N311 Care Plan 2

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N311: Foundations of Professional Practice

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Demographics

Date of Admission	**Client Initials**	**Age**	**Biological Gender**
9/15/2025	RAM	75	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Blackies Heating/Air	Divorced	Doxcycyline
Code Status	**Height**	**Weight**	
Full	5’ 11”	170lbs	

Medical History

Past Medical History: Anxiety, Diabetes Mellitus (HCC), Gastroesophageal Reflux Disease (GERD), Hyperlipemia, Hypertension

Past Surgical History: Carpal Tunnel Release, Cataract Removal, Upper Gastrointestinal Endoscopy (2/2/2024)

Family History: Patient denies any knowledge

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient states he drinks beer/whiskey very rarely, “once a month”. Patient states that he used to chew tobacco for 20+ years. He would use it several times a day, would usually use a whole can a day, he has since quit.

Education: 2.5 years in college, associates degree

Living Situation: Independently at home

Assistive devices: Glasses

Admission Assessment

Chief Complaint: Generalized weakness, fatigue

History of Present Illness (HPI) – OLD CARTS:

75-year-old male admitted to the emergency room due to complaints of generalized weakness. Patient states that he noticed increasing symptoms a week ago. Patient states that he feels weak in his torso area, more specifically, around his chest. Additionally, patient states that he first started noticing his symptoms about 2-3 weeks ago. Symptoms are mainly weakness around his chest and difficulty breathing, he states that his weakness is more of a “painful weakness”. Patient was questioned if anything he did aggravated it; the patient denies that anything aggravated it. Furthermore, patient was questioned if anything he tried relieved it. The patient states that he tried basic range of motion excercises and did not find that it helped. Patient states that no over-the-counter medication was taken to try to treat it.

Primary Diagnosis

Primary Diagnosis on Admission: Hyponatremia

Secondary Diagnosis (if applicable): Dehydration

Pathophysiology

Pathophysiology of the Disease, APA format:

Hyponatremia is a condition in which a patient's sodium serum level is less than 135mEq/L (Capriotti, 2024). Hyponatremia is represented by an imbalance of body fluid in which total body water is disproportionately high relative to total body sodium. Furthermore, it is classified by several factors: acute vs. chronic, and severity of neurological symptoms (Sumi et al., 2025). For example, mild hyponatremia (130–134 mmol/L) may cause less-severe symptoms like headache and irritability, whereas severe hyponatremia (<125 mmol/L) can lead to seizures, coma, and respiratory problems (Sumi et al., 2025). This condition can be quite prevalent in some hospitals, with 14–42% of patients being diagnosed with this condition. This is quite significant because its presence, even if it is mild, is associated with worsened outcomes (Sumi et al., 2025).

Most hyponatremia cases occur when one has trouble excreting water, combined with dilution of sodium within a large volume of water in the bloodstream (Capriotti, 2024). Furthermore, according to Capriotti (2024), "This is clinically significant when hyponatremia is part of a drop in the serum total osmolality, which is measured by the calculation: 2(Na) mEq/L + serum glucose (mg/dL) / 18 + BUN (mg/dL) / 2.8.". During an acute drop in the serum osmolality, swelling can occur in the brain due to the fluid shift from the extracellular space to the intracellular space (Capriotti, 2024). This swelling can result in two different consequences. First, it inhibits antidiuretic hormone secretion from the neurons in the hypothalamus and hypothalamic thirst center, leading to excess water elimination as dilute urine. Secondly, over the next few days, there is a more gradual loss of organic intracellular solutes due to the adaptation of the cells with the loss of electrolytes (Capriotti, 2024).

Signs and symptoms experienced by the patient are as follows. First, the chief complaint was weakness, which brought the patient into the emergency room. Secondly, the patient has a history of anxiety, which is another symptom of hyponatremia. Lastly, the patient is lethargic, stating that he rarely gets much exercise. The patient's primary diagnosis of hyponatremia was established through the objective lab finding of NA+ <135 mEq/L, which is a definitive sign of hyponatremia (Capriotti, 2024). Combined with the subjective reports of weakness, anxiety, and lethargy, this assessment confirms hyponatremia as the main reason for admission.

Pathophysiology References (2) (APA):

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

Sumi, H., Tominaga, N., Fujita, Y., & Verbalis, J. G. (2025, January). *Pathophysiology, symptoms, outcomes, and evaluation of hyponatremia: Comprehension and best clinical practice*. Clinical and experimental nephrology. https://pmc.ncbi.nlm.nih.gov/articles/PMC11828805/#:~:text=Hyponatremia%2C%20defined%20as%20a%20serum,24%2C%205

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0737	80BPM	137/44mmHg	16RR	96.7F	96% Room Air

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
1041	RASS	Foot; bilateral	5	Dull aching	Prescribed exercises encouraged

Intake and Output

Intake (in mL)	Output (in mL)
236mL	300mL

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. Risk for electrolyte imbalance due to hyponatremia	Hyponatremia is a condition of low sodium, leading to swelling of the cells (Capriotti, 2024)	**1.** Assess for neurological changes, for ex. confusion. **2.** Educate the patient on the limitation of water	**1.** Client electrolyte balance will be restored/sodium levels will increase to a minimum of 135 mEq/L	Evaluation will occur when lab results show NA+ ≥ 135 mEq/L. Signs of decreased weakness/difficulty breathing will show that this intervention worked.

		intake d/t dilution of sodium in the bloodstream.		
2. Fatigue d/t shift of fluids related to hyponatremia	Balance of electrolytes is impaired, therefore causing diminished muscular function (Sumi et al., 2025)	**1.** Encourage the patient to rest **2.** Educate patient on adequate nutrition relating to sodium and electrolytes	**1.** Client will feel improvement in energy and less fatigue	Evaluation will occur when the client states that he feels more energized. The client will be able to breathe without any pain.

Other References (APA):

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

Sumi, H., Tominaga, N., Fujita, Y., & Verbalis, J. G. (2025, January). *Pathophysiology, symptoms, outcomes, and evaluation of hyponatremia: Comprehension and best clinical practice*. Clinical and experimental nephrology. https://pmc.ncbi.nlm.nih.gov/articles/PMC11828805/#:~:text=Hyponatremia%2C%20defined%20as%20a%20serum,24%2C%205