

**N311 Care Plan 4**

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N311: Foundations of Professional Practice

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### Demographics (5 points)

<b>Date of Admission</b> 7/14/2023	<b>Client Initials</b> LB	<b>Age</b> 72	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian/White	<b>Occupation</b> Unemployed/ Social Security	<b>Marital Status</b> Widowed	<b>Allergies</b> Toradol, aspirin, sulfonamides, vanco, chocolate
<b>Code Status</b> DNR	<b>Height</b> 63 in.	<b>Weight</b> 206.4 lbs	

### Medical History (5 Points)

**Past Medical History:** Diabetes, depression, fall risk, hyperlipidemia, left foot drop, lower extremity edema, morbid obesity with BMI of 40-44.9, peripheral neuropathy, post-nasal drip, snoring

**Past Surgical History:** Partial hysterectomy

**Family History:** sister diagnosed with uterine cancer.

**Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):** past alcohol user up until 6/24/2020; no substance tobacco; former smoker, quit 2/26/2020.

### Admission Assessment

**Chief Complaint (2 points):** Self-care assistance

**History of Present Illness – OLD CARTS (10 points):** After talking to the patient, she explained that her chief of complaint was not being able to take care of herself properly. She noticed this about 3-6 months prior to admission. It did not have anything to do with her mobility, more so with her mind/thoughts. She constantly felt this way, all day every day. She described this in ways that she felt like she needed someone to take care of her. If it wasn't her family coming over to help her, she would not shower. There were not many associated symptoms, more so just wanted to have the help to know she was getting done what she needed

to get done and was not confident enough that she would get it done on her own. To relieve this feeling, she had her family come help her and then when her family was not able to, she had a at home aid that she could call whenever she felt like she needed help. She admitted herself into the facility because she felt like she needed the help, did not really try any other treatments to help that.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (3 points):** Depression

**Secondary Diagnosis (if applicable):** Diabetes, depression, fall risk, hyperlipidemia, left foot drop, lower extremity edema, morbid obesity with BMI of 40-44.9, peripheral neuropathy, post-nasal drip, snoring.

### **Pathophysiology**

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

#### **Depression**

**Major depression is a diagnosis that needs to be taken very seriously. It is a diagnosis that people seem to brush off when really, they need to be very concerned. “Depression can occur at any age from childhood to late life and, if left untreated, can be fatal” (Brigitta, 2022). Once depression became a more apparent diagnosis, they came up with a medication, called antidepressant, in the 1950s (Brigitta, 2022). “Depression is not a homogenous disorder, but a complex phenomenon, which has many subtypes and probably more than one etiology” (Brigitta, 2022).**

### **Pathophysiology**

**Different deficiencies come with major depression disorder. It is a “depletion of the neurotransmitters serotonin, norepinephrine or dopamine in the central nervous system” (Hasler, 2010). “Serotonin is the most extensively studied neurotransmitter in depression” (Hasler, 2010). When there is a reduction in serotonin, it “leads to the development of depressive symptoms in the subjects at increased risk of depression” (Hasler, 2010).**

### **Signs and Symptoms**

**Major depression disorder is characterized by “persistent low mood, lack of energy and the absence of pleasure” (Parkes, 2023). There are many risk factors for depression. For example, “history of depression, having a chronic illness, and also being a female” (Parkes, 2023). Other signs and symptoms of depression could be “low concentration, changes in appetite and weight, feelings of worthlessness, suicidal thoughts, sleep disturbances, moving or talking more slowly, and having difficulty with decision-making” (Parkes, 2023). To be diagnosed with depression, the patient will or should have these sign symptoms for at least two weeks. What these signs do is, they interfere with social and occupational functions (Parkes, 2023). Other factors to look for with a patient showing signs of depression is hypothyroidism or certain medications (Parkes, 2023).**

### **Pathophysiology References (2) (APA):**

Brigitta, B. (2002, March). *Pathophysiology of depression and mechanisms of treatment.*

Dialogues in clinical neuroscience.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181668/>

Hasler, G. (2010, October). *Pathophysiology of depression: Do we have any solid evidence of interest to clinicians?*. *World psychiatry* : official journal of the World Psychiatric Association (WPA).

