N441 Care Plan

Lakeview College of Nursing

Byron Grant

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
2/10/2023	J.S	80 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	TeePak	Married	No Known Allergies
Code Status	**Height**	**Weight**	
Full	6’5	185 pounds	

Medical History (5 Points)

Past Medical History: Atrial fibrillation on anticoagulation, back pain, heart rate fast, hydrocephalus, stroke, hyperlipidemia, hypertension, lipoma intra cerebral

Past Surgical History: Cataract removal, Glaucoma repair, joint replacement, skin cancer excision, hand surgery bilaterally, tumor excision, appendectomy, cholecystectomy

Family History: Family history not pertinent.

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

He reports that he has quit smoking, smokeless tobacco include chew, does not drink alcohol and does not use drugs.

Assistive Devices: Uses a walker

Living Situation: lives with wife

Education Level: N/A

Admission Assessment

Chief Complaint (2 points): Fall left side

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

Patient is an 80-year-old man who fell down in the bathroom and could not get up. Patient stated that he lost his balance and that how the fall happened. Patient complained of pain and was

unable to put weight on leg, so he was brought to the emergency department. Patient denied losing conscious or head pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Closed left hip fracture.

Secondary Diagnosis (if applicable): A-Fib

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

The Hip fracture has a break in the upper end of the femur. These fractures can happen at any age but are majority found in the elderly population (Emmerson et al., 2020). *Pathological fracture* is caused by a disease process unrelated to trauma; malignancy and bisphosphonate use are the two most common hip fractures (Emmerson et al., 2020). Hip fractures could be described as underlying osteoporosis but are rarely labeled this way (Emmerson et al., 2020). Magnetic resonance imaging is primarily used to diagnose a hip fracture as they show 93% to 100% specificity in diagnosing hip fractures. Computerized tomography is a good alternative but can miss fractures, especially those in the axial plane (Emmerson et al., 2020). The elderly with a complex background, such as myocardial infarction, syncope, or stroke, are often the patients with a fall occurring, fracturing the hip. The patient has a complex history of dealing with stroke, atrial fibrillation, and a fast heart rate. During a physical examination, the client will demonstrate pain, immobility, and potentially a deformed limb (Emmerson et al., 2020). Arthroplasty has been shown to work great in elderly patients with hip fractures regarding pain, postoperative function, and complications. (Emmerson et al., 2020). If there is consideration after taking into account the patient's history and presentation, labs should be ordered on the

potential of surgery (Bhatti, 2019). These labs include CBC, creatinine value, Urinalysis, prothrombin time, activated partial thromboplastin time, and arterial blood gasses (Bhatti, 2019).

Pathophysiology References (2) (APA):

Bhatti, N. S. (2019, November 12). *Hip Fracture Workup: Laboratory Studies, Imaging Studies*. Medscape.com. https://emedicine.medscape.com/article/87043-workup

Emmerson, B. R., Varacallo, M., & Inman, D. (2020). *Hip Fracture Overview*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK557514/

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	**4.40-5.80**	**3.88**	**3.08**	**Patient is on anticoagulant medication** (Capriotti,2020).
Hgb	**13.0**	**12.1**	**9.6**	**Patient is on anticoagulant medication** (Capriotti,2020).
Hct	**38.0-50.0**	**35.8**	**29.8**	
Platelets	**140-440**	**179**	**246**	
WBC	**4.00-12.00**	**18.90**	**9.70**	**Patient recently had surgery** (Capriotti,2020).
Neutrophils	**40-68%**	**71.8**	**69.7**	**Patient could have infection** (Capriotti,2020).
Lymphocytes	**19.0-49.0**	**9.7**	**16.2**	**Patient could have infection, with high neutrophils and low lymphocytes** (Capriotti,2020).
Monocytes	**3.0-13.0%**	**16.6**	**12.1**	**Monocytes could be high patient might not have taken medication for anticoagulation, clotting can been**

