

N311 Care Plan #

Lakeview College of Nursing

Kate Dominguez

Demographics (5 points)

Date of Admission 9/23/2021	Patient Initials S.S	Age 63	Gender Female
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Married	Allergies Doxycycline, Penicillin, Latex, and tape.
Code Status Full Code	Height 62"	Weight 241.2 pds	

Medical History (5 Points)

Past Medical History: The patient's past medical history includes diabetes, Melita, Hypertension, Hypothyroid, Urinary Tract Infections, Covid-19, Shingles, and Pneumonia.

Past Surgical History: The patient's past surgical history includes laparoscopic cholecystectomy and a total hysterectomy. No dates for these surgeries were available.

Family History: N/A

Social History (tobacco/alcohol/drugs): The patient has occasional alcohol use, but does not have any tobacco or drug use.

Admission Assessment

Chief Complaint (2 points): The patient was transferred via EMS to the Emergency Department from her home. The patient fell in the bathroom and states that she did not lose loss of conscious and has not been feeling well the past few days.

History of present Illness (10 points):The patient fell in the bathroom and was transported to the emergency department via ambulance. At the hospital, they

found that she had a displaced intertrochanteric fracture of the right femur. The patient has had 4 times where she has fallen, and she does experience neuropathy in her feet and states that it feels as if she is walking on pebbles. Ever since she was diagnosed with COVID-19, she claims that she has not felt well. The patient has symptoms of nausea, vomiting, and very severe hip pain. The patient has also had multiple sinus infections and has had pneumonia.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): The patient's primary diagnosis on admission was a displaced intertrochanteric fracture on the right femur.

Secondary Diagnosis (if applicable): N/A

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

The patient has a fracture in the right hip and it is caused by a fall. It is more common in the elderly due to how frail their bones are. With these fractures, there are two types; stable and unstable. With stable fractures, they will normally have an "intact posteromedial cortex" (StatPearls). With that, unstable fractures will contain either a comminution of the posteromedial cortex or a thin lateral wall. With the fractures, there are a type I, type II, and a type III. For type I's, they are used when the fracture is not displaced. For type II, their subclassification will refer to a trochanter fragment.

Attum, B. (2021, August 11). *Intertrochanteric femur fracture*. StatPearls

Retrieved October 10, 2021, from <https://www.ncbi.nlm.nih.gov/books/NBK493161/?fbclid=IwAR28BW1C18I5xjXW95ggHGI8S4s-9Gjitw73WEhZG2f-u6O6w0mTR19j2YU>

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	4.0-5.8x10 ⁶ /mcl	4.34 g/dL	N/A	N/A
Hgb	12.0-15.8g/dL	13.7 g/dL	N/A	N/A
Hct	36.0-47.0%	38.4%	N/A	N/A
Platelets	140-440K/mcl	116K/mcL	N/A	The patient has a low platelet count due to her most likely having pneumonia.
WBC	4.0-12.0K/mcl	8.8K/mcL	N/A	N/A
Neutrophils	4.0-12.0K/mcl	No Diff	N/A	No differential was determined
Lymphocytes	19-49%	No Diff	N/A	No differential was determined
Monocytes	3.0-13.0%	No Diff	N/A	No differential was determined
Eosinophils	0.0-8.0%	No Diff	N/A	No differential was determined
Bands	0.0-10.0%	No Diff	N/A	No differential was determined

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	133	N/A	The patient was constipated which would result in a low value
K+	3.5-5.1mmol/L	4.1	N/A	N/A
Cl-	98-107mmol/L	95	N/A	The patient was constipated which would result in a low value
CO2	21-31mmol/L	23	N/A	N/A
Glucose	70-99mg/dL	395	N/A	The patient has diabetes which would result in a high glucose
BUN	7-25 mg/dL	15	N/A	N/A
Creatinine	0.50-1.20mg/dL	0.76	N/A	N/A
Albumin	3.5-5.7 g/dL	4.1	N/A	N/A
Calcium	8.6-10.3 mg/dL	9.2	N/A	N/A
Mag	1.6-2.6 mg/dL	N/A	N/A	No value was determined
Phosphate	2.4-4.5 units/L	N/A	N/A	No value was determined
Bilirubin	0.3-1.0 mg/dL	1	N/A	N/A
Alk Phos	34-104 units/L	117	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,	Light,	N/A	N/A

	clear	Clear yellow		
pH	5.0-9.0	5.5	N/A	N/A
Specific Gravity	.003-1.013	1.043	N/A	The patient is likely dehydrated which would result in this
Glucose	Glucose	Greater than 1,000	N/A	The patient is diabetic which would result in this
Protein	Glucose	Trace	N/A	The patient is diabetic which would result in this
Ketones	Glucose	2+	N/A	The patient is diabetic which would result in this
WBC	0.0-0.5	1	N/A	There is an infection, but it is common in people with diabetes
RBC	0.0-3.0	1	N/A	N/A
Leukoesterase	Negative	Negative	N/A	The value was not provided

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	Urine was not assessed
Blood Culture	Negative	N/A	N/A	Blood was not assessed
Sputum Culture	Negative	N/A	N/A	Sputum was not assessed
Stool Culture	Negative	N/A	N/A	Stool was not assessed

