N311 Care Plan 3

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N311: Foundations of Professional Practice

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Demographics

Date of Admission 3/11/2025	Client Initials CD	Age 52	Biological Gender Female
Race/Ethnicity White	Occupation District 87	Marital Status Divorced	Allergies Penicillins: N/V Citrus: rash, itching, swelling Derivatives: rash, itching, swelling Sulfa: rash Tetracycline: rash
Code Status Full	Height 5’ 7”	Weight 170 lb 3.1 oz	

Medical History

Past Medical History:

- asthma
- rectal cancer
- history of radiation therapy
- hypothyroidism

Past Surgical History:

- right ankle surgery
- left knee cartilage surgery
- right shoulder surgery
- right subclavian catheter insertion
- tonsillectomy
- tubal ligation

Family History:

father:

multiple sclerosis

thyroid

mother:

stroke

thyroid

heart

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

smoking/smokeless tobacco: never

alcohol: not currently (rare)

substance use: not currently

sex: not currently

drug use: not currently

vaping: former

Education:

some college

Living Situation:

lives with her children

Assistive devices:

none

Admission Assessment

Chief Complaint: weakness

History of Present Illness (HPI) – OLD CARTS:

The patient presented to the ED with complaints of generalized weakness, noticing black stools over a span of days. She came in feeling very weak and fatigued, worsening over the past two weeks. She denies any fevers, chills, headaches, chest pain, dyspnea, or urinary symptoms. The patient complains of nausea and a sore throat, experiencing chronic nasal congestion and a productive cough. She had fallen more than once while at home due to her weakness, hitting her head once.

Primary Diagnosis

Primary Diagnosis on Admission: acute anemia

Secondary Diagnosis (if applicable):

Pathophysiology

Pathophysiology of the Disease, APA format:

Pathophysiology References (2) (APA):

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
WBC	**0.66 LL**	**0.63 LL**	**4.00-11.00 K/uL**	**infection**
HGB	**8.7 L**	**8.3 L**	**11.0-16.0 gm/dL**	**oxygen deficiency**
HCT	**25.3 L**	**24 L**	**34.0-47.0%**	**low red blood cell count**
Platelet count	**31 LL**		**140-400**	**blood is not able to clot**

			K/uL	**properly**
Albumin	**2.9 L**		**3.5-5.0 gm/dL**	**not enough protein in blood**
Potassium	**3.0 LL**	**2.7 LL**	**3.5-5.0 mmol/L**	**low on electrolytes**
Glucose	**117 H**	**101 H**	**70-99 mg/dL**	**high blood sugar**

Diagnostic Test & Purpose	**Clients Signs and Symptoms**	**Results**
CT of head	**increased weakness, oncologic history, fall a week ago**	**no acute abnormalities**
Chest X-ray	**look for pneumonia d/t cough**	**no metastatic disease**

Diagnostic Test Reference (1) (APA):

Assessment

Physical Exam – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

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

The student and instructor may complete these assessments together.

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**patient was alert and oriented x4** **no signs of distress** **patient lying in bed, seemed tired**
INTEGUMENTARY: **Skin color: sand** **Character: warm, dry** **Temperature: 98.1º F** **Turgor: less than 3 sec** **Rashes: no noted** **Bruises: no noted** **Wounds: no noted** **Braden Score: 19** **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: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	.
GASTROINTESTINAL: **Diet at home: liquid** **Current Diet: liquid** **Height: 5' 7"** **Weight: 170 lb 3.1 oz** **Auscultation Bowel sounds: normoactive** **Last BM: 3/12/25** **Palpation: Pain, Mass etc.: none** **Inspection:** **Distention: none** **Incisions: none** **Scars: none** **Drains: none** **Wounds: none** **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:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**fall risk: 29 (high risk)**
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): watching television** **Developmental level: adulthood** **Religion & what it means to pt.: no religion** **Personal/Family Data (Think about home environment, family structure, and available family support):** **the patient is supported and taken care of by her family**	

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
12:28 pm	98 bpm	110/58 mmHG	18 breaths/min	98.1^0 F	98% room air

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
12:36 pm	1-10	N/A	0	N/A	N/A

Intake and Output

Intake (in mL)	Output (in mL)
120 mL	0 mL

The patient has been getting fluids through an IV and also by mouth but has not been urinating or getting rid of any of these fluids. She had gotten about 800 mL of fluids throughout the night and when a bladder scan was done, only 200 mL was shown in her bladder.

Nursing Diagnosis
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. impaired urinary elimination related to not voiding as evidenced by taking in	**this nursing diagnosis was chosen because the patient has been getting fluids constantly either by IV or by mouth and has not**	**1. scheduled bladder scans** **2. indwelling catheter**	**1. be able to void 5 mL of urine before being discharged**	**the patient was willing to try and void before being discharged**

more liquids than putting out	**been urinating**			
2. risk for impaired swallowing	**this nursing diagnosis was chosen because the patient complains of struggling to swallow**	**1. talk to speech therapy** **2. keep on a full liquid diet**	**1. the patient will feel more comfortable swallowing after talking with a speech therapist**	**the patient agreed to see a speech therapist to see why she is struggling to swallow**

Other References (APA):

Pathophysiology of Disease

This patient came to the ED for weakness and was later diagnosed with acute anemia. Depending on the main cause of anemia, the pathophysiology will be different depending on which type of anemia it is. For example, the pathophysiology of anemia and acute anemia are completely different in the fact that acute anemia is the result of anemia itself. Acute anemia "is the restoration of blood volume with intracellular and extracellular fluid that dilutes the remaining red blood cells" (Turner, 2023). A plasma and red blood cell reduction causes an untrue normal of hematocrit and hemoglobin. Anemia is caused by an imbalance in red blood cell destruction and/or removal (Turner, 2023). In this case, the patient has had surgery due to rectal cancer which could have been a starting cause of the acute anemia. Another reason for the patient's acute anemia could be due to her increased risk of infection. Acute anemia is usually caused for one of two reasons. These reasons being hemolysis or a hemorrhage which both lead to a decrease in red blood cells (Killeen, 2025). When red blood cells drop at a rapid pace, the hemoglobin level drops to about an 8 or 7 which then results in signs and symptoms. These signs and symptoms are consistent with those of hypovolemia (Killeen, 2025). Some signs and symptoms that the patient experienced included difficulty maintaining a normal blood pressure, her blood pressure dropping suddenly when sitting, and an altered mental state. The patient started becoming more alert and oriented once she was started on continuous fluids. Her blood pressure started rising and became more normal than when she was first admitted. She was starting to not feel as dizzy and weak once the fluids were in her system more fully.

References:

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