N311 Care Plan #

Lakeview College of Nursing

Name

Demographics (5 points)

Date of Admission 6/25/2019	Patient Initials RB	Age 66 years old	Gender Male
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Widowed	Allergies Timertin, Zosyn, Unosyn, Augmentin, Cephalosporins, Penicilian G
Code Status DNR	Height 5 ft 6 in	Weight 197.2 lbs	

Medical History (5 Points)

Past Medical History: The patient has multiple sclerosis (MS), spastic quadriplegia, urinary tract infections (UTI) and pressure ulcer.

Past Surgical History: The patient had coronary artery bypass surgery to restore normal blood flow to the heart by creating a bypass around the blocked artery/arteries.

Family History: None

Social History (tobacco/alcohol/drugs): None

Admission Assessment

Chief Complaint (2 points): The patient is complaining of a pressure ulcer of the ischium, left stage 3.

History of present Illness (10 points): The patient is still admitted at Illini Heritage for a pressure ulcer. The wound is located on the left ischium. The pressure ulcer is at a stage 3 and has been present for long than three months. The ulcer may be extended into the subcutaneous tissue layer. The patient was diagnosis was MS and is wheelchair bound which could be associated

with the pressure ulcer. The patient stated he isn't in pain and no need to relieve his left ischium. Treatment for the ulcer is to spend time out of his wheelchair and lay off of the pressure sore.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Pressure Ulcer

Secondary Diagnosis (if applicable): Multiple Sclerosis (MS)

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

Pressure ulcers also known as bedsores are localized areas of tissue necrosis that occur when soft tissue is crushed for an extended period of time between a bony prominence and an external surface. Full-thickness skin loss may spread into the subcutaneous tissue layer in stage 3 pressure ulcers. Pressure ulcers in stages 3 and 4 involve more underlying tissue and result in more extensive damage. Stage 3 affects the entire thickness of the skin, as well as the subcutaneous tissue layer; granulation tissue and edible are common. There may be undermining and/or tunneling at this stage, making the wound appear much larger than it is on the surface.

Signs and symptoms when dealing with pressure ulcer at a stage 3 are sore that resembles a crater and may have an unpleasant odor. It may have red edges, pus, odor, heat, and/or drainage, which are all indicators of infection. If the tissue in or surrounding the sore has died, it is black.

When discovering an ulcer at a stage 3 tell the doctor, remove any dead tissue and prescribe antibiotics to fight infection. For a stage 3 ulcer to heal it can take up to 6 months. There is no lab test that can guarantee that a patient will develop a pressure ulcer.

Managing a patient's protein level is important because malnutrition is a risk factor for pressure ulcers.

Pathophysiology References (2) (APA):

What Are the Stages of Pressure Sores? (2016, October 18). WebMD.

https://www.webmd.com/skin-problems-and-treatments/pressure-sores-4-stages

Stage 3 Bedsores. (2021, September 29). MedMalFirm.Com. https://www.medmalfirm.com/news-and-updates/bedsore-lawyer/

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	4.7 - 6.1	N/A	N/A	
Hgb	13.5 - 17.5	N/A	N/A	
Hct	41% - 50%	N/A	N/A	
Platelets	150,000-450,000	N/A	N/A	
WBC	5,000 - 10,000	N/A	N/A	
Neutrophils	2,500 - 7,000	N/A	N/A	
Lymphocytes	1,000 - 4,800	N/A	N/A	
Monocytes	1% - 10%	N/A	N/A	
Eosinophils	500	N/A	N/A	
Bands	10% or less	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 - 145	N/A	N/A	
K+	3.6 - 5.2	N/A	N/A	
Cl-	96 - 106	N/A	N/A	
CO2	21-31	N/A	N/A	
Glucose	70 - 99	227 H	N/A	Hyperglycemia(high blood glucose) means there is too much sugar in the blood because the body lacks enough insulin. (Cleveland Clinic, 2021)
BUN	2 - 24	34 H	N/A	The patient consumes a high protein diet to maintain physiological function. (Hansen, 2021)
Creatinine	0.6 - 1.2	34 H	N/A	The reason of inadequate dialysis time and the breakdown of muscle in the client. (Hansen, 2021)
Albumin	3.4 -5.4	3.0 L	N/A	Low albumin can be caused by various conditions like malnutrition. (Medscape, 2021)
Calcium	8.5 - 10.5	N/A	N/A	
Mag	1.7 - 2.2	N/A	N/A	
Phosphate	2.5 - 4.5	N/A	N/A	
Bilirubin	0.2 - 1.2	N/A	N/A	
Alk Phos	44 - 147	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	Light yellow	N/A	N/A	
pH	5.0 - 9.0	N/A	N/A	
Specific Gravity	1.003 - 1.030	N/A	N/A	
Glucose	Negative	Negative	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	Negative 0-5	N/A	N/A	
RBC	Negative 0-2	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	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):