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2950973/#:~:text=The%20monoamine%2Ddeficiency%20theory%20posits,extensively%20studied%20neurotransmitter%20in%20depression.>

YouTube. (2023). *Major Depressive Disorder (MDD)*. *YouTube*. Retrieved October 26, 2023, from <https://www.youtube.com/watch?v=uEod4sa-qPc>.

#### 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	4.5-6.5	4.5	4.8	
Hgb	135-180	172	140	
Hct	36-54%	48%	38%	
Platelets	150-400	220	323	
WBC	4.00-11.00	5.6	5.8	
Neutrophils	2.0-7.5	3.4	6.7	
Lymphocytes	1.0-4.5	1.4	2.2	
Monocytes	0.0-0.8	0.7	0.7	
Eosinophils	0.0-0.5	0.5	0.2	
Bands	<10%	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	139	139	
K+	3.5-5.1	3.5	3.2	
Cl-	98-107	100	98	
CO2	21-31	32	34	Can be low because of a hormonal disorder and my pt. has depression
Glucose	74-109	227	318	Type 2 diabetic
BUN	7-25	10	17	
Creatinine	0.60-1.20	0.90	0.95	
Albumin	3.5-5.2	3.9	4.1	
Calcium	8.6-10.3	8.5	8.6	Depression medication that the pt. is on
Mag	N/A	N/A	N/A	
Phosphate	N/A	N/A	N/A	
Bilirubin	0.3-1.0	0.6	0.7	
Alk Phos	34-104	111	115	One of the bile ducts that drains your liver is blocked

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	Yellow/clear	Yellow/clear	Yellow/clear	
pH	4.5-8	5	5.6	

<b>Specific Gravity</b>	<b>1.005-1.025</b>	<b>1.012</b>	<b>1.007</b>	
<b>Glucose</b>	<b>&lt;130</b>	<b>96</b>	<b>120</b>	
<b>Protein</b>	<b>&lt;150</b>	<b>132</b>	<b>121</b>	
<b>Ketones</b>	<b>None</b>	<b>None</b>	<b>None</b>	
<b>WBC</b>	<b>2,000-5,000</b>	<b>2,200</b>	<b>3,400</b>	
<b>RBC</b>	<b>&lt;2</b>	<b>1.2</b>	<b>1.9</b>	
<b>Leukoesterase</b>	<b>Neg</b>	<b>Neg</b>	<b>Neg</b>	

Cultures **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Explanation of Findings</b>
<b>Urine Culture</b>	<b>10,000-100,000</b>	<b>96,000</b>	<b>43,000</b>	
<b>Blood Culture</b>	<b>7-10 mL</b>	<b>7</b>	<b>8</b>	
<b>Sputum Culture</b>	<b>&lt;10 cells</b>	<b>4</b>	<b>8</b>	
<b>Stool Culture</b>	<b>0.25-0.5 mg/dL</b>	<b>0.3</b>	<b>0.42</b>	

**Lab Correlations Reference (1) (APA):**

Lerma, E. (2023, June 13). *Urinalysis*. Reference Range, Interpretation, Collection and Panels.

<https://emedicine.medscape.com/article/2074001-overview?form=fpf>

*What can a full blood count test? how to interpret the result?: Bowtie*. Bowtie [Blog]. (2021, July

21). <https://www.bowtie.com.hk/blog/en/full-blood-count/>

### Diagnostic Imaging

All Other Diagnostic Tests (10 points): No other diagnostic testing found in pt. chart.

Diagnostic Imaging Reference (1) (APA): N/A

Current Medications (10 points, 2 points per completed med)

**\*5 different medications must be completed\***

Medications (5 required)