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):

- 1. X-Ray of right hip/pelvis (2 View). This showed a right hip fracture.**
- 2. X-Ray of Right Knee (3 View): The x-ray showed no acute fracture or malalignment, but did show that the patient does have a severe case of osteoarthritis.**
- 3. X-Ray of chest (1 view). The x-ray showed evidence of pulmonary opacities that are consistent with pneumonia.**

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

Medications (5 required)

Brand/ Generic	Levothyroxine/ Synthroid	Amlodipine/ Norvasc	Gabapentin/ Neurontin	Oxybutynin Vhloride- ER/Ditrop an XL	Trulicity Solution Pen Injector
Dose	150 mcg	10 mg	300 mg	10 mg	0.75 mg
Frequency	QD	QD	TOD	BID	QD
Route	PO	PO	PO	PO	Subcutan eous
Classificati on	Synthetic thyroxine: Thyroid hormone replacement	Calcium channel blocker: Antianginal, antihyperten sive	Analgesic Adjuncts	Anticholin ergic; Antispasm odic (urinary)	Glucagon : 1 receptor antagonis t- Antidiabe tic
Mechanism of Action	Replaces endogenous thyroid hormone; Controls DNA transcription and protein synthesis	Binds to dihydropyrid ine and nondihydrop yridine and will decrease intracellular calcium levels	unknown	Releases antimusca rinic and potent direct antispasm odic actions on the smooth muscle in the bladder	Activates the GLP- 1 receptor to increase intracellu lar cyclic AMP. In the beta cells, it causes a glucose- dependen t insulin release
Reason Client Taking	Hypothyroid	Hypotension	Neuropathy	Urinary incontinen ce	Diabetes
Contraindi cations (2)	Patient with hypersensitivity Adrenal insufficiency was not corrected	Patients with hypersensitiv ity Patients with cardiogenic shock, severe	Hypersensitivi ty to medication and use consciously for renal	Angle- closure glaucoma Urine retention	Either has a personal or family history of medullar

		aortic stenosis, and unstable angina	impairment		y thyroid carcinoma Severe gastrointestinal
Side Effects/Adverse Reactions (2)	Alopecia Diaphoresis	Arrhythmias Hypotension	Confusion and hypertension	Abnormal behaviors Agitation	Hyperglycemia pancreatitis

Medications Reference (APA):

Jones, D.W. (2021). Nurse’s drug handbook. (A. Bartlett, Ed.) (19th ed.). Jones & Bartlett

Bulsara, K. G. (2021, August 8). Amlodipine. StatPearls.
<https://www.ncbi.nlm.nih.gov/books/NBK519508/#:~:text=Amlodipine%20is%20contraindicated%20in%20patients,heart%20failure%2C%20and%20hepatic>

Assessment

Physical Exam (18 points)

GENERAL: Alertness: X4 Orientation: X4 Distress: No signs of distress. Overall appearance: Well groomed	Patient was alert (x4) Patient was well orientated (x4) The patient showed no signs of distress Overall appearance was clean and well cared for
INTEGUMENTARY: Skin color:	The patient’s skin was a normal pink color. Patient’s skin was intact and dry.

<p>Character: Temperature: Warm Turgor: Elastic Rashes: None Bruises: None Wounds: The patient has 3 Steri strips on her right hip. Braden Score: 17 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>The patient’s skin was warm. The patients skin had an elastic turgor No rashes were observed No bruised were observed No wounds were observed The patient’s Braden score was a 17 and is at mild to no risk of pressure ulcers The patients has no drains</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>The patient has a “scratchy throat” but when inspected, she had a red irritated color to it. The trachea was palpated and was determined symmetrical. The patients’ ears were symmetrical and had no drainage that was visible. The patient does not wear glasses and they did show PERRIA. The eyes were able to show good movement when the 6 cardinal directions test was performed. The nose has no polyps, deviated septum, or epistaxis. The patient is missing several teeth on her left side of the mouth.</p>
<p>CARDIOVASCULAR: Heart sounds: S1 and S2 are osculated S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Normal sinus Peripheral Pulses: Capillary refill: Less than 3 seconds. Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema: The patient has +1 on both legs.</p>	<p>S1 and S2 were osculated. The patient has normal sinus rhythm Peripheral pulses were assessed as 3+ and 2+. Capillary refill was less than 3 seconds. The patient has edema 1+ edema on lower legs and feet</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character: The patient has osculated bilaterally, posterior, clear, and equal breath sounds. She does have diminished breath sounds on her left side.</p>	<p>No use of accessory muscles Patient’s breath sounds were auscultated bilaterally (Posterior and anterior). They showed clear diminished equal breathing sounds.</p>
<p>GASTROINTESTINAL:</p>	<p>Normal diet</p>

