

N311 Care Plan #2

Lakeview College of Nursing

Patricia East

Demographics (5 points)

Date of Admission 6/13/2016	Patient Initials BC	Age 94	Gender Male
Race/Ethnicity White	Occupation Teacher	Marital Status Divorced	Allergies None
Code Status N/A	Height 5'9"	Weight 173.6 lbs	

Medical History (5 Points)

Past Medical History: Patient has a history of GERD, hypertension, arthritis, heart disease, ischemic cardiomyopathy, prostate cancer, hypercholesterolemia, vision problems, hearing loss.

Past Surgical History: Patient had a heart cath, loop recorder insertion, mitral valve surgery, pacemaker insertion X3, PTCA, tonsillectomy and adenoidectomy.

Family History: Patient did not recall any family history from maternal or paternal side. His daughter did have a history of breast cancer.

Social History (tobacco/alcohol/drugs): Patient has been living at CLV for the past three years. Before coming to CLV, he lived by himself. He was a previous pipe smoker. He smoked about 2-3 pipes/day. He states that he quit in January 2985. He also was a previous drinker. He states he had 21 glasses of wine/week. He does not attend church or any other social outings.

Admission Assessment

Chief Complaint (2 points): Syncope

History of present Illness (10 points): Patient reports he has been feeling dizzy and generalized weakness. He says that sometimes he passes out while going to the bathroom. CT scan was ordered, the results were negative. Urinalysis was order – positive for UTI.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Syncope

Secondary Diagnosis (if applicable): Urinary Tract Infection

Pathophysiology of the Disease, APA format (20 points): Patient has had frequent urinary incontinence throughout the day and night. He states that sometimes he doesn't get to change his depends as quickly as he wants. This increases his risk for bacteria to grow and cause an infection. When there is a high percentage of bacteria growth, they start to travel upward in the urethra. Urinary tract infections are developed from a pathogen entering the urethra and colonizing. Organisms, like gonococcus and E. coli, are enter the urethra, attaching to the mucosa epithelium, and are not flushed out during normal urine output. This is what causes a UTI. If untreated, his UTI that started in the urethra will continue to multiply and move towards the bladder, the ureter, and eventually to the kidneys. His symptoms include dysuria, frequency, urgency. Urine also has a cloudy tint and odor.

Pathophysiology References (1) (APA):

Capriotti, T., & Frizzell, J.P. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. 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	3.50-5.20		4.00	

N311 Care Plan

Hgb	14-18		7.4	Pagana (2019) states that elderly “values may slightly be decreased”. No other findings why Hgb would be decreased (p.485).
Hct	42%-52%		25.9%	Pagana (2019) states that elderly “values may slightly be decreased” (p.488). No other findings why Hct would be decreased.
Platelets	140-400		212	
WBC	4.00-11.0		6.17	
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-	135-145		137	
K+	3.5-5.1		4.7	
Cl-	N/A		N/A	
CO2	N/A		N/A	
Glucose	70-99		82	
BUN	6-20		23	Pagana (2019) states that elderly BUN levels “may be slightly higher than those of adult” (p.155)
Creatinine	0.6-1.2		1.44	Pagana (2019) states an increase in creatine can be caused by “reduced renal blood flow due to atherosclerosis” (p.302).

N311 Care Plan

Albumin	3.5-5.5		N/A	
Calcium	8.4-10.5		8.4	
Mag	N/A			
Phosphate	N/A			
Bilirubin	N/A			
Alk Phos	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, clear		Yellow, cloudy	Pagana (2019) states urine can be cloudy because of “pus, RBC, or bacteria present in the urine”(p.931)
pH	5.0-7.0		6.0	
Specific Gravity	1.003-1.035		1.014	
Glucose	Neg		Neg	
Protein	Neg		Neg	
Ketones	Neg		Neg	
WBC	Neg		Positive >1,000 present	Pagana (2019) states when WBC are present in urine, it “indicates a UTI” (p.935).
RBC	Neg			
Leukocytes esterase	Neg		Postive	Pagana (2019) states when WBC are present in urine, it “indicates a UTI” (p.935).

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):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory test reference*. St. Louis, MO: Elsevier.

