N321 Care Plan #1

Lakeview College of Nursing

Delaney Lockard

Demographics (3 points)

Date of Admission 9/5/19	**Patient Initials** DLH	**Age** 69 years old	**Gender** Male
Race/Ethnicity White/Caucasian	**Occupation** Retired	**Marital Status** Married	**Allergies** Victoza, Sulfa
Code Status Full code	**Height** 183 cm	**Weight** 105.3 kg	

Medical History (5 Points)

Past Medical History: CAD, CHF, COPD, cataract, diabetes mellitus, hypertension, dyspnea, history of seizures, Parkinson's disease, atrial fibrillation, GERD, obesity

Past Surgical History: Cataract surgery, total knee replacement, total hip replacement, implantation of a pacemaker, insertion of a cardiac catheter, application of a neurostimulator (no date noted for any of these)

Family History: History of maternal side with hypertension, sibling with hypertension and diabetes mellitus

Social History (tobacco/alcohol/drugs): former smoker (40 years ago), denies use of alcohol and/or substances

Assistive Devices: CPAP, BiPAP, walker and cane

Living Situation: Lives with spouse at home

Education Level: Some college

Admission Assessment

Chief Complaint (2 points): "low blood pressure"

History of present Illness (10 points): Patient had surgery in June 2019 to put a lead in his pacemaker. Since then, he has had trouble with hypotension along with lethargy. On 9/3/19,

patient went to his PCP and had the following labs ordered and drawn; hemoglobin A1C, CMP, CBC, and urinalysis. On Thursday 9/5/19, the patient went back to his PCP. He was very confused with a LOC of 2. His BP was 89/50. The PCP also informed the patient and his wife that his creatinine was low in the lab results. His PCP advised him to be admitted to SBL. On 9/5/19, he was admitted into the ED for treatment of his hypotension and low creatinine levels. Dr. Deal was assigned to this patient for further care.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Hypotension

Secondary Diagnosis (if applicable): Decreased PO intake, lethargy and CHF

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

Low blood pressure is when blood pressure is lower than 90/60 mm Hg. This may happen in the human body for many reasons, acute and chronic. A number of systems feed into blood pressure and can cause this to sway from the normal blood pressure of 120/80 mm Hg. Patients with Parkinson's disease, for example, can have low blood pressure, also known as hypotension. NHBLI states that "older adults are also more likely to develop low blood pressure as a side effect of medicines taken to control high blood pressure.

Pathophysiology References (2) (APA):

NHBLI. (n.d.). Low Blood Pressure. Retrieved from https://www.nhlbi.nih.gov/health-topics/low-blood-pressure

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value (taken on 9/6)	Today's Value	Reason for Abnormal Value
RBC	4.5-6	3.79	3.3	
Hgb	14-16	10.5	9.3	
Hct	35-47	32.1	28.6	
Platelets	150-400	233	191	N/A
WBC	4500-11000	5,000	8,300	N/A
Neutrophils	45-75%	56.2	71.3	N/A
Lymphocytes	20-40%	32.3	17.8	N/A
Monocytes	1-10%	8.8	8.1	N/A
Eosinophils	< 7%	1.9	2.5	N/A
Basophils	< 3%	0.8	0.5	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 (taken 9/6)	Today's Value (9/8)	Reason For Abnormal
Na-	135-145	142	143	N/A
K+	3.5	3.8	4.3	N/A
Cl-	97-107	107	112	
CO2	20-30	27	26	N/A
Glucose	70-110	121	128	
BUN	10-20	52	16	

Creatinine	0.6-1.3	1.95	1.42	
Albumin	3.5-5.2	3.8	N/A	N/A
Calcium	8.6-10.2	8.4	8.3	
Mag	1.6-2.4	N/A	N/A	N/A
Phosphate	3.0-4.5	N/A	N/A	N/A
Bilirubin	0.1-1.2	0.5	N/A	N/A
Alk Phos	30-120	65	N/A	N/A
AST	10-30	13	N/A	N/A
ALT	10-40	< 5	N/A	N/A
Amylase	56-90	N/A	N/A	N/A
Lipase	0-110	N/A	N/A	N/A
Lactic Acid	0.5-1	N/A	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	2-4	N/A	N/A	N/A
PT	9.6-11.8	N/A	N/A	N/A
PTT	30-40	N/A	N/A	N/A
D-Dimer	< or = 250	N/A	N/A	N/A
BNP	< 125	N/A	N/A	N/A

