

N321 Care Plan 1

Lakeview College of Nursing

Kristina Stewart

Demographics (3 points)

Date of Admission 2-19-22	Client Initials M.L	Age 72	Gender Female
Race/Ethnicity Hispanic	Occupation Retired	Marital Status Widowed	Allergies Bananas, shellfish, cyclobenzaprine
Code Status Full Code	Height 5'2"	Weight 106lbs	

Medical History (5 Points)

Past Medical History: HTN, A-Fib, HLD, CHF

Past Surgical History: Cholecystectomy in 1995, TKA in 2009

Family History: Diabetes (mother, brother) MI (father)

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

no alcohol, drug (elicit), or tobacco use

Assistive Devices: unknown

Living Situation: Oaks Manor Assisted Living Facility

Education Level: GED

Admission Assessment

Chief Complaint (2 points): Ankle edema, weight gain (12lbs in 4 days)

History of Present Illness – OLD CARTS (10 points):

O-4 days ago

L-bilateral ankles and pedal area

D-daily

C-swelling

A-worsens with ambulation, rest and elevation alleviates

R-N/A

T-rest and elevation

Primary Diagnosis

Primary Diagnosis on Admission (2 points): CHF

Secondary Diagnosis (if applicable): N/A

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

Pathophysiology References (2) (APA):

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				
Hgb		13.6		
Hct				
Platelets				
WBC		9.4		
Neutrophils				
Lymphocytes				
Monocytes				
Eosinophils				
Bands				

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
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Na-		138		
K+		3.1		
Cl-				
CO2				
Glucose		94		
BUN		24		
Creatinine		2.8		
Albumin				
Calcium				
Mag				
Phosphate				
Bilirubin				
Alk Phos				
AST				
ALT				
Amylase				
Lipase				
Lactic Acid				

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				
PT				
PTT				
D-Dimer				
BNP		4,923		
HDL				
LDL				
Cholesterol				
Triglycerides				
Hgb A1c				
TSH				

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				
pH				
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				
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (1) (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CXR-enlarged heart, pulmonary vascular congestion

EKG shows a-fib with rate of 88

Diagnostic Test Correlation (5 points):

Diagnostic Test Reference (1) (APA):

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

Home Medications (5 required)

Brand/ Generic	Lisinop ril/	Pacerone/ Amiodarone	Bayer Aspirin/As pirin	Lipitor/ Atorvastatin	Lasix/ furosemide
Dose	40mg	200mg	81mg	40mg	40mg
Frequency	daily	daily	daily	Daily at bedtime	daily
Route	PO	PO	PO	PO	PO
Classification	ACE inhibito r	Antiarrhythmic	NSAIDs	Statin	Loop diuretic
Mechanism of Action					
Reason Client Taking	HTN	A-fib	A-fib	HLD	CHF
Contraindica tions (2)					
Side Effects/ Adverse					

Reactions (2)					
Nursing Considerations (2)					

Hospital Medications (5 required)

Brand/ Generic	Lasix/ furosemide	Potassium Chloride	Tylenol/ Acetaminophen	Colace/ docusate	MS Contin/ morphine
Dose	40mg	40mEq	650mg	100mg	1mg
Frequency	BID	once	Q6H PRN	BID PRN	Q4H PRN
Route	IV	PO	PO	PO	IV
Classification	Loop diuretic	Electrolyte	Analgesics/ Antipyretics	Stool Softener	Opioid
Mechanism of Action					
Reason Client Taking	CHF	Electrolyte replenish ment-also because taking lasix	Pain/fever relief	Constipation relief	Pain relief
Contraindications (2)					
Side Effects/ Adverse					

Reactions (2)					
Nursing Considerations (2)					

Medications Reference (1) (APA):

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Kept appearance Alert A/O x 4 Does not appear to be in distress Well kept, dressed appropriately
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	No discoloration, appropriate per ethnicity Intact Warm Quick No rashes No bruising No wounds Unavailable

<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>WNL</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: 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:</p>	<p>WNL Pt in a-fib Bilateral feet, 3+ pitting</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Bilateral crackles in bases of lungs</p>
<p>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 <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>1L fluid restriction 5'2" 106lbs Audible and active in all 4 quadrants Today x 2 Soft, nontender WNL</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>WNL</p>

<p>Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>WNL Patient is a fall risk due to the medications that she takes plus the 3+ pitting edema</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: Sensory: LOC:</p>	<p>WNL</p>
<p>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):</p>	<p>GED</p>

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	88	152/68	24	36.5	98% on 2L NC
1100	68	138/62	24	36.8	97% on 2L

					NC
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Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	0/10				
1100	1/10	head	mild	headache	Tylenol administered

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g Location of IV:LAC Date on IV: 2/21/22 Patency of IV: patent Signs of erythema, drainage, etc.: no complications IV dressing assessment: clean/dry/intact	Saline lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
360ml	1750ml

Nursing Care

Summary of Care (2 points)

Overview of care: patient is stable, diuresing well

Procedures/testing done: CXR, EKG

Complaints/Issues: Bilateral edema with weight gain

Vital signs (stable/unstable): stable

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

Physician notifications:N/A

Future plans for client: one-time visit from Care Coach

Discharge Planning (2 points)

Discharge location: back to ALF

Home health needs (if applicable): requesting one time visit from Care Coach

Equipment needs (if applicable):N/A

Follow up plan: PCP in 1 week following discharge

Education needs:N/A

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components • Listed in order by priority – highest priority to lowest priority pertinent to this client 	<p>Rationale</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Interventions (2 per dx)</p>	<p>Outcome Goal (1 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the client/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1.</p>		<p>1.</p>	<p>1.</p>	

		2.		
2.		1. 2.	1.	
3.		1. 2.	1.	

Other References (APA):

Concept Map (20 Points):



