

N311 Care Plan 4

Bailey McMasters

Lakeview College of Nursing

N311: Foundations of Professional Practice

Travis Whisman

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Demographics (5 points)

| | | | |
|--|---------------------------------|----------------------------------|--------------------------|
| Date of Admission 10/22/24 | Client Initials PM | Age 73 | Gender Female |
| Race/Ethnicity White/Caucasian | Occupation Beautician | Marital Status Married | Allergies None |
| Code Status Full | Height 5' 7" | Weight 145 lbs | |

Medical History (5 Points)

Past Medical History: Anxiety disorder, Atrial fibrillation (HCC), Depression, Diabetes mellitus type 2 (HCC), DKA (Diabetic keto-acidosis) (HCC) (05/04/23), Esophageal reflux, Hypercholesteremia, Thyroid condition

Past Surgical History: Cholecystectomy, Kidney surgery, Tonsillectomy, Cataract removal (bilateral), Tibia Fracture surgery, (right, 02/14/18), Rotator cuff repair (left, 12/03/20), EGD (08/24/21), EGD (11/01/22), Partial hip arthroplasty (right, 08/11/23), ORIF Humerus proximal (right, 08/11/23), Hip surgery (left, 05/31/24)

Family History: Sister has diabetes, father has Rheumatoid Arthritis, no other known family history

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient quit smoking cigarettes (unknown date), has never used smokeless tobacco, no drug use currently, used to use Hydrocodone (unknown date), the patient does not drink alcohol.

Admission Assessment

Chief Complaint (2 points): Decreased mobility and ADLs

History of Present Illness – OLD CARTS (10 points): The patient present to a post operation appointment and reported a decrease in her mobility, affecting her ability to independently complete her ADLs. The patient was then admitted into hospital care upon recommendation. The patient’s hip replacement was then reassessed and had to be removed due to a left hip nonunion. The patient was transferred to the rehabilitation floor on 10/22/24. The patient does not experience pain unless pressure is applied to the left leg. The patient states this pain is a 4 on a scale of 1-10.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Left Hip Nonunion

Secondary Diagnosis (if applicable): UTI (Urinary Tract Infection)

Pathophysiology

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

Nonunion can be defined in multiple ways. The FDA defines nonunion as fractures nine months from the initial injury that have been without any signs of healing for three months, Babcock & Kellam (2018). Other definitions include a fracture in which the physician believes it will not heal without intervention and a fracture that has not shown healing progression within the last three radiographic images with the patient showing the symptoms of nonunion, Babcock & Kellam (2018). This relates to my patient because she was admitted by her physician due to the lack of signs of healing from her previous surgery. In conclusion, a nonunion is the inability of a fracture to heal on its own. Osteomyelitis or bone infection is normally the cause of nonunion. This can be caused

through bacteria such as *Staphylococcus aureus*, *Escherichia coli*, and enterococci, Capriotti (2024). Other causes can include metabolic diseases, poor circulation, and inadequate nutrition such as a lack in calcium. Not to mention, modifiable risk factors such as smoking can have an impact on the bones healing process, Capriotti (2024).

Nonunion can result in a patient having abnormal gait, motor weakness, constant pain, and changes in limb function, Capriotti (2024). This relates to my patient as she presented with a decrease in mobility and ADLs. Diagnostics that are used to diagnose nonunion are x-rays, bone scintigraphy, and CT scans, Capriotti (2024). This relates to my patient because she received multiple x-rays in order to diagnose the nonunion. However, these diagnostics look for nonunion by tracking the healing process. In order to rule out or diagnose infection of the bone, lab results should be run on the patient. Labs such as WBC count, ESR, and CRP should be evaluated, Babcock & Kellam (2018). If these are elevated or show as positive, it is a sign of infection.

Treatment of a nonunion can depend on the cause of the fracture not healing. With a nonunion due to infection, patients should be given antibiotics intravenously, Capriotti (2024). In cases where the tissue and bone have become necrotic, debridement is required. Other treatments can include bone grafting, fracture stabilization, and surgical correction, Capriotti (2024). This relates to my patient because she underwent fracture stabilization to fix the nonunion. According to Babcock and Kellam (2018), Arthroplasty can also be seen as a reliable treatment as patients are able to instantly bear weight as well as it discards the physiological load of healing the fracture.

