

N311 Care Plan #2

Lakeview College of Nursing

Ryan Croy

Demographics (5 points)

Date of Admission 04/17/2019	Patient Initials S.B.	Age 79	Gender 79
Race/Ethnicity white	Occupation bookkeeper	Marital Status divorced	Allergies Aricept, Darvou, Statins
Code Status DNR	Height 61 inches	Weight 182.9lbs	

Medical History (5 Points)

Past Medical History: dementia, HTN, allergic rhinitis, hyperlipidemia, obesity, depression, vertigo, anxiety, kidney disease, elevated levels of transaminase and lactic acid, dehydration, hypotension, back pain

Past Surgical History: Tonsils, hysterectomy, gallbladder, teeth extraction

Family History: Patient reports no family history.

Social History (tobacco/alcohol/drugs): Patient has an occasional glass of wine.

Admission Assessment

Chief Complaint (2 points): Sinus pressure and headache

History of present Illness (10 points): Patient states: "I have sinus pressure causing a headache." Patient has a diagnoses of seasonal allergies.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Unspecified dementia without behavioral disorder

Secondary Diagnosis (if applicable): Essential (primary) hypertension

Pathophysiology of the Disease, APA format (20 points): Dementia is usually associated with older patients. However, dementia is not a part of the natural aging process. Dementia is somewhat of an umbrella term for several neurocognitive disorders. It is most often

caused by Alzheimer's disease, Lewy body dementia, frontotemporal dementia, vascular dementia, or Parkinson disease (Pinsen, 2018). It is vital to document as much information as possible, including the suspected underlying cause. Unspecified dementia without behavioral disturbance fits underneath the umbrella of dementia. Unspecified dementia includes senile or presenile dementia. As with all dementias, defects with “memory and language are almost always present” (Pinsen, 2018).

Essentially, dementia is caused by damage to brain cells. When synapses are destroyed and neurons are killed, brain cells communicate ineffectively (Alzheimer’s Association, 2019). This lack of communication in areas of the brain is what causes symptoms to manifest. Symptoms include impaired memory, communication, and thinking (MacGill, 2017). It is difficult to be certain with a dementia diagnosis as symptoms overlap. Dementia without behavioral disturbance would not include symptoms such as psychotic symptoms, mood disturbance, agitation, apathy, aggression, combativeness, and “wandering off” (Pinsen, 2018).

There is no one test to determine if a patient has dementia or not. Diagnosing dementia is “based on a careful medical history, a physical examination, laboratory tests, and the characteristic changes in thinking, day-to-day function and behavior associated with each type” (Alzheimer’s Association, 2019). While dementia does not have a cure, if diagnosed at an early stage there are some treatments to slow the progression. Some treatments for memory loss include donepezil, galantamine, memantine, and rivastigmine (Alzheimer’s Association, 2019).

Pathophysiology References (2) (APA):

Alzheimer's Association. (2019). What Is Dementia? Retrieved October 7, 2019, from

<https://www.alz.org/alzheimers-dementia/what-is-dementia>.

MacGill, M. (2017). Dementia: Symptoms, treatments, and causes. Retrieved October 7, 2019, from

<https://www.medicalnewstoday.com/articles/142214.php>.

Pinson, R. (2018). Dementia. Retrieved October 6, 2019, from [https://acphospitalist](https://acphospitalist.org/archives/2018/07/coding-corner-dementia.htm).

[org/archives/2018/07/coding-corner-dementia.htm](https://acphospitalist.org/archives/2018/07/coding-corner-dementia.htm).

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-	136-145mmol/L		140mmol/L	
K+	3.5-5.1mmol/L		4.5mmol/L	
Cl-	98-107mmol/L		106mmol/L	
CO2	21-31mmol/L		26mmol/L	
Glucose	74-109mg/dL		101mg/dL	
BUN	7-25mg/dL		21mg/dL	
Creatinine	0.50=0.90mg/dL		1.01mg/dL	
Albumin	3.5-5.2g/dL		3.7g/dL	
Calcium	8.6-10.3mg/dL		9.3mg/dL	
Mag				
Phosphate				
Bilirubin	0.3-1.0mg/dL		0,3mg/dL	
Alk Phos	35-105intl unit/L		69intl unit/ L	

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	No growth		No growth	
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

1. Sarah Bush Lincoln Health Center (2019). *Reference Range. (lab values)* Mattoon, IL.

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	Acetaminophen	Claritin Tablet Loratadine	Colace Capsule Docusate Sodium	Ibuprofen Tablet	Allopurinol Tablet
Dose	650mg	10mg	100mg	200mg	100mg

