N311 Care Plan 3

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N311: Foundations of Professional Practice

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Demographics (5 points)

Date of Admission 3/4/24	Client Initials L.R.	Age 84	Gender Female
Race/Ethnicity Asian	Occupation N/A	Marital Status Divorced	Allergies None
Code Status DNR	Height 5'3	Weight 124 lbs 9.6 oz	

Medical History (5 Points)

Past Medical History: Dementia (HCC), Hyperlipidemia, Hypertension, Kidney Infection, Kidney Stone, Memory Loss, & Transient Ischemic Attack

Past Surgical History: Removal of Gallbladder, Kidney Stone Surgery, & Kidney Surgery

Family History: No known problems in father, paternal grandfather, paternal grandmother, mother, maternal grandfather, maternal grandmother

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Never smoked, never used smokeless tobacco, does not drink alcohol, does not use drugs

Admission Assessment

Chief Complaint (2 points): Per nursing home altered mental status

History of Present Illness – OLD CARTS (10 points): Patient came in for altered mental status and is non-verbal with dementia. Patient was unable to give a time of when symptoms had started. There was no specific location for pain. The chart does not state how long this had been occurring. Patient unable to give characteristics of pain and unable to verbally state aggravating and relieving factors. Patient looked to be resting

comfortably, not in any distress. Patient was diagnosed with hypernatremia while in the hospital. Pain was a 0 and not severe.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Hypernatremia

Secondary Diagnosis (if applicable): N/A

Pathophysiology

“Cell damage can result from biological chemical imbalances in the body, including those involving electrolytes” (Capriotti, 2020). Hypernatremia is classified as high sodium levels in the bloodstream. This is putting the person at risk for intracellular fluid depletion, which is cellular dehydration. It is also putting them at risk for reversible cell shrinkage. “The Antidiuretic hormone causes the urine to become more concentrated” (Sonani et al, 2023). This will cause the body to increase fluid intake due to having a strong thirst response to the hormone. This process allows the body to maintain sodium and water balance. The two main causes of hypernatremia are an excess of solute and water storage. The most frequent cause of hypernatremia is weight loss in relation to solute loss. In order to be diagnosed with Hypernatremia, your sodium level in the blood will be over 145 meq/l.

One of the most dangerous side effects of Hypernatremia is subarachnoid or subdural hemorrhage, which occurs due to Dural sinus thrombosis and bridging vein rupture. This is extremely dangerous and could lead to death. There are many common signs and symptoms that are associated with Hypernatremia. One of the most common is dehydration. This is due to the sodium and water levels becoming unequal and unable to maintain balance. “A few other symptoms are lethargy, weakness, irritability, and confusion” (Capriotti, 2020).

“The high serum sodium concentration is the basis for the diagnosis of hypernatremia” (Lukitsch, 2023). This lab is anything over 145 meq/l and there are other labs that can be used to determine the etiology of Hypernatremia. These labs include the serum electrolytes such as Na+, K+, Ca2+, glucose levels, Urea, Creatinine. You can also take a urine sample to check the Na+

and K+ in the urine. You should also check the patients 24-hour urine volume, so we can tell how much output they have and compare it to their fluid intake.

References

Capriotti, T. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives.* F.A. Davis.

Lukitsch, I. (2023, January 3). *Hypernatremia Workup: Laboratory Studies, Imaging Studies, Histologic Findings*. Emedicine.medscape.com. https://emedicine.medscape.com/article/241094-workup?form=fpf#c5

Srividya Naganathan, & Al-Dhahir, M. A. (2018). *Hypernatremia*. Nih.gov; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK441960/

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	4.4-5.8	Not done on admission	4.45	
Hgb	13-16.5	Not done on admission	10.0 (Low)	Low iron
Hct	38-50	Not done on admission	32.2 (Low)	This could be due to being dehydrated and not getting enough water.
Platelets	140-440	Not done on admission	118 (Low)	When someone has a low platelet count, this could be due to having anemia or a viral infection.
WBC	4-12	Not done on admission	7.73	
Neutrophils	40-68	Not done on admission	54.0	
Lymphocytes	19-49	Not done on admission	34.8	
Monocytes	3-13	Not done on admission	8.2	
Eosinophils	0-8	Not done on admission	2.7	
Bands	N/A	Not done on admission	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-	135-145	161	145	This is due to the patient being

