N311 Care Plan # 1

Lakeview College of Nursing

Tyrika Walls

Demographics (5 points)

Date of Admission October 3, 2021	Patient Initials	Age 88 years old	Gender Male
Race/Ethnicity Caucasian	Occupation Retired History Teacher	Marital Status Widowed	Allergies Codine – rash and hives
Code Status Full Code	Height 6 foot	Weight 165 pounds	

Medical History (5 Points)

Past Medical History: Appendicitis, Heart Failure, Asthmatic

Past Surgical History: Patient states he had his appendix removed as a young boy

Family History: Mother (deceased) - Heart failure, asthma. Father (deceased) – Heart Disease, Dementia.

Social History (tobacco/alcohol/drugs): Patient states he likes to enjoy a glass of wine with dinner at least 3x per week. Patient states he does not use drugs or tobacco.

Admission Assessment

Chief Complaint (2 points): Patient states the pain is in his left hip area and rates pain 8/10.

History of present Illness (10 points):. Patient presented to the Sarah Bush ER via ambulance after calling for help, when he fell on his kitchen floor. Patient states he, " felt heavy in the chest before feeling weak in the legs and losing balance before he fell." Upon assessment patient stated pain level at 8/10.

Primary Diagnosis

Primary Diagnosis on Admission (3 points):. Weakness of lower extremities as evidenced by , " I felt weak in my legs before the fall".

Secondary Diagnosis (if applicable):. Congestive Heart Failure

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

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	4.0-5.8x10^6/mcL	4.4/mcL	4.8/mcL	N/A
Hgb	12.0-15.8g/dL	13.5g/dL	13.2g/dL	N/A
Hct	36.0-47.0%	38%	37.6%	N/A
Platelets	140-440K/mcL	240K/mcL	238K/mcL	N/A
WBC	4.0-12.0K/mcL	6.0K/mcL	5.8/mcL	N/A
Neutrophils	40-60%	N/A	N/A	N/A
Lymphocytes	19-49%	N/A	N/A	N/A
Monocytes	3.0-13.0%	N/A	N/A	N/A
Eosinophils	0.0-8.0%	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-	134-144mmol/L	**136 mmol/L**	**134 mmol/L**	**N/A**
K+	3.5-5.1mmol/L	**4mmol/L**	**4.2mmol/L**	**N/A**
Cl-	98-107mmol/L	**100mmol/L**	**98mmol/L**	**N/A**
CO2	21-31mmol/L	**22mmol/L**	**22mmol/L**	**N/A**
Glucose	70-99mg/dL	**86mg/dL**	**88mg/dL**	**N/A**
BUN	7-25 mg/dL	**12mg/dL**	**12mg/dL**	**N/A**
Creatinine	0.50-1.20mg/dL	**1.10mg/dL**	**1.08mg/dL**	**N/A**
Albumin	3.5-5.7 g/dL	**4mg/dL**	**4.2 mg/dL**	**N/A**
Calcium	8.6-10.3 mg/dL	**9mg/dL**	**9mg/dL**	**N/A**
Mag	1.6-2.6 mg/dL	**2.2mg/dL**	**2.2 mg/dL**	**N/A**
Phosphate	2.4-4.5 units/L	**2.4units/L**	**2.5 units / L**	**N/A**
Bilirubin	0.3-1.0 mg/dL	**.06 mg/dL**	**0.6 mg/dL**	**N/A**
Alk Phos	34-104 units/L	**96 units/L**	**90 units /L**	**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	**Pale yellow clear**	**Pale yellow clear**	**Pale clear yellow**	**N/A**
pH	**6-9**	**N/A**	**N/A**	**N/A**

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	**Negative**	**N/A**	**N/A**	**N/A**
Blood Culture	**Negative**	**N/A**	**N/A**	**N/A**
Sputum Culture	**Negative**	**N/A**	**N/A**	**N/A**
Stool Culture	**Negative**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (10 points): N/A

