N311 Care Plan # 1

Lakeview College of Nursing

Abbie Horatschki

Demographics (5 points)

Date of Admission 8/26/19	Patient Initials GLW	Age 80	Gender Male
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Married	Allergies Niacin
Code Status DNR	Height 5'7"	Weight 204 lbs	

Medical History (5 Points)

Past Medical History: A-fib and DVT on anti-coagulation with Coumadin, obstructive sleep apnea, implantable look recorder, significant coronary artery disease history, right ankle fracture

Past Surgical History: Right hip hemiarthroplasy (8/22/19)

Family History: Mother had arthritis and father had glaucoma. Brother had Alheiner's and sister had Parkinson's. All four are deceased.

Social History (tobacco/alcohol/drugs): Client is a former smoker, quit in 1996.

Admission Assessment

Chief Complaint (2 points): Pain on right hip

History of present Illness (10 points):. Broken hip after falling (7/23/19), had right hip hemiarthroplasty on 8/22/19. Client states that his pain was "very, very painful" and became "incapacitating". Client rated pain 10/10 on the pain scale when initially hurt hip. Standing and laying in one position too long aggravate pain. Tramadol and applied ice are the client's methods of trying to relieve pain.

Primary Diagnosis

Primary Diagnosis on Admission (3 points):.Right femur neck fracture

Secondary Diagnosis (if applicable):.Antiphospholipid Syndrome

N311 Care Plan

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

There are a number of ways you can break a leg, including falls, motor vehicle accidents, sports injuries, and overuse. This client's cause of his femur fracture was a fall. The first and most obvious symptom of a fracture is pain. Other symptoms are swelling, tenderness, bruising, and the inability to walk or put pressure on the limb.

Healthy lifestyle choice can impact your bone growth and strength as you age. There are many things that you can do to decrease your chances of bones weakening and falls. According to Mayo Clinic, these include getting enough calcium and vitamin D, exercising to strengthen bones and improve balance, avoiding smoking or excessive drinking, assessing your home for hazards, checking your eyes, watching your medications, standing up slowly, using a walking stick or walker.

The client's age makes him more susceptible to leg fractures. The risk for hip fractures increases as we age. In 2010, more than 80% of the people hospitalized for hip fractures were age 65 and older, according to the National Hospital Discharge Survey (NHDS). Although the client quit smoking in 1996, smoking tobacco can weaken bones. Physical frailty, arthritis, unsteady balance, poor eyesight, senility, dementia and/or Alzheimer's disease can increase the likelihood of falling.

Many medicines can affect balance and strength. Side effects of some medications can also include drowsiness and dizziness. X-rays and CT scans are two ways of testings and diagnosing a femoral neck fracture. Treatment for hip fracture usually involves a combination of surgery, rehabilitation and medication. The client is using the combination treatment plan of the three.

Pathophysiology References (2) (APA):

Longhurst, A. (2018). Overview of Femoral Neck Fracture of the Hip. Retrieved from https://www.healthline.com/health/femoral-neck-fracture

Mayo Clinic (2019). Hip fracture. Retrieved from https://www.mayoclinic.org/diseases-conditions/hip-fracture/symptoms-causes/syc-20373468

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	**4.10-5.70**	**4.28**	**None**	
Hgb	**12.0-18.0**	**12.2**	**None**	
Hct	**37.0-51.0**	**39.2**	**None**	
Platelets	**140-400**	**186**	**None**	
WBC	**4.00-11.00**	**10.45**	**None**	
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-	136-145	134	None	Client is taking Tylenol Extra Strength, which can lower sodium levels. Other pain medications can lower levels as well.
K+	3.5-5.1	4.3	None	
Cl-				
CO2				
Glucose				
BUN	7-18	30	None	High BUN levels can be caused by kidney problems, UTI's, certain medications, a high protein diet, or dehydration.
Creatinine	.7-1.3	.8	None	
Albumin	3.4-5.0	2.5	None	Most cases of hypoalbuminemia are caused by acute and chronic inflammatory responses. The client still has a healing wound, so it is possible that it could be slightly inflammed.
Calcium	8.5-10.1	8.5	None	
Mag	1.6-2.6	2.3	None	
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		**NO URINALYSIS ON FILE**		
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 CULTURE ON FILE**		
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Tests Index. Retrieved from https://labtestsonline.org/tests-index

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Client had a CT of right hip without contrast on 8/19/19. Findings included a slightly displaced, impacted, and angulated right femoral neck fracture. Client had an x-ray of his right femur on 8/19/19. Findings included a mildly displaced acute fracture involving the right femoral neck. Client had an x-ray of his pelvis on 8/22/19 (post surgery). No fracture was found.

Current Medications (10 points, 2 points per completed med)
5 <u>different</u> medications must be completed

Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol Extra Strength)	Salbutamol (Albuterol)	Absorbic Acid (Vitamin C)	Atorvastatin Calcium (Lipitor)	Cholecalciferol (Vitamin D3)
Dose	1000 mg tablet	Inhaler 1-2 puffs	500 mg tablet	20 mg tablet	1000 units tablet
Frequency	2 tablets 3x day	1-2 puffs every 6 hours	1 tablet 3x day	1 tablet/day	1 tablet/day
Route	PO	PO	PO	PO	PO
Classification	Antipyretic, nonopiod analgesic	Bronchodilator	Vitamin	Antihyperlipidemic HMG-CoA reductase inhibitor	Vitamin
Mechanism of Action	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain	Relaxes bronchial smooth-muscle cells and inhibit histamine release	Necessary to maintain connective tissue and bone	Reduces cholesterol and lipoprotein levels	Functions as prohormone

	impulse generation in the peripheral nervous system				
Reason Client Taking	For pain	Wheezing	Boost immune system	Helps body lower “bad” cholesterol and fats	Helps body absorb calcium and phosphorus
Contraindications (2)	Acetaminophen overdose, caloric under nutrition	Hypersensitivity to albuterol or its components, glaucoma	Sickle cell disease, hemochromatosis	Active hepatic disease, recent operation	Kidney stones, Sarcoidosis
Side Effects/Adverse Reactions (2)	Agitation, headache	Altered taste, dry mouth and throat	Headaches, flushing	Abnormal dreams, amnesia	Muscle weakness, bone pain

