N311 Care Plan #

Lakeview College of Nursing

Name

Demographics (5 points)

Date of Admission	Client Initials	Age	Gender
9/13/2022	A.H.	74 yrs.	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Fast Food Worker/ Retired	Single/Widowed	Aspirin, Lipitor, Penicillin
Code Status	**Height**	**Weight**	
Full Code	5'1	129 lbs.	

Medical History (5 Points)

Past Medical History: Polio, Orthostatic Hypertension, Hypertension, Chronic Hip Pain, Syncope and Collapse, Osteoporosis, Small bowel obstruction (SBO)

Past Surgical History: Colon Resection

Family History: chronic obstructive pulmonary disease (brother, father, sister), Congestive Heart Failure (mother), Diabetes (sister), heart disease (brother)

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): The client reports that she's never smoked and does not drink or use any drugs.

Admission Assessment

Chief Complaint (2 points): The client came into the hospital complaining of hip and foot pain due to a fall from passing out. The client suffers from syncope.

History of Present Illness – OLD CARTS (10 points): Client was admitted to the hospital on 9/12/2022 due to a fall she had while on an outing to the local Walmart with other residents from the facility she lives at. She states that she did not hit her head and that she only has pain in her right hip and her right foot. The pain was severe on the first day but has gotten better since being admitted. The client states that it "feels like my foot is on fire" and "it's burning" when describing what the pain feels like. Things that make the pain worse are getting up and moving around for long periods. She is a fall risk and needs

assistance when walking, make sure to use a gate belt because the patient may become unsteady. Some things that relieve the pain are sitting down and elevating her legs. For treatment, this patient is receiving physical therapy and getting acetaminophen every four hours prn.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Syncope and collapse

Secondary Diagnosis (if applicable): N/A

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

Pathophysiology References (2) (APA): Attached

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	3.80-5.30	3.68	N/A	The client has anemia. (Pagana, 2019)
Hgb	12.0-16.0	10.6	N/A	The client has anemia (Pagana, 2019)
Hct	37.0-47.0	31.5	N/A	The client has anemia (Pagana, 2019)
Platelets	140-440	185	N/A	
WBC	4.00-12.00	5.20	N/A	
Neutrophils	47.0-73.0	60.9	N/A	
Lymphocytes	18.0-42.0	25.2	N/A	
Monocytes	4.0-12.0	10.0	N/A	

Eosinophils	**0.0-5.0**	**2.9**	**N/A**	
Bands	**10% or less**	**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-	**133-144**	**140**	**N/A**	
K+	**3.5-5.1**	**3.9**	**N/A**	
Cl-	**98-107**	**107**	**N/A**	
CO2	**21-31**	**26**	**N/A**	
Glucose	**70-99**	**79**	**N/A**	
BUN	**10-20**	**31**	**N/A**	**The client is dehydrated. (Pagana, 2019)**
Creatinine	**0.5-1.1**	**0.45**	**N/A**	**The client's age is over 65. (Pagana, 2019)**
Albumin	**3.5-5.7**	**N/A**	**N/A**	
Calcium	**9-10.5**	**7.9**	**N/A**	**The client's age is over 65. (Pagana, 2019)**
Mag	**1.3-2.1**	**N/A**	**N/A**	
Phosphate	**1.6-2.6**	**N/A**	**N/A**	
Bilirubin	**0.2-0.8**	**N/A**	**N/A**	
Alk Phos	**34-104**	**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 Yellow**	**Hazy Yellow**	**N/A**	**The client is dehydrated. (Pagana, 2019)**
pH	**5.0-9.0**	**5.0**	**N/A**	
Specific Gravity	**1.003-1.030**	**1.024**	**N/A**	
Glucose	**Negative**	**Negative**	**N/A**	
Protein	**Negative**	**Negative**	**N/A**	
Ketones	**Negative**	**3+**	**N/A**	**The client has a poor diet. (Pagana, 2019)**
WBC	**Negative 0-5**	**11-20**	**N/A**	**The client has an infection. (Pagana, 2019)**
RBC	**Negative 0-2**	**Negative**	**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	**< 10,000**	➢ **100,000**	**N/A**	**E Coli present**
Blood Culture	**No growth normal**	**N/A**	**N/A**	
Sputum Culture	**No growth normal**	**N/A**	**N/A**	
Stool Culture	**No growth normal**	**N/A**	**N/A**	

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): N/A

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

Medications (5 required)

