N311 Care Plan 5

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N311: Foundations of Professional Practice

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Demographics

Date of Admission 10/21/2025	**Client Initials** M.H.	**Age** 71 years old	**Biological Gender** Female
Race/Ethnicity White/Caucasian	**Occupation** Retired LPN	**Marital Status** Widowed	**Allergies** 1. Iodine 2. Sulfacetamide Sodium 3. Wound dressing adhesive 4. Nitrofurantoin Macrocrystal 5. Pencillins 6. Sulfa Antibiotics
Code Status Full Code	**Height** 5 ft 7.5 inches (171.5 cm)	**Weight** 111.5 kg (245 lb 13 oz)	

Medical History

Past Medical History: Arrhythmia, arthritis, atrial fibrillation, hypertension, and disorders of lipoid metabolism

Past Surgical History: Left cardiac catheterization (8/22/2023), cesarean section, corneal transplant, Hx heart catheterization

Family History: Mom hypertension, sister and father cardio myopathy, and patient stated “I have history of diabetes on both paternal and maternal sides of my family but I can’t remember who did.”

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient stated she has not used tobacco, alcohol, or any drugs in the past.

Education: Associate degree

Living Situation: Patient currently resides in a skilled nursing facility

Assistive devices: Hearing aids, glasses, and wheelchair

Admission Assessment

Chief Complaint: Cellulitis

History of Present Illness (HPI) – OLD CARTS: Patient stated her cellulitis started on the evening of 10/20/2025. The patient showed the student nurse her cellulitis is located on her right neck. Patient stated she has had cellulitis for four days and started on 10/20/2025. Patient characterized her cellulitis with facial swelling, pain and tenderness upon touching, and warm to the touch. Patient stated touching her neck hurts the most. Patient stated not touching it helps relieve her pain and tenderness with her cellulitis. Patient stated she is taking antibiotics to treat her cellulitis at this time. Patient stated her cellulitis is not severe and does not impact her every day life.

Primary Diagnosis

Primary Diagnosis on Admission: Cellulitis

Secondary Diagnosis (if applicable): Hypokalemia

Pathophysiology

According to Capriotti and Frizzell, cellulitis is a bacterial infection of the skin that causes redness of the skin, swelling, warmth, and tenderness in the affected tissue (Capriotti & Frizzell, 2023). If not treated quickly the cellulitis can go deeper into the layers of the tissue and go into the bloodstream and cause sepsis. Sepsis is when the blood circulating the body becomes infected (Capriotti & Frizzell, 2023). Sepsis presents itself with low blood pressure, elevated pulse, pH of the blood decreased, and the widening of the blood vessels (Capriotti & Frizzell, 2023).

The client presents with pain and tenderness upon palpation of her right neck. As well as warm to the touch and swelling around her neck and face. As well, the patient presents with high levels of white blood cells which indicate an infection is happening in the body. When an infection is noted in the body, a culture must be done to see what type of pathogen it is and what can be done to remove it from the body. When the pathogen is identified, antibiotics should be used to help treat cellulitis since it is a bacterial infection. When a severe infection or signs of sepsis are shown, medical treatment such as antibiotics should be started before a culture is done to show what pathogen it is.

According to the National Library of Medicine, the patient's skin should be closely evaluated to find where the cellulitis is by looking for injuries, insect bites, pressure ulcers, or sites where an IV was used (Brown & Watson, 2023). If cellulitis is seen in the legs, they should be assessed between the patient's toes for cracks in the skin or a fungal infection of the feet (Brown & Watson, 2023). Cellulitis can also cause problems in the lymphatic system and lead to swollen lymph nodes (Brown & Watson, 2023). If edema is also present with cellulitis it can cause blisters, large sacs in the skin that are filled with fluid, and make the skin appear like an

orange peel (Brown & Watson, 2023). The patient was noted to have swollen tonsillar lymph nodes on the right side of her neck, as well as swelling in her lower legs and feet.

Pathophysiology References (2) (APA):

Brown, B., & Watson, K. (2023, August 7). *Cellulitis*. National Library of Medicine. Retrieved October 26, 2025, from https://www.ncbi.nlm.nih.gov/books/NBK549770/