Pathophysiology References (2) (APA):

Babcock, S., & Kellam, J. F. (2018). Hip Fracture Nonunions: Diagnosis, Treatment, and Special Considerations in Elderly Patients.

Advances in Orthopedics. DOI: [10.1155/2018/1912762](https://doi.org/10.1155/2018/1912762)

Capriotti, T. (2024). *Pathophysiology Introductory Concepts and Clinical Perspectives* (3rd ed.). F.A. Davis.

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 | 3.8-5.3 | Not done | 2.57 | Decreased RBCs are most likely due to bone marrow failure from infection of the bone, Pagana et al. (2023). Also, it could be seen with Rheumatoid disease, which is included in the patient's family history. |
| Hgb | 12-15.8 | Not done | 8.3 | Decreased Hgb is most likely from anemia due to loss of blood from procedure, Pagana et al. (2023). |
| Hct | 36-47 | Not done | 24.9 | Decreased Hct is most likely due to bone marrow failure from infection of the bone, Pagana et al. (2023). |
| Platelets | 140-440 | Not done | 386 | Normal value |
| WBC | 4-12 | Not done | 6.4 | Normal value |
| Neutrophils | 47-73 | Not done | Not done | Not done |

| | | | | |
|--------------------|-----------------|-----------------|-----------------|-----------------|
| Lymphocytes | 18-42 | Not done | Not done | Not done |
| Monocytes | 4-12 | Not done | Not done | Not done |
| Eosinophils | 0-5 | Not done | Not done | Not done |
| Bands | Not done | Not done | Not done | Not done |

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 | Not done | 140 | Normal value |
| K+ | 3.5-5.1 | Not done | 3.9 | Normal value |
| Cl- | 98-107 | Not done | 104 | Normal value |
| CO2 | 22-30 | Not done | 28 | Normal value |
| Glucose | 70-99 | Not done | 144 | Elevated glucose is most likely from acute stress response due to anxiety disorder, Pagana et al. (2023). |
| BUN | 10-20 | Not done | 38 | Elevated BUN is most likely due to dehydration, Pagana et al. (2023). |

| | | | | |
|-------------------|-----------------|-----------------|-----------------|---------------------|
| Creatinine | .60-1.0 | Not done | .94 | Normal value |
| Albumin | 3.5-5.0 | Not done | Not done | Not done |
| Calcium | 8.7-10.5 | Not done | 8.9 | Normal value |
| Mag | 1.6-2.6 | Not done | Not done | Not done |
| Phosphate | Not done | Not done | Not done | Not done |
| Bilirubin | 0.0-0.5 | Not done | Not done | Not done |
| Alk Phos | 40-150 | Not done | Not done | Not done |

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 | Yellow | Not done | Normal |
| pH | 5.0-9.0 | 5.5 | Not done | Normal |
| Specific Gravity | 1.003-1.030 | >1.030 | Not done | Elevated specific gravity is most likely due to high concentration of urine, Pagana et al. (2023). |
| Glucose | negative | 3+ | Not done | Positive glucose is most likely due to Diabetes mellitus, Pagana et al. (2023). |

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|----------------------|----------|----------|----------|--|
| Protein | negative | trace | Not done | Positive protein is most likely from Diabetes mellitus, Pagana et al. (2023). |
| Ketones | negative | negative | Not done | Normal |
| WBC | negative | 21-50 | Not done | Positive WBCs are most likely due to UTI, Pagana et al. (2023). |
| RBC | negative | 3-5 | Not done | Positive RBCs are most likely due to glomerulonephritis as it can be linked to diabetes, Pagana et al. (2023). |
| Leukoesterase | Not done | Not done | Not done | Not done |

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 | Negative | positive | Not done | Positive findings are most likely due to patient's UTI, Pagana et al. (2023). |
| Blood Culture | Negative | Negative | Not done | Normal |
| Sputum Culture | Not done | Not done | Not done | Not done |
| Stool Culture | Not done | Not done | Not done | Not done |

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's Diagnostic & Laboratory Test Reference* (16th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (10 points): The patient received x-rays of her femur and hip. The patient received these x-rays for the physician to be able to diagnose her nonunion, Pagana et al. (2023). Evaluating lab results, as well as running x-rays, are the diagnostic procedures to diagnose nonunions. This is because x-rays are used to see how a fracture heals, and labs can show infection which could be a factor as to why a fracture is not healing, Pagana et al. (2023). Since a nonunion is a fracture that is not able to heal, it allows x-rays to diagnose them.