<b>Brand/Generic</b>	Acetaminophen (Tylenol)	Atrovastatin Calcium Oral Tablet	Escitalopram Oxalate	Lantus Subcutaneous Solution	NovoLOG Insulin Aspart
<b>Dose</b>	1000 mg	20 mg	10 mg	25 units	8 units
<b>Frequency</b>	Every 6 hrs as needed	Every night at bedtime	Once a day	Every night at bedtime	Before meals
<b>Route</b>	Oral	Oral	Oral	Subcutaneous injection	Subcutaneous injection
<b>Classification</b>	Nonsalicylate, para-aminophenol derivative	HMG-CoA reductase inhibitors, or statins	Selective serotonin reuptake inhibitor (SSRI)	Insulin analog	Insulin analog
<b>Mechanism of Action</b>	Inhibits an enzyme that helps block pain in the peripheral nervous system	Competitively inhibits an enzyme HMG-CoA reductase	Increasing the amount of serotonin available in nervous synapses	Long-acting insulin	Hormone that is produced in the body, used to treat type 1
<b>Reason Client Taking</b>	Pain	High cholesterol	Major depressive disorder	Diabetes mellitus	Diabetes mellitus
<b>Contraindications (2)</b>	“Hypersensitivity to acetaminophen or its components, severe hepatic impairment, severe active liver disease” (NDH, 2023 p 111)	“Atrovastatin contraindications include patients with hypersensitivity to any of its components” (McIver & Siddique, 2022)	“Concomitant therapy with promazine; hypersensitivity to escitalopram, citalopram or its components” (NDH, 2023 p 483)	“Helps bring sugar from your blood into your cells, and the cells then use the sugar for energy” (Slowiczek, 2022)	Hypersensitivity to NovoLog, cartridge compatible insulin delivery

<b>Side Effects/Adverse Reactions (2)</b>	<b>Agitation, anxiety, fatigue, fever, headache, insomnia</b>	<b>Dyspepsia, diarrhea, nausea, insomnia</b>	<b>Abdnormal gait, delirium, dizziness</b>	<b>Itchy skin, rash, edema, weight gain</b>	<b>Swelling, rapid weight gain, SOB, leg cramps</b>
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**Medications Reference (1) (APA):**

[Atorvastatin - StatPearls - NCBI Bookshelf. \(n.d.\).](#)

<https://www.ncbi.nlm.nih.gov/books/NBK430779/>

[McIver, L. A., & Siddique, M. S. S. S. \(2017, February 6\). \*How it's made: Cholesterol production in your body.\* Harvard Health.](#)

<https://www.health.harvard.edu/heart-health/how-its-made-cholesterol-production-in-your-body>

Westphalen, D. (2022, November 20). *Lantus (insulin glargine): Side effects, dosage, cost, and more.* Medical News Today. <https://www.medicalnewstoday.com/articles/325973#What-is-Lantus>

Cunha, J. P. C. P. (2023, March 15). *Novolog (insulin aspart [rdna origin] inj): Uses, dosage, side effects, interactions, warning.* RxList. <https://www.rxlist.com/novolog-drug.htm>

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

General, Psychosocial/Cultural, and TWO focused assessment specific to the client.

<b>GENERAL:</b> <b>Alertness:</b> <b>Orientation:</b> <b>Distress:</b> <b>Overall appearance:</b>	<b>Patient is awake and alert, in no acute distress or pain.</b>  <b>A &amp; O x4</b>  <b>Comfortable</b>
<b>INTEGUMENTARY:</b> <b>Skin color:</b> <b>Character:</b> <b>Temperature:</b> <b>Turgor:</b> <b>Rashes:</b> <b>Bruises:</b> <b>Wounds:</b> <b>Braden Score:</b> <b>Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b> <b>Type:</b>	<b>Skin color pink/light brown. Skin warm and dry upon palpation. No rashes, lesions, or bruising. Normal quantity, distribution, and texture of hair. Nails without clubbing or cyanosis. Skin turgor normal mobility. Capillary refill less than 3 seconds fingers and toes bilaterally.</b>
<b>HEENT:</b> <b>Head/Neck:</b> <b>Ears:</b> <b>Eyes:</b> <b>Nose:</b> <b>Teeth:</b>	<b>Pupils PERRLA, EOM intact,</b>  <b>Mouth and throat show pharynx is clear; likely cavity</b>  <b>or broken tooth; teeth have fallen out</b>  <b>Neck normal range of movement with no swelling</b>  <b>Ears and nose symmetrical with no drainage or lesions</b>
<b>CARDIOVASCULAR:</b> <b>Heart sounds:</b> <b>S1, S2, S3, S4, murmur etc.</b> <b>Cardiac rhythm (if applicable):</b>	<b>Regular heart rate and rhythm with no murmur, click, or rubbing.</b>  <b>No vein distention, palpable pulse bilaterally</b>  <b>Edema in left leg</b>