Capriotti, T. & Frizzell, J. P. (2023). *Pathophysiology: Introductory concepts and clinical perspectives.* (4th ed.). F.A. Davis Company.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Sodium	146 mEq/L	145 mEq/L	136-145 mEq/L (Pagana et al., 2025)	The patient's sodium level upon admission could be elevated due to too much sodium intake in her diet (Pagana et al., 2025).
Potassium	2.8 mEq/L	2.7 mEq/L	3.5-5 mEq/L (Pagana et al., 2025)	The patient's potassium could be decreased due to water pills, taking insulin, or any trauma(Pagana et al., 2025).
Chloride	108 mEq/L	107 mEq/L	98-106 mEq/L (Pagana et al., 2025)	The patient's chloride could be elevated due to not drinking enough fluids or having an overactive parathyroid gland (Pagana et al., 2025).
Calcium	9.0 mg/dL	8.9 mg/dL	9-10.5 mg/dL (Pagana et	The patient's calcium could be decreased due to inflammation of the pancreas or impaired

			al., 2025)	absorption (Pagana et al., 2025).
Glucose	143 mg/dL	146 mg/dL	82-115 mg/dL (Pagana et al., 2025)	The patient's glucose could be elevated due to diabetes or their fight or flight response activated (Pagana et al., 2025).
Anion Gap	13.0 mEq/L	11.0 mEq/L	16±4 mEq/L (Pagana et al., 2025)	The patient's anion gap could be decreased due to toxicity to cough syrup or eating too much alkali (Pagana et al., 2025).
BUN	24 mg/dL	21 mg/dL	10-20 mg/dL (Pagana et al., 2025)	The patient's blood urea nitrogen could be elevated due to not eating enough food or a heart attack (Pagana et al., 2025).
White Blood Cells	13.37/mm^3	12.44/mm^3	5,000-10,000/mm^3 (Pagana et al., 2025)	The patient's white blood cell count could be elevated due to a disease or swelling and tenderness (Pagana et al., 2025).
Red Blood Cells	3.38 x10^6/µL	3.21 x10^6/µL	4.2-5.4 x10^6/µL (Pagana et al., 2025)	The patient's red blood cell count could be decreased due to pulmonary heart disease or not drinking enough fluids (Pagana et al., 2025).
CO2, Venous	25 mEq/L	27 mEq/L	23-30 mEq/L (Pagana et al., 2025)	Within normal limits

Creatinine, Blood	1.08 mg/dL	0.94 mg/dL	0.5-1.1 mg/dL (Pagana et al., 2025)	Within normal limits
Platelet Count	156 x10^9/L	111 x10^9/L	150-400 x 10^9/L (Pagana et al., 2025)	The platelet count could be decreased due to short or long term infection. As well as a blood clotting disorder that can lead to organ damage and uncontrollable bleeding (Pagana et al., 2025).

Diagnostic Test & Purpose	**Clients Signs and Symptoms**	**Results**
XR Shoulder Complete Right	The patient stated she has a history of arthritis. As well, she complained of pain and tenderness upon palpation, and swelling in her right neck.	No broken bones or dislocation in the shoulder joint seen. There is average to acute arthritis in the shoulder and the joint where the collarbone connects with the shoulder. There is flattening of the bone in the upper arm. This is probably caused by arthritis, but not due to an injury or dropping of blood supply to that bone (Pagana et al., 2025).
Imaging Miscellaneous Scan	Patient shows edema in bilateral legs.	No lung problems noted. No changes seen from last (Pagana et al., 2025).
XR Chest Single View	The patient stated she has a history of atrial fibrillation and presents with	Findings came back negative.

	heart sounds that are in irregular rhythm.	
XR Knee Minimum 4 Views Bilateral	The patient has swelling in bilateral lower legs and feet. As well the patient complains of scattered bruising in bilateral lower legs.	The x-rays of bilateral knees show the bilateral knee replacements are in proper position and doing well (Pagana et al., 2025).
XR Lumbar Spine 2 or 3 Views	The patient shows weakness in her legs, signs of infection, and can not control her bladder anymore.	No new bone injuries are seen. There is a grade two forward slip of the fifth lumbar back bone, that is over the one below S1. As well, there are small cracks in bilateral sides of the fifth lumbar. Further x-rays while bending and standing straight could be done further to check to see if the spine is unstable. There is bad wear and tear on the spine due to age at L5-S1 (Pagana et al., 2025).

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2025). *Mosby's diagnostic and laboratory test reference* (17th ed.). Mosby.