Diagnostic Imaging Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's Diagnostic & Laboratory Test Reference* (16th ed.). Elsevier.

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

5 different medications must be completed

Medications (5 required)

| | | | | | |
|--------------------------------|--|--|---|--|--|
| Brand/ Generic | Apixaban/Eliquis | Insulin glargine/ Lantus | Amiodarone/ Cordarone | Atorvastatin/ Lipitor | Midodrine/ Proamatine |
| Dose | 5 mg | 10 units | 200 mg | 20 mg | 5 mg |
| Frequency | Two times daily | Every morning | Once daily | Nightly | Two times daily before meals |
| Route | Orally | subcutaneous | Orally | Orally | Orally |
| Classification | Pharmacologic class: Factor Xa inhibitor Therapeutic class: Anticoagulant | Long-acting insulin | Pharmacologic class: Benzofuran derivative Therapeutic class: class III antiarrhythmic | Pharmacologic class: HMG-CoA reductase inhibitor Therapeutic class: Antihyperlipidemi c | Miscellaneous cardiovascular agents |
| Mechanism of Action | It decreases development and generation of thrombin, 2024 Nurse's Drug Handbook (2023). | To inject insulin in the body from bodies inability to produce it, 2024 Nurse's Drug Handbook (2023). | It improves cardiac blood flow, 2024 Nurse's Drug Handbook (2023). | It decreases plasma lipoprotein and cholesterol levels, 2024 Nurse's Drug Handbook (2023). | It increases blood pressure, Multum (2024). |
| Reason Client | The patient has a history of atrial | The patient has a history of Diabetes | The patient has a history of atrial | To balance the levels of lipids due | To help combat orthostatic |

| | | | | | |
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| Taking | fibrillation, this medication reduces the risks of this. | mellitus type two. | fibrillation. | to patient's history of hypercholesterolemia | hypotension from lack of activity. |
| Contraindications (2) | <ol style="list-style-type: none"> 1. Active bleeding 2. Hypersensitivity | <ol style="list-style-type: none"> 1. Hypersensitivity 2. Hypoglycemia | <ol style="list-style-type: none"> 1. Bradycardia 2. hypersensitivity | <ol style="list-style-type: none"> 1. Hypersensitivity 2. Acute liver failure | <ol style="list-style-type: none"> 1. Kidney disease 2. Heart disease |
| Side Effects/Adverse Reactions (2) | <ol style="list-style-type: none"> 1. Hypotension 2. Hemorrhagic stroke | <ol style="list-style-type: none"> 1. Diabetic ketoacidosis 2. UTI | <ol style="list-style-type: none"> 1. Confusion 2. Fatigue | <ol style="list-style-type: none"> 1. Arrhythmias 2. Hyperglycemia | <ol style="list-style-type: none"> 1. Severe headache 2. Shortness of breath |

Medications Reference (1) (APA):

Multum, C. (2024, September 16). *Midodrine*. Drugs.com. [Midodrine Uses, Side Effects & Warnings](#)

2024 Nurse's Drug Handbook, (2023). Jones & Bartlett Learning. 691-693.

Assessment

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

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

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|---------------------|---|
| GENERAL: | The patient is alert and oriented to person, place, time, and chief complaint. The patient is well groomed, appropriate for age, with no signs of distress. |
| Alertness: | |
| Orientation: | |

