

N311 Care Plan #1

Lakeview College of Nursing

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Demographics

Date of Admission 9/4/19	Patient Initials SF	Age 93	Gender Female
Race/Ethnicity White	Occupation Retired typist/ band member	Marital Status married	Allergies Adhesive tape, Dyazide, Inderal, Keflex, Tetanus & Toxoid Valium
Code Status Full code	Height 4'11" (59")	Weight 95 lbs.	

Medical History

Past Medical History: Congestive Heart Failure, Asthma, Urinary Tract Infection, Weakness, Hypervolemia

Past Surgical History: Hysterectomy

Family History: N/A

Social History (tobacco/alcohol/drugs): No history of drug, tobacco, or alcohol abuse. Did inhale secondhand smoke while performing in a band.

Admission Assessment

Chief Complaint: Falls

History of Present Illness: Most recent fall on 8/23/19 but has fallen many times before. She has been to Clark-Lindsey many times for rehab for her falls. She has weakness and pain in her legs.

Primary Diagnosis

Primary Diagnosis on Admission: Falls related to osteopenia and physical deconditioning

Secondary Diagnosis (if applicable): Urinary Tract Infection

Pathophysiology of the Disease, APA format:

There is not a single cause for falls, but the risk for falls increase the older someone is because falls are normally accompanied by a chronic disease or cognitive impairment. In this patient's case, her falls are most likely caused by the weakness and pain in her legs.

Pathophysiology References (APA):

Capriotti, T., & Frizzell, J. (2015). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. F.A. Davis Company.

Laboratory Data

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	3.50-5.20	3.93		
Hgb	11.0-16.0	11.4		
Hct	34.0-47.0	35.3		
Platelets	140-400	238		
WBC	4-11.0	7.74		
Neutrophils	1-4.90	0.51		
Lymphocytes	1.0-4.90	6.6		Lymphocytes are high because of the UTI that is being fought.
Monocytes	0-0.50	1.94		Monocytes are high because of the UTI that is being fought
Eosinophils	0-0.20	0.02		
Bands	0-0.09	0.04		

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-	136-145	139		
K+	3.5-5.1	3.1		The most likely cause of the low K+ level is the medications that she is taking.
Cl-	98-107	104		
CO2	21-32	28.2		
Glucose	60-99	94		
BUN	7-18	35		Her high BUN seems to be related to her heart condition.
Creatinine	0.55-1.02	1.35		Her high creatinine is most likely caused by her low muscle mass or medications.
Albumin				
Calcium	8.5-10.1	8.4		Her slightly low calcium level may be caused by her diet.
Mag	1.6-2.6	2.1		
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	Colorless, clear	Red, cloudy		Urine is red and cloudy because the patient had a UTI upon admission

pH	5.0-7.0	8.0		The acidity is abnormal because of the UTI that is present.
Specific Gravity	1.003-1.035	1.014		
Glucose	negative	Negative		
Protein	negative	30		There is protein in the urine because of the UTI that is present.
Ketones	negative	negative		
WBC	0-25	820		There is a high WBC count because the WBC's are trying to fight off the UTI.
RBC	0-20	28		The high RBC level is because of the UTI that is present.
Leukoesterase	negative	small		The is a high leukoesterase level because of the UTI the patient has.

Lab Correlations Reference (APA):

Nabili, S. (n.d.). Urinalysis. Retrieved September 30, 2019, from

emedicinehealth website: <http://www.emedicinehealth.com/urinalysis/>

article_em.htm#what_is_a_urine_test_urinalysis

Diagnostic Imaging

All Other Diagnostic Tests: Echocardiogram-adult

CT of brain after fall; mild to moderate chronic microangiopathic change

X-Ray of chest- mild vascular congestion

Current Medications
5 different medications must be completed

Medications (5 required)

Brand/Generic	Acetaminophen	Albuterol	Benzonatate	Heparin	Levofloxacin
Dose	650mg	2 puffs	100mg	5,000 units	500mg
Frequency	Every 4hrs PRN	3 daily PRN	3 daily PRN	Every 12 hrs.	Daily
Route	Oral	Inhalation	Oral	Subcutaneous	Oral
Classification	Antipyretic	Bronchodilator-or	Non-narcotic antitussive	Anticoagulant	Antibiotic
Mechanism of Action	Blocks prostaglandin production, interferes with pain impulse generation	Relax bronchial muscle cells and inhibit histamine release	Anesthetizes stretch receptors in lungs and pleura	Inactivates thrombin	Interferes with bacterial cell replication
Reason Client Taking	Fever or mild pain	Shortness of breath	Cough	Blood clots	UTI
Contraindications	Hypersensitivity, severe active liver disease	Hypersensitivity to albuterol	Hypersensitivity to benzonatate	Uncontrolled active bleeding	Hypersensitivity, myasthenia gravis
Side Effects/Adverse Reactions	Anxiety, hypotension, constipation, oliguria	Anxiety, angina, hyperglycemia Bronchospasm cough	Confusion, headache, laryngospasm, constipation, bronchospasm	Chills, fever, chest pain, hematuria	Anxiety, arrhythmias, acute renal failure, arthritis, anaphylaxis

Medications Reference (APA):

Nurse's Drug Handbook (18th ed.). (2019). Burlington, MA: Jones & Bartlett

Learning.

