N311 Care Plan #

Lakeview College of Nursing

Shanique Williams

Demographics (5 points)

Date of Admission 10/11/2022	Client Initials B.I	Age 94	Gender Female
Race/Ethnicity Non-Hispanic	Occupation Home Maker	Marital Status Widow	Allergies Atorvastatin
Code Status Full code	Height 5'0	Weight 106 lbs.	

Medical History (5 Points)

Past Medical History: The client has a past medical history of 3 vessel CAD (96'), (abdominal aortic aneurysm) (HCC), Carcinoma (HCC), depression (depression/anxiety), dyslipidemia, GERD, Hiatal hernia, hypertension, MI (HCC) (16'), PAD (Peripheral artery disease).

Past Surgical History: The client has a history that includes hysterectomy; appendectomy, breast surgery, cataract removal (right); Femoral-popliteal bypass graft (right, 3/15/18), cardiac surgery procedure unlisted, mastectomy, vascular surgery procedure unlisted, abdominal aortic aneurysm repair (n/a, 3/30/18), and hip fracture surgery (right, 8/12/18).

Family History: Family history not on file

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): client reports that she has never smoked. The client has never used smokeless tobacco. Client reports that she doesn't drink alcohol and doesn't use drugs.

Admission Assessment

Chief Complaint (2 points): Generalized weakness

History of Present Illness – OLD CARTS (10 points): Betty L. Ingram is a 94-year-old female with history of hypertension, depression, dyslipidemia, and GERD who presented to the hospital

with complaints of generalized weakness. Initially, patient went to Christie Clinic where client

was diagnosed with urinary tract infection. Since client continues to feel weak, she presented to

the emergency room. Client denies any headaches or dizziness, no chest pain, no shortness of

breath, no abdominal pain, no constipation or diarrhea, no arthralgias or myalgias. Client said

that she was extremely weak and did not feel like doing anything and that is not normal for her.

After coming to the hospital the client was found to have creatine of 2.43 and potassium of 5.4.

the client was given 1 dose of Rocephin since the client was found to have urinary tract infection.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Acute renal failure

Secondary Diagnosis (if applicable): Hypertension 3/15/18, hyperlipidemia 3/15/18, GERD

3/30/28, metabolic acidosis 10/11/22, hyponatremia 10/11/22

Pathophysiology of the Disease, APA format (20 points): Acute renal failure occurs when

your kidneys suddenly become unable to filter waste products from your blood. When the

kidneys no longer have that filtering ability dangerous levels of wastes may accumulate and

it can cause an unbalance in your blood chemical makeup (Mayo Clinic, 2022). Acute renal

failure can be life threating and require intensive treatments, but this disease can be

reversible if your are following preventative measures such as eating better, following up to

see your doctor to check your kidney levels, maintaining a healthier life style overall (Mayo

Clinic, 2022). The cause of acute renal failure can occur when you experience injuries

directly to the kidney or when you have an underlying condition you are already dealing

with that could possibly slow blood flow to your kidneys. Signs and symptoms to look for

are fatigue, nausea , weakness, decrease in urine output, and fluid retention, which causes

swelling in the lower extremities (Mayo Clinic, 2022). The treatments can include treating

what is causing you to have acute renal failure, this includes the symptoms you are

experiencing. Reducing the symptoms that are contributing to this disease can help to treat

patient back to full health. Check in with your provider to check kidney levels, some

treatments require you to stay in the hospital. In more serious cases dialysis may be

required. The patient is currently with the help of family looking to get in a nursing home

facility seeing as that would be better so someone can look after her 24 hours a day. Patient

has currently made appointments to see the primary care provider to seek better treatment

for acute renal failure. Client is actively changing diet habits and making life style changes

to help with recovery of acute renal failure (National Kidney Foundation, 2022).