Brand/ Generic	Acetaminophen /Tylenol	Amlodipine/ Norvasc	Calcium Carbonate / Tums	Enoxaparin/ Lovenox	Magnesium hydroxide/ Milk of Magnesia
Dose	650 mg	10 mg	1000 mg	40 mg	30 mL
Frequency	Every 4 hours PRN	daily	Every 8 hours PRN	Nightly	Daily PRN
Route	Oral	Oral	Oral	Subcutaneous	Oral
Classification	Normal	Normal	Normal	Normal	Normal
Mechanism of Action	Blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system	Binds to dihydropyridine and nondihydropyridine cell membrane receptor sites on myocardial and vascular smooth muscle cells and inhibits influx of extracellular calcium ions across slow calcium channels.	Increase levels of intracellular and extracellular calcium, which is needed to maintain homeostasis, especially in the nervous and musculoskeletal systems.	Potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors	A hyperosmotic effect in the small intestine. It causes water retention that distends the bowel and causes the duodenum to secrete cholecystokinin, this substance stimulates fluid secretion and intestinal motility.
Reason Client Taking	Mild pain	Blood pressure	Heartburn indigestion	Prophylaxis	Constipation
Contraindications (2)	Severe hepatic impairment, severe active liver disease	Hypersensitivity to amlodipine or its components	Cardiac resuscitation with risk of existing digitalis toxicity or presence of ventricular fibrillation, concurren	Active major bleeding, history of immune-mediated heparin-induced-induced thrombocytopenia within the past 100 days or in the presence of circulating	Acute abdominal problem, diverticulitis, fecal impaction, intestinal obstruction or perforation, colostomy, or ileostomy

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, place, and time.** **Alert and responsive** **Complains of pain (level 4)** **Well-groomed**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 **White** **Intact, dry** **Skin is warm** **No rashes** **Small bruise on right forearm** **No wounds** **Braden score = 22**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Normocephalic and atraumatic** **Symmetric** **No drainage or ear wax** **White, no drainage** **No drainage** **Dentures**
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: right foot**	**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** **Regular** **5'1** **129 lbs.** **Bowel sounds are normal.** **9/19/2022** **Abdomen is soft** **Skin looks normal and intact.** **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** **Hazy** **Incontinent** **Genitals normal**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 60** **Activity/Mobility Status: Can stand with assistance** **Independent (up ad lib)** ☐	**Right foot appears more swollen than left foot.** **Full ROM of RLE and right hip** **Client uses a walker** **Grips equal bilaterally**

Needs assistance with equipment ☒ **Needs support to stand and walk☒**	
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, place, and time.** **Client is in a good mood** **Speech is normal** **Client wears 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 watches TV and lives in a nursing home** **Adult, within normal limits for age** **The client does not practice any religion** **Has 1 son and lives in a nursing home, she is widowed.**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:45 am	**66**	**124/56**	**18**	**97.4**	**91%**

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
7:45am	**0-10**	**Right hip/right foot**	**4**	**“burning”**	**Tylenol**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

240mL	**Wears Depends**

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. Decreased cardiac output related to inadequate blood pumped to the heart as evidenced by one b/p being 125/56 and another being 140/60	**The client has a history of orthostatic hypertension**	**1. Monitor b/p every 4 fours** **2. move slowly from 1 place to another**	**1. To get a normal b/p range**	**Blood pressure stayed within normal range but still needs to be checked regularly.**
2. Impaired mobility	**The client requires the**	**1. Walking with**	**1. Patient achieves highest**	**Patient was monitored**

related to walking as evidenced by use of a walker	**use of equipment to move around.**	**assistance 2. Perform ROM exercises**	**mobility level possible**	**walking and still requires help, cannot stand or walk for long periods of time and is high risk of falling.**

Other References (APA): N/A

Concept Map (20 Points): Attached

Subjective Data

The patient stated that "my feet burn" and "it feels like it's on fire" when referring to the pain in her feet.

Nursing Diagnosis/Outcomes

Decreased cardiac output related to inadequate blood pumped to the heart as evidence by one b/p being 125/56 and another being 140/60.

Impaired mobility related to walking as evidenced by use of a walker.

Objective Data

Patient needs assistance with walking.
Urine lab abnormal, Hazy yellow due to client being dehydrated.
Urine culture abnormal, due to E coli being present.

Client Information

Andrea Harris
Single white female
Height: 5'1
Weight: 129lbs
Full code
Allergic to aspirin, Lipton, and Penicillin, worked in fast food.

Nursing Interventions

Move slowly from one place to another
Monitor b/p every 4 fours
Walk with assistance and use a gate belt
Perform range of motion exercises.