N321 Care Plan #1

Lakeview College of Nursing

Whitney Simlin

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
8/29/21	J.T.	50 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/ Black	Not employed	Single	Dilantin
Code Status	**Height**	**Weight**	
Full	5'7"	170. 11 lb	

Medical History (5 Points)

Past Medical History: Urethral stone, Gerd, Diabetes insipidus, Tracheostomy, Hydrocephalus

Past Surgical History: Ureter Stent placement 5/3/21, Cystoscopic calculus removal 9/2/21

Family History: No known family history. The client was unable to answer questions.

Social History (tobacco/alcohol/drugs): No tobacco, alcohol, or recreational drug use.

Assistive Devices: Wheelchair

Living Situation: Long term care facility

Education Level: Highschool

Admission Assessment

Chief Complaint (2 points): Increased Frequency of Urination

History of present Illness (10 points):. On August 29, 2021 the patient was admitted to Carle Foundation Hospital for increased frequency of urination. Upon observation, smelly and cloudiness was noted by the emergency room registered nurse. Her illness is moderate to severe. There are no known aggravating factors. There are no known relieving factors. She is currently being treated at Carle Foundation Hospital with prescribed medication. Because the patient is nonverbal, several assumptions are made in regards to the patients pain level.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Urinary Tract Infection (UTI)

Secondary Diagnosis (if applicable):

Pathophysiology of the Disease, APA format (20 points): Urinary Tract Infection is an infection in your urinary system (Capriotti & Frizzell, 2015). A urinary tract infection can be in your ureters, bladder, kidneys, or urethra. The most common etiology of UTI is Escherichia coli (Capriotti & Frizzell, 2015). Other forms of irritants to the urinary system are streptococci and proteus (Capriotti & Frizzell, 2015). The patient has a history of UTI's and wears depends which allows stool to enter urinary system regularly.

Risk factors for UTI's are improper perineal hygiene restrictive clothing (Capriotti & Frizzell, 2015). From J.T.'s chart, we know she has worn restrictive clothing (depends) for 25 + years. We are unaware of improper perineal hygiene but are aware that she's had several caretakers over the years.

Symptoms of UTI's include frequency, pain and burning on urination(dysuria), urgency, and occasional hematuria (Martini et al., 2018). Because the patient is unable to communicate, the only symptom we are aware of is the frequency of urination.

Some physical findings found in UTI's are foul smelling, cloudy urine and in severe cases, we see bladder spasms (Martini et al., 2018). The patient's urine was foul smelling and cloudy when analyzed. Since bladder spasms are usually subjective, we weren't able to determine if the patient was experiencing them.

Urinalysis and urine cultures are used to diagnose UTI's (Capriotti & Frizzell, 2015). A urinalysis uses a dipstick to show red blood cells (RBC's), positive leukocyte esterase (WBC's), and nitrates(bacteria). A urine culture shows an infection indicated by a colony of bacteria greater than 10^5 mL (Capriotti & Frizzell, 2015).

Forms of treatment for UTI's are usually antibiotics (Martini et al., 2018). The appropriate antibiotic can be determined by culture and sensitivity testing (Martini et al., 2018). Nitrofurantoin is an antibiotic that is commonly used to treat UTI's and the patient was prescribed this medication until the UTI cleared up. Hydration helps accentuate the clearance of bacteriuria (Capriotti & Frizzell, 2015).

Pathophysiology References (2) (APA):

Capriotti, T.M., & Frizzell, J.P., "Pathophysiology: Introductory Concepts and Clinical Perspectives" (2015).

Martini, F., Ober, C. E., Welch, K., & Hutchings, R. T. "Visual Anatomy & Physiology" (2018)

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	**Male 4.7-6.1 Female 4.2-5.4**	**n/a**	**4.7**	
Hgb	**Male: 14-18 g/dL**	**n/a**	**12.2**	

	Female:12-16 g/dL			
Hct	**Male:40-52% Female:36-47%**	**n/a**	**41%**	
Platelets	**150-400 x 10^9L**	**n/a**	**270**	
WBC	**5-10x 10^9/L**	**n/a**	**8.0**	
Neutrophils	**55-70**	**n/a**	**62**	
Lymphocytes	**20-40**	**n/a**	**26.7%**	
Monocytes	**2-8**	**n/a**	**8%**	
Eosinophils	**1-4**	**n/a**	**2%**	
Bands	**0.5-1**	**n/a**	**0.7**	