				higher with monocytes high (Capriotti,2020).
Eosinophils	**0-8.0%**	**1.2%**	**1.6%**	
Bands	**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**	**137**	
K+	**3.5-5.1**	**4.1**	**3.8**	
Cl-	**98-107**	**106**	**107**	
CO2	**22-30**	**22**	**22**	
Glucose	**70-99**	**130**	**101**	**Patient may be pre-diabetic** (Capriotti,2020)
BUN	**8-26**	**19**	**23**	
Creatinine	**0.70-1.30**	**0.95**	**0.82**	
Albumin	**3.5-5.7**	**3.8**	**N/A**	
Calcium	**8.7-105**	**8.7**	**8.8**	
Mag	**1.6-2.6**	**1.9**	**N/A**	
Phosphate	**N/A**	**N/A**	**N/A**	
Bilirubin	**N/A**	**N/A**	**N/A**	
Alk Phos	**34-104**	**76**	**N/A**	
AST	**13-39**	**20**	**N/A**	
ALT	**7-52**	**31**	**N/A**	

Amylase	**N/A**	**N/A**	**N/A**	
Lipase	**11-82**	**16.6**	**N/A**	
Lactic Acid	**0.5-2.0**	**1.7**	**N/A**	
Troponin	**0.000-0.040**	**<0.030**	**N/A**	
CK-MB	**N/A**	**N/A**	**N/A**	
Total CK	**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	**0.8-1.1**	**1.4**	**N/A**	**Patients has suffered from a stroke in the past,** (Capriotti,2020).
PT	**10.1-13.1**	**15.1**	**N/A**	**Blood takes longer to clot, on medication** (Capriotti,2020).
PTT	**25-36**	**20**	**N/A**	**Anticoagulation medication making the blood harder to clot** (Capriotti,2020).
D-Dimer	**N/A**	**N/A**	**N/A**	
BNP	**0-100**	**N/A**	**N/A**	
HDL	**N/A**	**N/A**	**N/A**	
LDL	**N/A**	**N/A**	**N/A**	
Cholesterol	**N/A**	**N/A**	**N/A**	
Triglycerides	**N/A**	**N/A**	**N/A**	
Hgb A1c	**N/A**	**N/A**	**N/A**	
TSH	**N/A**	**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**			
pH	**5.0-9.0**			
Specific Gravity	**Negative**			
Glucose	**Negative**			
Protein	**Negative**			
Ketones	**Negative**			
WBC	**Negative**			
RBC	**Negative**			
Leukoesterase	**Negative**			

Arterial Blood Gas 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
pH	**N/A**			
PaO2	**N/A**			
PaCO2	**N/A**			
HCO3	**N/A**			
SaO2	**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**			
Blood Culture	**N/A**			
Sputum Culture	**N/A**			
Stool Culture	**N/A**			

Lab Correlations Reference (1) (APA):

Capriotti, T. (2020). *Davis Advantage for Pathophysiology*. F.A Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): X-ray of the femur, pelvis, hip unilateral, X-ray of the chest.

Diagnostic Test Correlation (5 points): The pelvic X-ray is the simplest, cheapest, and fastest method for diagnosing femoral fractures (Beyaz, 2020). Although femoral neck fracture detection rates using MRI, CT, and radionuclide methods are higher, their routine is not cost-effective (Beyaz, 2020).

Diagnostic Test Reference (1) (APA):

Beyaz, S. (2020). Femoral neck fracture detection in X-ray images using deep learning and genetic algorithm approaches. *Joint Diseases and Related Surgery*, *31*(2), 175–183. https://doi.org/10.5606/ehc.2020.72163

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**Acetaminophen (Tylenol)**	**Calcium carbonate chewable (tums)**	**Dabigatran (Pradaxa)**	**Diltiazem (Cardizem)**	**Lisinopril (Zestril)**
Dose	**650 mg**	**1000 mg**	**150 mg**	**30 mg**	**5 mg**
Frequency	**X 4 hours prn**	**X 8 hours prn**	**2x daily**	**4x daily**	**Daily**
Route	**oral**	**oral**	**oral**	**oral**	**oral**
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations (2)					
Key Nursing Assessment(s)/Lab(s) Prior to Administration					
Client Teaching needs (2)					

Hospital Medications (5 required)

Brand/Generic	**Metoprolol tartrate (Lopressor)**	**Tamsulosin (Flomax)**	**Finasteride (Proscars)**	**Polyethylene Glycol**	**Melatonin (circadin)**
Dose	**125 mg**	**0.4mg**	**5 mg**	**17 g**	**6 mg**
Frequency	**2x daily**	**Every morning**	**Daily**	**2x daily prn**	**nightly**
Route	**oral**	**oral**	**oral**	**Oral**	**oral**
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations (2)					
Key Nursing Assessment(s)/Lab(s) Prior to Administration					
Client Teaching needs (2)					