Pathophysiology References (2) (APA):

Acute kidney injury (AKI). National Kidney Foundation. (2022, August 11). Retrieved October 26, 2022, from https://www.kidney.org/atoz/content/AcuteKidneyInjury

Mayo Clinic. (2022, July 30). *Acute kidney failure*. Mayo Clinic. Retrieved October 26, 2022, from https://www.mayoclinic.org/diseases-conditions/kidney-failure/symptoms-causes/ syc-20369048#:~:text=Acute%20kidney%20failure%20can%20occur,your%20body %20through%20your%20urine

Laboratory Data (20 points)
If laboratory data is unavailable, values will be assigned by the clinical instructor

CBC <mark>Highlight All Abnormal Labs</mark>—**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	3.19	3.20	The client has a history of acute renal failure which caused levels to be low (Pagana, 2019).
Hgb	13.0-16.5	9.7	9.6	The client has a history of acute renal failure with cause levels to be low (Pagana, 2019).
Hct	38-50	29.6	29.0	the client has a history of acute renal failure which caused levels to be low (Pagana, 2019).
Platelets	140-440	206	216	
WBC	4.00-12.00	8.00	6.00	
Neutrophils	40.0-68.0	84.8	76.1	levels where high due to the patient being diagnosed with acute renal failure (Pagana, 2019).
Lymphocytes	19.0-49.0	4.9	8.8	The client has a history of acute renal failure which caused levels to be low (Pagana, 2019).
Monocytes	3.0-13.0	8.6	11.4	
Eosinophils	0-8.0	1.2	2.9	
Bands	10% or less	N/A	N/A	

Chemistry <mark>Highlight All Abnormal Labs</mark>—**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	138	136	
K+	3.5-5.1	5.1	4.5	
Cl-	98-107	114	117	levels where high due to the patient being diagnosed with acute renal failure (Pagana, 2019).
CO2	21-31	14	13	The client has a history of acute renal failure which caused levels to be low (Pagana, 2019).

Glucose	**70-99**	**83**	**97**	
BUN	**7-25**	**42**	**32**	**levels where high due to the patient being diagnosed with acute renal failure (Pagana, 2019).**
Creatinine	**0.5-1.1**	**2.04**	**1.74**	**levels where high due to the patient being diagnosed with acute renal failure (Pagana, 2019).**
Albumin	**3.5-5.7**	**N/A**	**N/A**	
Calcium	**8.8-10.2**	**9.6**	**9.5**	
Mag	**1.3-2.1**	**N/A**	**N/A**	
Phosphate	**N/A**	**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**	**Clear-yellow**	**Clear-yellow**	
pH	**5.0-9.0**	**5.0**	**N/A**	
Specific Gravity	**1.003-1.030**	**1.014**	**N/A**	
Glucose	**Negative**	**Negative**	N/A	
Protein	**Negative**	**2+**	**N/A**	**There as a trace of protein in the urine due to the patient have acute renal failure allowing protein to leak in urine (Pagana, 2019).**
Ketones	**Negative**	**Negative**	**N/A**	
WBC	**Negative 0-5**	**Negative**	**N/A**	
RBC	**Negative**	**Negative**	**N/A**	

	0-2			
Leukoesterase	**N/A**	**N/A**	**N/A**	

Cultures <mark>Highlight All Abnormal Labs</mark>—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**	**100,000-CFU**	**N/A**	**Growth of E. Coli was found due to pt having a UTI. UTI are limited to bladder; however, kidneys can also be a source of infection (Pagana, 2019).**
Blood Culture	**No growth**	**N/A**	**N/A**	
Sputum Culture	**No growth**	**N/A**	**N/A**	
Stool Culture	**No growth**	**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):

XR lumbar spine 2 or 3 views: for history of falls; impression; compression deformities of

the lumbar vertebral bodies especially T12 which is worse compared to previous study.

Patient received XR lumbar spine 2 or 3 views due to history of falls (Pagana, 2019). The XR Lumbar spine indicated that there were compression deformities of the lumbar vertebral bodies especially T12 which is worse compared to previous study, which could be the cause of patient having history of falls. Compression deformities of the lumbar vertebral bodies can stem from people that have healthy spines that may have suffered from severe trauma, such as a car accident, sports injury or a hard fall (AANS, 2022). This specific patient had experienced a fall, and the fall resulted in compression deformities of the lumbar vertebral bodies.