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 mEq/L**	**n/a**	**143**	
K+	**3.5-5 mEq/L**	**n/a**	**4.0**	
Cl-	**98-106 m/Eq/L**	**n/a**	**99**	
CO2	**23-30 mEq/L**	**n/a**	**27.0 mg/dL**	
Glucose	**74-106 mEq/L**	**n/a**	**80**	
BUN	**10-20 mEq/L**	**n/a**	**15**	
Creatinine	**0.5-1.1 mEq/L**	**n/a**	**0.45**	
Albumin	**3.5-5 g/dL**	**n/a**	**3.7**	
Calcium	**9-10.5 mg/dL**	**n/a**	**9.0 mg**	
Mag	**1.3-2.1 mEq/dL**	**n/a**	**2.1 mg/dL**	

Phosphate	**3-4.5 mg/dL**	**n/a**	**3.5 mg/ dL**	
Bilirubin	**0.3-1 mg/dL**	**n/a**	**0.4 mg**	
Alk Phos	**30-120 U/L**	**n/a**	**57**	
AST	**8-33 U/L**	**n/a**	**11**	
ALT	**7-55 U/L**	**n/a**	**9**	
Amylase	**40-140 U/L**	**n/a**	**n/a**	
Lipase	**10-140 U/L**	**n/a**	**n/a**	
Lactic Acid	**4.5-19.8 mg/dL**	**n/a**	**n/a**	

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	**< 1.1**		**n/a**	
PT	**11-13.5**		**n/a**	
PTT	**25-35**		**n/a**	
D-Dimer	**<250**		**n/a**	
BNP	**<100**		**n/a**	
HDL	**60>**		**n/a**	
LDL	**<100**		**n/a**	
Cholesterol	**<130 mg/dL**		**n/a**	
Triglycerides	**<150 mg/dL**		**n/a**	
Hgb A1c	**4-5.6**	**n/a**	**n/a**	
TSH	**0.5-5.0 mIU/ L**	**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	Clear, Amber/ Yellow	n/a	n/a	
pH	4.6- 8.0	n/a	n/a	
Specific Gravity	1.005-1.030	n/a	n/a	
Glucose	50-300 mg/day	n/a	n/a	
Protein	0-8 mg/dL	n/a	n/a	
Ketones	negative	n/a	n/a	
WBC	0-4 per low-power field Negative for cast	n/a	n/a	
RBC	Less than or equal to 2 Negative for cast	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: less than 10,000 per mm of U Positive:	n/a	n/a	

	greater than 100,000 per mm of U			
Blood Culture	**Negative**	**n/a**	**n/a**	
Sputum Culture	**Normal Upper RT**	**n/a**	**n/a**	
Stool Culture	**Normal intestinal flora**	**n/a**	**n/a**	

Lab Correlations Reference (1) (APA):

Chernecky, C. C., & Berger, B. J. (2008). ***Laboratory tests and diagnostic procedures*****. St. Louis, MO: Saunders Elsevier.**

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). ***Mosby's diagnostic and laboratory test reference*****. St. Louis, MO: Elsevier.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points): n/a

Diagnostic Test Correlation (5 points): n/a

Diagnostic Test Reference (1) (APA): n/a

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

Home Medications (5 required)

Brand/ Generic	**Tylenol/ acetaminophen**	**Tums/ Calcium carbonate**	**Cholecalciferol/ Vitamin D3**	**Ferrous sulfate/ Iron**	**Guaifenesin/ Robutussin**
Dose	**650 mg/ 20.3 mL**	**400 mg**	**400 IU**	**325 mg**	**400 mg**
Frequency	**Every 6 hours**	**Every 6 hours**	**Daily**	**Daily**	**Every 4 hours**
Route	**Gastric tube**	**Gastric tube**	**PO**	**PO**	**PO**
Classification	**Pain relief**	**Antacids**	**Vitamin D analogs**	**Iron**	**Expectorants**
Mechanism of Action	**Reduce production of prostaglandins**	**Inhibit pepsin**	**The active form of vitamin D binds to intracellular receptors that then**	**Iron combines with porphyrin and globin chains to**	**increases the volume and reducing the viscosity of secretions in the trachea and bronchi**

