed

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

Metabolic encephalopathy (ME) is described as a syndrome of temporary or permanent disruptions of the brain that vary in clinical appearance (Berisavac, 2017). Encephalopathy comes from Greek origin meaning suffering inside the head (Berisavac, 2017). Symptoms can span from mild mental disturbance to coma and even death. ME has multiple causes ranging from age and pre-existing health conditions to toxic chemical exposure (Kumar, 2020).

ME occurs due to damage to the blood brain barrier initiating a disruption between amino acids and neurotransmitters (Berisavac, 2017). Disruption of neurotransmitter function can cause focal and global edema, build up of toxic metabolites, capillary vasogenic edema, and lack of energy for normal processing (Berisavac, 2017). Initially, global symptoms suck as confusion, disorientation, and delirium are observed. (Berisavac, 2017). Insomnia, nausea, breathing problems, and heart rhythm abnormalities are also noted (Berisavac, 2017). Focal symptoms present as the disease progresses and can be evident by seizures, pathological reflexes, tremors, and coma. (Berisavac, 2017). Delirium is the most common symptoms associated with ME and is considered an emergent situation (Kumar, 2020). Other general symptoms and complications associated with ME include dementia, agitation, illusions, decreased orientation to surroundings, ataxia (difficulty with motor tasks), frequent urinary tract and respiratory infections, and vision changes (Kumar, 2020).

ME most commonly occurs in those 65 or older. Pts residing in a nursing home and are over the age of 75 have a 60% chance of developing ME compared to those younger than 55 (Berisavac, 2017). ME occurs in 10-45% of patients hospitalized and above 65 years. (Berisavac, 2017). Most frequent causes of ME are hypoxia, ischemia, systemic disease, and toxic agents (Kumar, 2020). Hypoxia is related to anemia and chronic obstructive pulmonary disease (Berisavac, 2017). Ischemia is due to cardiovascular diseases including acute congestive heart failure (Berisavac, 2017). Multiple systemic diseases such as hepatic and renal insufficiency, pancreatitis, malnutrition, diabetes, congestive heart failure, electrolyte imbalance, hypocalcemia, complications caused by sepsis, infection, and vasculitis (Berisavac, 2017). High doses or incorrect dosing of medications can have a toxic affect causing ME (Berisavac, 2017).

These drugs are typically neuroleptics, antidepressants, hypnotics, analgesics, opioids, and anti-Parkinsonian medications (Berisavac, 2017).

Diagnosis of ME is dependent on several different labs and tests. Arterial gases give quick information on respiratory, cardiac, and metabolic levels of functioning and can be very helpful in an emergency (Berisavac, 2017). Arterial gas tests will also give information regarding the patient's sodium, potassium, glucose, and bicarbonate status (Berisavac, 2017). A complete blood count (CBC) should be performed as anemia, leukopenia, thrombocytopenia, elevated levels of urea, and infection can be detected and used to diagnose underlying conditions which may be contributing to the development of ME (Berisavac, 2017). An electroencephalogram (EEG) is also important diagnostic test as it can detect generalized slowing or suppression of activity within the brain (Berisavac, 2017). Computed tomography (CT) scans provide images of the brain which can be evaluated for lesions or swelling. (Kumar, 2020).

Treatment of ME involves management of the underlying condition from which ME emerged. (Berisavac, 2017). Early recognition of the pre-existing conditions is key. Patients respiratory and cardiac functions should be monitored continually (Kumar, 2020). Analgesics can be prescribed to help manage pain (Kumar, 2020). Antipsychotics can also be given in low doses (Kumar, 2020). In cases of delirium, patients can be treated with dexmedetomidine, midazolam, or lorazepam (Kumar, 2020). Patients should follow a low protein diet to maintain low ammonia levels as ammonia is a byproduct of metabolized protein (Kumar).