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| Distress: Overall appearance: | |
| INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type: | <p>The patient's skin color is cream, with character being appropriate for age. The temperature or the skin is warm with normal turgor reaction of less than 3 seconds. There are no rashes present. The patient has small, minimal bruises along both legs, most likely due to increased ability to bruise because of age. The patient has a wound on her hip due to her hip replacement surgery. The patient has a Braden Score of 19 and has no drains present.</p> |
| HEENT: Head/Neck: Ears: Eyes: Nose: Teeth: | <p>The patient's head and neck are symmetrical without bumps, lesions, or rashes. The trachea is non-deviated with no palpable lymph nodes. The patient's ears are symmetrical without any deformities, lesions, or wounds. The patient's eyes are symmetrical without any discharge present. PERRLA and EMOs are intact. The patient's nose is symmetrical with septum non-deviated. The patient's teeth are intact.</p> |
| CARDIOVASCULAR: | <p>The patient's S1 and S2 sounds are present and regular. There are no S3, S4, murmurs, or gallops</p> |

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| <p>Heart sounds: S1, S2, S3, S4, murmur etc.</p> <p>Cardiac rhythm (if applicable):</p> <p>Peripheral Pulses:</p> <p>Capillary refill:</p> <p>Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Location of Edema: Left hip/leg</p> | <p>heard. Cardiac rhythm is regular. The peripheral pulses are palpable, 2+, and non-bounding. The patient's pulse rate is 66 bpm. The patient's capillary refill is less than three seconds bilaterally. The patient has no signs of neck vein distention. The patient is positive for edema located on the left hip/leg due to hip replacement surgery.</p> |
| <p>RESPIRATORY:</p> <p>Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Breath Sounds: Location, character</p> | <p>Patient's lung sounds are clear and heard throughout the lungs with no crackles, wheezes or rhonchi heard. There is no stridor present. The patient does not exhibit accessory muscle use.</p> |
| <p>GASTROINTESTINAL:</p> <p>Diet at home:</p> <p>Current Diet</p> <p>Height:</p> <p>Weight:</p> <p>Auscultation Bowel sounds:</p> <p>Last BM:</p> <p>Palpation: Pain, Mass etc.:</p> | <p>The patient's diet at home is reported as normal with no restrictions. The patient's current diet at the hospital is a carbohydrate consistent diet. The patient's height is 5' 7" and she weighs 145 lbs. The patient's bowel sounds are present and normal in all four quadrants. The patient's last bowel movement could not be remembered. Upon inspection there was no distention, incisions, scars, drains, or wounds noted. The patient did not have an ostomy, nasogastric, or feeding tubes.</p> |

| | |
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| <p>Inspection:</p> <p>Distention:</p> <p>Incisions:</p> <p>Scars:</p> <p>Drains:</p> <p>Wounds:</p> <p>Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Size:</p> <p>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Type:</p> | |
| <p>GENITOURINARY:</p> <p>Color:</p> <p>Character:</p> <p>Quantity of urine:</p> <p>Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Inspection of genitals:</p> <p>Catheter: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> External</p> <p>Type: Purewick</p> | <p>The patient's urine was yellow and not hazy. The patient was urinating in normal intervals, with pain, and did not have a dialysis. Inspection of genitals was appropriate for age. The patient used a purewick during the night.</p> |

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|---|--|
| Size: | |
| <p>MUSCULOSKELETAL:</p> <p>Neurovascular status:</p> <p>ROM:</p> <p>Supportive devices:</p> <p>Strength:</p> <p>ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Score:</p> <p>Activity/Mobility Status:</p> <p>Independent (up ad lib) <input type="checkbox"/></p> <p>Needs assistance with equipment <input type="checkbox"/></p> <p>Needs support to stand and walk <input type="checkbox"/></p> | <p>The patient's neurovascular status and active ROM were intact. The patient used a walker to help get around because of her hip replacement surgery. The patient's strength was appropriate for age but slightly impaired with the left leg due to surgery. The patient needed minimal assistance for ADLs and did have a fall risk due to hip replacement surgery. The patient's fall score was 83. The patient's activity/mobility status was slightly impaired. The patient required a walker to get around and minimal support due to fall risk.</p> |
| <p>NEUROLOGICAL:</p> <p>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input checked="" type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/></p> <p>Orientation:</p> <p>Mental Status:</p> | <p>Strength is not equal in legs due to hip replacement surgery on left hip. The patient was oriented and conscious. Her mental status, speech, and sensory were appropriate for age and intact.</p> |

| | |
|--|---|
| Speech: Sensory: LOC: | |
| PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support): | The patient used the television and her smartphone as coping methods. The patient's developmental level was appropriate for age. The patient's support system includes her husband, four children, and eight grandchildren. |

