N311 Care Plan #

Lakeview College of Nursing

Name

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
11/27/2015	C.W.	91	**F**
Race/Ethnicity White	**Occupation** Housewife	**Marital Status** Widowed	**Allergies** amoxicillin, clarithromycin, hydromorphone, morphine, quinine
Code Status DNR	**Height** **59 inches**	**Weight** **116.1 lbs**	

Medical History (5 Points)

Past Medical History: CFH, RLS, Pulmonary HTN, GERD, A-fib, allergic rhinitis, anemia, atherosclerosis, HTN, Depression, Osteoathritis, Hypothyroidism, and altered mental status

Past Surgical History: Stitches in the head twice due to falls, stitches on upper right thigh, appendix removed

Family History: N/A

Social History (tobacco/alcohol/drugs): Never has participated in any drugs/alcohol/tobacco

Admission Assessment

Chief Complaint (2 points): No bowel movement

History of present Illness (10 points):. Illness started this morning. The location of pain is in the abdominal area. Patient states "I was born with it". Tends to have cramps and has association with back pain. Patient is treating the pain with Tylenol which seems to relieve the pain. Patient stated a 5 out of 10 pain.

Primary Diagnosis

Primary Diagnosis on Admission (3 points):.Chronic Obstruction Pulmonary Disease

Secondary Diagnosis (if applicable):.Parkinson's

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

Chronic obstructive pulmonary disease involves bronchitis, a hyperactive airway and bronchitis. This disease is due to a weak airflow. Usual causes of this disease is from smoking. This would connect with our patient's history from being around secondhand smoke during her childhood.

Parkinson's disease is a disease that is neurodegenerative. The etiology is unknown for parkinsons. Genetics can play a huge role in risk factors as well as age. Signs can be nonexistent until a certain percent has been affected.

Pathophysiology References (2) (APA):

1. **Capriotti, T., Frizzell, J.P. (2016) Chronic Obstructive Pulmonary Disease. In *Pathophysiology: Introductory concepts and clinical perspectives* (pp. 466-470). Philadelphia: F.A. Davis Company.**
2. **Capriotti, T., Frizzell, J.P. (2016) Parkinson's Disease. In *Pathophysiology: Introductory concepts and clinical perspectives* (pp. 781-783). 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				

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 <u>different</u> medications must be completed

Medications (5 required)

Brand/Generic	Coumadin	Colace	Carbidopo	Toprol XL	Tessalon

	(Warfarin sodium)	Capsule (Docusate Sodium)	Levidopa Sinemet	ER 24hr (Metoprolol Succinate)	Perles Capsule (Benzonate)
Dose	3mg/4mg	100mg	25-100mg	100mg	100mg
Frequency	QD (T, Th, S, S)/ QD (M, W, F)	QD	TID	QD	QAH PRN
Route	PO/PO	PO	PO	PO	PO
Classification	anticoagulant	laxative	central nervous agent	antianginal	non-narcotic antitussive
Mechanism of Action	Interfere's with liver's ability to synthesize vitamin k-dependant clotting factors.	softens stool by decreasing surface tension between oil and water in feces.	arobic amino acid andamino acid decarboxylation	inhibits stimulation of beta reeptor sites	anesthetizes stretch receptors in respiraory tract, lung tissue, and pleura interfering with their activity and reducing cough reflex.
Reason Client Taking	**A-fib/ A-fib**	Constipation	Parkinsons Tremors	Hypertension	Cough
Contraindications (2)	bleeding and blood dyscrasias	fecal impaction, nausea	hypersensitivity and narrowing angle glaucoma	acute heart failure, shock	hypersensitivity to benzonatate and related compounds
Side	coma,	dizziness,	dyskinesia	anxiety,	confusio

Effects/Adverse Reactions (2)	weakness	palpitations	s and nausea	confusion	n, hallucinations

Medications Reference (APA):

1. Jones & Bartlett Learning. (2019). 2019 Nurses drug handbook. Burlington, MA.

2. Sinemet (Carbidopa-Levodopa): Side Effects, Interactions, Warning, Dosage & Uses. (n.d.). Retrieved September 29, 2019, from https://www.rxlist.com/sinemet-drug.htm#side_effects.