Hansen, P. (2021). Nfb.org. Retrieved from https://nfb.org//images/nfb/publications/vodold/vspr9815.htm#:~:text=%20%20%20Blood%20Chemistry%20%20%20Normal,from%20d%20...%20%2012%20more%20rows%20

Peralta, R., MD. (2021, April 3). Hypoalbuminemia: Background, Pathophysiology, Etiology. Medscape. https://emedicine.medscape.com/article/166724-overview

Hyperglycemia: Causes, Symptoms, Treatments & Prevention. (2021). Cleveland Clinic. **https://my.clevelandclinic.org/health/diseases/9815-hyperglycemia-high-blood-sugar**

Diagnostic Imaging

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

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

Brand/Generic	**Baclofen**	**Bisacodyl**	**Calcium Citrate**	**Cholecaleiferol**	**Denosumab**
Dose	**10mg**	**10mg**	**5mg**	**200mg**	**60mg/mL**
Frequency	**TID**	**q.o.d.**	**BID**	**BID**	**QD**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Injection**
Classification	**Skeletal muscle relaxants**	**Stimulant laxatives**	**2-hydroxpropane 1,2,3-tricarboxylate**	**Vitamin D analogs**	**Bone-modifying agent (RANK**

					inhibitor)
Mechanism of Action	**It reduces the release of excitatory neurotransmitters and substance P by binding to the GABA-B receptor.**	**Stimulating enteric neurons to cause peristalsis, colonic contractions etc.**	**Increase plasma calcium levels.**	**Binds to vitamin D receptors and modulates gene expression.**	**Binds the cytokines RANKL (receptor activator of NFkB ligand)**
Reason Client Taking	**Muscle stiffness and tightness**	**Constipation**	**Low calcium levels**	**Helps body absorb calcium**	**Treat bone loss**
Contraindications (2)	**Confusion** **Stroke**	**Appendicitis** **Ileus**	**Kidney stones** **Sarcoidosis**	**Hypervitaminosis** **Hypercalcemia**	**Hypotension** **Pruritus**
Side Effects/Adverse Reactions (2)	**Dizziness** **Weakness**	**Vomiting** **Diarrhea**	**Low blood pressure** **Constipation**	**Chest pain** **Growth problems**	**Back pain** **Nausea**

Medications (5 required)

Medications Reference (APA):

Jones & Bartlett Learning. (2011). 2011 Nurse's drug handbook. Jones & Bartlett Learning.

Assessment

GENERAL: **Alertness:** **Orientation:**	**Alert** **Oriented person, place, and time** **Distressed**

Distress: **Overall appearance:**	**Appropriate**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N x** **Type:**	 **Pallor** **Dry** **Warm** **None** **None** **None** **Ulcer** **12**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 **Symmetrical** **No Drainage from eye** **Oral Cavity Moist and pink**
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N x** **Edema Y ☐ N x** **Location of Edema:**	**Cap refill less than 3 seconds on extremities** **Radial pulse +2** **No murmur, gallop or rub**
RESPIRATORY: **Accessory muscle use: Y☐ N x** **Breath Sounds: Location, character**	**None**

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 x** **Nasogastric: Y ☐ N x** **Size:** **Feeding tubes/PEG tube Y ☐ N x** **Type:**	**Regular diet** **5 ft 7 in** **197.2lb** **Normal bowel sounds** **Soft abdomen** **Wounds: pressure ulcer**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N x** **Dialysis: Y ☐ N x** **Inspection of genitals:** **Catheter: Y ☐ N x** **Type:** **Size:**	**N/A**

MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N x** **Fall Risk: Y ☐ Nx** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	**Wheelchair bound due to MS**
NEUROLOGICAL: **MAEW: Y ☐ Nx** **PERLA: Y ☐ Nx** **Strength Equal: Y ☐ N x if no -** **Legs x Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Retired** **Widowed** **English** **None** **None**
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):**	**Lives in the nursing home.** **No religion** **Has a sister and a niece.**

Physical Exam (18 points)

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
11:37 am	76	125/78	18	97.5 F	98%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:45 am	**0**	**Ischium**	**Stage 3**	**Full thickness tissue loss**	**Antibiotic therapy**

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.