<p><b>Peripheral Pulses:</b></p> <p><b>Capillary refill:</b></p> <p><b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input type="checkbox"/> <b>Edema</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Location of Edema:</b></p>	<p><b>Capillary refill less than 3 seconds</b></p>
<p><b>RESPIRATORY:</b></p> <p><b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Breath Sounds: Location, character</b></p>	<p>No accessory muscle use when breathing.</p> <p><b>Clear and normal sounds to auscultation equally throughout each part of both lungs.</b></p> <p><b>No wheezes, rales, or rhonchi.</b></p>
<p><b>GASTROINTESTINAL:</b></p> <p><b>Diet at home:</b></p> <p><b>Current Diet</b></p> <p><b>Height:</b></p> <p><b>Weight:</b></p> <p><b>Auscultation Bowel sounds:</b></p> <p><b>Last BM:</b></p> <p><b>Palpation: Pain, Mass etc.:</b></p> <p><b>Inspection:</b></p> <p><b>Distention:</b></p> <p><b>Incisions:</b></p> <p><b>Scars:</b></p> <p><b>Drains:</b></p> <p><b>Wounds:</b></p> <p><b>Ostomy:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Nasogastric:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Size:</b></p> <p><b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Type:</b></p>	<p><b>Pt. lives at facility. Eats a low fat and low sodium diet.</b></p> <p><b>Height:63 inches</b></p> <p><b>Weight: 206.4 lb.</b></p> <p><b>The abdomen is soft, non-tender, with no organomegaly or masses notes upon palpation of all four quadrants. Bowel sounds are normoactive in all four quadrants. No CVA tenderness noted bilaterally.</b></p>

<p><b>GENITOURINARY:</b></p> <p><b>Color:</b></p> <p><b>Character:</b></p> <p><b>Quantity of urine:</b></p> <p><b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Dialysis:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Inspection of genitals:</b></p> <p><b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Type:</b></p> <p><b>Size:</b></p>	<p><b>Yellow and clear</b></p> <p><b>No sediment or odor</b></p> <p><b>2 L output</b></p>
<p><b>MUSCULOSKELETAL:</b></p> <p><b>Neurovascular status:</b></p> <p><b>ROM:</b></p> <p><b>Supportive devices:</b></p> <p><b>Strength:</b></p> <p><b>ADL Assistance:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fall Risk:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fall Score:</b></p> <p><b>Activity/Mobility Status:</b></p> <p><b>Independent (up ad lib)</b> <input type="checkbox"/></p> <p><b>Needs assistance with equipment</b> <input type="checkbox"/></p> <p><b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>Hand grips and pedal pushes and pulls equal bilaterally.</p> <p><b>Balanced gait</b></p> <p><b>A &amp; O x4</b></p> <p><b>Wheelchair to go to and from meals</b></p> <p><b>Fall risk</b></p> <p><b>Able to be self-sufficient but feels like she needs help.</b></p>
<p><b>NEUROLOGICAL:</b></p> <p><b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/></p> <p>Arms <input type="checkbox"/> Both <input type="checkbox"/></p> <p><b>Orientation:</b></p> <p><b>Mental Status:</b></p>	<p>PERRLA</p> <p><b>A &amp; O x 4</b></p> <p><b>Widowed</b></p> <p><b>Clear speech</b></p> <p><b>Cranial nerves intact</b></p>

Speech: Sensory: LOC:	
<b>PSYCHOSOCIAL/CULTURAL:</b> Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	Christian religion; Developmental level appropriate for age.  <b>Enjoys reading and coloring to pass time.</b>  <b>No family to be seeing her, only her sister left.</b>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0847	63 BPM	114/50	20	98.7 F	96%

**Pain Assessment, 1 set (5 points)**

Time	Scale	Location	Severity	Characteristics	Interventions
0847	8/10	Left leg	Moderate/severe	“Take a rubber band, stretch it”, aching, tight muscle and spasms feel	Therapist to be seen; takes Tylenol