Assessment

Physical Exam (18 points)

GENERAL: **Alertness: Good** **Orientation: Good** **Distress: None** **Overall appearance: Groomed/ healthy**	(X3) Patient was alert and and showed no signs of distress. Overall appearance was healthy and groomed.
INTEGUMENTARY: **Skin color: normal** **Character: normal** **Temperature: warm** **Turgor: Good** **Rashes: none** **Bruises: none** **Wounds:** .none **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	**Skin color was normal and warm to touch. There were no signs of rashes, bruises, or wounds.**

HEENT: **Head/Neck: Normal** **Ears: Hearing aide** **Eyes: Normal** **Nose: Normal** **Teeth: Dentures**	Patient had no abnormalities. Hygiene is up to standard. **Patient had no abnormalities. Hearing aides are needed. Patient has glasses but states she does not need them. Dentures are needed for chewing.**
CARDIOVASCULAR: **Heart sounds: Regular** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 56** **Capillary refill: Good** **Neck Vein Distention: Y ☐ N: X** **Edema Y: X N ☐** **Location of Edema:** Edema was located in the left ankle.	Heart sounds are regular as well as cardiac rhythm. Peripheral pulse is 56 bpm. Capillary refill is normal. There is slight edema in the left ankle.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**Patient's breathing is normal.**
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height: 59 inches** **Weight: 116.1 lbs** **Auscultation Bowel sounds: Present** **Last BM: Yesterday** **Palpation: Pain, Mass etc.: soft, no pain or masses** **Inspection:** **Distention: none** **Incisions: none** **Scars: none** **Drains: none** **Wounds: none** **Ostomy: Y ☐ N: X** **Nasogastric: Y ☐ N: X** **Size:** **Feeding tubes/PEG tube Y ☐ N: X** **Type:**	**Patient is on a "no added salt and regular texture diet". Last bowel movement was yesterday. Bowel sounds are present. Palpation is soft with no pain nor masses. Upon inspection there is no distention, incisions, scars, drains, or wounds.**

GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM: Active range of motion** **Supportive devices: wheelchair, walker** **Strength: equal bilaterally** **ADL Assistance: Y: X N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient has active range of motion. Needs supportive devices such as a walker and wheel chair. Strength is equal bilaterally. Does not need assistance with equipment.
NEUROLOGICAL: **MAEW: Y: X N☐** **PERLA: Y: X N☐** **Strength Equal: Y: X N ☐ if no - Legs ☐ Arms ☐ Both: X** **Orientation: Normal** **Mental Status: Normal** **Speech: slow** **Sensory: hearing aide, glasses** **LOC: Alert**	**Moves all extremities. Pupils are equal, react to light, and accommodate. Strength in extremities are equal. Patient is alert.**
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Christian** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Has a supportive family including her daughters and son who live close by. Dad and half-brother smoke and drank when she was younger.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

11:40am	62	120/52	20	97.9	97

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:40am	5/10	abdominal area	5	cramps	Tylenol