CT head or brain without contrast: for head trauma; impression: moderate to marked cerebral atrophy with prominence of the sulci and ventricles. Also, some cerebellar atrophy. vascular calcification. Deceased attenuation of the periventricular white matter indicating small vessel disease.

Patient received CT head or brain without contrast due to head trauma (Pagana, 2019). The CT indicated that there was moderate to marked cerebral atrophy with prominence of the sulci and ventricles. Moderate Cerebral atrophy can happen when people have a loss of brain cells, and connections between their brain cells and brain volume often decreases. Injuries such as traumatic brain injuries can cause moderate cerebral atrophy, in which this specific patient is experiencing (Cleveland Clinic, 2022).

Diagnostic Imaging Reference (1) (APA): Pagana, Kathleen. (2019). Mosby's Diagnostic and

Laboratory Test Reference, (14th ed.). Elsevier.

Vertebral compression fractures. AANS. (n.d.). Retrieved October 25, 2022, from
https://www.aans.org/en/Patients/Neurosurgical-Conditions-and-Treatments/Vertebral-
Compression-Fractures

Brain atrophy: What it is, causes, symptoms & treatment. Cleveland Clinic. (n.d.). Retrieved
October 25, 2022, from https://my.clevelandclinic.org/health/diseases/22515-brain-atrophy

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

Medications (5 required)

Brand/ Generic	Lorazepam (Ativan)	Amlodipine (Norvasc)	Acetaminopren (Tylenol)	Carvedilol (Coreg)	Enoxaparin (Lovenox)
Dose	0.5 mg Tablet	5 mg Tablet	650 mg Tablet	25 mg Tablet	30 mg
Frequency	Every 8 hrs. PRN	Daily	Daily- every 4hrs- PRN	2 times daily	Daily- every 24 hrs.
Route	Oral	Oral	Oral	Oral	injection
Classification	Anxiolytic controlled substance schedule: IV	Antianginal, antihypertensive	Antipyretic, nonopioid analgesic	Antihypertensive, heart failure treatment adjunct	Anticoagulant
Mechanism of Action	GABA inhibits excitatory stimulation, which helps control emotional behavior. Limbic system contains a highly dense area of benzodiazepine receptors, which may explain drug's antianxiety effects. (Jones & Bartlett Learning,	Decreasing peripheral vascular resistance and reducing systolic and diastolic blood pressure (Jones & Bartlett Learning, 2023)	Acetaminophen acts directly on temperature -regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2. (Jones & Bartlett Learning, 2023)	Reduces cardiac output and tachycardia, causes vasodilation. (Jones & Bartlett Learning, 2023)	Without thrombin, fibrinogen can't convert to fibrin and thrombus can't form. (Jones & Bartlett Learning, 2023)

	2023)				
Reason Client Taking	**Anxiety**	**Lower blood pressure**	**Mild pain or severe pain**	**Lower blood pressure**	**Prevent blood clots**
Contraindications (2)	**Acute angle-closure glaucoma, hypersensitivity to lorazepam**	**Hypersensitivity to acetaminophen or its component.**	**Hypersensitivity to acetaminophen or its component, severe hepatic impairment, severe active liver disease.**	**Cardiogenic shock: decompensated heart failure that requires I.V. bronchial asthma**	**Active major bleeding; history of immune-mediated heparin-induced thrombocytopenia (HIT) within past 100 days or in the presence of circulating antibodies**
Side Effects/ Adverse Reactions (2)	**Depression, Confusion**	**Anxiety, light-headedness**	**Hypertension, anxiety**	**Depression, hypertension**	**Elevated liver injury, confusion**

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

Assessment

Physical Exam (18 points) – <mark>HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS</mark>

