N311 Care Plan #

Lakeview College of Nursing

Eryka Williams

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
1/21/21	LC	99	
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Widow	N/a
Code Status	**Height**	**Weight**	
DNR	63in	125.11 lbs	

Medical History (5 Points)

Past Medical History: Aortic stenosis, chronic back pain, fracture of femur, left humerus, and left wrist

Past Surgical History: ORIF left hip 4/25/2017, ORIF left wrist 4/25/2017

Family History: n/a

Social History (tobacco/alcohol/drugs):n/a

Admission Assessment

Chief Complaint (2 points): Fall w/ head injury, no loc, right hip pain

History of present Illness (10 points):. Client was in the kitchen she turned around and lost balance and fell onto her right side. Client complains of right hip pain that she described as constant and sharp. The pain worsens with moving or touching area. Client also hit the back of head but denies LOC, client refused pain meds and IV access

Primary Diagnosis

Primary Diagnosis on Admission (3 points):. Nonrheumatic aortic valve stenosis

Secondary Diagnosis (if applicable): N/a

Pathophysiology of the Disease, APA format (20 points): nonaortic valve stenosis. This occurs when the heart's aortic valve narrows and doesn't open fully which blocks blood flow from the heart into the aorta and rest of the body.

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	4.0-4.9	4.7	N/a	
Hgb	12-16	14.1	N/a	
Hct	37-48%	43.7	N/a	
Platelets	90,000-450,000	203	N/a	
WBC	4,000-8,000	14	N/a	
Neutrophils	40%-80%	85.3	N/a	
Lymphocytes	20-40%	8.6	N/a	
Monocytes	2-10%	5.7	N/a	
Eosinophils	1-7%	0.5	N/a	
Bands	0-10%	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-	134-144	137	N/a	
K+	3.5-5.1	4.8	N/a	
Cl-	98-107 mml	106	N/a	
CO2	21-31mml	25	N/a	
Glucose	70-99mg	127	N/a	
BUN	7-25 mg	21	N/a	
Creatinine	0.50-1.20 mg	1.76	N/a	
Albumin	3.5- 5.7g	4.0	N/a	
Calcium	8.6- 10.3	9.3	N/a	
Mag	1.6 – 2.6 mg	N/a	N/a	
Phosphate	2.4- 4.5 units	N/s	N/a	
Bilirubin	0.3 -1.0 mg	1.7	N/a	
Alk Phos	34-104 units	81	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	Clear/slightly cloudy, yellow, amber, blue	N/a	N/a	

pH	**5-9**	**N/a**	**N/a**	
Specific Gravity	**1.000-1.013**	**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	**0.0-4.0**	**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	**10,000-1,00,000**			
Blood Culture				
Sputum Culture	**10-25**			
Stool Culture	**Appears brown, soft, well formed**			

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

CT brain no acute disease, CT brain no acute disease, CT of right hip

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

Medications (5 required)

Brand/Generic	**Metoprolol**	**Calcium D+**	**Vitamin D**	**Norco**	**Colace**
Dose	**50mg**	**400-600mg**	**1.25mg**	**5325**	**100mg**
Frequency	**BID**	**1tab in the morning**	**Every Friday**	**1 tab, every 6 hours**	**1 cap in the morning**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Ora**
Classification	**Beta blocker**	**Calcium supplement & phosphate binder**	**Vitamin D analogs**	**Analgesics, opioid**	**Stool softener**
Mechanism of Action	**Increase heart rate**	**Vitamin D**	**Vitamin D binds to intracellul**	**Narcotic pain reliever**	**Stool softener**

			ar receptors		
Reason Client Taking	**Hypertension**	**Osteoporosis**	**Vitamin D deficiency**	**Hip**	**Constipation**
Contraindications (2)	**Diabetes, low blood sugar, depression, heart block**	**Hypersensitivity, kidney stones, low phosphate levels**	**Sarcoidosis, kidney stones, decreased kidney function**	**Gastrointestinal obstruction**	**Hypersensitivity, nausea**
Side Effects/Adverse Reactions (2)	**Depression, nausea, dry mouth, stomach pain, gas or bloating/**	**Little to no urine, swelling, nausea, vomiting**	**Elevated blood levels and blood calcium levels, kidney failure**	**Nausea, vomiting, drowsiness**	**Stomach pain, diarrhea**

Medications Reference (APA):

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Alert** **A &o x3** **No signs of distress** **Well groomed**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:**	 **Appropriate** **Dry, flakey** **Warm**

Turgor: **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	**Loose** **N/a** **Generalized** **N/a** **18** **No drains**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	.**No abnormalities noted** **Symmetrical, no drainage** **Perrla, eoi intact** **Patent** **Denture**
CARDIOVASCULAR: **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:**	. **S1 S2** **3t** **Decreased 3** **No accessory muscles being used** **No edema** **N/a**
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	. **No** **Anterior: clear and equal** **Posterior: clear and equal**
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:**	. **No current diet** **Regular diet** **63in** **125.11lbs** **Active in all 4 quads** **Yesterday** **No masses / no pain** **N/a** **N/a** **N/a** **Midline on abdomen** **N/a** **N/s** **No** **No** **No**

Feeding tubes/PEG tube Y ☐ N ☒ **Type:**	**No**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**Not assessed**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 45** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	. **In tact** **Active/ passive intact** **Wheelchair** **Weak 3+** **Yes, adl** **Yes** **Fall score 45** **Active mobility** **No** **Yes** **Yes**
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	. **Yes** **Yes** **Yes** **Both** **X4** **Appropriate for age** **Speech is clear** **Glasses and hard of hearing** **N/a**

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):**	. **Crochet, socializes a lot** **Appropriate for age** **Baptist, very religious** **N/a**

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
9:20	**72 radial**	**120/50**	**20**	**97.4**	**98%**

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9:33	**5 on a scale from 1-10**	**Generalized pain**	**N/a**	**Achy pain from arthritis**	**N/a**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
N/a	**N/a**

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

1. Achy generalized pain	**The client fell in her kitchen awhile back and rates her pains 5 out of 10 on a scale from 1-10 .**	**1. The client rolls around in wheelchair to prevent pain.** **2.**	**The client met proper goals, the patient receives help when needed to help reduce pain.**
2. Risks for falls	**The client fell on her side and also hit her head.**	**1. Teach client about the importance of using a gait belt.** **2. Remove sharp edges and other object that could hurt the patient if they were to fall again.**	**Goal is met because the patient patient uses call light when needing to be transferred, food, water, etc.**

Overall APA format (5 points):

Concept Map (20 Points):

Subjective Data

- Patient complained achy pain all over the body .
- Patient rates pain on scale from 1-10, as a 5.
- Patient complains of hip pain

Nursing Diagnosis/Outcomes

- Risk for falls r/t to balance
  Goals: the client will be able to be self efficient as far as being able to push herself in the wheelchair from her bed to the hallway by next month.
- Risk for generalized pain
  Goals: patient will be able to find other ways to cope with pain such as natural ways.

Objective Data

- Patient has arthritis
- ADL assistance
- Fall risk
- BP: 120/ 50
- Temp: 97.4
- Pulse: 72
- Respirations: 20

Patient Information

Patient is at the nursing home due to nonfheumatic aortic stenosis, patient is also a fall risk she fell in the past and

- Client was in the kitchen she turned around and lost balance and fell and hurt her right side
- Patient is 99 years old and widowed

Nursing Interventions

- Making sure the client has everything they need is within range. If it's not the patient should press the button. I would notify the patient to never