

N321 Care Plan 1

Lakeview College of Nursing

Tyler Edwards

N321 CARE PLAN

Demographics (3 points)

Date of Admission 05/17/2022	Client Initials R.H.	Age 80	Gender M
Race/Ethnicity White Non-Hispanic	Occupation Not Employed	Marital Status Widow	Allergies NKA
Code Status Full	Height 70 in	Weight 239 lb	

Medical History (5 Points)

Past Medical History: GERD (gastroesophageal reflux disease), Obstructive sleep apnea, Heart murmur, hx of concussion, Diabetes mellitus type II, Depression, Basal cell cancer of the forehead and ear

Past Surgical History: Tonsillectomy and adenectomy, skin cancer excision, Laparoscopic esophageal hernia repair, colposcopy (2009, 2019, 2020, 2022)

Family History: Mother: cancer, hypertension, and diabetes. Sister: cancer. Daughter: heart arrhythmia

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

Former smoker for 2 years of 1 PPD. Quit smoking on 1/1/1975. No drug use alcohol use or smokeless tobacco use.

Assistive Devices: CPAP device that patient hasn't used for the past 6 months because they, "noticed no difference in their health"

Living Situation: Patient lives alone and performs all activities without help. Patient has 1 dog.

Admission Assessment

Chief Complaint (2 points): Dizziness and stomach problems

History of Present Illness – OLD CARTS (10 points): Patient describes the onset of dizziness and confusion beginning in the last month and it got unmanageable the day before admission to

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the hospital. Chronic digestive issues with GERD and chronic diarrhea. Patient states that the dizziness has cleared up but is unable to recall what he had for lunch and dinner yesterday.

Patient mentioned abdominal tenderness but then denied any abdominal pain or pain in general.

No facial reaction upon palpation of the abdomen during the physical exam. Upon a large bowel movement the patient's mood and concern of abdominal issues resolved themselves.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute Kidney Injury

Secondary Diagnosis (if applicable): N/A

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

Acute kidney injury, also known as acute renal failure, is a rapid onset failure of the kidneys. The kidneys are at high risk for injury from disease that affect blood flow because they require a large amount of blood flow to function properly (Bartlett, 2019). This puts the kidney's at risk for ischemic injury from small decrease in blood perfusion. In addition to blood perfusion, any decrease in blood pressure or urinary backup into the kidneys can cause injury. This is due to the fact that fluid filtered from the blood travels from the nephrons, through the renal pelvis, and out the ureters. This fluid contains waste products making it toxic to the cells in the kidneys. Stasis or pooling of this fluid can result from low blood pressure or fluid backup into the kidneys from genitourinary dysfunction (Capriotti, 2020).

Kidney dysfunction is broken up into three categories depending on the cause of injury. The first cause is prerenal dysfunction which refers to a decrease in blood flow to the kidneys and a resulting decrease in kidney perfusion. Ischemia and hypoxia are examples of prerenal dysfunction and are the most common cause of acute kidney injury (Capriotti, 2020). The second

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category of kidney dysfunction is intrarenal dysfunction which refers to a secondary response to actual injuries of the kidneys themselves. Intrarenal kidney trauma is often caused by nephrotoxicity from NSAIDs (Capriotti, 2020). In addition uncontrolled diabetes is also a common cause of intrarenal kidney damage. The third category of kidney dysfunction is postrenal dysfunction which refers to obstruction of urine outflow from the kidneys. Kidney stones, prostate gland enlargement and any other disease that prevents urine outflow are examples of postrenal dysfunction (Capriotti, 2020).

Diagnosis of acute kidney injury is performed from a combination of imaging, urine tests, and blood tests. An ultrasound, which was used for this patient, can assess the size, shape, and location of the kidneys (pagana, 2018). The ultrasound indicated signs of acute kidney injury. Additionally this patient had a urine test which came back negative for acute kidney injury. They also had a chemistry test that came back positive for acute kidney injury with elevated levels of creatinine, BUN, potassium, and chloride (Pagana, 2018).