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

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|--------------|--------------|---------------|------------------|---------------|---------------|
| 06:31 | 66 | 126/66 | 16 | 97.9 F | 94% |

Pain Assessment, 1 set (5 points)

| Time | Scale | Location | Severity | Characteristics | Interventions |
|--------------|--------------|-----------------|-----------------|---------------------------|---|
| 09:47 | 1-10 | Left hip | 4 | Consistent, aching | Offered to reposition, offered extra pillows |

Intake and Output (2 points)

| | |
|---|--|
| Intake (in mL) | Output (in mL) |
| The patient is drinking normally | The patient is voiding normally |

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

| Nursing Diagnosis | Rationale | Interventions (2 per dx) | Outcome Goal (1 per dx) | Evaluation |
|---|---|--|---|--|
| <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen | | | <ul style="list-style-type: none"> • How did the client/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan. |
| <ol style="list-style-type: none"> 1. Decreased activity tolerance related to fear of pain as evidence by the patient’s anxiety disorder. | <p>The patient has a history of anxiety disorder which can lead to the patient reducing her activity level due to the fear of pain from moving.</p> | <ol style="list-style-type: none"> 1.To slowly introduce the patient to different movements and help them repeat them a few times throughout the shift. If the patient practices and repeats movements such as picking up the leg | <ol style="list-style-type: none"> 1. The patient will feel comfortable walking around and complete daily activities by discharge. | <p>The patient is no longer anxious or scared and has a new sense of freedom by being able to move without being worried it will cause pain.</p> |

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| | | <p>throughout the day, they will grow comfortable and no longer fear that it will hurt them.</p> <p>2.To listen to the patient’s concerns as to what activities might cause them pain. This can allow education as to how to complete these certain activities differently to be able to avoid pain.</p> | | |
| <p>2. Impaired physical mobility related to anxiety as evidence by patient’s fear of falling.</p> | <p>The patient’s anxiety can impact the patient from walking around due to the risk of falling. The patient was also hesitant and verbalized the fear of falling.</p> | <p>1. To discuss the patients support system and educate the patient on the benefits of a good support system. Once the patient goes home, a good support system can allow the patient to have help with getting around. This way they feel safer until they regain the confidence to walk on their own.</p> | <p>1. The patient will be able to identify fall risks and the importance of removing them by discharge.</p> | <p>The patient will remove fall risks within their home and feel more comfortable with ambulating.</p> |

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|--|--|---|--|--|
| | | <p>2. To educate the patient on being able to identify fall risks within their household so they can remove them. For example, this can allow a sense of comfort that the patient will not have to worry about tripping on a rug which they might not have thought of as a fall risk.</p> | | |
|--|--|---|--|--|

Other References (APA):

Phelps, L. L. (2022). *Nursing Diagnosis Reference Manual: Twelfth Edition*. Wolters Kluwer.

Concept Map (23 Points):

Subjective Data

Nursing Diagnosis/Outcomes

Patient was experiencing pain severity of a 4 on a scale of 1-10 when bearing weight to left leg.
Glucose: 144

Patient is fearful of falls and increased pain.
Objective Data

The patient is a 72-year-old female who was admitted for a left hip nonunion by discharge. She has an anxiety disorder and fears of possible harm that could potentially re-hospitalize her after discharge.

Client Information

1. To slowly introduce the patient to different movements and help them repeat them a few times throughout the shift. If the patient practices and repeats movements such as picking up the leg throughout the day, they will grow comfortable and no longer fear that it will hurt them.

2. To listen to the patient's concerns as to what activities might cause them pain. This can allow education as to how to complete these certain activities differently to be able to avoid pain.

3. To discuss the evidence supporting fear of falling. The patient on the benefits of a good support system. Once the patient goes home, a good support system can allow the patient to have help with getting around. This way they feel safer until they regain the confidence to walk on their own.

4. To educate the patient on being able to identify fall risks within their household so they can remove them. For example, this can allow a sense of comfort that the patient will not have to worry about tripping on a rug which they might not have thought of as a fall risk

