N311 Care Plan 3

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N311: Foundations of Professional Practice

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Demographics (5 points)

Date of Admission	Client Initials	Age	Gender
03/04/2024	N.L.	69	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired LPN	Divorced	Albuterol, Codeine, Iodine, Levofloxacin, Levofloxacin in D5w, Metoclopramide, Metoclopramide HcI
Code Status	**Height**	**Weight**	
Full Code	5'3"	108.6lbs	

Medical History (5 Points)

Past Medical History: A-fib (HCC), Anemia, Arrhythmias, Arthritis, Asthma, Atrial Fibrillation with Rapid Ventricular Response (HCC), Congestive Heart Failure, COPD, Coronary Artery Disease, Dizziness/Fainting, Hematuria, History of stress incontinence, Hyperlipidemia, Hypertension, Kidney disease, Parkinson Disease, Sleep Apnea, Stone/Urinary tract.

Past Surgical History: Ankle fracture surgery (Left on 10/22/2023), Back surgery, Cataract removal (bilaterally on 12/2021), Exploratory of abdomen, Hip surgery, Leg surgery, Lithotripsy (Left on 09/03/2019 and 09/05/2019), Open Skull Supratentorial explore, Septoplasty without out fracture, total hip arthroplasty (Bilaterally), Tubal Ligation, Wound Treatment (Left on 12/21/2023)

Family History: Mother (deceased)- cancer and hypertension. Father (Alive)- Hypertension, Macular Degeneration, Arthritis.

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

Tobacco: Former cigarettes about 0.25 packs/day (12.5 total for a year). Unknown for how long.

Alcohol: About 1 glass of wine, 1 can of beer, and/or 1 shot of liquid occasionally. Unknown for how long.

Drugs: N/A

Admission Assessment

Chief Complaint (2 points): Patient came in with generalized weakness and Covid 19.

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

The patient was admitted to the hospital on 03/04/2024 for general weakness and positive Covid 19. The patient has not been treated to for in the past. There is no defined location besides it is an all over body infection that travels through the bloodstream. The patient does expresses that with the weakness, she has nausea, incontinence, and denies any pain. The nausea happens when she takes her medication on an empty stomach. The weakness increases when she is moving around for a long period of time and is relieved when she is at rest in bed.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Sepsis

Secondary Diagnosis (if applicable): Shaking

Pathophysiology

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

With sepsis, it takes time for it to develop. According to Capriotti and Frizzell, it is a "body-wide infection that overwhelms the immune system and causes severe multiorgan compromise." (Capriotti & Frizzell, 2020, p. 1152). When it starts, it begins as an infection in one organ system. From there, it will spread into the bloodstream, affecting the whole body. A patient's body will become overwhelmed with the infection being spread throughout their body, which causes them to feel weak. The way to overcome sepsis is by getting treated with an antibiotic.

Just like anything, everyone will experience different symptoms at different times. According to Penn Medicine, someone could experience confusion, chills, fever/low body temperature, rapid heartbeat, warm/rash skin, and/or lightheadedness. (Penn Medicine, 2022). The lightheadedness is caused by having low blood pressure and a rapid heartbeat. Having these symptoms can lead to shock. The shock will cause the "major systems to stop working properly because of poor blood flow." (Penn Medicine, 2022).

The way that someone would be testing for sepsis is with blood work. According to Fulton, the labs that someone would draw are "blood lactate, complete blood count (CBC), chemistry panel, and liver function test" (Fulton, 2024). The one used is the CBC because it will inform us of the white blood cell out. According to Mosby's Diagnostic and Laboratory Test Reference, someone's white blood count that is elevated "indicates infection, inflammation, tissue necrosis, and leukemic neoplasia." (Pagana, 2021, p. 973). To get the chemistry panel, you would draw a comprehensive metabolic panel (CMP). A CMP lab has the chemistry panel and liver function within one sample. (Pagana, 2021 p. 270). A blood lactate test is to see the level of

lactic acid within the blood. If levels are increased, it increases the likelihood of having sepsis. (Pagana, 2021 p. 556).

Pathophysiology References (2) (APA):

Capriotti, T. & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives.* (2nd ed.). F.A. Davis Company.

II, M. R. F. (2023, August 27). *Laboratory evaluation of sepsis*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK594258/#:~:text=A%20laboratory%20workup%2C%20including%20CBC,has%20diagnostic%20and%20prognostic%20value

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic and laboratory test reference* (15th ed.). Mosby.