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

Medications (5 required)

Brand/Generic					
Dose					
Frequency					
Route					
Classification					
Mechanism of Action					
Reason Client Taking					

Contraindications (2)					
Side Effects/Adverse Reactions (2)					

Medications Reference (APA):

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient is alert and oriented x3, with a little confusion about why he ended up in the hospital. Patient does not remember what led to his fall and cannot recall how the fall occurred. Patient is calm and willing to answer questions and be assessed.** **Overall appearance is clean, neat, and well put together.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 6** **Drains present: Y☐ N ☒** **Type:**	**Patient Skin is pink clean and intact, The skin is warm to the touch, And skin turgor is less than two seconds with no evidence of rashes, bruises, or wounds.** **The patients Braden score is at six so patient is a very high fall risk. The patient has a fractured hip and should be assisted to getting up and transfers.** **There are no drains present.**
HEENT:	**Patient have no deformities in the skull neck is**

Head/Neck: **Ears:** **Eyes:** **Nose:** **Teeth:**	**straight and trachea is midline, ears are soft and no drainage present. eyes are PERLA and responsive to light. No deviated spectrum found in the nose and teeth are clean and intact**
CARDIOVASCULAR: **Heart sounds: Normal , regular** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 3 Secs** **Capillary refill: 2 secs** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:** **Thoracic Cavity**	**Heart sounds are normal and regular S one S2 can be clearly heard. No sound of S3 or S4 there is also no present heart murmur. Peripheral pulses are at three seconds and capillary refill is less than two seconds. Patient does have edema in the thoracic cavity around the heart and is currently taking diuretic.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**The patient does not use accessory muscle to breathe , Breath sounds normal and regular**
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 have a regular diet at home where he eats meals that are prepared by himself. Current diet here at the hospital is a regular diet. Bowel sounds are present last BM was noted on yesterday October 2, 2021.** **No abdominal mass or pain. No distention in the abdomen no unusual scars, drains, or wounds. The patient does not have a ostomy or a nasogastric tube.** **The patient is on a regular diet and does not need feeding tubes.**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒**	**Patient uses a hand urinal and urine is pale yellow with no abnormal odor. The patient does not complain of pain with urination and it's not on dialysis genitalia's are round and equal with no abnormalities in shape or size.**

Inspection of genitals: **Catheter: Y ☐ N ☒** **Type:** **Size:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 50** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐X** **Needs support to stand and walk☐X**	**.The patient have free range of motion with no limits. The patient does not use of any support of devices and is a High-fall risk with a fall score of 50. The patient will need assistance with getting on the fracture pan as well as getting up and transferring.**
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**.The patient has equal strength on both sides of body he is alert and oriented mental status is calm and aware of where he is. His speech is clear it easily to understand. Patient is fully conscious and aware of surroundings.**
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):**	**.N/A**

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
11:45 am	**66**	**118/68**	**18**	**37.5**	**98%**

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:45 am	**3**	**Hip**	**Moderate**	**Dull, achy pain**	**Turn patient off left hip bone and place a pillow under him for comfort**

Intake and Output (2 points)

