N311 Care Plan 2

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Lakeview College of Nursing

N311: Foundations of Professional Practice

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Demographics (5 points)

Date of Admission	Client Initials	Age	Gender
10/05/2024	D.W.	81 y/o	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	Retired	Widowed	Propoxyphene
Code Status	**Height**	**Weight**	
Full Code	5'2"	185 lb 10 oz	

Medical History (5 Points)

Past Medical History: Patient has a past medical history of anxiety, generalized aortic stenosis, diabetes, diabetes mellitus, hyperlipemia, hypertension, hypertriglyceridemia, pacemaker and peripheral vascular disease.

Past Surgical History: Patient's surgical history includes a harvest femoral popliteal vein, cystoscopy, insert urethral stent lap, inguinal hernia repair, c1760 vascular closure device, and a colonoscopy on 05/26/2022

Family History: Patient's family history includes diabetes and hypertension in her mother, and a stroke in her sister.

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

Patient states she quit smoking 11 years ago and does not drink alcohol or take drugs.

Admission Assessment

Chief Complaint (2 points): Patient presented to the emergency department for a fall.

History of Present Illness – OLD CARTS (10 points): Patients symptoms started October 3rd, 2024. Location of the pain is all over patients' body, due to the nature of the diagnosis. The duration and characteristics of symptoms were difficult to determine, due to patients' confusion. Alleviating factors include resting and taking pain medications as needed. The patient did state

that the pain radiates to her head and causes headaches. Patient has not been treated for this

diagnosis before and has not done anything prior to arrival to the emergency department.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Rhabdomyolysis

Secondary Diagnosis (if applicable): N/A

Pathophysiology

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

Rhabdomyolysis is a musculoskeletal disease that causes muscle tissue to break down. Common signs and symptoms presented with Rhabdomyolysis can be different with each patient, but generally include weakness, muscle pain and tea colored urine which is usually the first sign. There is no one exact cause of Rhabdomyolysis, but there are several reasons that symptoms may begin to show and slowly get worse. Some of these may include motor vehicle accidents, specific infections, toxins, bed rest, and even working out too hard in the gym. If muscle injury occurs due to trauma, this can cause the ATP to deplete, which then causing harm to the muscles and they are unable to repair or regulate calcium (Cabral, M.D., 2020).

In Rhabdomyolysis, cellular elements such as myoglobin, aldolase, and creatine kinase are released into the bloodstream and start to accumulate. Due to the accumulation of these elements, if Rhabdomyolysis goes untreated for too long, it can cause kidney failure. Nephrons in the kidney filter out blood and waste, however myoglobin is toxic to nephrons therefore of it is introduced into the bloodstream, can cause them to malfunction. (Capriotti, 2024).

The main indication of Rhabdomyolysis is a diagnostic test that looks at creatine phosphokinase (CPK) levels in the blood. If CPK levels in the blood are elevated, that is

usually a sure indication of traumatic muscle injury. Though tea colored urine is a symptom of Rhabdomyolysis, a urinalysis can also be performed to test blood. Other tests can look for electrolyte levels, including looking specifically at potassium, phosphorus and calcium (Stanley, 2023). As we saw with our patient, increased BUN levels can also indicate a kidney issue or rhabdomyolysis specifically.

Pathophysiology References (2) (APA):

Cabral, M.D., B. M. I. (2020, June 10). *Rhabdomyolysis*. Disease-a-Month.

https://www.sciencedirect.com/science/article/pii/S0011502920300778?

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Capriotti, T. (2024). Musculoskeletal Disorders (p. 971). F.A. Davis Company.

Stanley, M. (2023, April 16). *Rhabdomyolysis*. StatPearls.

https://www.ncbi.nlm.nih.gov/books/NBK448168/

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1500	68	==143/57==	18	97.1	97%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1725	1-10	Feet and legs	7	Throbbing pain	Nurse was notified and will follow up with pain medication, if needed.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
480 mL	1000 mL

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. **Deficient Fluid Volume** related to electrolyte imbalance, as evidenced by high BUN level.	Nursing diagnosis was selected after observing cloudy urine from foley urine output and checking labs for high BUN level.	1. Access skin turgor and oral mucosa membranes every 8 hours to check for dehydration. 2. Measure intake and output every 1 to 4 hours. Report any significant changes.	1. Patients urine output remains at volume established for patient.	Patient was unsure about dehydration, because the patient had regular cups of water.

2. **Acute pain** related to physical injury, as evidenced by presenting to the ED for a fall and positioning to ease pain.	Nursing diagnosis was chosen because of patients inability to gain comfort, even when changing positions in bed and grimacing when being moved.	**1.** Perform comfort measures to promote relaxation. **2.**Apply heat or cold to relieve pain.	**1.** Patient will decrease amount and frequency of pain meds within 72 hours.	Patient and family were helpful and listened when the nurse explained comfort measures that can be practiced at home.

Other References (APA):

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

Concept Map (23 Point

Subjective Data

Patient grimaced when turned in bed. Patient said "ouch!" when being transferred from hospital to transport bed. Patient rates her pain 7 out of 10.

Nursing Diagnosis/Outcomes

1. **Deficient Fluid Volume** related to electrolyte imbalance, as evidenced by high BUN level.
   ➔ **Outcome:** Patients urine output remains at volume established for patient.

2. **Acute pain** related to physical injury, as evidenced by patient admitting to the ED for a fall and positioning to ease pain.
   ➔ **Outcome:** Patient will decrease amount and frequency of pain meds within 72 hours.

Objective Data

Pulse 68	BP 143/57
Resp 18	Temp 97.1
O2 Sat 97%	
Sodium 143	Potassium 4.1
Chloride 108 (H)	Co2 21 (L)
Anion Gap 14.0	Glucose 114 (H)
BUN 30 (H)	Creatinine, blood 0.98
BUN/Creatinine ratio 31(H)	
Total protein 8.0	Albumin 4.0
a/g ratio 1.0	Calcium 10.0
T bili 0.9	Sgot(ast) 224
Magnesium 2.5	Alkaline phosphate 91
WBC 7.90	RBC 5.11
Hemoglobin 15.3	Hematocrit 46.1
Platelet count 286	

Client Information

81 y/o female complaining of hip pain, after presenting to the ED from a fall.

Admission: 10/05/2024
Ethnicity: African American
Height: 5'2"
Weight: 185 lb 10 oz
Allergies: Propoxyphene
Code Status: Full Code

Nursing Interventions

1. Access skin turgor and oral mucosa membranes every 8 hours to check for dehydration.
2. Measure intake and output every 1 to 4 hours. Report any significant changes.

1. Perform comfort measures to promote relaxation.
2. Apply heat or cold to relieve pain.