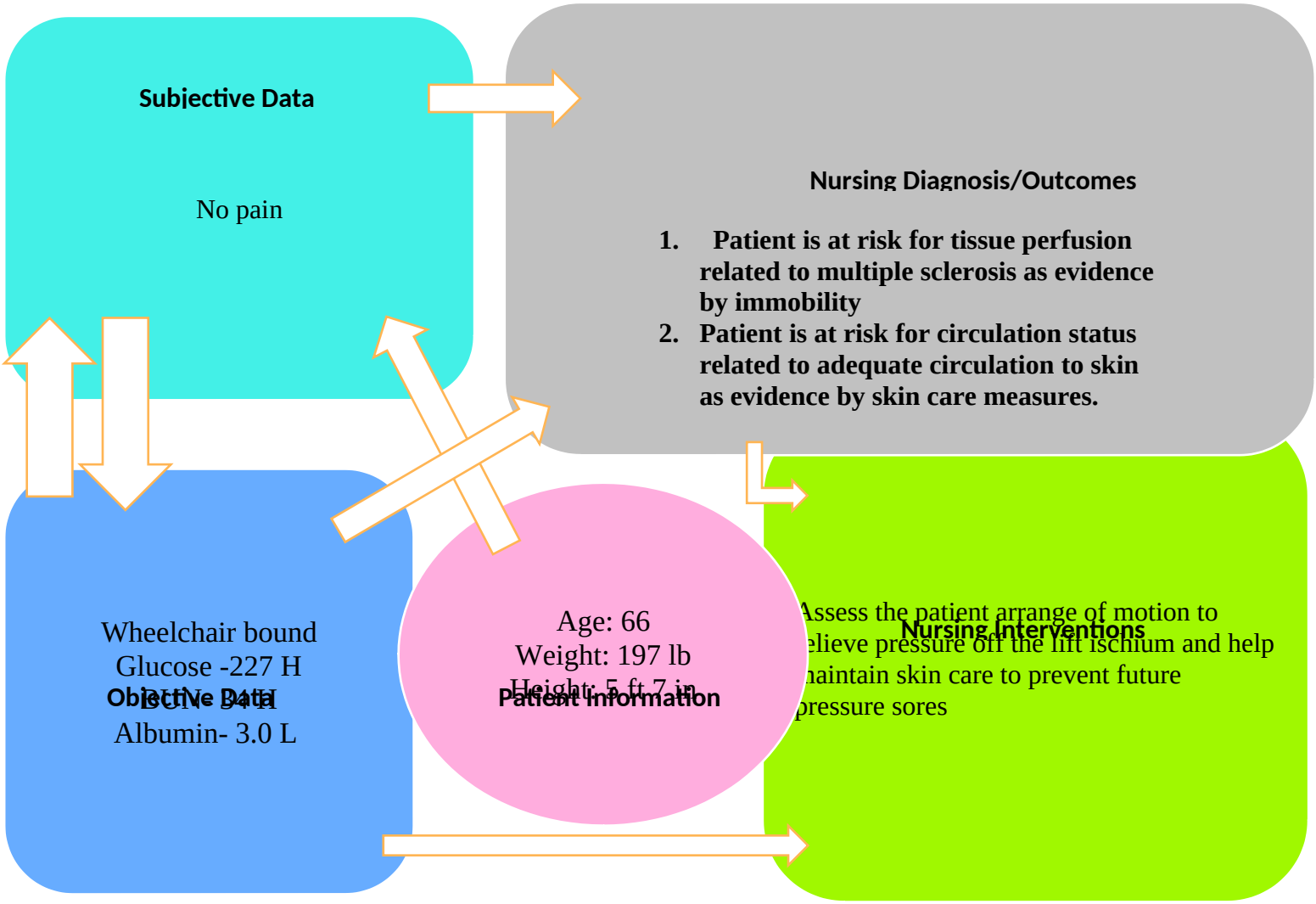
1. Patient is at risk for tissue perfusion related to multiple sclerosis as evidence by immobility	**The patient is unable to walk causing him to be bound to a wheelchair.**	**1. Assess clients range of motion of the pressure sore.** **2. Monitor the patients wound site.**	**The patient understands good range of motion is important to prevent pressure sore.**
2. Patient is at risk for circulation status related to adequate circulation to skin as evidence by skin care measures.	**The patient is laying on his left hip applying pressure to the around hours throughout the day.**	**1. The nurse will provide techniques to skin care.** **2. The nurse will help circulate the lower part of patient body.**	**The patient understands a demonstrates skin care measures is important for preventing futures pressure ulcer.**

Other References (APA):

Concept Map (20 Points):

Philips, L. (2020) Sparks & Taylor's Nursing Diagnosis Reference Manual. (11th ed.)

Wolters Kluwer Medical.


Subjective Data
No pain
Nursing Diagnosis/Outcomes
1. Patient is at risk for tissue perfusion related to multiple sclerosis as evidence by immobility
2. Patient is at risk for circulation status related to adequate circulation to skin as evidence by skin care measures.
Wheelchair bound
Glucose -227 H
BUN- 34 H
Albumin- 3.0 L
Objective Data
Age: 66
Weight: 197 lb
Height: 5 ft 7 in
Patient Information
Assess the patient arrange of motion to
elieve pressure off the lift ischium and help
aintain skin care to prevent future
pressure sores
Nursing Interventions