HDL	> 60	N/A	N/A	N/A
LDL	< 130	N/A	N/A	N/A
Cholesterol	< 200	N/A	N/A	N/A
Triglycerides	< 150	N/A	N/A	N/A
Hgb A1c	< 7%	N/A	N/A	N/A
TSH	0.4-4.0	N/A	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 (9/8)	Reason for Abnormal
Color & Clarity	**Clear-slightly hazy / straw to dark yellow**	N/A	Yellow, hazy	
pH	**4.5-8**	N/A	6.0	
Specific Gravity	**1.005-1.035**	N/A	1.019	
Glucose	**None**	N/A	50	
Protein	**None**	N/A	1+	
Ketones	**None**	N/A	Negative	
WBC	**None/rare**	N/A	11	
RBC	**None/rare**	N/A	Negative	
Leukoesterase	**None**	N/A	1+	

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 (9/8)	Explanation of Findings
Urine Culture	Negative	N/A	Positive	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Echocardiogram, Ejection fraction of 39%

Diagnostic Test Correlation (5 points): Congestive heart failure

Diagnostic Test Reference (APA):

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

Home Medications (5 required)

Brand/Generic	Ondansetron hydrochloride/ Zofran	Gabapentin/ Gralise	Lamotrigine/ Lamictal	Magnesium oxide/Mag-OX	Metoprolol succinate/Lopressor
Dose	4 mg tablet	600 mg tablet	200 mg tablet	400 mg tablet	25 mg tablet
Frequency	1x daily	HS	1x daily	1x daily	1x daily

Route	PO	PO	PO	PO	PO
Classification	Antiemetic	Anticonvulsant	Anticonvulsant, mood stabilizer	Antacid, anticonvulsant, antiarrhythmic, laxative, electrolyte replacement	Antianginal, antihypertensive, MI prophylaxis and treatment
Mechanism of Action	Blocks serotonin receptors in chemoreceptor trigger zone and at vagal nerve terminals in intestine. This reduces nausea and vomiting.	Structurally like GABA in the brain. GABA inhibits the rapid firing of neurons associated with seizures.	Blocks release of neurotransmitters, lamotrigine inhibits the spread of seizure activity in brain.	Assists all enzymes involved in ATP. Magnesium is required for normal function of ATP-dependent sodium-potassium pump.	Inhibits stimulation of beta-receptor sites, mainly in the heart, resulting in decreased cardiac excitability, cardiac output and myocardial oxygen demand
Reason Client Taking	Tx nausea	Tx seizures	Tx seizures	Tx hypertension	Tx hypertension
Contraindications (2)	Hypersensitivity to ondansetron, use of apomorphine at same time	Hypersensitivity to gabapentin or components	Hypersensitivity to lamotrigine or components	Hypersensitivity to magnesium salts or any components	Acute heart failure, pulse less than 60 per minute
Side Effects/Adverse Reactions (2)	Dizziness, diarrhea	Agitation, hypotension	Amnesia, chest pain	Confusion, hypotension	Anxiety, confusion
Nursing Considerations (2)	Hypokalemia/ hypomagnesia is present, treat these before administering Monitor for s/ s of hypersensitivity to ondansetron	Gabapentin capsules can be opened and mixed with applesauce, pudding, etc. Monitor patient for suicidal thinking or	Monitor patient for suicidal thoughts/behavior Monitor patient for seizure activity	Monitor serum electrolyte levels in patients with renal insufficiency Make sure pt chews all of the tablet	Use cautiously in patients with hypertension who have CHF because the beta blockers such as metoprolol can worsen heart failure

		behavior			

Hospital Medications (5 required)

Brand/Generic					
Dose					
Frequency					
Route					
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations (2)					

Medications Reference (APA):

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient appeared to be in and out of sleep in his chair. He appears tired with an A&O x3. Patient is not in pain or distress. Overall appearance x3.
INTEGUMENTARY (2 points): **Skin color: Normal for ethnic** **Character: dry** **Temperature: 36.4** **Turgor: Loose** **Rashes: None** **Bruises: None** **Wounds: None** **Braden Score: 19** **Drains present: Y☐ N ☐** **Type: N/A**	**Patient is Caucasian and presents a fair skin tone. Skin is warm to touch with a normal elasticity. Skin turgor is loose. No rashes or bruises, wrinkles are on face and neck.** **Braden scale: 19**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Patient's head is midline with no deviations. Ears show no abnormal drainage; the tympanic membrane is visible and pearly grey. Hair is a grey color, longer length, and balding in the center. PEERLA is noted. Nose shows the turbinates equal bilaterally. Oral mucosa is pink and moist with no abnormalities. Patient uses glasses.**
CARDIOVASCULAR (2 points): **Heart sounds:**	**Patient is not currently on telemetry. Heart sounds auscultated and S1 and S2 sounds**

S1, S2, S3, S4, murmur etc. **Cardiac rhythm (if applicable):** **Peripheral Pulses: 2+** **Capillary refill: < 3 seconds** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema: N/A**	**noted. Pulses graded at 2+ and present bilaterally. Capillary refill was < 3 seconds. Patient does not currently have edema. No signs of neck vein distention.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**No accessory muscle use when breathing. Patient denies SOB. Anterior lungs were auscultated. Lung sounds clear. Patient doesn't use oxygen at home.**
GASTROINTESTINAL (2 points): **Diet at home: regular** **Current Diet: regular** **Height: 183 cm** **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:**	.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	
MUSCULOSKELETAL (2 points): **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 (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
.					

