N431 Care Plan #1

Lakeview College of Nursing

Tayler Obenland

Demographics (3 points)

Date of Admission 8/30/2019	**Patient Initials** CJ	**Age** 92	Gender Female
Race/Ethnicity Caucasian	**Occupation** retired	**Marital Status** widowed	**Allergies** No known allergies
Code Status Full code	**Height** 5 feet	**Weight** 140	

Medical History (5 Points)

Past Medical History: Coronary artery disease, gall stones, hypertension, osteoarthritis

Past Surgical History: Coronary angioplasty with stent, appendectomy, cholecystectomy, total knee arthroplasty (Bilateral), hysterectomy, appendectomy

Family History: unable to obtain due to dementia

Social History (tobacco/alcohol/drugs): does not claim to drink alcohol, smoke tobacco, or do drugs

Assistive Devices: walker and a gait belt

Living Situation: going to a nursing home

Education Level: high school diploma

Admission Assessment

Chief Complaint (2 points): fatigue

History of present Illness (10 points):. 92-year-old female with past medical history significant for hypertension, hyperlipidemia and advanced dementia who presented to the ER for further management of debility and inability to preform ADL's. Daughter states she can not take care of her at home.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): UTI

Secondary Diagnosis (if applicable): Not applicable

Pathophysiology of the Disease, APA format (20 points): The urinary tract, from the kidneys to the urethral meatus, is normally sterile and resistant to bacterial colonization despite frequent contamination of the distal urethra with colonic bacteria. The major defense against UTI is complete emptying of the bladder during urination. Other mechanisms that maintain the tract's sterility include urine acidity, the vesicoureteral valve, and various immunologic and mucosal barriers (Imam, 2018).

Pathophysiology References (2) (APA): Imam, T. H. (n.d.). *Merck Manual Professional Version*. Retrieved from https://www.merckmanuals.com/professional/genitourinary-disorders/urinary-tract-infections-utis/bacterial-urinary-tract-infections-utis

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and 24.7

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.30	3.19	3.50	RBC can be high due to the coronary artery disease (Weatherspoon, 2017).
Hgb	12.0-15.8	9.7	10.7	HGB can be low due to coronary artery disease (Weatherspoon, 2017).
Hct	36.0-47.0	28.3	31.6	HCT could be low due to coronary artery disease (Weatherspoon, 2017).
Platelets	140-440	185	168	
WBC	4-12	7.40	7.50	
Neutrophils	47-73	61.2	64.5	
Lymphocytes	18-42	24.7	23.8	
Monocytes	4-12	12.6	9.6	Monocytes can be high due to the infection from the UTI (Smith, 2018).
Eosinophils	0-5	1.2	1.8	
Bands	3-30	N/A	N/A	

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-	133-145	142	142	
K+	3.5-5.1	3.2	3.6	K+ can be low from vomiting (Lewis,2018).
Cl-	98-107	108	107	Cl- can be high due to kidney problems (Lewis, 2018).
CO2	21-31	25	25	
Glucose	70-99	93	75	
BUN	7-25	15	17	
Creatinine	.50-1.20	0.64	0.72	
Albumin	3.5-5.7	3.8	4.0	
Calcium	8.6-10.3	8.9	9.1	
Mag	1.6-2.6	1.7	1.7	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	0.2-0.8	0.6	0.7	
Alk Phos	34-104	36	39	
AST	13-39	21	29	
ALT	7-52	13	22	
Amylase	30-110	N/A	N/A	
Lipase	60-160	N/A	N/A	
Lactic Acid	0.5-2.0	0.6	0.6	

Troponin	.0-.040	.030	.030	
CK-MB	5-25	N/A	N/A	
Total CK	22-198	N/A	N/A	

Other Tests 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
INR	.9-1.1	1.1	1.1	
PT	10.1-13.1	12.4	12.4	
PTT	60-70	N/A	N/A	
D-Dimer	>500	N/A	N/A	
BNP	>125	N/A	N/A	
HDL	40-59	N/A	N/A	
LDL	100-129	N/A	N/A	
Cholesterol	>200	N/A	N/A	
Triglycerides	>150	N/A	N/A	
Hgb A1c	4-5.6	N/A	N/A	
TSH	0.4-4.0	N/A	N/A	