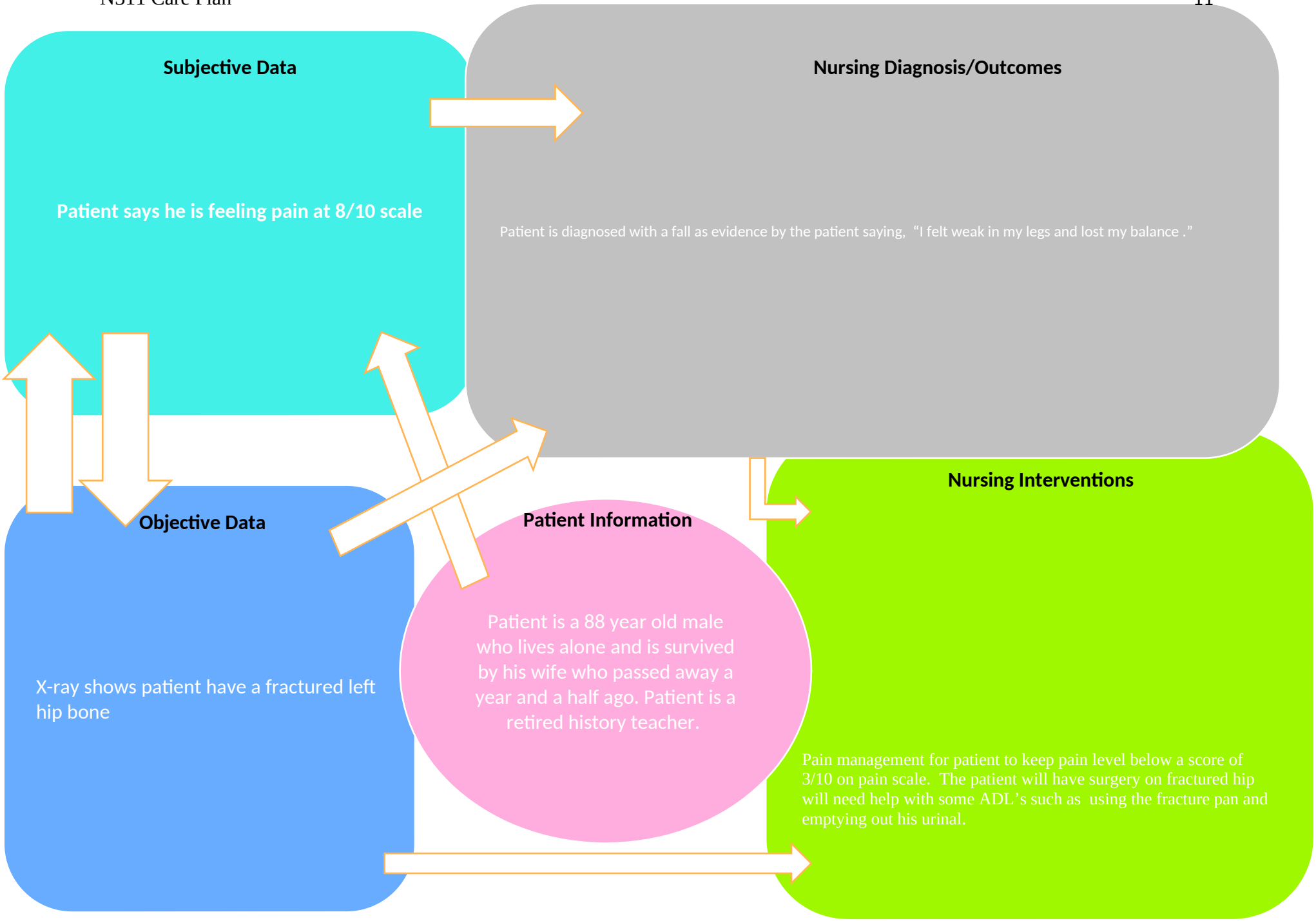
Intake (in mL)	Output (in mL)
N/A	**400mL**

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.		**1.** **2.**	
2.		**1.** **2.**	

Overall APA format (5 points):

Concept Map (20 Points):


Subjective Data
Patient says he is feeling pain at 8/10 scale
Nursing Diagnosis/Outcomes
Patient is diagnosed with a fall as evidence by the patient saying, "I felt weak in my legs and lost my balance ."
Nursing Interventions
Objective Data
X-ray shows patient have a fractured left hip bone
Patient Information
Patient is a 88 year old male who lives alone and is survived by his wife who passed away a year and a half ago. Patient is a retired history teacher.
Pain management for patient to keep pain level below a score of 3/10 on pain scale. The patient will have surgery on fractured hip will need help with some ADL's such as using the fracture pan and emptying out his urinal.