N311 Care Plan #

Lakeview College of Nursing

Name

Demographics (5 points)

Date of Admission	Client Initials	Age	Gender
9-20-2022	R.F	67	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	Central State	Married	No known
Code Status	**Height**	**Weight**	
Full	5’10	169 lb	

Medical History (5 Points)

Past Medical History: Anemia, Benign Prostatic Hyperplasia (BPH), Chronic Kidney Disease, Cirrhosis of the liver with ascites, congestive heart failure, esophageal varices, gastropathy, Hypertension, non-compliance

Past Surgical History: Paracentesis- patient had abdomen drained last week, upper gastrointestinal endoscopy two times.

Family History: No Known Family History

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The client is a current smoker of tobacco, the client reports to smoking a pack every other day.

Admission Assessment

Chief Complaint (2 points): The client was admitted to the hospital with altered mental status.

History of Present Illness – OLD CARTS (10 points): The client is a 67 year old male with a history of cirrhosis who presents with family member for altered mental status that has gradually worsened over the last two weeks. The patient refused any treatment, doesn’t want any invasive procedures, and has been trying to get into hospice but the referral hasn’t gone through. The family has spoken with the primary physician and was given

instructions to go to the emergency department. Family has reported that the confusion has gotten much worse over the last two-three days, he has not slept, he has been up, and very agitated. They reported he has had recent falls, has been incontinent for urine, the patient can not give any history.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Hepatic Encephalopathy

Secondary Diagnosis (if applicable): cirrhosis of liver with ascites: 3/25/2022, Hypertension(chronic):3/25/2022, acute kidney injury:3/25/2022, thrombocytopenia:3/25/2022, hypokalemia: 9/20/2022, hypomagnesemia:9/20/2022, macrocytic anemia:9/20/2022, elevated troponin:9/20/2022

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

Pathophysiology References (2) (APA):

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	4.40-5.80	2.77	2.55	The client has anemia. (Pagana, 2019)
Hgb	13.0-16.5	10.1	9.3	The client had anemia. (Pagana, 2019)

Hct	**38-50**	**28.8**	**26.8**	**The client has anemia. (Pagana, 2019)**
Platelets	**140-440**	**144**	**132**	**The client has cirrhosis of liver with ascites. (Pagana, 2019)**
WBC	**4.00-12.00**	**9.40**	**7.60**	
Neutrophils	**40.0-68.0**	**56.1**	**66.7**	
Lymphocytes	**19.0-49.0**	**27.0**	**20.4**	
Monocytes	**3.0-13.0**	**15.2**	**9.6**	**The client is diagnosed with hepatic encephalopathy. (Pagana, 2019)**
Eosinophils	**0-8.0**	**1.3**	**3.0**	
Bands	**10% or less**	**N/A**	**N/A**	

Note: Bands not obtained at this visit

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-	**133-144**	**141**	**142**	
K+	**3.5-5.1**	**2.8**	**3.8**	**The client was diagnosed with hepatic encephalopathy. (Pagana, 2019)**
Cl-	**98-107**	**112**	**113**	**The client has chronic kidney disease. (Pagana, 2019)**
CO2	**21-31**	**16**	**19**	**The client chronic kidney disease. (Pagana, 2019)**
Glucose	**70-99**	**186**	**135**	**The client has Cirrhosis of liver (Pagana, 2019)**
BUN	**7-25**	**16**	**17**	
Creatinine	**N/A**	**N/A**	**N/A**	
Albumin	**3.5-5.7**	**1.51**	**2.9**	**The client has Cirrhosis of liver (Pagana, 2019)**
Calcium	**8.8-10.2**	**3.4**	**9.7**	**The client has Cirrhosis of liver (Pagana, 2019)**
Mag	**1.3-2.1**	**1.6**	**N/A**	

Phosphate	**N/A**	**N/A**	**N/A**	
Bilirubin	**0.2-0.8**	**1.1**	**2.7**	**The client has Cirrhosis of liver. (Pagana, 2019)**
Alk Phos	**34-104**	**100**	**86**	

Note: Phosphate not obtained during this visit

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-yellow**	**Clear-yellow**	**Clear-yellow**	
pH	**5.0-9.0**	**7.0**	**N/A**	
Specific Gravity	**1.003-1.030**	**1.007**	**N/A**	
Glucose	**Negative**	**186**	**135**	**The client has cirrhosis of liver. (Pagana, 2019)**
Protein	**Negative**	**Negative**	**N/A**	
Ketones	**Negative**	**Negative**	**N/A**	
WBC	**Negative 0-5**	**0-5**	**N/A**	
RBC	**Negative 0-2**	**0-2**	**N/A**	
Leukoesterase	**N/A**	**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	**No growth**	**N/A**	**N/A**	
Blood Culture	**No growth**	**No**	**N/A**	

		growth		
Sputum Culture	**No growth**	**N/A**	**N/A**	
Stool Culture	**No growth**	**N/A**	**N/A**	

Note: No urine, sputum, stool obtained during visit

Lab Correlations Reference (1) (APA): Pagana, Kathleen. (2019). Mosby's Diagnostic and Laboratory Test Reference, (14th ed.). Elsevier.

Diagnostic Imaging

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

Diagnostic Imaging Reference (1) (APA): client has Altered Mental Status, Chest X-Ray was completed, Impression- Cardiomegaly Noted, No consolidation or pneumothorax seen.