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	Sertraline/Zoloft	Melatonin	Omeprazole/ Losec (CAN), Prilosec	Lisinopril/ Zestril	Clopidogrel/ Plavix
Dose	25 mg	10mg	20mg delayed release	25 mg tablet	75 mg
Frequency	1 tablet/day	1 tablet at bedtime	1 capsule/day	1 tablet/day	1 tablet/day
Route	Oral	Oral	Oral	Oral	Oral

N311 Care Plan

Classification	Chemical Class: Naphthylamine derivative Therapeutic class: antianxiety, antidepressant, antiobsessant, antipanic, antiposttraumatic stress	Chemical Class: Acetamide, Tryptamine. Therapeutic class: Serotonin-derived neurohormone .	Chemical Class: Substituted benzimidazole Therapeutic class: Antiulcer	Chemical class: Lysine ester of enalaprilat Therapeutic class: Antihypertensive, vasodilator	Chemical class: Thienopyridine derivative Therapeutic Class: Platelet aggregation inhibitor
Mechanism of Action	Inhibits reuptake of neurotransmitter serotonin by CNS neurons. This increases serotonin available in nerve synapses. Elevated serotonin results in elevated mood and reduce depression	Controls the circadian rhythm of the body. Darkness increases melatonin levels and light decreases melatonin levels.	Interferes with gastric acid secretions by inhibiting hydrogen potassium adenosine triphosphatase enzyme system or proton pumps, in gastric parietal cells.	Reduces blood pressure to inhibiting conversion of angiotensin I to angiotensin II. Angiotensin II is a potent vasoconstrictor that stimulates adrenal cortex to secrete aldosterone. Lisinopril also inhibits renal and vascular production of angiotensin II. Decrease release of aldosterone reduces sodium/ water reabsorption and increase their excretion, this decreases blood pressure.	Binds to adenosine diphosphate receptors on active platelet's surface. This blocks ADP which deactivates glycoprotein IIb/ IIIa receptors and prevents fibrinogen from attaching to the receptors. The platelets then are inhibited from aggregation and forming thrombi.
Reason Client Taking	To treat depression	To reduce time needed to fall asleep. To improve sleep.	To treat GERD	To treat hypertension, heart failure, and acute MI	To prevent thrombotic events to patients with atherosclerosis.
Contraindications (2)	Disulfiram Pimozide	Anticoagulants Sedative medications	Therapy with rilpivirine-containing products	Concurrent aliskiren use in patients with diabetes or renal	Active pathological bleeding, including peptic

			Hypersensitivity to Omeprazole	impairment. Hypersensitivity to lisinopril, other ACE inhibitors, or their components.	ulcer and intracranial hemorrhage; hypersensitivity to clopidogrel or its components
Side Effects/Adverse Reactions (2)	CNS: abnormal dreams, aggressiveness, confusion. RESP: Bronchospasm, coughing, dyspnea, pulmonary hypertension	CNS: Depression, Seizure disorder. CV: High blood pressure.	CNS: Agitation, dizziness, fatigue, and headaches. CV: Chest pain, hypertension	CNS: Vertigo, ataxia, insomnia, syncope, stroke. CV: Arrhythmias, chest pain, fluid overload, MI, palpitations	CNS: confusion, dizziness, fatal intracranial bleeding, fatigue, fever, hallucinations, headache. GU: elevated serum creatine level, UTI

Medications Reference (APA):

Jones & Barlett Learning. (2019). *2019 Nurses Drug Handbook*. Burlington, MA.

Kerkar, P. (2018, September 21). *Mechanism of Action of Melatonin, Its Usage and Side Effects*. Retrieved October 6, 2019, from <https://www.epainassist.com/opioid-treatment/medications/mechanism-of-action-of-melatonin>.

WebMD (2019). *Melatonin: Uses, Side Effects, Interactions, Dosage, and Warning*. (n.d.). Retrieved from <https://www.webmd.com/vitamins/ai/ingredientmono-940/melatonin>.