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

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:**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

Nursing Care

Summary of Care (2 points)

Overview of care:

Procedures/testing done:

Complaints/Issues:

Vital signs (stable/unstable):

Tolerating diet, activity, etc.:

Physician notifications:

Future plans for patient:

Discharge Planning (2 points)

Discharge location:

Home health needs (if applicable):

Equipment needs (if applicable):

Follow up plan:

Education needs:

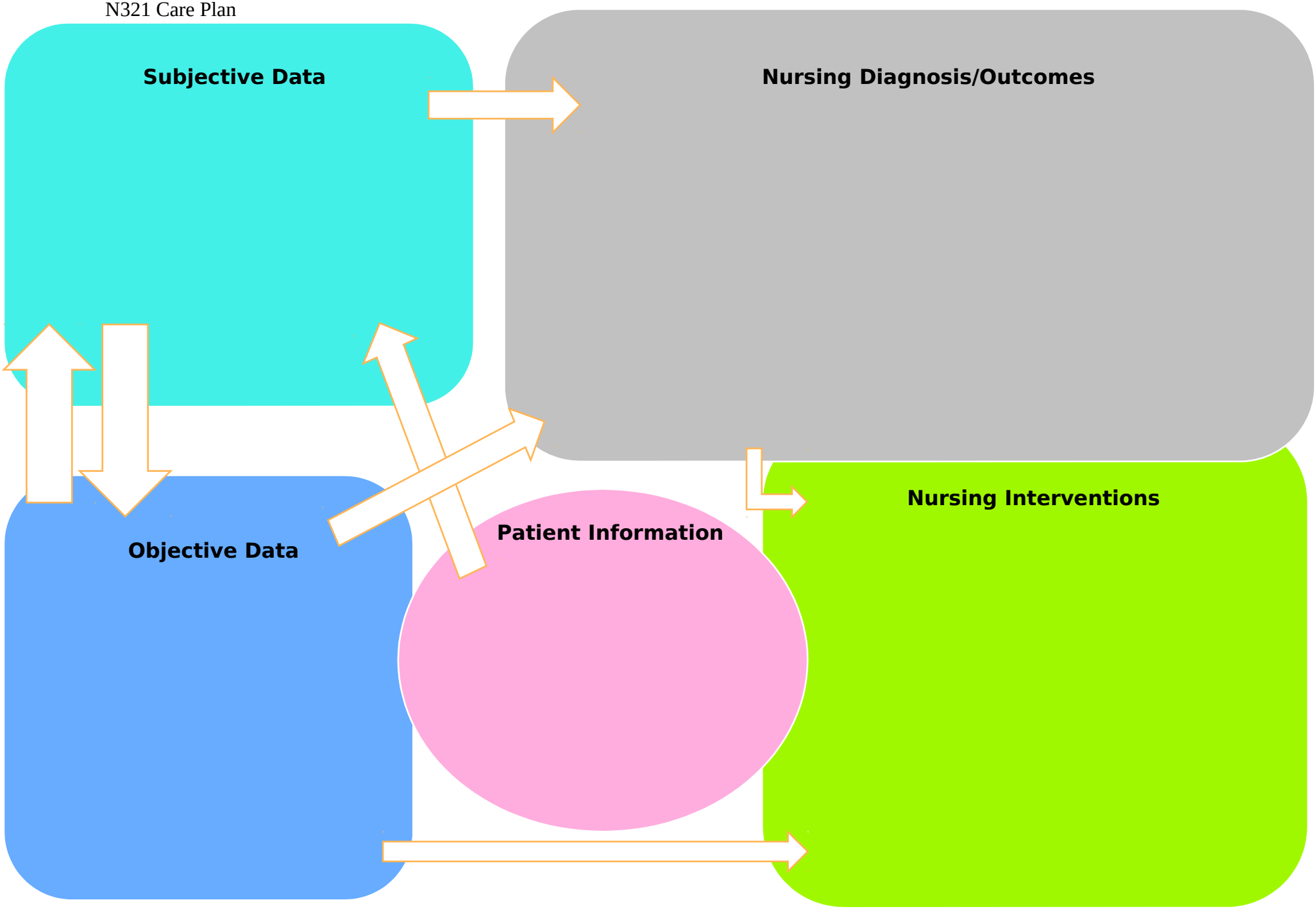
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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.		**1.** **2.**	
2.		**1.** **2.**	
3.		**1.** **2.**	

Other References (APA):

Concept Map (20 Points):

N321 Care Plan



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