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

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

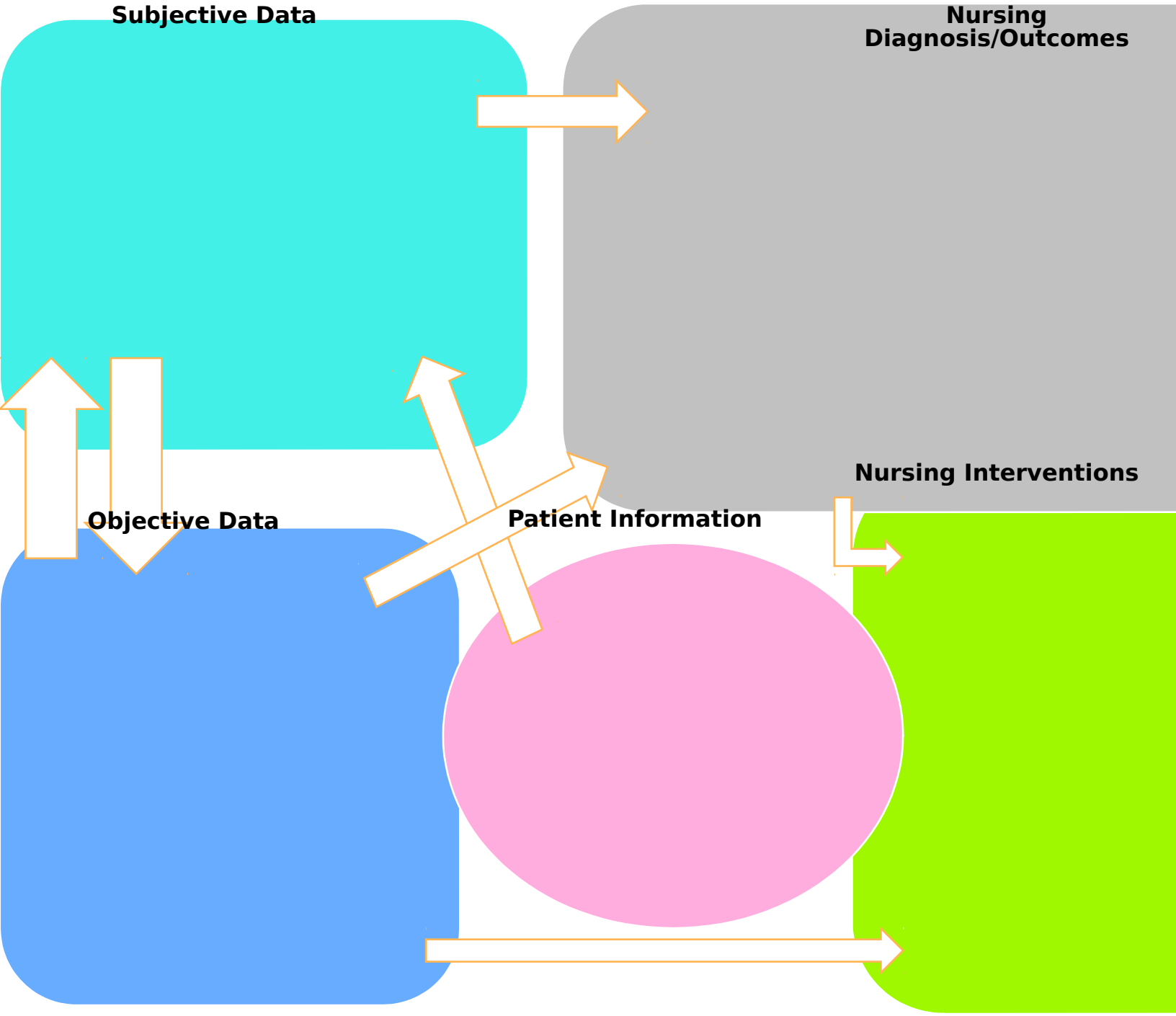
Nursing Diagnosis ● Include full nursing diagnosis with "related to" and "as evidenced by" components	Rational ● Explain why the nursing diagnosis was chosen	Intervention (2 per dx)	Evaluation ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Patient has COPD evidence by symptoms and family history	**Diagnoses was chosen due to symptoms and environmental exposure**	**1. assess respiratory status** **2. ascultate breaths**	**Unknown**
2. Patient was diagnosed	**This is an easy a noninvasive way**	**1. teach patient to walk with a wide**	**Patient is able to ambulate without**

based on physical assessment	**to determine this diagnoses**	**arc** **2. Have the patient remain a wide base gait**	**assistance.**

Other References (APA):

1. **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
Nursing
Diagnosis/Outcomes
Nursing Interventions
Objective Data
Patient Information

Subjective data: Abdominal pain, no bowel movement

objective data: pulse: 62, BP: 120/52, Resp rate: 20, Temp: 97.9, Oxygen: 94

Intervention: exercise, drink more fluids, increase fiber intake

Diagnosis/Outcome: Constipation; hope to have a bowel movement

Patient Information: 91 year old patient with three surgeries (2 for head, 1 for leg). Patient is alert.