		(high)		**diagnosed with hypernatremia and could be due to being dehydrated.**
K+	**3.5-5.1**	**3.9**	**3.6**	
Cl-	**98-107**	**128 (high)**	**114 (high)**	**This is most likely due to the patient being dehydrated.**
CO2	**22-30**	**Not done on admission**	**22**	
Glucose	**70-99**	**140 (high)**	**114 (high)**	**This is could be high due to someone having a severe infection.**
BUN	**8-26**	**48**	**11**	
Creatinine	**0.70-1.30**	**1.33**	**0.71**	
Albumin	**3.5-5**	**Not done on admission**	**N/A**	
Calcium	**8.7-10.5**	**9.1**	**9.0**	
Mag	**1.6-2.6**	**Not done on admission**	**N/A**	
Phosphate	**N/A**	**Not done on admission**	**2.0**	
Bilirubin	**0.2-1.2**	**Not done on admission**	**Negative**	
Alk Phos	**40-150**	**Not done on admission**	**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**	**Not done on admission**	**Colorless, Clear**	

pH	**5-9**	**Not done on admission**	**7.0**	
Specific Gravity	**1.003-1.030**	**Not done on admission**	**1.004**	
Glucose	**Negative**	**Not done on admission**	**Negative**	
Protein	**Negatice**	**Not done on admission**	**Negative**	
Ketones	**Negative**	**Not done on admission**	**Trace**	**They may have a trace of ketones because of their body being too acidic.**
WBC	**0-5**	**Not done on admission**	**N/A**	
RBC	**0-2**	**Not done on admission**	**N/A**	
Leukoesterase	**N/A**	**Not done on admission**	**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	**Neg. with no growth**	**Undefined**	**N/A**	**Urine was contaminated**
Blood Culture	**Neg. with no growth**	**No growth within 3 days**	**N/A**	**Patient did not receive anymore cultures**
Sputum Culture	**Neg. with no growth**	**N/A**	**N/A**	**Patient did not receive anymore cultures**
Stool Culture	**Neg. with no growth**	**N/A**	**N/A**	**Patient did not receive anymore cultures**

Lab Correlations Reference (1) (APA):

References

Cleveland Clinic. (2021, November 4). *Chloride Blood Test: What It Is, Procedure, Risks & Results*. Cleveland Clinic. https://my.clevelandclinic.org/health/diagnostics/22023-chloride-blood-test

Hematocrit Information | Mount Sinai - New York. (n.d.). Mount Sinai Health System. https://www.mountsinai.org/health-library/tests/hematocrit#:~:text=Low%20hematocrit%20may%20be%20due

Ketones in Urine: MedlinePlus Medical Test. (2022, August 3). Medlineplus.gov. https://medlineplus.gov/lab-tests/ketones-in-urine/#:~:text=If%20your%20cells%20can

NHS. (2023, January 17). *Hyperglycaemia (high blood sugar) - Illnesses & conditions*. Www.nhsinform.scot. https://www.nhsinform.scot/illnesses-and-conditions/blood-and-lymph/hyperglycaemia-high-blood-sugar/

Thrombocytopenia (low platelet count) - Symptoms and causes. (n.d.). Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/thrombocytopenia/symptoms-causes/syc-20378293#:~:text=Factors%20that%20can%20decrease%20platelet

Diagnostic Imaging

All Other Diagnostic Tests (10 points): Head CT without contrast, CT Renal Stone Study (Abdomen & Pelvis without contrast), Chest X-Ray, EKG 12 Lead, EKG Scan. Another possible test could be a 24-hour urine output.