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Alert, oriented to person, place, time and situation** **Alert and responsive** **No acute distress** **Well groomed**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 **White skin** **Intact, dry** **Skin warm** **Skin turgor good mobility** **No rashes** <mark>**Bruising and swelling of left arm due to IV placement**</mark> **No wounds** **Braden score = 15**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is round and symmetrical of skull** **And face** **Trachea is midline no deviations** **No drainage or ear wax** **Conjunctiva clear/ Bilateral sclera, white** **Oral cavity pink/ moist and clear**
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:**	**Clear S1 and S2 without murmur gallops, or rubs** **Pulses 2+ bilaterally** **Chest is clear to auscultation, with regular rate and rhythm. Breathing is non-labored** **Capillary refill less than 3 seconds**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**The pulmonary effect is normal breath sounds are clear throughout** **Clear throughout**
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:**	**Regular diet** **Regular diet** **5'0** **106 lbs.** **No irregular bowel sounds** **last bowel movement was 10/11/22**

Palpation: Pain, Mass etc.:
Inspection:
   Distention:
   Incisions:
   Scars:
   Drains:
   Wounds:
Ostomy: Y ☐ N ☒
Nasogastric: Y ☐ N ☒
   Size:
Feeding tubes/PEG tube Y ☐ N ☒
   Type:
	abdomen is soft, non-distended and non-tender. No masses noted
	skin is intact with no scaring, bruising
	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
	Continent to toilet
	<mark>**Client had high levels of E. coli due to patient having UTI.**</mark>

MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance:** Y ☒ N ☐ **Fall Risk:** Y ☒ N ☐ **Fall Score: 65** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☒ **Needs support to stand and walk** ☒	**Extremity intact, no swelling, no edema, no cyanosis present** **Full ROM of all body joints** <mark>**Client uses a gait belt when getting assistance**</mark> **Grip equal bilaterally** **No DVT in legs** <mark>**client need assistance with walker and gait belt**</mark> **client is a 1 assist with gait belt/walker**
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, time and situation** **Client was calm upon meeting** **Speech was clear** **Client doesn't wear any contact/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 at home with self Client is a Christian

Vital Signs, 1 set (5 points) – <mark>HIGHLIGHT ALL ABNORMAL VITAL SIGNS</mark>

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:10 am	61	159/89	18	97.3	99

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
7:10 am	0-10		0		

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL	300 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	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

• Listed in order by priority – highest priority to lowest priority pertinent to this client				response, status of goals and outcomes, modifications to plan.
1. **At risk for falls related to generalized weakness as evidence by morse scale being 65**	**The patient requires use of equipment, such as a walker and gait belt with the assist of 1 person to help patient ambulate safety. While getting out of bed, walking down hall etc.**	**1. assess the patient ability to use call light to call for help.** **2.identify available resource the patient can access to help them with ongoing fall preventions.**	**1. The patient would find resources to help them with fall preventions**	**patient followed treatment and have found resources to help them with ongoing fall preventions.**
2. **Risk for kidney impairment related to decrease in kidney functions as evidence by patient being diagnosed with acute renal failure**	**The patient has acute renal failure**	**1. proper medication use should be improved, avoid infections** **2. maintain cholesterol levels, keep it in normal ranges**	**1. the patient will maintain better eating habits and take medications to improve lifestyle**	**Patient follows prescribed treatment by taking measures to maintain a healthier lifestyle.**

Other References (APA):

Concept Map (20 Points):

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1.At risk for falls related to generalized weakness as evidence by morse scale being 65.

Subjective Data

The patient stated she wanted to get out of bed and transfer to chair. Patient stated she was more comfortable sitting up then lying down. Patient stated she was in no pain

Objective Data

Client Information

Upon meeting the patient, patient was calm and in good spirits. Patient appeared to be a alert and oriented x4. The patient needs a gait belt and walker with 1 assist to get around due to being unstable with balance. Patient was in no acute distress.

B.I
Widow/ Non-Hispanic
Height: 5'0
Weight: 106 lbs.
Full Code
Allergies: Atorvastatin, Gabapentin, Ibuprofen

1.   assess the patient ability to use call light to call for help.

2.identify available resource the patient can access to help them with ongoing fall preventions.

3.   proper medication use should be improved, avoid infections

4. maintain cholesterol levels, keep it in normal ranges