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**	**Yellow**	
pH	5-9	6.0	7.0	

Specific Gravity	1.003-1.030	1.011	1.013	
Glucose	Negative	Negative	Negative	
Protein	Negative	Negative	Negative	
Ketones	Negative	2+	Negative	
WBC	0-5	51-130	11-20	WBC can be high in urine due to UTI (Marcin, 2016).
RBC	0-2	3-5	0-2	RBC can be high in urine due to UTI (Marcin, 2016).
Leukoesterase	4.5-11	N/A	N/A	

Arterial Blood Gas 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
pH	7.35-7.45	N/A	N/A	
PaO2	75-100	N/A	N/A	
PaCO2	38-42	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	80-100	N/A	N/A	

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	10-100	N/A	N/A	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Normal	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (APA): Weatherspoon, D. (2017, April 6). Red Blood Cell Count. Retrieved from https://www.healthline.com/health/rbc-count

Smith, L. (2018, November 21). High White Blood Cell Count. Retrieved from https://www.medicalnewstoday.com/articles/315133.php

Lewis, J. L. (2018, September 5). Hypokalemia . Retrieved from https://www.merckmanuals.com/home/hormonal-and-metabolic-disorders/electrolyte-balance/hypokalemia-low-level-of-potassium-in-the-blood

Marcin, J. (2016, July 21). Leukocytes in Urine. Retrieved from https://www.healthline.com/health/leukocytes-in-urine

Diagnostic Imaging

All Other Diagnostic Tests (5 points): None while admitted

Diagnostic Test Correlation (5 points): None while admitted

Diagnostic Test Reference (APA): None

Current Medications (10 points, 1 point per completed med)
10 different medications must be completed

Home Medications (5 required)

Brand/Generic	Famotidine (PEPCID)	Docusate sodium (Colace)	Acetylsalicylic (Aspirin)	N/A	N/A
Dose	20 mg	4100 mg	81 mg	N/A	N/A
Frequency	BID	BID	DAILY	N/A	N/A
Route	ORAL	ORAL	ORAL	N/A	N/A
Classification	Antiulcer Agent	Laxative	Anti-inflammat	N/A	N/A

			ory		
Mechanism of Action	Provide short term treatment of active duodenal ulcer	Acts as a stool softener	Blocks the activity of cyclooxygenase	N/A	N/A
Reason Client Taking	Acid reflux	Constipation	To thin blood	N/A	N/A
Contraindications (2)	Hypersensitivity to famotidine and H2 receptors	Fecal impaction, hypersensitivity to docusate salts	Allergy to tartrazine dye, asthma	N/A	N/A
Side Effects/Adverse Reactions (2)	Anxiety, dizziness	Dizziness, abdominal cramps	Confusion, CNS depression	N/A	N/A
Nursing Considerations (2)	Shake well before use, dilute with normal saline	Assess for laxative abuse, long term use can cause constipation	Do not crush, ask about tinnitus	N/A	N/A
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check electrolytes and do and EKG	Check CMP panel, do a neuro check	Check PT, and do a CMP panel	N/A	N/A
Client Teaching needs (2)	Avoid alcohol, don’t take with another acid reducing product	Do not use when you have abdominal pain, encourage patient to increase fiber	Take a low dose, take with food	N/A	N/A

Hospital Medications (5 required)

Brand/Generic	Calcium carbonate (TUMS)	Carvedilol (Coreg)	Enoxaparin (lovenox)	Lisinopril (Prinivil)	Pravastatin (Pravachol)