R.P. was admitted in November of 2020 with the primary diagnosis of metabolic encephalopathy. Patient has a history of sepsis which could attribute to his onset of ME. His chart contained no history of labs or diagnostic imagining. R.P. does present with symptoms of confusion (only alert and oriented to self), agitation, dementia, ataxia, decreased orientation to

surroundings, and depression. All of which are related to ME. He is currently taking 20 mg of Paxil daily to help maintain his depression and 0.25 mg of Xanax every 24 hours for anxiety. R.P. is also being treated with Bactrim DS to resolve a urinary tract infection, another potential association of ME.

Pathophysiology References (2) (APA):

Kumar, K. (2020, October 1). *What Is Metabolic Encephalopathy?* MedicineNet. https://www.medicinenet.com/what_is_metabolic_encephalopathy/article.htm

Berisavac, I. I. (2017, January 1). *How to recognize and treat metabolic encephalopathy in Neurology intensive care unit Berisavac II, Jovanović DR, Padjen VV, Ercegovac MD, Stanarčević PD, Budimkić-Stefanović MS, Radović MM, Beslać-Bumbaširević LG Neurol India*. Neurology India. https://www.neurologyindia.com/article.asp?issn=0028-3886%3Byear%3D2017%3Bvolume%3D65%3Bissue%3D1%3Bspage%3D123%3Bepage%3D128%3Baulast%3DBerisavac%3Btype%3D3

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 com12plete 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**	**	**	
Hgb	**Male:14-18 g/dL Female: 12-16 g/dL**	**	**	
Hct	**Male: 40-52%**	**	**	

	Female: 36-47%			
Platelets	**150-400 x 10^9/L**	**	**	
WBC	**5-10 x 10^9/ L**	**	**	
Neutrophils	**55-70**	**	**	
Lymphocytes	**20-40**	**	**	
Monocytes	**2-8**	**	**	
Eosinophils	**1-4**	**	**	
Bands	**0.5-1**	**	**	

****No labs in pts chart**

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**	**	**	
K+	**3.5-5 mEq/L**	**	**	
Cl-	**99-111 mEq/L**	**	**	
CO2	**23-30 mEq/L**	**	**	
Glucose	**74-106 mg/dL**	**	**	
BUN	**10-20 mg/dL**	**	**	
Creatinine	**0.5-1.1 mg/dL**	**	**	
Albumin	**3.5-5 g/dL**	**	**	
Calcium	**9-10.5 mg/dL**	**	**	
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**	**	**	

****No labs in pts chart**

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**	**	**	
pH	**4.6-8 Average: 6**	**	**	
Specific Gravity	**1.005-1.03**	**	**	
Glucose	**50-300 mg/day**	**	**	
Protein	**0-8 mg/dL**	**	**	
Ketones	**negative**	**	**	
WBC	**0-4 per low-power field Negative for cast**	**	**	
RBC	**Less than or equal to 2 Negative for cast**	**	**	
Leukoesterase	**negative**	**	**	

****No labs in pts chart**

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**	**	**	

****No labs in pts chart**

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.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

**No additional testing listed in pts chart

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

Brand/ Generic	Paxil (Paroxetine HCL)	Flomax) (Tamsulosin HCL)	Prinivil (Lisinopril)	Bactrim DS tablet (sulfamethoxazole Trimethoprim)	Xanax (AlPRAZola tablet
Dose	20 mg	0.4 mg	5 mg	800-160 mg	0.25 mg
Frequency	Daily	Daily-Evenings	Daily	2x Daily for 10 days	Every 8 hrs
Route	po	po	po	po	po
Classification	Antidepressant	Genitourinary Agent	Antihypertensive	Anti-Infective	Anti-Anxiety
Mechanism of Action	Exerts antianxiety, antidepressant, antiobsessional, and antipanic effects as well as relieving symptoms by potentiating serotonin reuptake at presynaptic neural membranes. Blocked	Blocks alpha1-adrenergic receptors in the prostate. Inhibits smooth muscle contraction in the bladder neck and prostate, prostatic capsule, and prostatic urethra,	May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II. May also inhibit renal and vascular production of	Sulfamethoxazole and trimethoprim combination is an antibiotic. It works by eliminating the bacteria that cause many kinds of infection including ear and urinary tract.	May increase of gamma-aminobutyric (GABA) and inhibitory neurotransmi binding to sp benzodiazepi receptors in c and limbic ar

