N311 Care Plan # 3

Lakeview College of Nursing

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Demographics (5 points)

Date of Admission 03/22/2021	**Patient Initials** JR	**Age** 89	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Mechanic	**Marital Status** Widow	**Allergies** N/A
Code Status Full Code	**Height** 6 (182.9cm)	**Weight** 96.2 kg (212lb)	

Medical History (5 Points)

Past Medical History: Acute respiratory failure with hypoxia, HCC, HTN (2005), Chronic Kidney disease stage 3, Category 5 blindness of right eye and category 4 blindness of left eye.

Past Surgical History: Mitral valve replacement (2008).

Family History: Sister-impaired vision, and brother impaired vision

Social History (tobacco/alcohol/drugs): Patient stated: “I used to smoke for 30 years than I quit in 2015”. The patient state “ I take a shot of liquor a few times a month”.

Assistive Devices: N/A

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): The patient stated, “ I just feel sick and I had a cough and was short of breath.”

History of present Illness (10 points):. On March 10th, the patient stated, “ I felt very sick and I had a cough and was short of breath (onset). The patient was living with his daughter who caught COVID on 03/09/2021 than moved with his brother the next day. The same day the patient moved in with the brother, he was diagnosed with COVID. The patient quarantine for 10 days but was still feeling sick even when he didn’t have COVID anymore. The patient was

rushed to the hospital on March 22nd, where he was admitted for pneumonia due to COVID. The patient also said " My chest was really tight, I originally thought I was having a heart attack and was having abdominal discomfort" (location). The patient stated, "I was feeling sick all day with constant coughing and having trouble breathing" (duration). The patient said he felt tightness in his chest and throbbing pain in the abdominal (characteristics). The patient had increased septum and body aches (associated). The patient stated " I will just got to sleep and feel slightly better when I woke up" (relieving). The patient didn't take any medication because he wanted it to naturally go away (treatment). The Patient has history COPD that could contribute to his lingering sickness from COVID.

Primary Diagnosis

Primary Diagnosis on Admission (3 points):. Pneumonia due to COVID

Secondary Diagnosis (if applicable):. Post-viral debility

Pathophysiology of the Disease, APA format (20 points): Scleroderma is an autoimmune disease that has no known cause and there is an abnormal build up of fibrous tissue on the skin and organs (Capriotti, 2020). Scleroderma can be classified as disease affecting on the skin or systemic disease of the whole body (Capriotti, 2020). The patient was diagnosed with systematic sclerosis because it affected her skin and other organs like kidney and muscles. The clinical presentation of the disease can be chronic pain, fatigue, muscle aches, and swelling with limited range of motion (Capriotti, 2020). The patient stated " I started to see changes in the appearance of my skin and I started to become extremely tired all of the time". The patient also mentioned that she eventually experienced difficulty swallowing than switch over to only

consuming liquid flood and non-solid. When you have Scleroderma, there is an inflammatory reaction when there is injury to the endothelial lining (Capriotti, 2020). The reaction activates cell infiltrate of the vascular, skin, and some organs (Capriotti, 2020). This whole process leads to extensive deposition of collagen, which causes fibrosis in the skin, subcutaneous tissues, and deep tissues (Capriotti, 2020). Since Scleroderma is still considered rare, there is no exact test to diagnosis it. The diagnosis is just based on patient symptoms and physically finding abnormal skin on the body (Capriotti, 2020). There is no specific treatment for the disease; the doctors just treat the symptoms (Capriotti, 2020). The patient is treated with immunosuppressive therapy because the disease affects her skin severely. The nurse priorities are to monitor any changes of the patient symptoms to help treat them.

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis.

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	3.90-4.98x10^6/mcL	5.06	4.69	
Hgb	12.0-15.5g/dL	14.6	13.5	n/a
Hct	35-45%	43.3	41.8	n/a
Platelets	140-400K/mcL	363	291	n/a
WBC	4.0-9.0K/mcL	12.90	12.40	

Neutrophils	40-70%	n/a	n/a	n/a
Lymphocytes	10-20%	n.a	n/a	n/a
Monocytes	3.0-13.0%	n/a	n/a	n/a
Eosinophils	0-8.0%	n/a	n/a	n/a
Bands	0.0-10.0%	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-	**135-145mmol/L**	**136**	**136**	**n/a**
K+	**3.5-5.1mmol/L**	**34.6**	**5.1**	**n/a**
Cl-	**98-107mmol/L**	**98**	**100**	**n/a**
CO2	**22-29mmol/L**	**31**	**31**	**n/a**
Glucose	**70-99mg/dL**	**124**	**101**	The patient has diabetes, which is why the blood glucose is high. The body using or isn't making enough hormone insulin (Capriott, 2020).
BUN	**7-18mg/dL**	**8**	**11**	
Creatinine	**0.50-1.00mg/dL**	**1.41**	**1.36**	When the creatinine is high, it indicates possible malfunction or failure of the kidneys (Capriott, 2020).
Albumin	**3.5-5.2g/dL**	**1.0**	**1.0**	
Calcium	**8.4-10.5mg/dL**	**9.0**	**8.9**	
Mag	**1.6-2.6mg/dL**	**n/a**	**n/a**	
Phosphate	**2.4-4.5 units/L**	**n/a**	**n/a**	
Bilirubin	**.3-1.0 mg/dL**	**n/a**	**n/a**	