Dose	2 tabs (1000mg)	1 tab 12.5mg	40 mg	20 mg	40 mg
Frequency	Every 8 hours PRN	BID	Every 24 hours	Daily	Nightly
Route	oral	oral	Sub cu	oral	oral
Classification	antacid	Nonselective beta blocker	Low molecular weight heparin	antihypertensive	antihyperlipidemic
Mechanism of Action	Increases levels of intracellular and extracellular calcium	Reduces cardiac output	Coagulation inhibitor	May reduce blood pressure	Inhibits cholesterol synthesis in liver
Reason Client Taking	Acid reflux	Heart problems	Heart problems	High blood pressure	Cholesterol problems
Contraindications (2)	Hypercalcemia, renal calculi	Asthma, cardiogenic shock	Active major bleeding, hypersensitivity to heparin	Hypersensitivity to ACE inhibitors, patients with renal impairment	Active hepatic disease, breast feeding
Side Effects/Adverse Reactions (2)	Hypotension, nausea/vomiting	Angina, blurred vision	Confusion, congestive heart failure	Ataxia, dizziness	Blurred vision, anxiety
Nursing Considerations (2)	Store at room temperature, check regular for infiltration	Use continuously, also give digoxin if they have heart failure	Use enoxaparin with extreme caution, don’t give by IM injections	Do not give to patient if they have an MI, use cautiously in patients with fluid volume deficit	Use cautiously in patients with hepatic or renal impairment, report unexplained muscle aches
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check for infiltration often, check electrolytes	Monitor blood glucose, do and EKG	Do an EKG, monitor for DVT	Monitor patients blood pressure, check CMP panel	Monitor patients BUN, monitor liver enzymes
Client Teaching needs (2)	Drink a glass of water	Swallow the whole	Notify provider if	Take at the same time	Take drug at bedtime, do

	after taking medication, store at room temperature	capsule, if they have heart failure tell doctor if they gain more than 5 pounds.	bleeding, teach patient to give shots properly at home	every day, avoid hazardous activity	not stop taking without consulting a doctor

Medications Reference (APA):

Jones, & Bartlett. (2018). *Nurse's Drug Handbook* (7th ed.). Burlington, MA: Jones & Bartlett

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** alert **Orientation:** orient **Distress:** no distress **Overall appearance:** clean	Patient was alert and orient, clean overall appearance, no distress, occasionally gets confused due the dementia
INTEGUMENTARY (2 points): **Skin color:** white **Character:** dry **Temperature:** 97.0 F **Turgor:** normal **Rashes:** none **Bruises:** none **Wounds:** redness on the tailbone **Braden Score:** 15 **Drains present:** **Y☐** **N ☒** **Type:**	Skin color is white and dry, has a temperature of 97.0 F, skin turgor is normal and quick, has no rashes and has no bruises, has some redness on the tailbones due to laying on her back for too long without getting up, she is now turn Q2, Braden score is 15, no drains are present
HEENT (1 point): **Head/Neck:** normocephalic, clean **Ears:** pearly grey TM, auricle is pink **Eyes:** PERRLA **Nose:** no deviated septum **Teeth:** clean and white	Head and neck: normocephalic, clean appearance, small cut on the head due to falling at home. Ears: pearly grey TM, pink auricle Eyes: PERRLA Nose: no deviated septum or turbinate's present Teeth: clean and white .

CARDIOVASCULAR (2 points): **Heart sounds:** clear **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** normal **Peripheral Pulses:** 2+ **Capillary refill:** less than 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	Heart sounds are clear, S1 and S2 are clear, no S3 or S4 is applicable as well as no murmur is present, 2+ peripheral pulses, capillary refill is less than 3 seconds, no edema or neck vein distention is present
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Lung sounds are clear, no wheezing or rhonchi is present, no accessory muscles are used
GASTROINTESTINAL (2 points): **Diet at home:** normal **Current Diet** Normal **Height:** 5 feet **Weight:** 140 Ibs **Auscultation Bowel sounds:** active **Last BM:** last night **Palpation: Pain, Mass etc.:** no pain **Inspection:** **Distention:** No **Incisions:** No **Scars:** No **Drains:** No **Wounds:** redness on the tailbone **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Diet at home is normal, current diet at the hospital is normal, height is 5 feet and the patient weighs 140 pounds, bowel signs were active, no pain in the abdomen during palpitations, no masses were present, no distention or incisions, no scars or any drains, has redness on tailbone, no ostomy, no NG tube, no feeding tube
GENITOURINARY (2 Points): **Color:** yellow **Character:** cloudy **Quantity of urine:** 1,070 **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine was yellow and slightly cloudy; quantity was close to 1,070. No pain during urination, no dialysis, genitals were pink. No wounds, had no catheter