Active Orders

Active Orders	Rationale
Activity order- as tolerated per mobility goal	This order is relevant to the client's current

	condition because to maximize the patient's healing process, the body needs to move to increase circulation so the body can get nutrients from oxygenated blood.
Admission weight	This order is relevant to the client's current condition because upon admission we need all of the information about the patient to come up with a diagnosis. So if her weight had decreased or increased more than usual it can help to decipher her condition.
Intake and Output	This order is relevant to the client's current diagnosis because to make sure the client is receiving adequate nutrition we need to record her intake and output to make sure she eats a good proportion of calories.
Vital signs per unit routine	This order is relevant to the client's current condition because vital signs are the first thing to see that changes when the body has an infection or other conditions.
Nursing Communication: Offer prune juice if available on the patient's diet	This order is relevant to the client's condition because she can not ambulate without a mechanical lift and her peristalsis is impaired due to immobility so the prune juice will help with bowel movements.
Perform POC blood glucose AC/HS	This order is relevant to the client's condition because the patient has diabetes and her glucose was elevated upon admission and today.
Post hypoglycemia treatment and blood sugar greater than or equal to 80 mg/dL	This order is relevant to the client's condition because the patient has diabetes, and her blood sugar needs to be regulated with insulin if high and orange juice if it's low.
Insert/maintain peripheral IV	This order is relevant to the client's condition because she is currently taking potassium chloride and the route of this medication is intravenous.
Maintain IV while on telemetry	This order is relevant to the client's condition because she needs her IV to continue taking the potassium chloride, and the telemetry to monitor her atrial fibrillation.
Notify physician- symptomatic bradycardia	This order is relevant to the client's condition because symptomatic bradycardia can present itself due to low potassium levels and taking medications.
Notify physician- ventricular arrhythmias	This order is relevant to the client's condition because with her heart rhythm being

	abnormal, we would need to notify the physician if a ventricular arrhythmias is starting to present itself.
For blood sugar of 70 mg/dL or less	This order is relevant to the client's condition because if she starts going into hypoglycemia we can give orange juice to maintain a stable blood glucose.
Ambulate patient	This order is relevant to the client's condition because it promotes circulation throughout the body, prevents pressure sores due to not repositioning the patient, and improves the expansion of the lungs.
Up with assistance	This order is relevant to the client's condition because it promotes protected mobility for the patient while also preventing falls or any injury.
Nursing night calls	This order is relevant to the client's condition because the patient prioritizes her sleep and kindly asks staff to get her morning labs when shift change happens in the morning instead of getting her labs done at 05:00AM.
Nursing Communications: Please provide patient education to reduce/avoid constipating foods such as red meat, fried or fatty foods, milk, and cheese	This order is relevant to the client's diagnosis because even though our goal is to make sure she ingests more calories, we want to also refrain from eating foods that can cause constipation.

Current Medications (5)

Brand/Generic	Amlodipine besylate/ Norvasc	Apixaban/ Eliquis	Escitalopram oxalate/ Lexapro	Meloxicam/ Mobic	Potassium Chloride/ K-10 (CAN)
Dosage, Route, Frequency given	10mg, oral, daily	5mg, oral, 2 times a day	10mg, oral, daily	15mg, oral, daily	20 mEq; 50 mL/hr, intravenous, once
Reason Client Taking	The patient could be taking this medication to control high blood pressure (Jones & Bartlett Learning, 2024).	The patient could be taking this medication to decrease the risk of blood clots in the legs and the	The patient could be taking this medication to help with serious depression (Jones & Bartlett	The patient could be taking this medication to help with pain, swelling, and stiffness in the joints	The patient could be taking this medication to help with low potassium due to low intake of

		lungs (Jones & Bartlett Learning, 2024).	Learning, 2024).	(Jones & Bartlett Learning, 2024).	potassium in diet (Jones & Bartlett Learning, 2024).

Medications Reference:

Jones & Bartlett Learning. (2024). *2025 Nurse's Drug Handbook* (22nd ed.). Jones & Bartlett Learning.

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:**	The patient appears alert and oriented to person, place, and time. Patient is well groomed and shows no acute distress.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐**	Patient's skin is pink upon inspection. The skin is warm and dry upon palpation. The patient has no rashes, lesions, or wounds. There is scattered bruising on the right and left lower quadrants of her abdomen, left forearm, and on the right and left calves. Normal quantity, distribution, and texture of hair. Nails appear without clubbing or cyanosis. Skin turgor has normal mobility. Patient's Braden Score is rated at a 16. Patient is a high fall risk. No drains present.