<p>Diet at home: Regular Current Diet: Regular Height: 62" Weight: 241.2 lbs. Auscultation Bowel sounds: Active bowel sounds in all 4 quadrants. Last BM: This morning, 10/5/2021 Palpation: Pain, Mass etc.: The patient has no tenderness and is soft. Inspection: Distention: She has a little pain due to her having some constipation. Incisions: She has incisions on her right hip due to hip surgery. Currently has 3 steri-strips on her right hip. Has a surgical incision. Scars: None Drains: None 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>Normal diet 62 inches 241.2 pounds Bowel sounds are active in all 4 quadrants Morning of 10/05/ 2021 No tenderness on palpitation A little distention was observed Incision on right hip from surgery No scars were observed No drains observed No ostomy observed No Ng tube observed No feeding tubes/PEG tube observed</p>
<p>GENITOURINARY: Color: Yellow Character: Clear Quantity of urine: N/a due to not observed. 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: N/A Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Light yellow Clear No quantity observed No pain with urination No dialysis Genitals not observed No catheter</p>
<p>MUSCULOSKELETAL: Neurovascular status: Intact ROM: Active and passive are intact Supportive devices: Wheelchair and walker. Strength: Left leg is a +3 and right leg is +1 ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 60</p>	<p>Neurovascular status is intact Passive and active range of motion is intact Patient used a wheelchair as a supportive device Patients' strength was normal. It was partially diminished in the right leg due to the hip surgery. Patient needs assistance with ADLS Patient is considered a fall risk Patient needs assistance transferring and</p>

<p>Activity/Mobility Status: As tolerated Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment: X- Wheelchair Needs support to stand and walk: X-Yes</p>	<p>ambulation Patient needs support to stand and walk</p>
<p>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input 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: Clear Sensory: Peripheral Neuropathy LOC:</p>	<p>Patient moves will with all extremities will with partially weakness in the rt leg due to recent hip surgery Patients eyes did exhibit PERRLA signs Strength is equal in all extremities except for the right leg Patient was alert (x4) Patients speech is clear Patient has a history of neuropathy, mostly in her feet, but in other areas as well. Patient has no LOC</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): Watching the show The Price is Right Developmental level: Appropriate for developmental age. Religion & what it means to pt.: Christian Personal/Family Data (Think about home environment, family structure, and available family support): Husband</p>	<p>The patient copes with watching the Price is Right Patients developmental age is appropriate for their age Patient identifies with Christianity Patient was living in a home with her husband before she was admitted to the nursing home</p>

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
08:00 am	72	120/68 Rt arm	20	97.0- Temporal	98%- O2 monitor

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:30	N/A	N/A	N/A	N/A	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
None observed	None observed

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? <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
<p>1. Immobility related to the hip surgery as evidence by the steri strips on her leg and the patient stated she had right hip surgery.</p>	<p>This was chosen due to the patient needing extra help when moving due to the right sided weakness.</p>	<p>1. Assist the patient to move.</p> <p>2. Bed low the patient, educate the patient, push call light before you try to move, always ask for help.</p>	<p>1. I would help the patient when needed. The patient moved well with my assistance.</p> <p>2. Goal was met since the patient did not fall when I was there and would ask for help when needed.</p>
<p>2. Fall risk due to displaced intertrochanteric right femur fracture and shingles</p>	<p>This was chosen due to the patient experiences neuropathy due to shingles and has right sides weakness</p>	<p>1. bed in low position, call light in reach, and check on</p> <p>2. limit any hard-working activities that would put too much work onto the right hip</p>	<p>The patient does understand what is going on and the risks that are associated with her diagnosis</p> <p>Patient does respond well to the nursing interventions</p> <p>Goals were met</p>

Overall APA format (5 points):

Attum, B. (2021, August 10).

Intertrochanteric femur fracture. StatPearls

Capriotti, T. (2020). *Davis Advantage for Pathophysiology: Introductory concepts and clinical*

Concept Map (20 Points):

Subjective Data

- Patient states that it “feels like she is walking on pebbles”
- Patient states that she “has not been feeling good since COVID-19”

Nursing Diagnosis/Outcomes

1. Fall risk due to displaced intertrochanteric right femur fracture and shingles
 - a. The patient does understand the risks that follow through with the right sided weakness
 - b. The patient does respond well to the nursing interventions
 - c. Goal was met
2. Impaired mobility due to the displaced intertrochanteric right femur fracture
 - a. The patient understands what she is able to and what she is not able to do
 - b. She used a wheelchair and does not attempt to move on her own
 - c. Goals were met

Objective Data

- An X-RAY of the right hip and the pelvis showed a displaced intertrochanteric right femur fracture
- The Sodium and chloride are low due to the patient being constipated
- The specific gravity, glucose, protein, ketones, and WBC count in her urine were abnormal due to her diabetes
- Her platelets are low due to the patient most likely having pneumonia

Patient Information

The patient is a 63 year old female with a history of diabetes, hypertension, hypothyroid, UTI, COVID, and shingles. She was admitted due to a displaced intertrochanteric right femur fracture that is due to a fall in her bathroom at her home.

Nursing Interventions

1. The bed is in a low position, call light in reach, and check on the patient
2. Understands that she needs to limit activities on the right leg
3. Let the patient and encourage her to try and do ROM
4. Try to ambulate the patient in the hallway with how much is tolerated