Assessment

Physical Exam

GENERAL: Alertness: Orientation: Distress: Overall appearance:	+3 alertness Very oriented Only distressed upon standing Overall appearance is great
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Skin color is pale pink as expected Character and temperature are as expected Turgor is slow as expected for age No rashes, bruises, or wounds noted Braden score of 18; mild concern because of movement issues No drains are present
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	Neck is strong and can hold up the head Auricle pale pink like the rest of the skin Ears, eyes, and nose are all symmetrical Teeth are white and pearly
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"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:	Heart sounds are strong, no abnormalities present Peripheral pulses are strong Capillary refill is less than 2 seconds
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	Lung sounds are great

<p>GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: 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:</p>	<p>The diet at home and current diet are both a cardiac diet Height is 4'11" Weight is 95lbs Bowel movement is heard in all 4 quadrants Last bowel movement was 9/22/19 There is no pain upon palpation There are no masses present No distention, incisions, scars, drains, or wounds upon inspection. No presence of ostomy, nasogastric, or feeding tube.</p>
<p>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:</p>	<p>Did not urinate while being assessed There is no pain with urination currently but has been previously in relation to the UTI Genitals are pink as expected. No catheter is present</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input checked="" type="checkbox"/> Needs support to stand and walk <input checked="" type="checkbox"/></p>	<p>There is only pain upon standing, pallor is as expected, pulse is strong, there is no evidence of paresthesia or paralysis. ROM was as expected Patient uses a walker and wheelchair Strength is equal on both sides; there is less strength in legs than arms Patient has fallen in the past and that is chief complaint Patient's fall score is 75 Nurse is present when patient would like to move and has to assist</p>
<p>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p>	<p>Has slight issues moving legs related to pain upon standing Strength is equal on both sides, legs are</p>

Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:	weaker than arms Patient is oriented, has good mental status, speech and sensory There has not been any LOC noted in chart
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 is very happy and loves the Clark-Lindsey facility. Patient's developmental level is as expected for age ie. She is very knowledgeable. No religion was referenced. The patient's son calls frequently to check in with the patient.

Vital Signs, 1 set

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
11:10 a.m.	70 (radial)	122/59	12	98° (temporal)	95%

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
11:20a.m.	0-10	Legs & feet	4/10	Ache upon standing	Sitting and therapy

Nursing Diagnosis
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. Falls related to pain as evidence by generalized weakness.	The patient does not want to stand because of the pain in her legs.	1. Assess the patient’s fall risk 2. Refer to the health provider	She was understanding of the fact that she is a fall risk because of the pain in her legs. The patient seems to know her limits and will hopefully be able to bear her own weight in less than 2 weeks.
2. Falls related to osteopenia as evidence by generalized weakness	The patient has weakness upon standing	1. Have the patient walk with assistance. 2. Have patient practice strengthening exercise while sitting in her wheelchair.	The patient understands that in order to return home that she must strengthen her legs. The goal is to have her be able to bear her own weight with the assistance of her walker. She is doing well walking with assistance but she does have pain after she walks a large distance. She will hopefully be able to bear her own weight in less than 2 weeks.

Other References (APA):

Swearingen, P., & Wright, J. (2019). *All-in-One Nursing Care Planning Resource*

(5th ed.). St. Louis, MO: Elsevier.

Subjective Data

The patient rates pain 4/10 when she is standing and bearing her own weight. She does not have any pain when she is sitting. The patient does not have any pain with urination currently, but she has in the past. She is a retired typist and band member.

Nursing Diagnosis/Outcomes

My nursing diagnosis is falls related to pain as evidence by generalized weakness and falls related to osteopenia as evidence by generalized weakness. The patient does not want to walk because of the pain and weakness in her legs. The patient was very understanding of her fall risk and that she should not try to get up without assistance. She also knows that in order to return to her home that she will need to be able to bear her own weight without assistance of a nurse. The patient seems to know her limits. The goal is to have her bearing her own weight without direct assistance from a nurse in less than 2 weeks after rehab.

Objective Data

The patient's blood pressure is 122/59 mmHg. Her radial pulse is 70 bpm. Her respiratory rate is 12 breaths per minute. Her temperature is 98° F. Her oxygen was 95%. Her face is very symmetrical. The heart, respiratory, and bowel sounds were all as expected. Her strength was equal on both sides, with her legs being weaker than her arms.

Patient Information

The patient's initials are SF. She is a female, 93, married, and is a retired typist and band member. She was admitted on 9/4/19. She is 4'11" and weighs 95 lbs. She is white. Her allergies include: adhesive tape, Dyazide, Inderal, Keflex, Tetanus & Toxoid Valium.

Nursing Interventions

The interventions that I think should take place are to assess the patient's fall risk, refer to the health provider, and have the patient walk with assistance such as a walker, gait belt, and nurse. I also think that the patient and nurse should work on leg strengthening exercises while the patient is sitting in her wheelchair.

