N321 Care Plan # 2

Revised 11/19/21

Lakeview College of Nursing

Name: Shana. M. Stanley

Demographics (3 points)

Date of Admission 8-13-21	Patient Initials PD	Age 79	Gender F
Race/Ethnicity White non- Hispanic	Occupation Retired	Marital Status Divorced	Allergies Latex
Code Status DNR	Height 5'2"	Weight 170LB	

Medical History (5 Points)

Past Medical History: COPD, HNT, HLD, Back pain, Thyroid cancer, A-fib,

Past Surgical History: Colon resection, PR repair of incisional hernia, Thyroid surgery

Family History: Cancer

Social History (tobacco/alcohol/drugs): Past smoker of 25yrs quit 3 years ago, has one glass of wine monthly.

Assistive Devices: None

Living Situation: Lives at home with Daughter

Education Level: High school grade 12

Admission Assessment

Chief Complaint (2 points): Weakness and fever for two days.

History of present Illness (10 points): The client was brought to the emergency room at OSF with the complaint of weakness and fever for two days and twitching. She was then transferred to our facility with the same complaint. After assessment was done and diagnostic testing was finished it was determined that he patient was experiencing hypocalcemia and calcium supplements were started. This was indicated by her calcium level values presenting at a 7.5 (normal 8.5-10.1). The patient also presented with a urinary tract infection which may have been a contributing factor to her persistent fever.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Hypocalcemia

Secondary Diagnosis (if applicable): UTI

Pathophysiology of the Disease, APA format (20 points): According to Capriotti hypocalcemia is characterized by calcium blood levels less than 8.7mg/dl. The patient's labs indicate a value of 7.5mg/dl rendering her hypercalcemic. The patient presented with muscle twitching upon admittance, complications of hypocalcemia include muscle twitching and seizures as well as weakness (Capriotti and Frizzell (2016). It is also noted in the patients past medical history that she experienced thyroid cancer and had under gone thyroid surgery. Thyroid surgery can result in hypocalcemia causing the patient to need to take calcium supplements to replace what the body is lacking. During thyroid surgery it is possible for the parathyroid gland to become damaged which would inhibit the parathyroid hormone from being produced properly. With a reduced amount of parathyroid hormone calcium levels may fall causing the patient to experience hypocalcemia (Vol 5 issue 5 p.7 2021). With the patient's calcium labs indicating hypocalcemia and prompted the team to start supplementing calcium to treat the hypocalcemia and to prevent any atrial fib issues as this was a concern in the patients past medical history as well. After starting the calcium supplements the patient started to experience a urinary tract infection. This infection could have been caused be the amount of calcium supplements being administered. An excessive amount of calcium even if the patient is lacking can significantly increase in bacterial adherence in the bladder and may contribute to urinary tract infections (AE, 2021).

Pathophysiology References (2) (APA):

AE;, A. L. L. S. (n.d.). *Increased risk of urinary tract infection associated with the use of calcium supplements*. Urological research. Retrieved October 1, 2021, from https://pubmed.ncbi.nlm.nih.gov/2204174/.

Capriotti, T., & Frizzell, J. P. (2016). Pathophysiology: introductory concepts and clinical perspectives. Philadelphia: F.A. Davis Company.

Vol 5 issue 5 p.7. American Thyroid Association. (n.d.). Retrieved November 19, 2021, from https://www.thyroid.org/patient-thyroid-information/ct-for-patients/vol-5-issue-5/vol-5-issue-5-p-7/.

Laboratory Data (15 points)

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 10^6/uL		**3.42**	**These values are consistent with blood loss (Capriotti & Frizzell, 2016).**
Hgb	12.0-16.0 g/dL		**9.5**	**These values are consistent with blood loss (Capriotti & Frizzell, 2016).**
Hct	37.0-48.0%		**32.0**	**These values are consistent with blood loss (Capriotti & Frizzell, 2016).**
Platelets	150-400 10^3/uL		**304**	
WBC	4.1-10.9 10^3/uL		**14.59**	**These values are constant with presence of infection (Capriotti & Frizzell, 2016).**

Neutrophils	1.50-7.70 10^3/uL		**NA**	
Lymphocytes	1.00-4.90 10^3/uL		**8.6**	**These values are constant with presence of infection (Capriotti & Frizzell, 2016).**
Monocytes	0.00-0.80 10^3/uL		**10.3**	**Monocytes are elevated due to trauma and inflammatory response (Capriotti & Frizzell, 2016).**
Eosinophils	0.00-0.50 10^3/uL		**6.0**	**Eosinophils are elevated due to trauma and inflammatory response (Capriotti & Frizzell, 2016).**
Bands	**NA**		**14.8**	