			function as transcription factors to modulate gene expression.	**form hemoglobin**	
Reason Client Taking	**Pain**	**Indigestion**	**Vitamin D deficiency**	**Iron deficiency anemia**	**Chest congestion**
Contraindications (2)	**Liver problems, severe renal impairment**	**Dehydration, constipation**	**High amount of calcium in blood, excessive amount of vitamin D in blood**	**Ulcers from too much stomach acid, overload of iron in the blood**	**Overactive thyroid gland, diabetes**
Side Effects/Adverse Reactions (2)	**Nausea, stomach pain**	**Gas, burping**	**Nausea, vomiting**	**Nausea, stomach pain**	**Dizziness, drowsiness**
Nursing Considerations (2)	**Temporary use only, may cause hepatic damage**	**May cause cardiac arrest or dysrhythmias**	**Do not give to a child without medical advice, ask a doctor before using vitamin D3 while pregnant**	**Assess nutritional status, bowel function**	**Avoid irritants to stimulate cough, may cause drowsiness**

Hospital Medications (5 required)

Brand/ Generic	**Lovenox/ enoxaparin**	**Apresoline/ hydralazine**	**Hydrocort/ hydrocortisone**	**Zofran ODT/ ondansetron**	**Stemetil/ prochlorperazine**
Dose	**5000 units**	**10 mg**	**50 mg**	**8 mg**	**75 mg**
Frequency	**Every 8 hours**	**Every 6 hours**	**Daily**	**Every 8 hours**	**Every 6 hours**
Route	**Sub Q**	**PO**	**PO**	**PO**	**PO**
Classification	**Glycosaminoglycan**	**vasodilator**	**corticosteroids**	**antiemetic**	**antipsychotics**
Mechanism of Action	**accelerating the rate of the neutralization of certain activated coagulation factors by antithrombin**	**blood pressure lowering effects by vasoconstrictive repression**	**Hydrocortisone binds to the glucocorticoid receptor leading to downstream effects such as inhibition of phospholipase A2, NF-kappa B, other inflammatory transcription factors, and the promotion of anti-inflammatory genes.**	**serotonin 5-HT3 receptor antagonist used to prevent nausea and vomiting in cancer chemotherapy and postoperatively**	**Blocks the effects of a chemical in the brain.**
Reason Client Taking	**Prevent blood clots**	**High blood pressure**	**inflammation**	**Prevent nausea and vomiting**	**Migraines**

Contraindications (2)	**known hypersensitivity, past or present heparin-induced thrombocytopenia and active bleeding**	**Decreased blood volume, low blood pressure**	**Diabetes, inactive tuberculosis**	**Low amount of magnesium, low amount of potassium**	**Avoid in patients with liver dysfunction, Avoid in patients with renal dysfunction**
Side Effects/ Adverse Reactions (2)	**Abdominal pain, back pain**	**Flushing, headache**	**Dizzy, headaches**	**Drowsiness, tiredness**	**Dizziness, lightheadedness**
Nursing Considerations (2)	**Notify physician or nursing staff immediately if heparin causes excessive anticoagulation. Monitor signs of allergic reactions and anaphylaxis**	**Check blood pressure weekly, assess feet and ankles for retention**	**Assess any muscle or joint pain, Monitor signs of hypersensitivity reactions or anaphylaxis**	**Assess for irregular heartbeat, assess for liver disease**	**Assess motor function, watch for signs of leukopenia**

Medications Reference (1) (APA):

Chernecky, C. C., & Berger, B. J. (2008). ***Laboratory tests and diagnostic procedures*****. St. Louis, MO: Saunders Elsevier.**

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). ***Mosby's diagnostic and laboratory test reference*****. St. Louis, MO: Elsevier.**

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 **A&O x 0- unable to assess** **Unable to assess** **No signs of distress** **Lethargic, clean and well kept**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	 **Pale** **Abnormal** **Cool** **Abnormal skin turgor- slow** **No rashes** **Scattered bruises** **2 deep tissue injuries on feet, pressure injury on left ear, stage II pressure injury on coccyx** **9** **No drains present**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 **Not normal, trach/stoma** **Unable to access** **Tearing in both eyes- small drainage** **Normal nose** **Teeth/ decay- carries(missing teeth)**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:**	**Clear S1 and S2, S3 and S4 are not present** Normal radial pulses <3 seconds