Assessment

Physical Exam (18 points)

GENERAL: Alertness: Orientation: Distress:	Patient is alert and oriented x3. Does not appear to be in any distress or pain. Overall appearance is good.
---	---

<p>Overall appearance:</p>	
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin color is pink and warm. Skin intact. Pt denies any itching/rashes. Turgor <3 second. No bruises, wounds, or rashes apparent. Braden score is 21. There are no drains present.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Denies any pain IN HEENT. Pt wears glasses for corrective vision. No hearing aids. No red/swelling in ears. Eyes are symmetrical. PERRLA. Conjunctiva pink and healthy looking. Denies feeling dizzy at the moment, feels dizzy when walking sometimes. No swollen glands or lymph nodes.</p>
<p>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:</p>	<p>All heart sounds present and are 2+. No murmur or gallops present. Peripheral pulses are palpable and are 2+. Capillary refill < 3 seconds.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Breath sounds were clear and normal bilaterally.</p>
<p>GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars:</p>	<p>Diet at home: regular Current diet: regular Height: 5'9" Weight: 173.6 lb Normal hyperactive bowel sounds in all four quadrants. Last BM:10/1/019 No pain present in four quadrants. Abdomen is soft. No distention, incision, scars, drains, or wounds. No ostomy, nasogastric, or feeding tube</p>

<p>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>present.</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>Patient states to have frequent output and excessive amount of output. Urine is yellow and cloudy. Sometimes has pain when urinating. Patient denies any hematuria. No dialysis. Perineal area appears to be clean, no sores or abnormalities present.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>No abnormalities found with neurovascular. Pt has good ROM. Walker is used when ambulating. Strength is equal in all four limbs. Pt requires little to no help with daily activities. Pt is not a fall risk. Fall score: 20. Up independently.</p>
<p>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 type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Pt moves all extremities well. Pupils are equal, round, react to light, and accommodate. Strength is equal in all four limbs. Pt is alert and communicates without ques. Speech is normal and clear.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home</p>	<p>Pt seems to cope well with lifestyle changes. No development problems. Pt states "I live here because I like it". He has lived at CLV for three years. He has a daughter whom he is close to. Daughter appears to be his biggest</p>

environment, family structure, and available family support):	support group. He has other kids, but doesn't remember who they are.
---	--

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1015	60	128-54	20	97.6	95

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0940	0	0	0	0	0

Intake and Output (2 points)

Intake (in mL):	Output (in mL) :
720	375

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none"> Include full nursing diagnosis with "related to" and "as evidenced by" components 	<ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 		<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.
<p>1. Patient is at risk for falls due to syncope evidence by patient passing out in the bathroom.</p>	<p>I chose this diagnosis because the patient has had previous episodes of syncope while ambulating.</p>	<p>1. Educate patient to utilize the call button for help when feeling dizzy.</p> <p>2. Patient will</p>	<p>Family and patient agreed and understood the nursing interventions. Patient acknowledges the importance of utilizing call light when</p>

		ambulate with walker and non-skid shoes when ambulating.	feeling dizzy to keep him safe. He also acknowledges that a walker and non-skid shoes can help him keep his balance when ambulating.
2. Patient is at risk for urinary incontinence due to recurrent UTI evidence by soiling depends with urine.	I chose this diagnosis because the patient says he has frequent urine incontinence throughout the day.	1. Encourage toileting every Q2 hours to train bladder. 2. Educated patient on proper perineal cleaning.	Family and patient agree and understand the nursing interventions. Patient understands and participated in toileting Q2 hours for bladder training. Patient learned the proper way to clean perineal area. He acknowledges that its important to properly clean to reduce the amount of bacteria exposed to prevent UTIs.

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 states that he feels weak and dizzy. He said that he passed out when going to the bathroom and hit his head.

Nursing Diagnosis

Patient is at risk for falls due to syncope evidence by patient passing out in the bathroom. - goal met. Patient was educated to utilize the call light when feeling dizzy and when ambulating he is to utilize walker and non-skid shoes. Patient was using non-skid shoes and walker while ambulating to and from dining hall. Patient understood and agreed to call for help when he felt weak and dizzy.

Patient is at risk for urinary incontinence due to recurrent UTI evidence by soiling depends with urine. - goal met. Patient is to toilet himself Q2 hours to help train bladder for incontinence & learn proper perineal care to decrease the risk of UTI. Patient was actively using the bathroom within 2 hours and he was learned the proper steps to cleaning perineal area and taught the steps back to me.

Objective Data

Patient is alert and oriented. CT scan of head was performed - negative. Urinalysis was collected - positive for UTI.

Patient Information

Pt is a 94 year old who is divorced. He lives at CLV and has been there for three years. He is a former smoker of 40 years and former drinker.

Nursing Interventions

Patient will call for help when feeling dizzy and weak.
Patient will use non-skid shoes and walker when ambulating.
Patient will use the restroom Q2 hours.
Patient will learn the proper technique when performing perineal care.

N311 Care Plan

N311 Care Plan