Pennmedicine.org. (2022). https://www.pennmedicine.org/for-patients-and-visitors/patient-information/conditions-treated-a-to-z/sepsis

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	**3.80-5.3 10(6)/mL**	**3.60**	**3.51**	The patient has a history of anemia; it is to be expected to have low red blood cell counts.
Hgb	**12.0-15.8 g/dL**	**10.3**	**10.0**	The patient has a history of anemia, and their RBC is decreased with has caused the Hgb to decrease due to the anemia.
Hct	**36.0-47.0%**	**31.4**	**31.0**	The patient has a history of anemia, decreased RBC and Hgb will cause the

				Hct to decrease.
Platelets	140-440 10(3)/mcL	145	==118==	The patient has an acute infection which will cause a decrease in the platelets.
WBC	4.00-12.00 10(3)/mL	4.6	5.10	
Neutrophils	1.60-7.70 10(3)/mL	2.6	3.40	
Lymphocytes	1.30-3.20 10(3)/mcL	1.50	==1.00==	The patient has been experiencing diarrhea and can lead to dietary deficiency which leads to a decrease in lymphocytes.
Monocytes	0.20-1.00 10(3)/mcL	0.40	0.50	
Eosinophils	0.00-0.40 10(3).mcL	0.00	0.10	
Bands	0.0-6.0%	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 mmol/L	140	141	
K+	3.5-5.1 mmol/L	4.0	3.7	
Cl-	98-107 mmol/L	100	98	
CO2	22-30 mmol/L	24	==32==	The patient was experiencing some diarrhea which could relate to why this level was slightly elevated.
Glucose	70-90 mg/dL	==104==	==106==	The patient is experiencing a level of acute stress response which is affecting her glucose levels.
BUN	12-20 ratio	==38==	14	The patient was diagnosed with sepsis and having elevated BUN is a one of the ways keys ways to diagnose someone having sepsis.
Creatinine	0.60-1.00 mg/dL	==1.21==	0.73	The patient was likely dehydrated when admitted and dehydration affects the kidney function, and the creatinine is used to determine

				kidney injury.
Albumin	**3.5-5.0 g/dL**	**3.5**	**3.0**	The patient had a minor urinary track infection as evidence to the urine culture which having a urinary tract infection will cause the albumin to decrease.
Calcium	**8.7-10.5 mg/dL**	**9.1**	**8.3**	The patient is low albumin levels and it will cause the calcium levels to decrease.
Mag	**1.6-2.6 mg/dL**	**2.0**	**1.9**	
Phosphate	**3.0-4.5 mg/dL**	**N/A**	**N/A**	
Bilirubin	**0.2-1.2 mg/dL**	**0.3**	**0.7**	
Alk Phos	**40-150 U/L**	**78**	**78**	

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**	**N/A**	
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**	**Trace**	**N/A**	The patient hemoglobin was decreased and could cause a positive result on the dip test.
Ketones	**Negative**	**Negative**	**N/A**	
WBC	**Negative, 0-5/hpf**	**21-50**	**N/A**	Having an elevation of white blood cells is evidence of an infection somewhere in the body.
RBC	**Negative, 0-2/hpf**	**6-10**	**N/A**	The patient has a history of anemia; it is to be expected to have low red blood cell counts.
Leukoesterase	**Negative**	**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	**Negative/No Growth**	<mark>**Greater than 100,000 CFU/mL Klebsiella pneumonia**</mark>	**N/A**	This positive culture proved that there was an infection within the urine tract system.
Blood Culture	**Negative/No Growth**	**0**	**N/A**	
Sputum Culture	**Negative/No Growth**	**N/A**	**N/A**	
Stool Culture	**Negative/No Growth**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic and laboratory test reference* (15th ed.). Mosby.

<center>**Diagnostic Imaging**</center>

All Other Diagnostic Tests (10 points):

- Chest X-Ray- previous 02/25/2024 which had left basilar atelectasis and heart size borderline.

  o Accounting to Mosby's Diagnostic and Laboratory Test Reference, a chest x-ray allows us to visualize the size of the heart and to see if there is inflammation or fluid built up in the lungs. (Pagana, 2021 p. 229).

Diagnostic Imaging Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic and laboratory test reference* (15th ed.). Mosby.

<div align="center">**Assessment**</div>

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

General, Psychosocial/Cultural, and ONE focused assessment specific to the client is required.

The student and instructor may complete these assessments together.

GENERAL: **Alertness:** Yes A/Ox4 **Orientation:** Yes **Distress:** None **Overall appearance:** Well Groomed	Patient appears to be alert and oriented x4, well groomed, and no distress.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . <mark>**Braden Score:**</mark> 18 **Drains present: Y☐ N ☐** **Type:**	Patients Braden Score is a low risk of developing a pressure ulcer.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:**	.

