N311 Care Plan 1

Jessica Hines

Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Hartke

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Demographics (5 points)

Date of Admission	**Client Initials**	**Age**	**Gender**
09-16-2023	E.S.	60 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Scandinavian	Disability	Married	Listed Below
Code Status	**Height**	**Weight**	
Full Code	5’4”	142 lbs	

Medical History (5 Points)

Past Medical History: Paroxysmal arterial fibrillation; hypertensive urgency, malignant; hyperlipidemia; essential hypertension, benign; palpitations; pancreatitis, recurrent; hypothyroidism; history of prediabetes; disturbance of skin sensation; left facial numbness, skin ulcer of hand; Parkinson’s; pseudo seizures, chronic pain syndrome, history of TBI, hemiparesis, syncope; Ischemic stroke; mild intermittent asthma without complication; cough; pneumonia; spondylosis of cervical spine, primary osteoarthritis of both knees, dorsalgia, lumbar degenerative disc disease, left shoulder pain, facial droop, arthralgia, splenic infarction, thrombosis, UTI, Hepatitis C, constipation, vomiting, acute colitis; hypokalemia; fatigue

Risks and Care Concerns: substance abuse (HCC), uncomplicated opioid use, tobacco use, routine health maintenance, osteopenia determined by x-ray, insomnia, elevated liver enzymes, drug-seeking behavior, cocaine abuse (HCC), body mass index 25.0-25.9, elevated troponin, fall risk

Mental/Behavior Health: psychiatric disorder, anxiety state, anxiety disorder, major depressive disorder, recurrent episode, mild (HCC)

Other: hemiplegic migraine, injury of the right hand, chest pain, thoracic aortic ectasia (HCC), opiate dependence, continuous (HCC), abdominal pain, muscle

spasm of the left lower extremity, mass of leg bilaterally, localized swelling on right hand, history of electroencephalogram, hormone replacement therapy, history of chronic pancreatitis, history of hysterectomy, chronic prescription benzodiazepine use, abdominal pain, fall at home, headache, cellulitis.

Past Surgical History: 7 Endometrioses, Appendectomy, Cholecystectomy, wisdom teeth removal of all four at 21, Tonsillectomy, Complete Hysterectomy, I & D of Right hand, I & D of Left hand

Family History: Alcohol/Drug Father

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): Cigarettes occasionally; Some days. No tobacco, drug, or alcohol abuse was stated.

Admission Assessment

Chief Complaint (2 points): "Client presents to the emergency department with swelling and redness of the left hand and distal forearm. She reports she had an IV placed at the hospital ten days ago, and symptoms worsened on Wednesday; she saw her primary doctor yesterday (9-16-23) and started on Keflex."

History of Present Illness – OLD CARTS (10 points): Onset: When the patient got an IV or blood drawn; Location: Left hand started to go up to the elbow; Duration: a week, as stated by the client; Characteristics: swelling, itchy, sharp pain, could not move wrist or thumb, white blister that spread, really red, hurts real bad; Associated/Aggravating factors: moving it, picking things up; Relieving: warm blanket, medication; Treatment: 4 mg Dilaudid @home orally, ibuprofen; Severity: 8/10 "pretty severe"

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Cellulitis of the left hand

Secondary Diagnosis (if applicable): N/A

Pathophysiology

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

Cellulitis

Cellulitis is a widespread bacterial skin infection. It can usually be diagnosed from a primary history and physical assessment. The bacteria that cause this infection is called *Streptococcus pyogenes* or *Staphylococcus aureus.* These bacteria live harmlessly on the skin, as these are our normal skin flora. What causes an infection is when your skin is damaged or injured, and your deep skin layers are open, the bacteria can get underneath it and cause an infection, such as cellulitis.