	serotonin reuptake increases levels and prolongs activity of serotonin at synaptic receptor sites. (Jones & Bartlett Learning, 2020)	which improves rate of urine follow and reduces symptoms of Benign Prostatic Hyperplasia (BPH). (Jones & Bartlett Learning, 2020)	angiotensin II. Decreased release of aldosterone reduces sodium and water reabsorption and increases their excretion, reducing blood pressure. (Jones & Bartlett Learning, 2020)	(Mayo Clinic, 2020)	the CNS. GA inhibits excit stimulation w helps control emotional be (Jones & Bar Learning, 20
Reason Client Taking	Depression	BPH	Hypertension (hold if systolic pressure is less than 120)	Urinary Tract Infection	Anxiety
Contrain dications (2)	hypersensitivity to paroxetine, use within 14 days of an MAO inhibitor (Jones & Bartlett Learning, 2020)	hypersensitivity to tamsulosin, hypersensitivity to quinazolines (Jones & Bartlett Learning, 2020)	Concurrent aliskiren use in patients with diabetes or renal impairment, hereditary or idiopathic angioedema. (Jones & Bartlett Learning, 2020)	Asthma, Folate (B9) deficiency (Mayo Clinic, 2020)	Acute angle-glaucoma, hypersensitiv alprazolam o components. (Jones & Bar Learning, 20
Side Effects/A dverse Reactions (2)	bone fracture, mania (Jones & Bartlett Learning, 2020)	Orthostatic hypotension, pharyngitis. (Jones & Bartlett Learning, 2020)	Mood alterations, orthostatic hypotension. (Jones & Bartlett Learning, 2020)	Severe rash, Decreased blood clotting (Mayo Clinic, 2020)	Hypotension, urinary hesita (Jones & Bar Learning, 20

Medications Reference (APA):

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

Mayo Clinic. (2021, February 5). *Sulfamethoxazole And Trimethoprim (Oral Route)*. https://www.mayoclinic.org/drugs-supplements/sulfamethoxazole-and-trimethoprim-oral-route/description/drg-20071899

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 A&O x1, person only Pt show no signs of distress. Well-groomed and dressed appropriately.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 White, blush Lentigo generalized, Delicate. Warm to touch Tenting 5+ No rashes observed. R and L forearm Stage 4 pressure ulcer R hip. 8x4x0.5 cm undermining 1.5 cm at 3:00, moderate serous drainage. Stage 2 pressure ulcer Sacrum 2x1 cm, light serous drainage Skin tears- L elbow (obtained while transferring with Hoyer), L forearm 13
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 symmetric, free of lesions symmetric, dry skin around auricles symmetric, sclera white, conjunctive pink symmetric, no deviation Edentulous, Pt only wears upper denture mucosa pink and moist .
CARDIOVASCULAR: **Heart sounds:**	.

S1, S2, S3, S4, murmur etc.	Clear s1 and s2 sounds w/o gallops, murmurs, or rubs
Cardiac rhythm (if applicable):	N/A
Peripheral Pulses:	Bilateral radial pulse 2+, Bilateral dorsalis pedis pulse +1
Capillary refill:	Capillary refill of fingers 3 seconds bilaterally and toes 3seconds bilaterally
Neck Vein Distention: Y ☐ N ☒ **Edema Y ☐ N ☒** **Location of Edema:**	No edema present.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	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.
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 ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Regular Mechanical soft Not listed in pts chart 125.2 lbs Normoactive bowel sounds in all 4 quadrants. Not listed in pts chart, pt was unsure. Felt like he had the urge to defecate but did not during shift. Abdomen is nontender and without palpable masses. No Costovertebral Angle (CVA) tenderness. No abnormalities observed. No distention present. No incisions present. 2” scar centrally located in the hypogastric region. No drains present. No wounds present.

GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	 Yellow Not observed Pt had a wet attend before breakfast and was dry the remainder of the shift. Pt indicated he had the urge to go but was unable to when put on the toilet. CNAs stated he is incontinent and frequently expresses desire to use toilet. Pt states no pain when urinating. No abnormalities observed during showering
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	 Pt has poor ROM in legs but is able to move arms with no issues. Hoyer, Wheelchair Pt can use arms to change position but has generalized weakness in both legs. 30 No Yes, 2-person transfer w/ Hoyer Yes, Pt unable to walk. Due to generalized weakness of legs and consistent bend of the knees at a 15-degree angle I do not believe patient would be able to stand either but was not observed.
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☒ Both ☐** **Orientation:** **Mental Status:**	 Arms only. Pts legs are continually bent at a 15-degree angle. Pupils are equal, round, reactive to light, and able to accommodate. Pts strength in both arms is equal and can reposition body with arms only. Legs have a generalized weakness and are of little assistance. Ox1, person only

Speech: **Sensory:** **LOC:**	Alert w/ confusion Comprehensible but occasionally slurred Hard of hearing No
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 likes to talk about his feelings especially to his wife. Appropriate for age Pt states "I don't think I am religious." Pt was living with his wife before he was moved to pleasant meadows facility. She was no longer able to keep up with his care. Pt has 1 daughter and 1 son.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	83	111/61	16	97.4 temporal	97%

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**

Intake and Output (2 points)

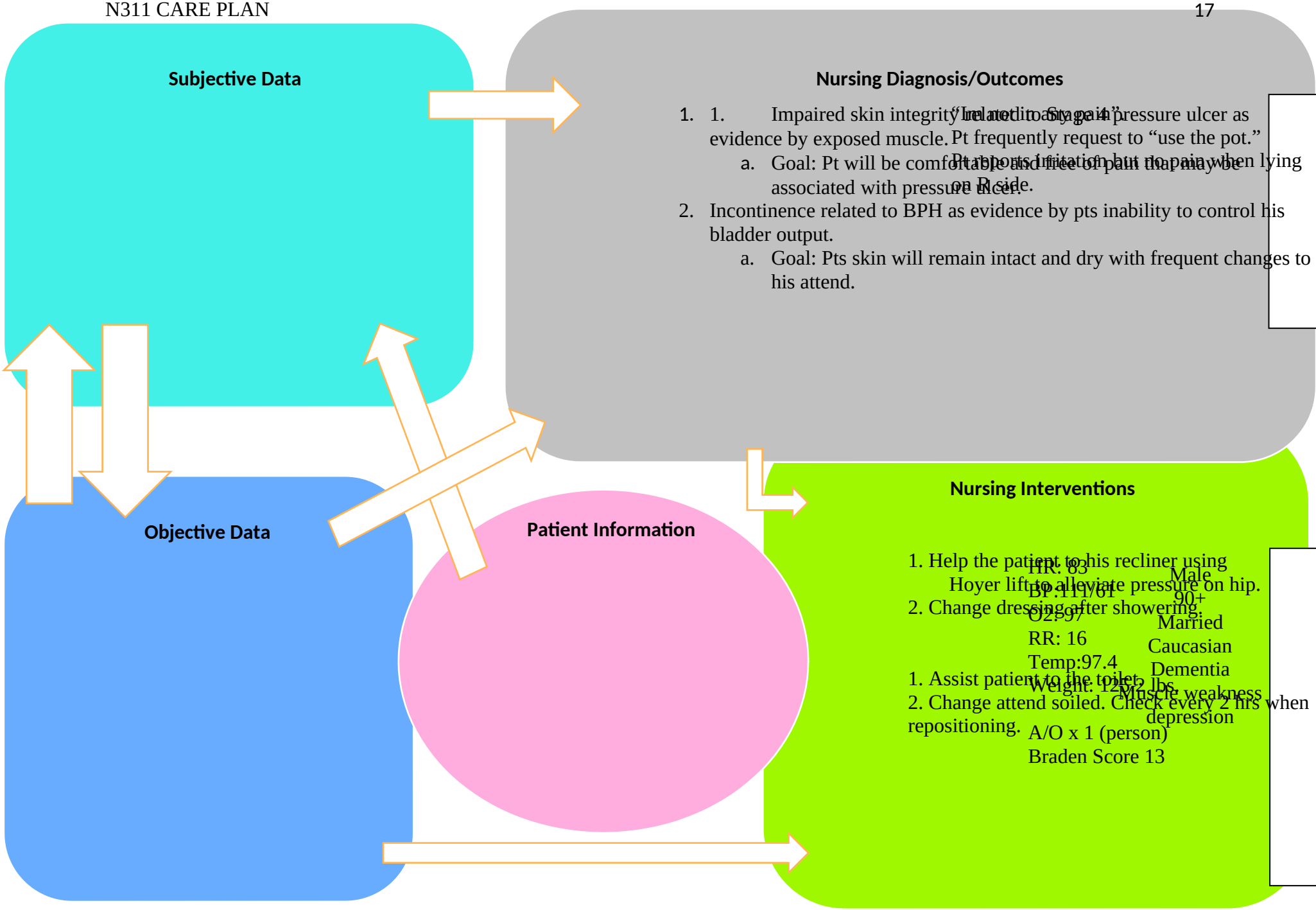
Intake (in mL)	Output (in mL)
240 mL Milk **240 mL Water**	**Pt had one wet attend before breakfast. Pt expressed urge to urinate and assisted to the toilet but was unable to go. Pt remained dry the rest of shift.**