Medications Reference (APA):

Abdullah M, Attia FN, Jamil RT (2019). Vitamin C. Contraindications. Retrieved from https://www.ncbi.nlm.nih.gov.books.NBK499877/#_article-31221_s5_

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

Mayo Clinic (2019). Vitamin D. Retrieved from https://www.mayoclinic.ord/drugs-supplements-Vitamin-d/art-20363792

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Client appears alert and oriented, AOx3. Client rated pain a 0/10 on the pain scale and appeared to be in no acute distress. Client is well groomed.**

INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score: 20** **Drains present: Y☐ N ■** **Type:**	**Client is at low risk for skin breakdown according to the Braden scale. Client's skin color is normal for race. No rashes or bruises were found. Client has a surgical incision on right hip from surgery (unable to see because it was bandaged up). Client is afebrile.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Client's head and neck are symmetrical, WDL. Client's auricle is pink and moist, no lesions noted. Canal is clear, TM is pearly grey. Client uses eye glasses to aid in sight, sclera is white, cornea is clear. Nares are intact. Muscosal membranes are in tact.**
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 66/minute** **Capillary refill: < 3 seconds** **Neck Vein Distention: Y ☐ N ■** **Edema Y ☐ N ■** **Location of Edema:**	**Clear S1 and S2 sounds without murmurs, gallops, or rubs. PMI @ 5th intercostal space.**
RESPIRATORY: **Accessory muscle use: Y☐ N ■** **Breath Sounds: Location, character**	**Respirations are regular, even, and nonlabored. No wheezes or crackles noted.**
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height: 5'7"** **Weight: 201 lbs** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention: None** **Incisions: None** **Scars: None** **Drains: None** **Wounds: None**	**Client has regular diet at home, he eats what he wants. His diet here is a regular diet with no added salt. Last BM was this morning after breakfast around 9 am. Bowel sounds heard in all four quadrants. No pain or masses were noted.**

Ostomy: Y ☐ N ■ **Nasogastric: Y ☐ N ■** **Size:** **Feeding tubes/PEG tube Y ☐ N ■** **Type:**	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ■** **Dialysis: Y ☐ N ■** **Inspection of genitals:** **Catheter: Y ☐ N ■** **Type:** **Size:**	**Urine is yellow and client is able to void in toliet. No abnormalities in urine noted.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y■ N ☐** **Fall Risk: Y ■ N☐** **Fall Score: 50** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☒**	**Due to a weakened lower right extremity (because of hip surgery) the client needs assistance standing and walking. Client is fall risk due to unsteady gait and current mobility deficit because of healing hip. Client uses a walker and wears a gait belt.**
NEUROLOGICAL: **MAEW: Y ☐ N■** **PERLA: Y ■ N☐** **Strength Equal: Y ☐ N ■ if no -** **Legs ■ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Client responds to questions when asked. Client does not MAEW because of his healing right hip. Pupils are equal and reactive to light and accommodation. Client's speech is fluent and sensory is intact. Level of consciousness and orientation are AOx3.**
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and**	**Client is caucasian and has no religious affiliation. Client's wife was present during my visit and was very supportive and helpful. Client is a former smoker who quit in 1996.**

available family support):	

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
10:43 am	**72/min**	**138/58**	**20/min**	**98.6 degrees F**	**95%**

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
6:04am	**Numerical 0-10**	**Right hip**	**0/10**		**None needed**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
N/A(Was not able to get before patient left)	**N/A(Was not able to get before patient left)**

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by"	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status

components			of goals and outcomes, modifications to plan.
1. Risk for falls	**Related to: Weakness and impaired balance due to healing hip**	**1. Assist the client as needed when unsteady gait or weakness is noted. Instruct the client to ask or call for assistance with ambulation. Stand on clients weak side when assisting. Use gait belt when ambulating.** **2. Maintain an uncluttered environment with unobstructed walkways. Make sure there is adequate lighting at night to help prevent falls in the dark.**	**Wife is willing to help as much as she can, she will help him ambulate whenever needed. Both client and his wife understand that he needs an uncluttered environment to come back to when he goes home. Wife notes that there will be night lights for when it is dark at night. Both partners are eager to get the client back to normal.**
2. Impaired comfort	**Related to: Surgical procedure**	**1. Use acetaminophen with caution. Must be aware of the total amount the client is receiving through over the counter and other combined medications.** **2. Carefully evaluate the client if sudden**	**The client will receive help from his wife to keep track of how much acetaminophen he is receiving to avoid an overdose. Client knows to let wife know if his pain suddenly increases out of nowhere.**

		or unexpected changes in pain intensity occur. Notify the health care provider immediately if so.	

Other References (APA):

Swearingen, P. L. (2016). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. St. Louis, MO: Elsevier.

Concept Map (20 Points):

N311 Care Plan