Pathophysiology References (2) (APA):

- Bartlett, C.T.P.L.J. L. (2019). *Lippincott CoursePoint Enhanced for Taylor's Fundamentals of Nursing* (9th Edition). Wolters Kluwer Health.
- Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives* (2nd Edition). F. A. Davis Company.
- Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

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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	3.8-5.3	3.99	3.78	N/A
Hgb	12.0 – 15.8	12.7	12.0	N/A
Hct	36.0 – 37.0	38.8	36.6	Elevated Hct related to dehydration (Pagana, 2018)
Platelets	140 – 440	211	84	Low platelets related to thrombocytopenia (Pagana, 2018).
WBC	4.00 – 12.00	6.57	7.43	N/A
Neutrophils	47.0 – 73.0	N/A	62.1	N/A
Lymphocytes	18.0 – 42.0	N/A	27.9	N/A
Monocytes	4.0 – 12.0	N/A	8.7	N/A
Eosinophils	0 – 5.0	N/A	1.1	N/A
Bands	N/A	N/A	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-	136 – 145	136	139	N/A
K+	3.5 – 5.1	6.1	4.5	Potassium elevation related to Acute Kidney Injury (Pagana, 2018).
Cl-	98 – 107	109	105	Chloride elevation related to Acute Kidney Injury (Pagana, 2018).
CO2	22.0 – 29.0	12.0	25.0	Low CO2 related to Acute Kidney Injury and diabetes (Pagana, 2018).
Glucose	74.0 – 100.0	158	115	Glucose elevation related to poorly managed type diabetes (Pagana, 2018).
BUN	8 – 26	21	33	BUN elevation related to Acute Kidney Injury (Pagana, 2018).

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Creatinine	0.55 – 1.33	6.92	1.49	Creatinine elevation related to Acute Kidney Injury (Pagana, 2018).
Albumin	3.4 – 4.8	3.7	3.7	N/A
Calcium	8.9 – 10.6	8.3	8.7	Low calcium levels related to nephrosis (Pagana, 2018).
Mag	1.6 – 2.6	2.3	1.9	N/A
Phosphate	N/A	N/A	N/A	N/A
Bilirubin	0.2 – 1.2	1.1	1.1	N/A
Alk Phos	34 – 104	97	93	N/A
AST	8 - 33	17	16	N/A
ALT	7 - 55	22	19	N/A
Amylase	40 - 140	N/A	71	N/A
Lipase	0 -160	44	44	N/A
Lactic Acid	N/A	N/A	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	0.9 - 1.1	N/A	1.1	N/A
PT	N/A	N/A	N/A	N/A
PTT	22.4 - 35.9	N/A	28.3	N/A
D-Dimer	< 500	N/A	529	Elevated D-Dimer related to heart disease (Pagana, 2018).
BNP	0 - 450	N/A	540	Elevated BNP is related to cardiac dysfunction (Pagana, 2018).
HDL	40 - 59	N/A	37	Low HDL related to insufficient

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				dietary intake (Pagana, 2018).
LDL	0 - 100	N/A	98	N/A
Cholesterol	< 200	N/A	126	N/A
Triglycerides	< 150	N/A	213	Elevated triglycerides related to dietary deficiency (Pagana, 2018).
Hgb A1c	12.0 - 18.0	12.7	12.0	N/A
TSH	0.358 - 3.74	N/A	1.870	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	Colorless - Yellow	N/A	Yellow	N/A
pH	5.0 – 7.0	N/A	5.0	N/A
Specific Gravity	1.003 – 1.035	N/A	1.014	N/A
Glucose	Negative	N/A	Negative	N/A
Protein	Negative	N/A	Negative	N/A
Ketones	Negative	N/A	Negative	N/A
WBC	0 – 25	N/A	17	N/A
RBC	0 – 20	N/A	1	N/A
Leukoesterase	Negative	N/A	Negative	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	N/A	N/A	N/A	N/A
Blood Culture	N/A	N/A	N/A	N/A
Sputum Culture	N/A	N/A	N/A	N/A

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Stool Culture	N/A	N/A	N/A	N/A
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Lab Correlations Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

Diagnostic Imaging**All Other Diagnostic Tests (5 points):**

US Kidneys

Indication: Acute renal failure

Technique: Multiple grayscale and color Doppler sonographic images of the kidneys were obtained.