Neck Vein Distention: Y ☐ N ☐ **Edema Y ☐ N ☐** **Location of Edema:**	No neck vein distention Y, generalized edema (2+) L and R hands L and R arms, L and R feet, L and R legs
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	 **No accessory muscle use** **Abnormal breathing/ brady** **Diminished breath sounds**
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:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	 **NPO- tube feeds** **5'7** **170 lbs** **Normal** **Today** **No Masses, Unable to assess for pain** **No distention** **No incisions** **No scars** **No drains** **No wounds** **No ostomy** **No nasogastric** **Peg tube is present**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	 **Yellow** **Clear** **250 cc** **Unable to assess** **No** **No** **Yes** **Urinary Catheter** **Unknown**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:**	 **Bed bound** **No ROM** **No supportive devices** **No strength** **No ADL assistance** **Low fall risk, 0**

Activity/Mobility Status: **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**No activity, Immobile** **No** **No** **No**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	 **No. no response to stimuli** **Yes** **No. Unequal strength in both arms and legs** **Disoriented x 4** **n/a** **trached/ unable to speak** **lethargic**
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 access coping methods and developmental levels** **n/a** **Mom is POA. Pt lived int a group home for 25+ years**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0726	**43**	**148/81**	**16**	**98.1**	**100**
1110	**51**	**125/76**	**18**	**96.5**	**100**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	n/a
Location of IV:	n/a
Date on IV:	n/a
Patency of IV:	n/a
Signs of erythema, drainage, etc.:	n/a
IV dressing assessment:	n/a

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
900 mL	**800 mL**

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was treated for the UTI and sepsis. Both infections are being managed according the provider's order.

Procedures/testing done: upper extremity imaging- x-ray shows bilateral effusions and air space densities

Complaints/Issues: Sepsis

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: tolerating diet and activity

Physician notifications: n/a

Future plans for patient: patient will be discharged to long term care facility after treatment

Discharge Planning (2 points)