MUSCULOSKELETAL (2 points): **Neurovascular status:** grossly intact **ROM:** yes **Supportive devices:** uses a walker **Strength:** weak **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 37 **Activity/Mobility Status:** needs assistance **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☒ **Needs support to stand and walk**☒	Neuro status is grossly intact, had ROM, needs to use a walker to get around, strength is fairly weak, is at a fall risk, fall score is 37, can't get up and walk without a walker and assistance, needs help with ADL's
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** alert and orient **Mental Status:** stable **Speech:** slurred **Sensory:** normal **LOC:** orient	MAEW, PERLLA, equal strength in all extremities even though the patient is still weak, patient is alert and orient, speech is a little slurred, mental status is stable
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** talks to family **Developmental level:** high school degree **Religion & what it means to pt.:** catholic **Personal/Family Data (Think about home environment, family structure, and available family support):** husband passed away	Patient has a high school diploma, husband passed away, she lives at a nursing home, patient is catholic, patient talks to family when needs to cope

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0818	62	115/67	16	98.9 F	97 room air
1100	63	120/70	17	98.0 F	98 room air

Vital Sign Trends: they stayed with in normal limits during my clinical rotation

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	0	0	0	0	0
1100	0	0	0	0	0

Patient had no pain while my clinical rotation

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	No IV during my clinical rotation

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1,070	1,050

Nursing Care

Summary of Care (2 points)

Overview of care: patient has no pain, stable vitals, and doesn't want her meds, she states she is ready to leave

Procedures/testing done: CT done on her head, it was clear

Complaints/Issues: no complaints, patient had no pain

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: normal diet, tolerating well

Physician notifications: needs assistance with walking and getting up

Future plans for patient: be discharged to the nursing home

Discharge Planning (2 points)

Discharge location: Illini Heritage Home

Home health needs (if applicable): needs help with ADL's

Equipment needs (if applicable): walker and assistance getting up

Follow up plan: make sure the patient has month follow up appointments

Education needs: needs to know she can get up on her own, needs assistance on ADL's