Findings: Suboptimal exam. No obvious hydronephrosis.

Right kidney measures 11.9 cm. Left kidney measures 12.3 cm.

Diagnostic Test Correlation (5 points):

Mild echogenic appearance of the bilateral renal cortices is nonspecific, however, is commonly associated with medical renal disease. Incompletely distended urinary bladder decreases sensitivity to detect urinary bladder pathology. Indication of acute renal failure.

Diagnostic Test Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

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

Home Medications (5 required)

Brand/Generic	buPROPion HCL (Wellbutrin XL)	finasteride (Proscar)	hydroCHLOR Othiazide (MICROZIDE)	metFORMIN (GLUCOPHA GE XR)	metoprolol succinate ER (TOPROL XL)
Dose	300 mg	5 mg	12.5 mg	1000 mg	100 mg

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Frequency	daily every morning	qd	qd	qd	qd
Route	po	po	po	po	po
Classification	Aminoketone	4-Azasteroid compound	Benzothiadiazide	Dimethylbiguanide	Beta1-adrenergic antagonist
Mechanism of Action	Inhibits dopamine, norepinephrine, and serotonin uptake by neurons	Inhibits 5-alpha reductase, an intracellular enzyme that converts testosterone to its metabolite in liver, prostate, and skin.	Promotes movement of sodium (Na ⁺), chloride (Cl ⁻), and water (H ₂ O) from blood in peritubular capillaries into nephron's distal convoluted tubule.	May promote storage of excess glucose as glycogen in the liver, which reduces glucose production. Metformin also may improve glucose use by adipose tissue and skeletal muscle by increasing glucose transport across cell membranes.	Inhibits stimulation of beta1-receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand.
Reason Client Taking	For mood and energy	For the prostate	Diuretic	Diabetes management	For blood pressure
Contraindications (2)	Hypersensitivity to bupropion, seizure disorders, discontinuation of alcohol	Childhood and female patients	Anuria and renal failure	Advanced renal disease and use of iodinated contrast within 48 hrs	Acute heart failure and cardiogenic shock
Side Effects/Adverse Reactions (2)	AV block and Arrhythmias	Hypotension and diarrhea	Dizziness and hypotension	Headache and diarrhea	Confusion and arrhythmias
Nursing Considerations (2)	Precautions for patients with renal impairment. Monitor depressed patients as they may worsen symptoms.	Patient should have a rectal examination of the prostate. Monitor PSA levels as for risk of high grade prostate cancer.	Give in the morning and early evening to prevent nocturia. Monitor blood pressure and electrolyte levels.	Should never be given to patients with severe renal impairment. Give with food to increase duration and reduce side	Assess ECG of patients who take metoprolol because they may be at risk for AV block. If AV block results from depressed AV node conduction, prepare to give appropriate drug, as

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				effects	ordered, or assist with insertion of temporary pacemaker. Metoprolol may interfere with therapeutic effects of insulin and oral antidiabetic drugs.
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Hospital Medications (5 required)

Brand/ Generic	prochlorperazine (Compazine)	loratadine (Claritin)	Heparin	insulin aspart (NovoLOG)	propafenone (Rythmol SR)
Dose	10 mg	10 mg	5,000 Units	correction	225 mg
Frequency	q6h PRN	q48h	q8h	qid AC & HS	q12h
Route	po	po	subq	subq	po
Classification	Phenothiazine	Antihistamine	Glycosaminoglycan	Human insulin	3-Phenylpropriophenone
Mechanism of Action	Alleviates psychotic symptoms by blocking dopamine receptors, depressing release of selected hormones, and producing alphaadrenergic blocking effect in the brain.	Non-sedating antihistamine that works by selectively binding to peripheral histamine H1 - receptors on effector cells.	Binds with antithrombin III, enhancing antithrombin III's inactivation of the coagulation enzymes thrombin (factor IIa) and factors Xa and XIa.	Lowers blood glucose by stimulating peripheral glucose uptake by fat and skeletal muscle and inhibiting hepatic glucose production.	Prolongs recovery period after myocardial repolarization by inhibiting sodium influx through myocardial cell membranes. This action prolongs the refractory period, causing myocardial automaticity, excitability, and conduction velocity