Teeth:	
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:**	.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** - Clear through out all lobs of the lungs	Patient had normal rate and pattern of respiration. Respiration was symmetrical and non-labored. All parts of both lungs (anterior/posterior) sounded clear with no wheezing or crackles noted.

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:	

GENITOURINARY:
 	
Color:
 	
Character:
 	
Quantity of urine:
 	
Pain with urination: Y ☐   N ☐
 	
Dialysis: Y ☐   N ☐
 	
Inspection of genitals:
 	
Catheter: Y ☐   N ☐
 	
   Type:
 	
   Size:	

MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance:** Y ☐ N ☐ **Fall Risk:** Y ☐ N ☐ **Fall Score:** <mark>High (82)</mark> **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Patient is at a high risk of falling.
NEUROLOGICAL:	.

MAEW: Y ☐ N☐ **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** TV and reading books. **Developmental level:** Appropriate to the age **Religion & what it means to pt.:** Unable to locate. **Personal/Family Data (Think about home environment, family structure, and available family support):** Lives alone; divorced; sister and daughter support system.	N.L. was a nice but quite lady who was admitted for general weakness. She was not in distress and well groomed. Her coping methods were watching TV and reading books. Her developmental level was appropriate for her age. I was unable to locate her religion and was unable to get to ask what it means to her. She lives alone and is divorced. Her support is from her sister and daughter.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0754	64	<mark>133/63</mark>	20	98.4°F	100% on 2L

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0754	Numeric Scale	N/A	0	N/A	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

- 960mL	- Patient was incontinent of urine 2 times and 1episode of stool incontinence between 0900-1100.

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. Nausea as related to treatment regimen as evidence by patient stating that they are were experiencing nausea from the antibiotic.	The patient has stated that they have been experiencing nausea after taking her antibiotic.	**1.** "Administer anti-nausea medication as prescribed to provide relief from nauseas and allow patient to eat." (Phelps, 2023, p. 432). **2.** "Encourage patient to eat dry, bland food during periods of nausea to	**1.** "Patient will take steps to ensure adequate nutrition when nausea abates." (Phelps, 2023, p. 432).	- "Patient and family members recorded intake and outtake measurements." (Phelps, 2023, p. 433). - "Patient was agreeable to the plan on informing staff regarding nausea and it's cause, then to re-evaluated." (Phelps, 2023, p. 433).

		make it possible for patient to eat." (Phelps, 2023, p. 432).		
2. Diarrhea as related to infection as evidence by patient having loose stool.	Patient stated that they were having loose stool for a day now and had 1 episode of loose stool between 0900-1100.	1. "Monitor and record patient intake and outtake, including the number of stool." (Phelps, 2023, p. 182). 2. "Provide replacement fluids and electrolytes as prescribed." (Phelps, 2023, p. 182).	1. "Patient diarrheal episodes will decline or disappear." (Phelps, 2023, p. 181).	- "Patient and family members will continue to motor the frequency and characteristic of stool." (Phelps, 2023, p. 183). - "Patient agreed and understood the plan to help her not to experience diarrhea when she is discharged." (Phelps, 2023, p. 182).

Other References (APA):

Phelps, L.L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

- Nausea
- Weakness
- Shaking at time
- Incontinence
- No pain

Nursing Diagnosis/Outcomes

1. Nausea as related to treatment regimen as evidence by patient stating that they are were experiencing nausea from the antibiotic.
   a. Patient will take steps to ensure adequate nutrition when nausea abates.
2. Diarrhea as related to infection as evidence by patient having loose stool.
   a. Patient diarrheal episodes will decline or disappear.

Objective Data

- Visual:
  o Well Groomed
  o No distressed
  o Normal breathing
- Abnormal Labs:
  o Chest X-Ray
  o Blood Work:
    ▪ Decreased: RBC, Hgb, Hct, Platelets, Lymphocytes, Albumin, and Calcium
    ▪ Increases: CO2, Glucose, BUN, and Creatinine.
  o Urine Dip: Trace of Protein, WBC and RBC elevated.
  o Urine Culture: Greater than 100,000 CFU/mL Klebsiella Pneumonia

Client Information

N.L. is a 69-year-old female who was admitted for general weakness and positive Covid-19. Patient has a history of asthma, COPD, and dizziness/fainting.

Nursing Interventions

- Administer anti-nausea medication as prescribed to provide relief from nauseas and allow patient to eat.

- Encourage patient to eat dry, bland food during periods of nausea to make it possible for patient to eat.

- Monitor and record patient intake and outtake, including the number of stools.

- Provide replacement fluids and electrolytes as prescribed.