**Intake and Output (2 points)**

Intake (in mL)	Output (in mL)
No intake monitored	No output monitored

**Nursing Diagnosis (15 points)**

**\*Must be NANDA approved nursing diagnosis\***

<b>Nursing Diagnosis</b> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> <li>• Listed in order by priority – highest priority to lowest priority pertinent to this client</li> </ul>	<b>Rationale</b> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<b>Interventions (2 per dx)</b>	<b>Outcome Goal (1 per dx)</b>	<b>Evaluation</b> <ul style="list-style-type: none"> <li>• How did the client/family respond to the nurse’s actions? <ul style="list-style-type: none"> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul> </li> </ul>
1. Self-care deficit	<b>The dependency the pt. has for others to do everything for her. If someone is not there to help her then she will not do the daily hygiene that needs to happen.</b>	<b>1. Assess the pt. and provide a routine/schedule that works for the pt. to help her get stronger as a individual</b>  <b>2. Assess to make sure the pt. is being social and going down to the cafeterias for all of meals.</b>	<b>1. Pt. has started getting up and getting dressed by herself in the morning before breakfast.</b>	<b>Family was supportive in more of a push with the pt. being more independent. Being able to do things herself and having her realize that will make her overall health better.</b>
2. Hopelessness	<b>Because of the lack of initiative, the pt. must do things herself.</b>	<b>1. Assess the pt. every morning to make sure the pt. is not turning her thoughts into negative thoughts.</b>  <b>2. Assess the pt. spiritual beliefs. Make sure the pt. knows all her resources to keep her positive in every</b>	<b>1. Pt. has been meeting with the Chaplin at least once a day.</b>	<b>None of the family was very religious, so they feel like this goal has even helped them become closer as a family and allowing the pt. to realize that she has that support to keep pushing forward.</b>

		<b>way possible.</b>		
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**Other References (APA):**

Wagner, M. (2023, January 9). *Major depression nursing diagnosis & care plan*. NurseTogether.

<https://www.nursetogether.com/major-depression-nursing-diagnosis-care-plan/>

**Concept Map (23 Points):**

### Subjective Data

#### Lack of initiative

No family besides her sister that is in different nursing home.

Does not like the nursing home and feels like she doesn't know anyone.

Wants to go to the nursing home where her sister is.

Will not do ADL without assistance.

Has pain in left lower leg, 8/10

### Objective Data

History of Diabetes, depression, fall risk, hyperlipidemia, left foot drop, lower extremity edema, morbid obesity with BMI of 40-44.9, peripheral neuropathy, post-nasal drip, snoring

Depression is apparent.

Lack of energy/motivation

Past alcohol drinker and former smoker; quit in 2020.

### Client Information

72-year-old female, Caucasian, unemployed most of her life, primary diagnosis of depression, and diagnosed with diabetes, risk fall, hyperlipidemia, morbid with BMI of 40-44.9, peripheral neuropathy, post-nasal drip, and edema.

### Nursing Diagnosis/Outcomes

Diagnosis: Self-care deficit, relating to the lack of motivation and energy, as evidence by the dependency the patient has for others to do her daily routines for her and not herself.

Outcome: Pt. has started getting up and getting dressed by herself in the morning before breakfast.

Diagnosis: Hopelessness, relating to the depressed cognitive functions (own decision making), as evidence by the lack of initiative the patient is showing about doing things herself.

Outcome: Pt. has been meeting with the Chaplin at least once a day.

### Nursing Interventions

#### 1. Diagnosis: Self-care deficit

Intervention 1: Assess the patient and provide a schedule routine that the patient agrees on to make her stronger as an individual.

Intervention 2: Assess the patient to make sure she is staying social in the facility. Going down to the cafeteria for meals to talk with her peers.

#### 2. Diagnosis: Hopelessness

Intervention 1: Assess the patient each morning to make sure she is staying in a positive mindset and not a negative mindset.

Intervention 2: Assess the patient and determine the patients spiritual beliefs and make sure the patient knows all the outlets there are to help stay positive.