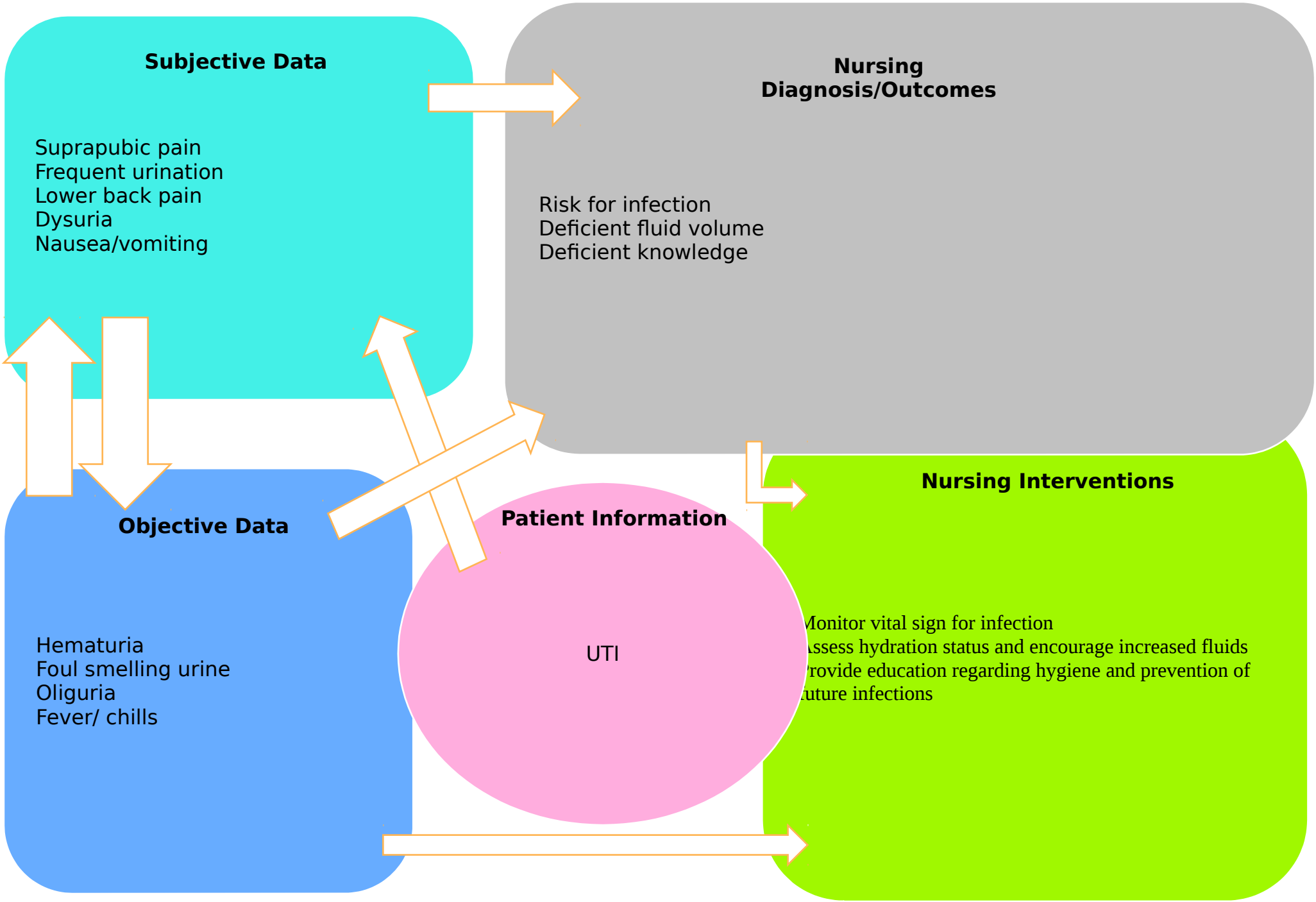
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk of Falls	She can not stand or walk by herself	1.Put bed alarm on **2.**Keep the bed all the way down	Puts the call light on if she needs to get up
2. Risk for impaired skin integrity	She can't roll over on her own	**1.** turn every 2 hours 2.Put a skin barrier on	The redness on her tailbone went away with turning and skin barrier ointments
3. Urinary incontinence, reflex	She must wear a depends because she can't hold her urine	**1.**use a depends to help prevent mess **2**medication	Wears a depends and tries to let us know when she must go to the bathroom
4. Imbalanced nutrition; less than body	She will not eat all her food	**1.**offer liquid energy supplements	Tries to eat in the morning and a small meal at night

requirements		**2.** determine time of day when the patterns appetite is at peak	

Other References (APA): Vera, M. (2019, February 3). NANDA Nursing Diagnosis . Retrieved from https://nurseslabs.com/nursing-diagnosis/

Concept Map (20 Points):


Subjective Data
Suprapubic pain
Frequent urination
Lower back pain
Dysuria
Nausea/vomiting
Nursing Diagnosis/Outcomes
Risk for infection
Deficient fluid volume
Deficient knowledge
Objective Data
Hematuria
Foul smelling urine
Oliguria
Fever/ chills
Patient Information
UTI
Nursing Interventions
Monitor vital sign for infection
ssess hydration status and encourage increased fluids
rovide education regarding hygiene and prevention of
uture infections