Symptoms

Cellulitis is usually easy to diagnose. Doctors can diagnose it by examining the affected skin during a physical exam. Patients with cellulitis usually present with reddening of the skin, warmth, swelling, and tenderness. Some patients may also experience blisters, rashes, and fatigue. National Library of Medicine states, “The cytokines and neutrophils are recruited to the affected area after bacteria have penetrated the skin, leading to an epidermal response. This response includes the production of antimicrobial peptides and keratinocyte proliferation and is postulated to produce the characteristic exam findings in cellulitis.” (Brown & Hood Watson, 2022)

Complications

A complete and thorough past medical history assessment is essential to evaluate for any other possible chronic medical conditions. The patient needs to seek medical help when they notice this infection. If it is not treated, it could reach the bloodstream and lead to bacteremia.

National Library of Medicine states, “Patients who have cellulitis along with two or more of the criteria (fever over 100.4 degrees F, tachypnea, tachycardia, or abnormal white cell count) get diagnosed with sepsis. If cellulitis moves from the deep dermis and subcutaneous tissue to the bone, it can lead to osteomyelitis.” (Brown & Hood Watson, 2022)

Treatment

Patients with mild cellulitis with no systemic signs of infection can be prescribed antibiotics to target the streptococcal species. Antibiotics will typically last for five to seven days. Patients who experience purulent cellulitis with extensive wounds or a history of drug use should also receive antibiotics to cover the methicillin-resistant staph aureus. Blood cultures are essential to determine if the patient is showing signs of systemic toxicity, persistent cellulitis, or has exposure to animal bites.

Pathophysiology References (2) (APA):

Boettler, M. A., Kaffenberger, B. H., & Chung, C. G. (2022). Cellulitis: A Review of Current Practice Guidelines and Differentiation from Pseudocellulitis. *American journal of clinical dermatology*, *23*(2), 153–165. https://doi.org/10.1007/s40257-021-00659-8

Brown, B. D., & Hood Watson, K. L. (2022b). *Cellulitis*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK549770/#article-19114.s19

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
9:10 am	44 bpm	171/95	16	97.2 F Temporal	96%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9:30 am	8	Left hand	“pretty severe”	Sharp, Throbbing	Dilaudid @10 am, Q4H

Allergies:	**Severity**	**Reaction**	**Comments**
Ketorolac	high	hives, rash	ibuprofen
Nalbuphine	high	hives, itching	hydromorphone
Metoclopramide	medium	unknown	hallucinations
Aripiprazole	-	unknown	dizzy
Beta-adrenergic blockers	-	unknown	patient has hx of cocaine abuse
Butorphanol	-	hallucinations	hydromorphone
Chlorpromazine	-	anxiety	
Depakote (valproic acid)			
Eggs and egg-derived products			
Haldol:			“My head got stuck to my shoulder; I could not release it.”
Hydrocodone			muscle spasms, shaking, blue lips
Hyoscyamine			GI cramps
Melatonin			hallucinations
Phenytoin			seizure
Sumatriptan			: “it affected my heart.”
Cyclobenzaprine	low	anxiety	muscles “tensed up”
Fentanyl	low		: “very sleepy & could not wake up shallow breathing.”
Promethazine			“freaked out & pulled out IVs”

Tramadol	low	itching
Prozac		vomiting, allergic to the generic version

Medications:

Albuterol nebulizer

Aspirin 81 mg

Carbidopan-levodopa 25-100 mg

Clonazepam tablet 1 mg

Dexamethasone injection 8 mg

Digoxin tablet 250 mcg

HYDROmorphone injection 2 mg

Levothyroxine tablet 100 mcg

Metoprolol succinate tablet 100 mg

Nicotine 14mg/24 hours 1 patch

Ondansetron injection 4 mg

Pantoprazole tablet 40 mg

Potassium chloride packet 40 mEq

Prochlorperazine tablet 10 mg

Sodium hypochlorite normal saline irrigation

tiZANidine tablet 8 mg

topirmate tablet 50 mg

vancomycin IV anti

vortioxetine TABS 10 mg