Medications Reference (1) (APA):

Assessment

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

GENERAL: **Alertness: A&O x3** **Orientation: Oriented to place, time, person** **Distress: appeared to be in some pain** **Overall appearance: well groomed**	
INTEGUMENTARY: **Skin color: White, normal for race** **Character: Bruised on upper arm** **Temperature: Warm** **Turgor: rapid recoil** **Rashes: none** **Bruises: yes upper right arm** **Wounds: gluteal pressure wound** **Braden Score: 16** **Drains present: Y☐ N ☐ No** **Type:**	
HEENT: **Head/Neck: symmetrical, No lesion or rashes noted** **Ears: Auricle pink, moist with no rashes or lesions noted** **Eyes: Sclera white, Cornea clear, conjunctiva pink, no lesions or** **Nose: Septum midline. No drainage or bleeding noted.** **Teeth: Patient has natural teeth**	.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): Clear S1 S2 no murmur, slightly tachycardic** **Peripheral Pulses: distal pulses weak** **Capillary refill: <3** **Neck Vein Distention: Y ☐ N ☐ No** **Edema Y ☒ N ☐**	.

Location of Edema: Right ankle	
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character** **Decreased breath sounds bilaterally.** **ET Tube: No** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	.
GASTROINTESTINAL: **Diet at home: Regular** **Current Diet : General** **Height: 6'5** **Weight: 185** **Auscultation Bowel sounds:** **Last BM: Yesterday** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention: no distention noted** **Incisions: Left hip incisions** **Scars: no scars** **Drains: none** **Wounds: none** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	.
GENITOURINARY: **Color: Dark** **Character: No cloudiness or sediment** **Quantity of urine: 200 mL** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:**	

Size: **CAUTI prevention measures:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM: Both arms and right leg, left leg cannot move due to surgery and fracture** **Supportive devices: walker** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 50** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐ Yes**	.
NEUROLOGICAL: **MAEW: Y ☐ N☒ Patient needed help with walking before fracture, cannot walk after surgery** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☒ Both ☐** **Orientation: A&O x3** **Mental Status: Conscious and aware** **Speech: Clear speech** **Sensory: Reflexes present** **LOC: Awake**	.
PSYCHOSOCIAL/CULTURAL: **Coping method(s): Watching Tv, talking with wife** **Developmental level: Adult** **Religion & what it means to pt.: Patient raised catholic.** **Personal/Family Data (Think about home environment, family structure, and available family support): Patient lives with wife and has a son.**	.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	**89**	**115/70**	**17**	**98.2**	**95**
0900	**90**	**120/75**	**18**	**99.1**	**93**

Vital Sign Trends/Correlation:

Vitals are stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	**1-10 5**	**Left Leg**	**mild**	**dull**	**Patient will receive Tylenol per nurse**
11:30	**1-10 5**	**Left Leg**	**mild**	**Dull**	**Bed rest, patent reported pain after therapy**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22G Location of IV: Right Arm Date on IV:2/09/23 Patency of IV: Patent Signs of erythema, drainage, etc.: None IV dressing assessment: Clean and dry	Amiodarone drip but was discontinued the day before I seen the patient.
Other Lines (PICC, Port, central line, etc.)	
Type: none Size: Location: Date of insertion: Patency: Signs of erythema, drainage, etc.: Dressing assessment: Date on dressing: CUROS caps in place: Y ☐ N ☐	

CLABSI prevention measures:	

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
250 mL	**225 mL**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient received medications and adjustments in bed, patient had physical therapy come to the room today as well and work with patient. Transferred out of ICU and onto med-surg floor

Procedures/testing done: No procedures done today.

Complaints/Issues: Patient complained of pain while doing physical therapy and resting.

Vital signs (stable/unstable): Vital signs were stable.

Tolerating diet, activity, etc.: Patient was able to void in the urinal no bowel movement while present.

Physician notifications: Patient will go to a rehab facility when discharged.

Future plans for client: Rehab center

Discharge Planning (2 points)

Discharge location: Undecided on which location will take him.

