

N311 Care Plan #1

Lakeview College of Nursing

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Demographics (5 points)

Date of Admission 9/16/2019	Patient Initials SC	Age 60	Gender M
Race/Ethnicity Caucasian	Occupation Factory	Marital Status Married	Allergies Amoxicillin, codeine, contrast media iodine based
Code Status DNR	Height 66in	Weight 95.5kg (210lbs)	

Medical History (5 Points)

Past Medical History: Bipolar disorder, anxiety disorder, GERD, cirrhosis of liver, hepatic failure, muscle weakness, opioid dependence, depressive disorder

Past Surgical History: Surgical scar was found on lower mid-abdomen, patient gave no clear answer

Family History: Patient gave no clear answer

Social History (tobacco/alcohol/drugs): Patient did not provide an answer

Admission Assessment

Chief Complaint (2 points): high ammonia levels

History of present Illness (10 points): Patient states that he has been in the nursing home facility for 6 months due to high ammonia levels. Patients was confused during physical assessment. Patient had no pain.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Cirrhosis of the liver

Secondary Diagnosis (if applicable): Hepatic failure without coma

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

Pathophysiology of Cirrhosis of the Liver

The progression of cirrhosis happens over several years. The liver goes through physical changes which results in function failure. The injury that is being done to the liver causes the activation of stellate cells, cells that produce the extracellular matrix of the liver. The increase in architectural changes and liver density is caused by collagen infiltration. Portal hypertension is a key give away of cirrhosis. Portal hypertension is caused by elevated blood pressure in the portal vein. The portal vein drains the venous circulation from the intestine, spleen, pancreas, stomach, and esophagus. When cirrhosis is at its beginning stages, large veins develop collateral branches that helps decrease the pressure in the portal vein. As cirrhosis progress into its later stages, the pressure in the portal vein increases again causing backup of pressure to the GI veins and collaterals. This increase in venous pressure eventually causes splenomegaly, esophageal varices, rectal varices, and ascites. Cirrhosis also causes decreased detoxification capability and may cause patients to experience the toxic effects of drugs due to lack of liver metabolism. Decreased detoxification capability may also cause an increase nitrogenous wastes to accumulate in the blood, i.e. high ammonia levels. Cirrhosis also puts the patient at risk to decreased bile synthesis and decreased albumin synthesis both play a key role in digestion. Bile enables the individual to digest fats; albumin is a protein produced in the liver that responsible for maintaining intravascular colloid osmotic pressure (COP). Unbalanced COP causes fluid to leak out which may cause edema, known as ascites. Cirrhosis also causes the inability to process bilirubin which builds up in the bloodstream and causes jaundice of skin and sclera known as hyperbilirubinemia. Cirrhosis also causes bleeding of esophageal varices meaning that the esophageal veins become distended and evolve into fragile varicose veins that rupture easily and bleed. The patient can also exhibit spontaneous bruising and nosebleeds because of the lack of

synthesis of coagulation factors because of thrombocytopenia. Malabsorption of vitamin D and decreased calcium ingestion also causes patients to develop osteoporosis when developing cirrhosis of the liver. Furthermore, everything prior can also cause hepatic encephalopathy which causes alterations in mental status and cognitive functions. Patients also can become confused and have a personality change with the development of asterixis, a flapping tremor of the hands.

Signs and symptoms

Patients developing cirrhosis of the liver usually show a handful of signs and symptoms ranging from fatigue to anorexia. The skin also shows a lot of signs such as jaundice, finger clubbing, and spider angiomas. Muscle atrophy and ascites, sign of portal hypertension, are very common signs because of protein loss. Hair loss in places like the axillary and pubic regions manifest in both men and women. In males, gynecomastia and impotency may occur.

Diagnosis

Lab test may seem normal in the beginning stages of the manifestation of cirrhosis, but there are signs that may give away the presence of cirrhosis. Thrombocytopenia is one major give away because of hypersplenism of portal hypertension as well as the signs of jaundice because on increased bilirubin in the blood. Liver enzymes will also show elevated numbers in lab results. Loss of blood through bleeding of esophageal varices may also cause the patient to become anemic.

Treatment

Discontinued consumption of alcohol is the first go to treatment for patients with cirrhosis. Adapting good nutrition and management of cirrhosis symptoms. Anti-inflammatory drugs can be used as well. Liver transplant is the only way to get rid of cirrhosis.

Pathophysiology References (2) (APA):

Capriotti, T., Frizzell, J. P., & undefined, undefined undefined. (2016). 31. In *Pathophysiology: introductory concepts and clinical perspectives* (pp. 716–719). Philadelphia: F.A. Davis Company.

Laboratory Data (20 points)

If laboratory data is unavailable, values will be assigned by the clinical instructor

CBC **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 Value
RBC				
Hgb				
Hct				
Platelets				
WBC				
Neutrophils				
Lymphocytes				
Monocytes				
Eosinophils				
Bands				

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-				
K+				
Cl-				

CO2				
Glucose				
BUN				
Creatinine				
Albumin				
Calcium				
Mag				
Phosphate				
Bilirubin				
Alk Phos				

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				
pH				
Specific Gravity				
Glucose				
Protein				
Ketones				
WBC				
RBC				

Leukoesterase				
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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				
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Current Medications (10 points, 2 points per completed med)

5 different medications must be completed

Medications (5 required)