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-	136-145 mmol/L		**140**	
K+	3.5-5.1 mmol/L		**3.9**	
Cl-	98-107 mmol/L		**104**	
CO2	21.0-32.0 mmol/L		**25.0**	
Glucose	60-99 mg/dL		**214**	**These values are constant with presence diabetes (Capriotti & Frizzell, 2016).**
BUN	5-20 mg/dL		**24**	**These values are constant with presence of infection (Capriotti & Frizzell, 2016). UTI**
Creatinine	0.5-1.5 mg/ dL		**0.76**	
Albumin	3.4-5.4 g/dL		**NA**	
Calcium	8.5-10.1 mg/dL		**7.5**	
Mag	1.6-2.6 mg/ dL		**NA**	
Phosphate	**3.4-4.5**		**NA**	

Bilirubin	**-**		**NA**	
Alk Phos	44-147 U/L		**NA**	
AST			**NA**	
ALT			**NA**	
Amylase			**NA**	
Lipase			**NA**	
Lactic Acid			**NA**	

Other Tests 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
INR			**NA**	
PT			**NA**	
PTT			**NA**	
D-Dimer			**NA**	
BNP			**NA**	
HDL			**NA**	
LDL			**NA**	
Cholesterol			**NA**	
Triglycerides			**NA**	
Hgb A1c			**NA**	
TSH			**NA**	

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**		**YELLOW**	
pH	5.0-7.0		**6.4**	
Specific Gravity	**1.003-1.030**		**NA**	
Glucose	**Negative**		**NA**	
Protein	**Negative**		**NA**	
Ketones	**Negative**		**NA**	
WBC	0-25/uL		**NA**	
RBC	0-20/uL		**NA**	
Leukoesterase	**Negative**		**NA**	

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	**NA**		**NA**	
Blood Culture	**NA**		**NA**	
Sputum Culture	**NA**		**NA**	
Stool Culture	**NA**		**NA**	

Lab Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). Pathophysiology: introductory concepts and clinical perspectives. Philadelphia: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): NA

Diagnostic Test Correlation (5 points):NA

Diagnostic Test Reference (1) (APA): NA

Current Medications (10 points, 1 point per completed med)
10 different medications must be completed

Home Medications (5 required)

Brand/Generic	**Albuterol**	**Metoprolol**	**Oxycodone**		
Dose	**90mcg/actuation**	**5mg**	**1 ml oral slution**		
Frequency	**Q4hr**	**PRN**	**Every 4hrs**		
Route	**Inhalant**	**IV push**	**NG**		
Classification	**Bronchodilator**	**Beta1-adrenergic blocker**	**opioid**		
Mechanism of Action	**Intended to relax bronchial smooth-muscles cells and inhibit histamine release.**	**Inhibits stimulation of beta 1 receptor site**	**Alters perception of pain at spinal cord levels**		
Reason Client Taking	**Covid-19**	**High B/P**	**Pain management**		
Contraindications (2)	**Hypersensitivity to albuterol**	**Acuter heart failure Cardiogenic shock**	**Asthma Gastrointestinal obstruction**		

Side Effects/Adverse Reactions (2)	**UTI ANXITY TREMORS**	**Anxiety CVA**	**Anxiety bradycardia**		
Nursing Considerations (2)	**Monitor serum potassium levels Be aware of drug tolerance**	**Uses caution with pt that have angina Watch heart rate**	**Opioid abuse Be careful with pts that have COPD**		

Hospital Medications (5 required)

Brand/Generic	**Insulin**	**Lactobacillus**	**Nystatin**	**Vancomycin**	
Dose	**1 unit**	**1 capsule**	**Powder**	**1g in 270ml NS**	
Frequency	**Before meals and bed time**	**Daily**	**X2 Daily**	**EVERY 12HRS**	
Route	**SUB Q**	**Oral NG**	**Topical**	**IV**	
Classification	**antidiabetic**	**Gastrointestinal , Herbals**	**antifungal**	**antibiotic**	
Mechanism of Action	**Lowers blood glucose levels by stimulating peripheral glucose uptake.**	**Inhibiting or decreasing the growth of harmful microorganisms in the gut by producing lactic acid.**	**Binds to sterols in fungal cell membranes impairing membrane integrity.**	**Inhibits bacterial RNA and cell wall synthesis**	

Reason Client Taking	**Diabetes**	**Supplement**	**Fungal infection**	**infection**	
Contraindications (2)	**Asthma COPD**	**Hypersensitivity to lactose or milk.**	**Skin sensitivity**	**Hypersensitivity to corn or vancomycin components**	
Side Effects/Adverse Reactions (2)	**Tachycardia UTI**	**Tachycardia Hives, itching, or rash.**	**Irritation Oral form may cause vomiting**	**c-diff hypotension**	
Nursing Considerations (2)	**Monitor blood glucose levels Monitor serum potassium levels.**	**Monitor for allergic reactions. Ask Dr. about possible side effects.**	**Keep area dry Keep away from eyes**	**Reconstitute correctly of IV use Infuse over at least 1hr or more**	