Hypernatremia Workup: Laboratory Studies, Imaging Studies, Histologic Findings. (2023, Janurary 3). Emedicine.medscape.com. https://emedicine.medscape.com/article/241094-workup?form=fpf

Assessment

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

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

The student and instructor may complete these assessments together.

GENERAL: **Patient was Alert and Oriented x0. Patient was able to nod and follow with eyes. Patient does not seem to be in distress. Patient clean and well taken care of.**	
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	
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: **There was no accessory muscle use. Lung sounds were normal and clear. No labored breathing. Patient was sitting up and leaned forward.**	.
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: **Patient was a fall risk. Score was 98%. Patients Braden score was a 12. Patient can sit up on own, needs help when standing.**	.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	.
PSYCHOSOCIAL/CULTURAL: **L.R. is a very kind woman who is admitted for altered mental status. Patient is not in distress. Patient was not responding and unable to identify coping methods. Patient seems well taken care of, but mental status does not seem well. Patient was unable to respond to questions. Chart states patient is not religious. Patient lives in nursing home, family visits frequently. Seems to have good**	.

family support.	

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0849	**72**	**123/74**	**14**	**96.8**	**98%**

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1040	**Wong Baker**	**N/A**	**0**	**N/A**	**N/A**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
50% 200mL	**Incontinent, Non-measurable**

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. Patient is at risk for dehydration related to	**I chose this nursing diagnosis**	**1. Offer patient fluids**	**1. The patients sodium level**	**The client took drinks of water only when**

medically diagnosed with Hypernatremia as evidenced by her Na- lab value being 161 on admission. **Highest priority would be to make sure the client is getting enough fluids, getting sodium level down, and making sure the client is on a low sodium diet.**	**because this could be very dangerous for this patient if they did not seek treatment. This is due to her age and her health.**	**every time you go in the room.** **2. Limit the patients sodium intake**	**will be between 135–145 before she is transferred back to the nursing home tomorrow.**	**offered. The clients sodium level went down to 145 after fluids and drinking more water before being discharged.**
2. The patient is at risk self-harm/falls related to altered mental status as evidenced by medical diagnosis of Dementia.	**I chose this nursing diagnosis due to the patient having altered mental status and confusion. This could cause many risks for the patient.**	**1. Making sure there is a bed alarm in place.** **2. Making sure the patients call light is within reach.**	**1. The patient will be A & O x1 by the end of her stay tomorrow.**	**The client stayed in bed and did not try to get out of bed with the bed alarm in place. The patient utilized the call light if in need of help.**

Other References (APA):

Phelps, L. (2021). *Nursing Diagnosis Reference Manual* (12th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Patient has altered mental status. Patient was non-verbal. Pain level was at a 0, was alert and oriented x0.

Nursing Diagnosis/Outcomes

Patient is at risk for dehydration related to medically diagnosed with Hypernatremia as evidenced by her Na- lab value being 161 on admission. The patients' sodium level will be between 135–145 before she is transferred back to the nursing home tomorrow. The client took drinks of water only when offered. The clients' sodium level went down to 145 after fluids and drinking more water before being discharged.

The patient is at risk self- harm/falls related to altered mental status as evidenced by medical diagnosis of Dementia. The patient will be A & O x1 by the end of her stay tomorrow. The client stayed in bed and did not try to get out of bed with the bed alarm in place. The patient utilized the call light if in need of help.

Objective Data

Patient follows with eyes and nods. Patient had clear lung sounds and no accessory muscle use. Patient was at risk for falls. Pulse was 72, Blood Pressure was 123/74, Respiratory rate was 14, Temperature was 96.8, and O2 Saturation was 98%.

Client Information

Client is an 84-year-old female that came in from the nursing home with altered mental status. Patient is unable to verbally communicate. It was found that patient has Hypernatremia. Patient will be transported back to nursing home.

Nursing Interventions

1. Offer patient fluids every time you go in the room.
2. Limit the patients' sodium intake
3. Making sure there is a bed alarm in place.
4. Making sure the patients call light is within reach.