Brand/Generic	Topamax/ Topiramate	Celexa/ Citalopram hydrobromide	Prilosec/ Omeprazole	Prinivil/ Lisinopril	Advil/ Ibuprofen
Dose	50mg	10mg	40mg	20mg	200mg
Frequency	1x per day	1x per day	1x per day	2x per day	PRN; every 4 hours
Route	Oral	Oral	Oral	Oral	oral
Classification	Anticonvulsant	Antidepressant	Antiulcer	Vasodilator	Antipyretic
Mechanism of Action	May block the spread of seizures by reducing the length and frequency of excitatory transmission.	Blocks serotonin reuptake by adrenergic nerves, which normally release this neurotransmitter from their storage sites when activated by a nerve impulse.	Interferes with gastric acid secretion by inhibiting the hydrogen potassium adenosine triphosphate enzyme system or proton pump, in gastric parietal cells.	May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II.	Antipyretic action probably stems from its effect on the hypothalamus, which increases peripheral blood flow, causing vasodilation and encouraging heat dissipation..
Reason Client Taking	Bipolar disorder	Depression	GERD	Hypertension	Fever
Contraindications (2)	Hypersensitivity to Topiramate; metabolic acidosis with concurrent metformin use	Congenital long QT syndrome; hypersensitivity to citalopram or its components	Hypersensitivity to omega 3-carboxylic acids or its components	Current aliskiren use in patients with diabetes or patients with renal impairment; hereditary or idiopathic angioedema	Angioedema; asthma
Side Effects/Adverse	Fatigue; headache	Anaphylaxis; angioedema	Fatigue; diarrhea	Anaphylaxis; ; angioedema	Anaphylaxis; angioedema

Reactions (2)					
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Medications Reference (APA):

Jones & Barlett Learning. (2019). *Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Patient is alert and oriented with no signs of distress. Patient's appearance is taken care of.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Patient's skin is warm with normal color. Turgor of the skin indicates that the patient is well hydrated. No rash or wounds that was found but there was bruising on the left lower quadrant of the patient's abdomen.
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	The lymph nodes of the patient were not palpated during the examination. PERRLA test was performed to examine the eyes which resulted in healthy eyes. Patient's tympanic membranes were intact and gray. The Nose showed a pink color with no drainage. The patient had no teeth and the tongue was normal in size and color.
CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	S1 and S2 were heard using the 5 locations: Aortic, Pulmonic, Tricuspid, Erb, and Mitral. Peripheral pulses had consistent rhythm, tested with radial and ulnar pulses. Patient's capillary refill was good. There was no neck vein distention or edema.

Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:	
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character	Breath sounds normal.
GASTROINTESTINAL: Diet at home: Current Diet Height: 66 inches Weight: 95.5 kg Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Patient has a regular soft diet. Abdomen was auscultated for bowel sounds; normal bowel sounds were heard. Abdomen was palpated and there was no sign of pain, discomfort, wounds, or drains. However, the patient had a surgical scar that started at the base of the naval and down the abdomen. The patient did not have an ostomy bag, nasogastric tube, or feeding tubes.
GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:	Patient did not express any discomfort while voiding. Patient does not use a catheter.
MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status:	Patient can perform active range of motion. Patient moves independently with no assistive devices being used, but needs assistance to stand up. Patient does require assistance for some activities of daily living such as pericare and donning of clothes. Patient can eat on their own with no assistance needed. Patient loses balance occasionally, which may put them at a slight fall risk.

Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/>	
NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:	Patient moves all extremities well. The Pupils were even, round, reactive to light, and accommodates for the other. The strength in the arms and legs were equal to the other. Patient is somewhat oriented with a little confusion. Patient can communicate with others with appropriate responses.
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):	

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0805	64bpm	128/84 mm Hg	14 rr	99.7 F	97%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions

**Patient reported of no pain at time of assessment

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
20mL (combined) water and OJ	

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

Nursing Diagnosis <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	Rational <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Intervention (2 per dx)	Evaluation <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for fall as evidenced by unsteady gait	Patient walks in an unsteady way and could trip easily	1.Assistance with walking 2.Impliment the use of assistive devices	Desired outcome is for patient to be able to walk independently in a safe manner.
2. Potential Delirium as evidenced by “I came here for high ammonia levels”	Cirrhosis causes nitrogenous gas build up	1. Have the patient demonstrate signature daily 2.Perform a baseline assessment of the pt’s personality characteristics, LOC, and orientation. Enlist aid of the pt’s significant others to help determine slight changes in personality or behavior	Desired outcome is for the patient to be able to verbalize orientation to person, place and time; exhibits intact signature

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. St. Louis, MO: Elsevier.

Concept Map (20 Points):

Subjective Data

Patient gave no data

Nursing Diagnosis/Outcomes

- Risk for falls
1. Risk for fall as evidenced by unsteady gait
 2. Potential for Delirium as evidenced "I'm here for high ammonia levels"

Objective Data

Pulse: 64bpm
BP: 128/84 mm Hg
Resp Rate: 14 rr
Temp 99.7 F
Oxygen: 97%

Patient Information

Date of admission: 9/16/2019
Initials: SC
Age: 60
Gender: M
Race: Caucasian
Occupation: Factory
Marital status: Married
Code: DNR
Height: 66in
Weight: 95.5kg

Nursing Interventions

1. Assistance with walking
2. Implement the use of assistive devices
 1. Have the patient demonstrate signature daily
 2. Perform a baseline assessment of the pt's personality characteristics, LOC, and orientation. Enlist aid of the pt's significant others to help determine slight changes in personality or behavior
- 3.