Alk Phos	**34-104 units/L**	**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	**Yellow,clear**	**n/a**	**n/a**	
pH	**5.0-9.0**	**n/a**	**n/a**	
Specific Gravity	**1.003-1.013**	**n/a**	**n/a**	
Glucose	**Negative**	**n/a**	**n/a**	
Protein	**Negative**	**n/a**	**n/a**	
Ketones	**Negative**	**n/a**	**n/a**	
WBC	**0.0-0.5**	**n/a**	**n/a**	
RBC	**0.0-3.0**	**n/a**	**n/a**	
Leukoesterase	**Negative**	**n/a**	**n/a**	

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**	**n/a**	**n/a**	

Blood Culture	**Negative**	**n/a**	**n/a**	
Sputum Culture	**Negative**	**n/a**	**n/a**	
Stool Culture	**Negative**	**n/a**	**n/a**	

Lab Correlations Reference (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis.

Malarkey, L. M., & McMorrow, M. E. (2012). *Saunders nursing guide to laboratory and diagnostic tests*. St. Louis, MO: Elsevier/Saunders.

Malenica, M., Prnjavorac, B., Bego, T., Dujic, T., Semiz, S., Skrbo, S., . . . Causevic, A. (2017, April). Effect of Cigarette smoking on HAEMATOLOGICAL parameters in healthy population. Retrieved March 09, 2021, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5511531/

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

XR Chest Views 08/18/2019- moderately extensive infiltrates in the lower lobe bilaterally. There are increased intestinal markings in the remainder of both lungs.

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

Brand/ Generic	Sodium chloria solutiom	Acetaminmine Tylenol	Albuterol Proventil ventolin	Amlodpie norvacs	Aspirin EC
Dose	75ml	650mg	2.5mg/31ml	45mg	81mg
Frequency	hourly	Every 4 hours	3 times a day	Daily	Daily
Route	PO	PO	Nebulization	Po	PO
Classification	Skeletal muscle relaxants (Jones, 2020).	Human insulin and antidiabetic (Jones, 2020).	Polyene macrolide and antifungal (Jones, 2020).	Proton pump inhibitor and antiulcer(Jones, 2020).	Selective serotonin reuptake and antidepressant (Jones, 2020).
Mechanism of Action	**“**It reduces the release of excitatory neurotransmitters and substance P by binding to the BABA-B receptor” (Jones, 2020**).**	“Lowers blood glucose levels by stimulating periphereal glucose uptsje by fat and skeletal muscle“(Jones,2020).	“Binds to sterols in fungal cell membranes, impairing membrane intergritiy” (Jones,2020)	“Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosin triphosphate enzyme system” (Jones,2020).	“Inhibits reuptake of the neurotransmitter serotonin by CNS neurons, thereby increasing serotonin ” (Jones,2020).
Reason Client Taking	To relax muscles	To lower blood glucose	To treat fungal infection	To treat erosixe esophagitis associated with GERD	To treat generalized anxiety disorder
Contraindications (2)	Active bleeding and coagulation disorders (Jones, 2020).	Chronic lung disease anf chronic obstructive pulmonary disease (Jones, 2020).	Hypersensitivity to nystatin or its components (Jones, 2020).	Hypersensitive to pantoprazole and benzimidazoles (Jones, 2020).	Therapy with pimozide and hypersensitive to escitalopram (Jones,

					2020).
Side Effects/Adverse Reactions (2)	Confusion and stroke (Jones, 2020).	Confusion and UTI. (Jones, 2020).	Leukopenia and lymphopenia (Jones, 2020).	C-diff and hepatic failure (Jones, 2020).	Seizures and suicidal ideation (Jones, 2020).

Medications Reference (APA):

Jones, D.W. (2020). Nurse's drug handbook. (A. Bartlett, Ed.) (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient was alert and oriented to person, place, time, and situation. (x3)** **Patient was showing no signs of distress or any pain. Overall physical appearance was clean and well taking care of.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐ x** **Type:**	**Patient skin was warm, pink, but had a pressure ulcer. Also had a lot of bruising. The patient. The skin turgor is less than 3. The patient had red dots all over face. The Braden score is 9 which is high risk of getting pressure sore due immobility from the stroke.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**The patient head appear to be normocephalic. The neck seems to be symmetrical. The patient was able to hear me very clearly. There were no signs of hearing loss. The patient eyes show PERRLA and shows good ROM. The patient had very dry eyes and takes medicated eye drops There was no drainage from the nose.**
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:**	**S1 and S2 were heard. I was not able to hear S3 or S4. The heartbeat seemed to be regular. I did not hear any murmur or anything unusual. I was able to palpate carotid, radial, and brachial pulses in the left arm but not the**