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

Medications (5 required)

Brand/Generic	**Acetaminophen/ Tylenol**	**Bupropion/ Wellbutrin SR**	**Calcium Carbonate/ Tums**	**Folic acid/ Folvite**	**Lactulose/ Chronulac**
Dose	**650 mg/ 2 tabs**	**150 mg/ 1 tab**	**1000 mg/ 2 tabs**	**1 mg/ 1 tab**	**20 g**
Frequency	**Every 4 hours**	**Every morning**	**Every 8 hours PRN**	**Daily**	**3 times daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Antipyretic**	**Antidepressant**	**Antacid**	**B-complex vitamin**	**Colonic acidifier**
Mechanism of Action	**Inhibits the enzyme cyclooxygenase blocking prostaglandi**	**Bind with CNS receptors to alter the perception of**	**Increase levels of intracellular and extracellular**	**An exogenous source of folate is**	**Breaks down into lactic acid**

	n production interfering with pain impulse generation in peripheral nervous system.	**an emotional response to pain. Buprenorphine act by displacing narcotic agonists from their bonding sites and competitively inhibiting their actions.**	**calcium, which is needed to maintain homeostasis, especially in the nervous and musculoskeletal systems.**	**required for nucleoprotein synthesis and the maintenance of normal erythropoiesis.**	**acidifying fecal content, acidification leads to increased osmotic pressure in colon which in turns increases stool water content and softens stool.**
Reason Client Taking	**Mild or severe pain**	**Stop smoking or depression**	**Heart burn indigestion**	**Treat high blood levels**	**Treat constipation**
Contraindications (2)	**Severe hepatic impairment. Severe active liver disease.**	**Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment, hypersensitivity to buprenorphine or its components, known or suspected GI obstruction including paralytic ileus, significant respiratory**	**Hypercalcemia, Hypophosphatemia.**	**Vitamin B12 deficiency must be included, neuropathy may be precipitated.**	**Hypersensitivity to lactulose, low-galactose diet.**

		depression.			
Side Effects/Adverse Reactions (2)	**Hepatotoxicity, hemolytic anemia with long term use**	**Hypertension, CNS depression**	**Irregular heart burn, hypercalcemia**	**Allergic sensitization, difficulty sleeping.**	**Abnormal cramps and distention hypernatremia, hypokalemia**

Medications Reference (1) (APA): Jones & Bartlett Learning, (2023). Nurse's Drug Handbook (22nd ed.). Jones & Bartlett

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Alert, oriented to person.** **Alert and Responsive** **No acute distress** **Disheveled**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:**	 **Brown** **Intact, dry** **Skin is warm** **No rashes** **Small bruise on right forearm**

Wounds: . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**No wounds** **Braden Score = 15**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 **Head is round symmetrical of skull and face, trachea is midline and no deviation** **No drainage or ear wax** **Bilateral sclera yellow (Jaundice), no drainage** **No teeth**
CARDIOVASCULAR: **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:**	.**Normal rate and normal rhythm** **Normal heart sounds**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**The pulmonary effort is normal** **Normal breath sounds** **Clear throughout**
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 ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	. **Regular diet** **Cardiac diet** **5’10** **168 lbs.** **No irregular bowel sounds** **9/20/2022** **Abdomen is soft** **Skin is intact and looks normal.** **No distention** **No incisions** **No scars** **No drains** **No wounds**
GENITOURINARY:	

Color: **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Yellow/ clear** **Can be incontinent to urine** **Genitals normal**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 55** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☒**	 **Extremity looks normal, no swelling** **Full ROM of all body joints** **Client uses a cane** **Grips equal bilaterally** **Can walk with assistance**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Alert and oriented to person.** **Client was agitated** **Speech is normal** **Client doesn't wear any contacts/ glasses** **No changes in LOC**
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):**	. **The client lives with wife and family** **The client was not oriented enough to recall questions.**

Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:45 am	86	154/84	18	97.8	100

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
7:45	**0-10**		**0**		

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL	**200 mL**

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

Nursing Diagnosis • 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	Rationale • Explain why the nursing diagnosis was chosen	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Cardia output, decreased related to insufficient blood amount pumping to	**The client has a history of hypertension**	**1. Monitor b/p every 4 hours** **2. Stop smoking**	**1. Get to a normal b/p range**	**Blood pressure should be checked regularly, and blood pressure stays in the normal range**

the heart as evidenced by one b/p being 154/84 and the other is 160/92				
2. Risk for impairment related to a decrease in liver functions	**The client has a history of cirrhosis of the liver**	**1. Avoid infections** **2.eat low sodium diet, eat a healthy diet , and avoid drinking.**	**1. patient will have liver functions within normal range**	**Patient follows proscribed treatment plan**

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient stated that he was ready to leave, and he didn't want to be in the "hotel" anymore. Meaning the hospital.

Nursing Diagnosis/Outcomes

Cardia output decreased related to insufficient blood amount pumping to the heart as evidenced by one b/p being 154/84 and the other is 160/92.

Risk for impairment related to a decrease in liver functions

Objective Data

Patient was agitated and confused, patient was oriented times 1. The patient needed assistance with walking. Patients' sclera was yellow indication of jaundice.

Client Information

Richard Ford
Married African American male
Height: 5'10
Weight: 169 lbs
Full code
No known allergies

Nursing Interventions

Monitor b/p every 4 hours
Quit smoking
Eat low-sodium diet, eat healthier diet
Avoid drinking.