Frequency	PRN	PRN	PRN	PRN	QAM
Route	PO	PO	PO	PO	PO
Classification	Antipyretic	antihistamine	Laxative	analgesic	antigout
Mechanism of Action	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system	temporarily relieves symptoms such as: runny nose, itchy eyes, sneezing, and itchy nose and throat	softens stool by decreasing surface tension between oil and water in feces.	blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling, and	Inhibits uric acid production by inhibiting xanthine oxidase, the enzyme that converts hypoxanthine and xanthine to uric acid
Reason Client Taking	pain/fever	congestion	constipation	pain	gout
Contraindications (2)	Hypersensitivity to acetaminophen or its components, severe active liver disease	liver failure, liver problems	fecal impaction, nausea	angioedema, asthma	Hypersensitivity to allopurinol or its components
Side Effects/Adverse Reactions (2)	anxiety, fatigue	headache, sleepiness	dizziness, palpitations	dizziness, headache	Chills, drowsiness

Medications Reference (APA):

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

2. **Claritin (Loratadine): Side Effects, Interactions, Warning, Dosage & Uses. (n.d.). Retrieved from <https://www.rxlist.com/claritin-drug.htm>.**

Assessment

Physical Exam (18 points)

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>A and O x3. Client was in no distressed and appeared well groomed.</p>
<p>INTEGUMENTARY: Skin color:NFR Character:intact, dry Temperature: warm Turgor: delayed Rashes: none Bruises: none Wounds: none . Braden Score: Drains present: Y <input type="checkbox"/> N X Type:N/A</p>	<p>The client's skin was war to touch and the skin color was NFR. The skin appeared dry and cracked. There was no risk for predicting a pressure ulcer based off of the Braden Scale.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>The patient had good hygiene overall. Patient had post nasal drip. The oral mucosa was moist and intact.</p>

<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: 93 Capillary refill: good 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: N/A</p>	<p>Client had regular heart beat sounds as well as cardiac rhythm. There appeared to be no edema.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Client's respiration was regular as well as breath sounds.</p>
<p>GASTROINTESTINAL: Diet at home: regular Current Diet: regular Height: 61 inches Weight: 182.4lbs Auscultation Bowel sounds: Last BM: medium 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>.Diet at home and current diet is regular. Last bowel movement occurred this morning. After palpating there appears to be no abnormalities.</p>
<p>GENITOURINARY: Color: yellow/clear Character: normal smell Quantity of urine: 1 cup 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: N/A Size: N/A</p>	<p>Client has no pain when urinating and is able to use the bathroom independently. Client stated her urine was “yellow/clear” and a normal odor at about 1 cup volume.</p>

MUSCULOSKELETAL: Neurovascular status: normal ROM: partial Supportive devices: none Strength: equal bilaterally ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: 15 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"/>	Client has partial ROM with left deltoid. Patient states “I think I slept on it wrong”. Strength is equal bilaterally. No assistance equipment is needed.
NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y X N <input type="checkbox"/> Strength Equal: Y X N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Normal Sensory: LOC:	Left deltoid has partial ROM. Eyes are equal and reactive to light and accommodate. Strength is equal in extremities. A and O x3. The patient stated My right eye is dead”.
PSYCHOSOCIAL/CULTURAL: Coping method(s): more difficult with age Developmental level: Religion & what it means to pt.: catholic/hope Personal/Family Data (Think about home environment, family structure, and available family support): 2 daughters, 5 grandkids, 3 great grandkids	Patient believes it is harder to cope due to her aging. Client stated she is catholic and that religion gives her hope. She has several family members and receives calls frequently as well as visits when they have time.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
10:20am	93	140/69	20	97.8	95%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions

10:20am	4/10	headache	4	pressure	instruct client on how much and how often she can consume claritn
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Intake and Output (2 points)

Intake (in mL)	Output (in mL)
360mL	

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.
1. Acute pain in the head.	“my head hurts this time of the year due to pressure”	1. Check the patient’s pain level 2. Give antihistamine	Patient decided to follow up with a pain scale.
2. Ineffective airway clearance	“I cant breathe through my nose”	1. Teamed with the medical physician for medication to	The patient agreed to medication and assessment for checking airway.

		relieve breathing. 2.Check for left behind build up of the mucous.	
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- 1. 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

“My pain is 4/10”
“I can’t breathe through my nose”
“My head hurts this time of the year”

Nursing Diagnosis/Outcomes

Diagnoses: Anxiety related to breathing.
Outcome: Client will evaluate her level of anxiety as well as coping abilities.

Diagnosis: acute pain in nose.
Outcome: patient stated the pain disappeared.

Diagnoses: Ineffective airway.
Outcome: patient is breathing normally again.

Objective Data

Patients had swelling in the nares.
Patient was breathing through the mouth.
Blood pressure was 140/69.

Patient Information

Has allergies
79yr old
female

Nursing Interventions

Assess the level of pain the client has.
Teach the patient on ways to relieve anxiety without the use of medications.
Give an antihistamine in order to help sinus.