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. Impaired skin integrity related to Stage 4 pressure ulcer as evidence by exposed muscle.	Pt is currently being treated for 2 pressure wounds. Stage 4 on R hip, and Stage 2 on sacrum.	1. Help the patient to his recliner using Hoyer lift to alleviate pressure on hip. 2. Change dressing after showering.	Pt was successfully transferred and made comfortable in chair. Stayed in chair for most of the morning. Stated he had "zero" pain. Pt was showered successfully using a shower chair. Would was rinsed and prepared for Nurse to apply new bandage.
2. Incontinence related to BPH as evidence by pts inability to control his bladder output.	Pt consistently feels the urge to "urinate" but is unable to differentiate when he is doing so.	1. Assist patient to the toilet. 2. Change attend soiled. Check every 2 hrs when repositioning.	Pt was assisted to the toilet. Pt expressed desire to go but was confused. He was unable to understand that he was sitting on the toilet. Continually asked to be take to "the pot". Pt did have a wet attend upon arrival. Attend was changed and pt remained dry the remainder of the shift.

Other References (APA):

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
1. 1. Impaired skin integrity related to stage 4 pressure ulcer as evidence by exposed muscle.
a. Goal: Pt will be comfortable and free of pain that may be associated with pressure ulcer.
2. Incontinence related to BPH as evidence by pts inability to control his bladder output.
a. Goal: Pts skin will remain intact and dry with frequent changes to his attend.
"I'm not in stage 4"
Pt frequently request to "use the pot."
Pt reports irritation, but no pain when lying on R side.
Objective Data
Patient Information
HR: 83
BP:111/61
O2:97
RR: 16
Temp:97.4
Weight: 125.2 lbs.
A/O x 1 (person)
Braden Score 13
Male
90+
Married
Caucasian
Dementia
Muscle weakness
depression
Nursing Interventions
1. Help the patient to his recliner using Hoyer lift to alleviate pressure on hip.
2. Change dressing after showering.
1. Assist patient to the toilet.
2. Change attend soiled. Check every 2 hrs when repositioning.