Discharge location: n/a

Home health needs (if applicable): total care

Equipment needs (if applicable): medical bed

Follow up plan: n/a

Education needs: n/a

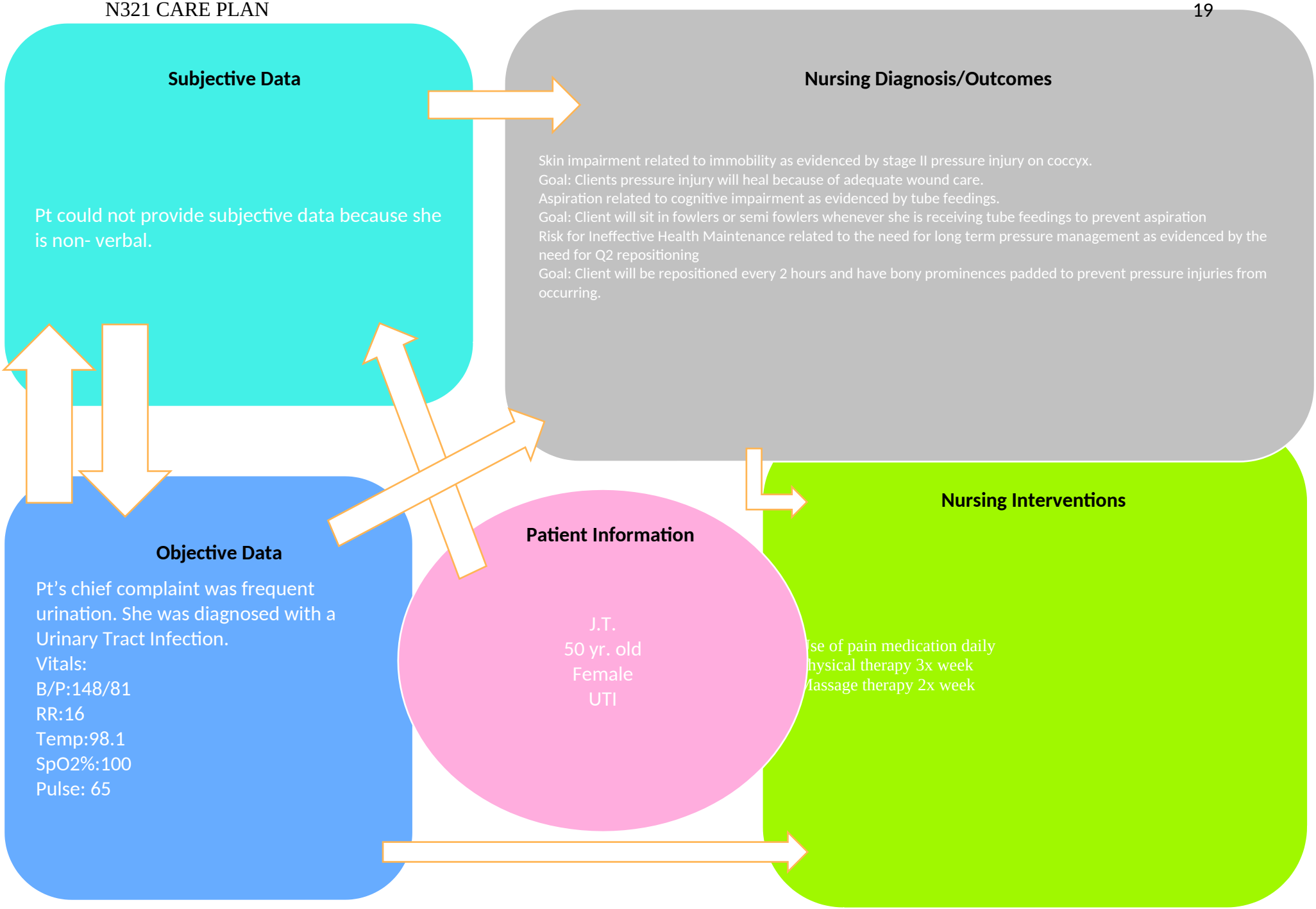
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Skin impairment related to immobility as evidenced by stage II pressure injury on coccyx.	The patient has a stage II pressure injury on her coccyx.	1. Wound consult 2.Nurse should assess daily to make sure the wound isn't worse	Patient is non- verbal. The family's response in unknown. Because the patient is non- verbal, the medical staff has to do what they deem best for the patient.
2. Aspiration related to cognitive impairment as evidenced by tube feedings	The patient is being fed with tube feedings for nourishment	1. Nurse should always make sure the patient is in fowlers or high fowlers during feedings 2.Patient should be assessed for aspiration frequently	The family's response is unknown and the patient is non- verbal. The medical staff has to do what they deem best for the patient.
3. Risk for ineffective Health Maintenance related to	The patient is bed bound and does not move. Therefore, the patient will need	1.Nurse should pad bony prominences 2Nurse should turn patient every 2 hours	The family's response is unknown and the patient is non- verbal. The medical staff has to do what they deem best for

need for long-term pressure management as evidenced by the need for Q2 repositioning.	to be repositioned every 2 hours to prevent pressure injuries.	to prevent pressure injuries	the patient.

Other References (APA):

Concept Map (20 Points):


Subjective Data
Pt could not provide subjective data because she is non- verbal.
Nursing Diagnosis/Outcomes
Skin impairment related to immobility as evidenced by stage II pressure injury on coccyx.
Goal: Clients pressure injury will heal because of adequate wound care.
Aspiration related to cognitive impairment as evidenced by tube feedings.
Goal: Client will sit in fowlers or semi fowlers whenever she is receiving tube feedings to prevent aspiration
Risk for Ineffective Health Maintenance related to the need for long term pressure management as evidenced by the need for Q2 repositioning
Goal: Client will be repositioned every 2 hours and have bony prominences padded to prevent pressure injuries from occurring.
Objective Data
Pt's chief complaint was frequent urination. She was diagnosed with a Urinary Tract Infection.
Vitals:
B/P:148/81
RR:16
Temp:98.1
SpO2%:100
Pulse: 65
Patient Information
J.T.
50 yr. old
Female
UTI
Nursing Interventions
se of pain medication daily
hysical therapy 3x week
Massage therapy 2x week