Home health needs (if applicable): People will need help maybe two assist

Equipment needs (if applicable): Walker, commode,

Follow up plan: N/A

Education needs:

Family will need to be educated on what treatments and help patient needs if he comes home after the facility.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Risk for falls related to hip fracture evidenced by patient not being able to withstand any pressure	During therapy patient could not stand on leg or put any weight on the fractured leg.	1. Maintain bed or limb rest as indicated. Provide support of joints above and below the fracture site,	1. Client maintain stabilization and alignment of fractures.	Patient and his wife were wiling to comply with the interventions to try and help better his self.

on leg.		especially when moving and turning. 2. Support fracture site with pillows or folded blankets.		
2. Acute pain related to hip fracture evidenced by patient complaining of pain.	Patient complained of hip pain during assessment	**1.** Assess and record the patient's level of pain. **2.** Elevate and support injured extremity.	1. Client will verbalize relief of pain.	Patient will verbalize pain with the nurse.
3. Impaired physical mobility related to hip fracture evidenced by patient not being able to walk.	Patient could not get himself out of bed.	**1.** Teach patient or assist with active and passive ROM exercises of affected and unaffected extremities. **2**Encourage the use of isometric exercises starting with the unaffected limb.	1. Client will regain/maintain mobility at the highest possible level.	Patient and wife agreed to try and do the exercises to help get him back walking
4. Impaired Skin Integrity related to physical immobilization evidenced by pressure wound on the patients gluteal.	Patient has a gluteal pressure wound.	1. Massage skin and bony prominences. Keep the bed linens dry and free of wrinkles. 2. Reposition frequently.	1. Client will achieve timely wound/lesion healing if present.	Patient and wife will work with nurse to continue to improve gluteal pressure wound.
5. Self-Care deficit related to decreased strength and	Patient will have trouble bathing himself and going to the bathroom.	1. Client will achieve timely wound/lesion healing if present.	1. Client will demonstrate optimal performance of activities of daily living.	Patient will be doing therapy at rehab facility to try and get better .

pain evidenced by patient not being able to stand during therapy and having pain.		**2.** Refer the patient to occupational therapy if indicated and use assistive devices and dressing/grooming aids as needed.		

Other References (APA):

Concept Map (20 Points):

Subjective Data

Patient stated he was having pain in his left leg. Rated it a 5 on a scale of 10. Patient was A&O x3.

Objective Data

No known allergies
Past Medical History: Atrial fibrillation on anticoagulation, back pain, heart rate fast, hydrocephalus, stroke, hyperlipidemia, hypertension, lipoma intra cerebral

Past Surgical History: Cataract removal, Glaucoma repair, joint replacement, skin cancer excision, hand surgery bilaterally, tumor excision, appendectomy, cholecystectomy

Client Information

J.S 80 years old
Male
Married
6'5 185 pounds
Caucasian

Risk for falls related to hip fracture evidenced by patient not being able to withstand any pressure on leg- client maintains stabilization and alignment of fractures

Acute pain related to hip fracture evidenced by patient complaining of pain

- **Client will verbalize relief of pain.**

Impaired physical mobility related to hip fracture evidenced by patient not being able to walk - Client will regain/maintain mobility at the highest possible level.

Impaired Skin Integrity related to physical immobilization evidenced by pressure wound on the patients gluteal- Client will achieve timely wound/lesion healing if present.

Self-Care deficit related to decreased strength and pain evidenced by patient not being able to stand during therapy and having pain. - Client will demonstrate optimal performance of activities of daily living.

Nursing Diagnosis/Outcomes

Nursing Interventions

Maintain bed or limb rest as indicated. Provide support of joints above and below the fracture site, especially when moving and turning.

Support fracture site with pillows or folded blankets.

Assess and record the patient's level of pain.

. Elevate and support injured extremity.

Teach patient or assist with active and passive ROM exercises of affected and unaffected extremities.

2Encourage the use of isometric exercises starting with the unaffected limb.

Massage skin and bony prominences. Keep the bed linens dry and free of wrinkles.

Reposition frequently.
.Refer the patient to occupational therapy if indicated and use assistive devices and dressing/grooming aids as needed.

Client will achieve timely wound/lesion healing if present.