Type:	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical and trachea is midline without deviation. The right tonsillar lymph nodes are swollen and tender upon palpation. Bilateral carotid pulses are palpable and 2+. Bilateral carotid pulses have irregular rhythm. Bilateral ears have no visible or palpable deformities, lumps, or lesions. Bilateral canals show no signs of pain or drainage. Bilateral sclera is white, bilateral cornea is clear, bilateral conjunctiva is pink, no visible drainage from bilateral eyes. Bilateral eyelids are moist and pink without lesions or discharge noted. PERRLA and EOMS intact bilaterally. Septum is midline, moist, and pink. Nostrils bilaterally moist, pink, and no visible bleeding or drainage noted. Bilateral frontal sinuses are nontender to palpation. Posterior pharynx and tonsils are moist and pink without exudate noted. Uvula and tongue are in midline. Soft palate rises and falls symmetrically. Hard palate intact. Dentition is good, oral mucosa overall is moist and pink with no lesions noted.
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:**	Clear S1 and S2 without murmurs, gallops, or rubs. Apical pulse was auscultated at the 5th intercostal space at the midclavicular line. No jugular vein distention (JVD) noted. Normal rate, but irregular rhythm noted. All extremities are warm, dry, and symmetrical. Pulses are 1+ bilaterally on dorsalis pedis and posterior tibial pulses. Bilateral brachial, radial, ulnar, and popliteal pulses have normal rate but irregular rhythm. Capillary refill is less than 3 seconds on bilateral fingers, but more than 3 seconds on bilateral toes. Edema is present on lower legs and feet. Patient is on telemetry.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Normal rate and rhythm of respirations. Respirations are symmetrical, non-labored, and no accessory muscles were used upon inspection. Lung sounds are clear throughout the bilateral anterior and posterior lungs with no wheezes, crackles, or rhonchi heard.
GASTROINTESTINAL: **Diet at home:**	Patient states she has no appetite at home due to past covid illness. Patient is currently on a carb restriction diet. Patient is 5 feet and 7.5 inches. Patient is 245 lbs

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:**	and 13 oz. Bowel sounds are normoactive in all four quadrants. Patient stated her last bowel movement was two days ago (10/21/2025). Abdomen is soft, nontender, no masses noted upon palpation of all four quadrants. The abdomen is intact and pink with no distention, incisions, scars, drains, or wounds. Abdomen has scattered bruising on left and right lower quadrants. Patient does not have an ostomy, nasogastric tube, or feeding tubes.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Patient stated her urine is light yellow. Patient stated she does not smell a foul odor upon urination. The patient stated “whenever I pee it’s not a little bit, I pee a lot”. Patient states no pain when urinating. Patient states she is not currently on dialysis. Genitals are intact, pink, and hair was observed upon inspection. Patient does not currently have a catheter. Patient currently uses incontinence briefs.
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☐**	
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient can not move all extremities well. Patient shows weakness in bilateral legs. PERLA is intact. Hand grips and pedal pushes and pulls demonstrate normal and equal strength. Patient is alert and oriented to person, place, time, and situation. The patient's speech is clear and easy to understand. The patient's sensation is intact throughout her body. The patient is alert and oriented, and responds when communicating with her.
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):**	Patient states whenever she has stress she copes by not eating foods. The patient’s developmental level is appropriate for her age. Patient states she is a lutheran nazarene and goes to church at her nursing facility. Patient states she does not need any special modifications or needs due to her religion. Patient states her son comes to visit her along with her two grandchildren.

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
07:37 AM	91 beats per minute	152/109 mm/Hg	16 breaths a minute	97.8 ℉	96% on room air

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
10:04 AM	1-10 Numeric Pain Rating Scale	Patient states no pain	Patient states no pain	Patient states no pain	None at this time, due to no pain

Intake and Output

Intake (in mL)	Output (in mL)
480 mL	400 mL

Discharge Planning

Discharge location: Upon discharge, the patient is being transferred to a skilled nursing facility.

Equipment needs: Upon discharge, the patient will require a wheelchair and a hoyer lift.

Education needs: These are possible discharge education objectives that need to be done. But specific discharge planning has not started yet. The patient must be educated on how to prevent falls that entail describing the risk factors, medications, and safety in the home. The patient must be educated about keeping a well nutritional diet and staying hydrated so that her body can heal and be healthy.

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 adult falls relating to being a high fall risk, as evidenced by weakness in bilateral legs (Phelps, 2023).	I chose this nursing diagnosis because the patient shows weakness in bilateral legs.	**1.** Identify factors that could cause or contribute to an injury from a fall (Phelps, 2023). **2.** Review medications with the patient and family (Phelps, 2023).	**1.** The patient shows the ability to walk without falling and have a balanced gait before the patient is discharged (Phelps, 2023).	I would evaluate the patient for strength in bilateral legs, as well as her gait upon being discharged.
2. Imbalance nutrition relating to low nutritional intake, as evidenced by the patient stating her breakfast muffin "tastes like	I chose this nursing diagnosis because the patient states her taste buds are different after covid, which makes her not want to eat.	**1.** Include family members in preparing meals (Phelps, 2023). **2.** Plan a diet prescribed for the patient's condition (Phelps, 2023).	**1.** The patient eats a precise amount of calories everyday upon discharge (Phelps, 2023).	I would evaluate the patient for improved nutrition by looking at her daily calories everyday for a specific amount of calories before she is discharged.

spider webs" (Phelps, 2023).				

Other References (APA):

Phelps, L.L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.