Medications Reference (1) (APA): Jones & Bartless Learning. (2020). 2020 Nurse's drug handbook (19th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Pt appears to be in distress, she is not alert and dose not communicate upon assessment.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Pt skin is warm, pink, and dry, with redness in vaginal area. Turgor slow return, Pt has a Braden score of 20.**

HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	• **Head and neck symmetrical, trachea midline no deviation, thyroid not palpable, no noted nodules. Bilateral carotid pulses palpable.** • **Eyes bilateral sclera white, bilateral cornea clear, conjunctive pink.** • **Nose septum midline turbinate's moist and pink.** • **Mouth pharynx moist and pink, dentation good, mucosa pink and moist with white film present on tong.**
CARDIOVASCULAR (2 points): **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:**	. **Clear S1 and S2 heard without gallops or rubs. Peripheral pulses palpable. Capillary refill is more than 3sec. Edema noted in both lower legs. Pt is in Atrial fibrillation.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**Respirations are irregular and uneven with laboring. Lungs sound are diminished and wet throughout bilaterally.**
GASTROINTESTINAL (2 points): **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: 16** **Feeding tubes/PEG tube Y ☐ N ☒**	. **Diet at home is normal, current diet is NPO and has NG tube in-place, Abdomen is soft, tender in LLQ and LRQ, and bowl sounds normal.**

Type:	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**Urine is yellow pt is incontinent x2 during rotation. No pain with urination noted. BM loose and light brown.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Pt cannot perform ROM and ADL's they must be performed by staff. Fall score NA patient is bed bound.**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Pt has positive MAEW and PERLA, strength unable to asses. Orientation, mental status, speech, sensory, and LOC unable to asses.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Unable to assess.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	67	159/71	20	97.5 F Temporal	97 room air
0930	70	148/70	20	98.2 Temporal	98 room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	Pt displayed grimace and grunting with movement				
0930	Pt displayed grimace and grunting with movement				

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	20 gage in right hand, IV was flushed no noted redness or swelling. Dressing was intact and initialed and dated 8/15/21.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
690ml	Incontinent x2

Nursing Care

Summary of Care (2 points)

Overview of care: I was able to perform a full body assessment on the pt including inspecting the IV site and flushing. Pt required total assistance for ADL's and medication administration which I also performed.

Procedures/testing done: Possible PEG tube placement.

Complaints/Issues: none

Vital signs (stable/unstable): B/P high

Tolerating diet, activity, etc.: na

Physician notifications: na

Future plans for patient: comfort

Discharge Planning (2 points)

Discharge location: To Home

Home health needs (if applicable): Feeding assistance PEG tube feeding.

Equipment needs (if applicable): Dressings for tube feeding, feeding equipment.

Follow up plan:

Education needs: Education on ADL assistance, tube feedings, and medication administration.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Impaired swallowing as related to patients NG placement as evidenced by patients NPO status	The patient is currently unable to swallow and has already experienced sings of aspirational pneumonia	**1.** Keep the head of the patient bed elevated. **2.**Provide oral hygiene regularly to prevent oral issues	Patient's family unhappy with NPO status.
2. Risk for urge urinary incontinence related to current condition as evidenced by inability to ambulate to restroom	The patient has now become too weak to get out of bed and due to medication doesn't always ask for the bedpan.	**1.** check patient every two hours for incontinence **2.**prompt patient to use call light when restroom is needed.	Patient does not seem willing to use call light.
3. Impaired comfort related to clients declining condition as evidenced by nonverbal pain indicators.	Patient currently has to maintain minimal 40 degree angle in bed due to NG placement upon movement patient displays grimacing and moaning.	1. Provide extra pillows for optimal positioning **2.** Reposition patient every two hours.	Patient seems to be more comfortable after positioning.

Other References (APA): Swearingen, P. L., & Wright, J. D. (2019). All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health. St. Louis, MO: Elsevier.

Concept Map (20 Points):

Subjective Data

Client was unable to give data.

Nursing Diagnosis/Outcomes

Impaired swallowing as related to patients NG placement as evidenced by patients NPO status

Promote feedings and nutrition through NG and check for comfortability.

Risk for urge urinary incontinence related to current condition as evidenced by inability to ambulate to restroom.

Provide frequent incontinent checks and turning and repositioning every two hours.

Impaired comfort related to clients declining condition as evidenced by nonverbal pain indicators.

Provide other therapeutic forms of comfort such as lavender patches and pillow placement to minimize pain.

Objective Data

Pt displays grimacing when moved, calcium lab is indicated at a 7.5 rendering her hypercalcemic.

Patient Information

PD is a 79yr old female that was admitted on 8/13/21 for weakness, twitching and a fever of 2 days.

Nursing Interventions