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					to decline.
Reason Client Taking	Alleviate confusion	Relief of allergic rhinitis	Blood thinner	Manage diabets	Maintain heart rhythm
Contraindications (2)	Arteriosclerosis and coronary artery disease	Pregnancy and lactation	Breastfeeding and uncontrolled bleeding	Chronic lung disease and episodes of hypoglycemia	Asthma and cardiogenic shock
Side Effects/Adverse Reactions (2)	Dizziness and hypotension	Fatigue and dizziness	Dizziness and chest pain	Hypoglycemia and hypokalemia	Dizziness and AV block
Nursing Considerations (2)	Advise patients to swallow capsule whole and not crush or chew them. Take with food or full glass of milk.	Skin color, lesions, texture; prostate palpation; serum transaminase levels	Avoid injecting any drugs IM during heparin therapy. Alternate injection sites, and watch for signs of bleeding and hematoma.	Should not be used to treat DKA. Monitor patients blood glucose and manage dose with consideration.	Assess patient for electrolyte imbalances, such as hyperkalemia. Use cautiously in patients with heart failure or myocardial dysfunction because beta-blocking activity may further depress myocardial contractility

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). 2022 Nurse's Drug Handbook.

Houston, B. T., & Chowdhury, Y.

Assessment

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

GENERAL:	Alert and oriented to person, place, and time;
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Alertness: Orientation: Distress: Overall appearance:	however there are signs of confusion as the patient doesn't remember lunch and dinner from yesterday and believes they are being released from the hospital this afternoon. In a calm relaxed mood after bowel movement.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: 14 Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:	Normal skin color temperature and turgor. No presence of rashes or bed sores.
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	No abnormal findings. No discharge or swelling. Negative for bruits.
CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: No Edema Yes Location of Edema:	RRR. S1 and S2 noted, no murmur Presence of 2+ pitting edema below the knee bilaterally. Peripheral pulses are normal.
RESPIRATORY: Accessory muscle use: No Breath Sounds: Location, character	Normal clear breath sounds without use of accessory muscles
GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection:	Distended abdomen Normal bowel sounds noted Large soft brown bowel movement this morning No masses or tenderness noted on palpation

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Distention: Incisions: Scars: Drains: Wounds: Ostomy: No Nasogastric: No Size: Feeding tubes/PEG tube No Type:	however patient complained of tenderness prior to bowel movement
GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: No Type: Size:	No pain, urgency, or frequency with urination. Light yellow urine No genital abnormalities
MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Yes Fall Score: 10 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"/>	Use of walker in hospital. Patient is sitting in a chair and can perform most activities without support. Use of walker to help with ambulation.
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:	Normal speech. No gross neurological defects. Monitor patient's neurological status as they don't remember lunch and dinner from yesterday and believe they are being released from the hospital this afternoon.
PSYCHOSOCIAL/CULTURAL: Coping method(s):	Minimal family support prior to admission. Patient was managing care on their own.

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Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	Mentioned, “daughter helps sometimes”. Belief in, “inevitability of disease with age”.
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Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
08:00	74	122/ 68	18	98.2	96
15:00	86	137/67	18	98.7	96

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8:00	Numerical	Abdominal	0	Tenderness	None
15:00	Numerical	N/A	0	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Blue. 20 gauge Location of IV: Left forearm Date on IV: 05/21/22 Patency of IV: Unknown Signs of erythema, drainage, etc.: Negative IV dressing assessment: Well dressed	Not currently being used. Saline lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
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1070 ml	Not measured

Nursing Care

Summary of Care (2 points)

Overview of care: Overnight asystole prompting cardiology to perform assessments and test

Procedures/testing done: Colonoscopy

Complaints/Issues: Complaints about the questions he is being asked

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Diet changed from

Physician notifications: More information and tests needed

Future plans for client: Electrophysiology consult

Discharge Planning (2 points)

Discharge location: Not discharged

Home health needs (if applicable): Medication management

Equipment needs (if applicable): May need walker supportive device

Follow up plan: Review medications

Education needs: Medication is the primary concern as the patient can not tell you any of the medication he is taking or what they are for.