Capillary refill: **Neck Vein Distention: Y ☐ N X ☐**	**right due to cast over arm. Capillary refill was than 3.**
RESPIRATORY: **Accessory muscle use: Y☐ N x ☐** **Breath Sounds: Location, character**	**The patient had no abnormal lung sounds. There was no wheezing or crackle in the lungs. The respiration rate was 17, which is normal. The patient oxygen level was 94%, which is also normal. The patient had a nasal cannula to help her get enough oxygen. Her oxygen level was 94%, which means it is effective.**
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:**	**The patient states that at home they usually eat liquids and gelatin due to Dysphagia.** **The patient height is 5'6 (66in).** **The patient weight is 172lb (78.9kg).** **I was able to see bowel sounds in all 4 quadrants. The patient last bowel movement was yesterday night (03/09/2021). The patient denies any diarrhea or nausea. There are open wounds in the abdominal area. The patient does have any drainage or and multiple wounds. The patient does not have an Ostomy or any feeding tubes or PEG tube.**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**The patient did not have to use the bathroom while I was there. I ask the patient did they notice and unusual color or smell of their urine. The patient mention there was nothing unusual about their urine and they were able to go regularly. The patient is not on dialysis or does not have a catheter. The patients wears a diaper due to immobility.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐**	**The patient neurovascular status seems to be intact. The patient has control of all their senses. The client was able to display ROM in left arm without help but couldn't move left are due to stroke. The patient was able to display opposition with left hands The patient is also using a gait belt to help get in**

Fall Score: **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	**wheelchair. The patient is maximum assist with ambulating and ADLs besides eating. Patient needs assistance with bathing and toileting but are able to eat all by herself. The patient current fall risk score is 90, which he is at high risk for falling. The patient upper extremities are not strong. The left arm can move but cannot move the right arm at all. The patient needs max support when standing up and walking.**
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**The patient is able to move left arm and left leg only due to stroke. Eyes show PERLA signs. The patient has no strength in right are but some strength in left arm. The patient is A&O x3 and is alert and no signs of distress .Patient has aphasia due to the stroke. She is unable to express herself most times.**
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):**	**Patient states "She is very frustrated because she can not express herself due to stroke". Patients seem to be extremely unhappy with her life because she usually loves to travel with her sister. The patient is a Christian, which helps her get through her illness. The patient has a sister she lives and takes good care of her.**

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9:21	**0/10**	**Body**	**0**	**n/a**	**n/a**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
450ml	**Changed one diaper**

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. Immobility: Immobility was related to the recent stroke the patient had evidenced by right side of body paralyzed.	**The nursing diagnosis was chosen because being immobile can cause complications with ADLS and really affect the quality of the patient's life.**	**1.I can safely transfer patient from the bed to the chair with assistance to avoid immobility complications.** **2. I can perform range of motion to all extremities.**	• **The patient seemed to be very unhappy about the stroke due to usually traveling a lot.** • **The sister was very supportive of the patient and assisted her in every way possible.** • **The long term goal of the patient is to be able to walk on her own with a assistive device such as a walker.**
2. Fall risk is related to the stroke the patient had and its evidenced by recent falls due to immobility and paralyzed on the right side of the	**The patient had some recent falls, which can be deadly. The patient fall risk is a 90, which is very high risk.**	**1. Keep the bed in lowest position and also keeping the bed rails up with call light in reach** **2. Make sure patient is wearing fall risk armband and make sure the**	• **The patient stated, " I don't think I will ever walk again". The patient was very unhappy and frustrated with the after affects of the stroke.**

body.		**bed alarm is on. Patient can also wear non-skid socks. Use gait belt and someone else for support when ambulating.**	

Overall APA format (5 points):

Concept Map (20 Points):

Subjective Data

The patient stated: " I don't think I would ever be able to walk again."
The patient stated: "I am very frustrated with not be able to walk."

Nursing Diagnosis/Outcomes

Immobility: Immobility was related to the recent stroke the patient had evidenced by right side of body paralyzed.
The patient seemed to be very unhappy about the stroke due to usually traveling a lot.
The sister was very supportive of the patient and assisted her in every way possible.
The long-term goal of the patient is to be able to walk on her own with a assistive device such as a walker.
Fall risk is related to the stroke the patient had and its evidenced by recent falls due to immobility and paralyzed on the right side of the body.
The patient stated, " I don't think I will ever walk again". The patient was very unhappy and frustrated with the after affects of the stroke

Objective Data

The patient had elevated HgB and HCT because she has an heart disease.
CT that the patient had a bled on her left side of her brain which is where the stroke was located.

Patient Information

The patient is a 70 year old female with Diabetes, heart disease, Heart failure and scleroderma. The patient was admitted on 03/06/2021 due to having a stroke affecting her right side of the body.

Nursing Interventions

I can safely transfer patient from the bed to the chair with assistance to avoid immobility complications.

I can perform range of motion to all extremities

Keep the bed in lowest position and also keeping the bed rails up with call light in reach
2. Make sure patient is wearing fall risk armband and make sure the bed alarm is on. Patient can also wear non-skid socks. Use gait belt and someone else for support when ambulating.