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rationale	Interventions	Outcome Goal	Evaluation
● Include full nursing diagnosis with	● Explain why the	(2 per dx)	(1 per dx)	● How did the client/family respond to the nurse's

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<p>“related to” and “as evidenced by” components</p> <ul style="list-style-type: none"> Listed in order by priority – highest priority to lowest priority pertinent to this client 	<p>nursing diagnosis was chosen</p>			<p>actions?</p> <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
<p>Risk for falls related to cognitive impairment as evidenced by confusion upon admission to the hospital.</p>	<p>The patient’s confusion is putting them at risk for future falls.</p>	<ol style="list-style-type: none"> Increased fluid intake to prevent dehydration. Modification of home environment. 	<p>Have a glass of water before every meal. Install a nightlight for safer home environment</p>	<p>The client was not receptive to education about the topic of fall risk. Their statement of the, “inevitability of disease with age” was a hindrance to teaching. They refused to change behaviors or believe they could manage the risk.</p>
<p>Excessive fluid volume related to acute kidney injury as evidenced by bilateral 2+ pitting edema.</p>	<p>The patient's acute kidney injury is causing fluid overload.</p>	<ol style="list-style-type: none"> Assess patients level of consciousness Monitor heart rate and blood pressure. 	<p>Prevent a regression in consciousness of confusion seen upon admission to hospital. Stabilize heart and blood pressure.</p>	<p>The client was accepting of talking with the nurse about their stay and demonstrated a more normalized level of consciousness. In addition, the patient's heart rate and blood pressure have stabilized.</p>
<p>Deficient knowledge related to acute kidney injury as evidenced by confusion upon admission to hospital and inaccurate recall of lunch and dinner.</p>	<p>The patient’s acute kidney injury is causing changes in the patient's consciousness.</p>	<ol style="list-style-type: none"> Review the use of the patient’s medication Provide education as to the purpose of different medications 	<p>Increase the patient’s understanding of the medication they are taking and the reasons for taking medication.</p>	<p>The patient acknowledges their lack of understanding of the medication they are taking. They are hoping to take fewer medications after a review of medication. They understand that knowing the medications can help them manage their disease.</p>

Other References (APA):

Concept Map (20 Points):

Subjective Data
Subjective Data

Dizziness, confusion, and stomach issues upon admission
Abdominal tenderness prior to bowel movement.
Pain score: 0

Nursing Diagnosis/Outcomes
Nursing Diagnosis/Outcomes

Risk for falls related to cognitive impairment as evidenced by confusion upon admission to the hospital. Have a glass of water before every meal

Excessive fluid volume related to acute kidney injury as evidenced by bilateral 2+ pitting edema. Monitor patients level of consciousness.

Deficient knowledge related to acute kidney injury as evidenced by confusion upon admission to hospital and inaccurate recall of lunch and dinner. Provide education in regards to medication

Objective Data
Objective Data

Pulse: 86 BPM
Oxygen: 96%
Respiration: 18
Blood Pressure: 137/67
Temperature: 98.7
Large Brown Bowel Movement

Client Information
Client Information

Date of Admission: 05/17/2022
Client Initials: R.H.
Age:80
Race/Ethnicity:White Non-Hispanic
Occupation: Not Employed
Marital Status:Widow
Code Status:Full
Height: 70 in
Weight: 239 lb

Nursing Interventions
Nursing Interventions

1. Increased fluid intake to prevent dehydration.
2. Modification of home environment.

1. Assess patients' level of consciousness.
2. Monitor heart rate and blood pressure.

1. Review the use of the patient's medication.
2. Provide education as to the purpose of different medications.



