

Running head: N311 Care Plan 3

Demographics (5 points)

Patient Initials	Age	Gender
AL	91	Female
Medical Status	Weight	
	130 lbs	

Medical History (5 Points)

Past Medical History: Hypertension, stroke, depression of brain, abnormal ECG, and mild chronic obstructive pulmonary disease. She has a history of a myocardial infarction in 2008, as well as a stroke in 2010.

Family History: No family history of heart disease or stroke.

Social History: No tobacco or alcohol use. No recent history of falls.

N311 Care Plan # 3

Lakeview College of Nursing

Name Ethon Richardson

Chief Complaint (2 points): Chest pain

History of present illness (10 points): Patient placed chest pain while resting at home. She reports a sharp, stabbing pain that began this morning around 10:00 AM. The pain is located in the left chest area and radiates to the left arm. She has no shortness of breath, sweating, or nausea. The pain is not relieved by rest or over-the-counter pain medication.

Primary Diagnosis on Admission (2 points): Myocardial Infarction

Secondary Diagnosis (if applicable): Atherosclerosis

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

Pathophysiology References (2) (APA):

Demographics (5 points)

Date of Admission 1/17/19	Patient Initials AC	Age 91	Gender Female
Race/Ethnicity White	Occupation seamstress/factory	Marital Status widowed	Allergies DeKromadison, mibegron, ofloxacin, penicillin, Plavix, Site Dionein, Dactinon
Code Status DNR	Height 65 inches	Weight 126.8 lbs	

Medical History (5 Points)

Past Medical History: Heart failure, Senile degeneration of brain, abnormalities of gait and mobility, neuro muscular dysfunction of bladder, Hypertension, recurrent depressive disorders, insomnia

Past Surgical History: ~~kidney surgery, history of falling, UTI~~

~~breast removal, hysterectomy~~

Family History: per patient report no family history

Social History (tobacco/alcohol/drugs): none per patient report no social history.

Admission Assessment

Chief Complaint (2 points): Catheter pain

History of present illness (10 points): Catheter placed 01/17/19 with the medical diagnoses of neuro muscular dysfunction of bladder. Catheter pain began this morning upon walking up and being transferred out of bed. Catheter in place is a 16 FR patient states that the pain is worse when they make her move. Her pain was rated at 7 out of 10

Primary Diagnosis on Admission (3 points): palliative care

Secondary Diagnosis (if applicable): Atherosclerotic heart disease of native coronary arteries without angina

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

Pathophysiology References (2) (APA):

## Pathophysiology of Atherosclerotic Heart Disease of Native Coronary Artery without Angina

Heart disease is a debilitating disease that effects the lives of millions of Americans every day. A patient who seeks medical attention for this condition usually is having some mild to severe symptoms (Mayo Clinic 2018). These symptoms include chest pain, chest tightness, chest pressure, chest discomfort, shortness of breath, pain and numbness in limbs, syncope, and pain in upper abdomen (Mayo Clinic 2018). The dangerous part of this disease is that this disease might not be diagnosed with heart disease until you have a stroke or a heart attack (Mayo Clinic 2018). Often times this disease is associated with a higher risk for more heart attacks in the future (Mayo Clinic 2018).

This disease can be caught early with certain tests that can be run in a medical setting. These tests include an Electrocardiogram, Holter monitor, echocardiogram, stress test, Cardiac catheter, a CT scan of the chest, and an MRI on the chest (Mayo Clinic 2018). The physician can also order blood work and get a chest X-ray determine a diagnosis of heart disease (Mayo Clinic 2018). If these tests are run early enough there is enough time to make a treatment plan to avoid stroke and heart attack. (Mayo Clinic 2018)

The most important aspect to avoid sever complications from the disease is making huge lifestyle changes (Mayo Clinic 2018). These lifestyle changes include quitting smoking, getting adequate exercise, low-fat and sodium diet, and lowering alcohol intake (Mayo Clinic, 2018). A doctor can also prescribe medications that can help manage the disease (Mayo Clinic 2018). If the medications and lifestyle changes do not help with the disease, surgery might be the only lifesaving option

(Mayo Clinic 2018). Other things that are important when having this diagnosis is managing stress, keeping a healthy weight, good mental health, managing cholesterol, and regularly check blood pressure (Mayo Clinic 2018).

### References

Heart disease. (2018, March 22). Retrieved from

<https://www.mayoclinic.org/diseases-conditions/heart-disease/diagnosis-treatment/drc-20353124>.



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	4.28-5.56		4.0	
Hgb	13.0-17.0		12.0	Count is slightly low possibly due to catheter pain leading to UTE.
Hct	38.1-45%		45.0%	
Platelets	149-393		200	
WBC	4.0-11.7		5.0	
Neutrophils	2.4-8.4		5.0	
Lymphocytes	0.8-3.7		20.0	could be high due to infection
Monocytes	4.4-12.0		5.0	
Eosinophils	0.0-6.3		1.0	
Bands	6.0-5		50.02	

**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 mmol/L		150	could be due to dehydration
K+	3.5-5.1 mmol/L		5.3	could be caused by dehydration
Cl-	98-107 mmol/L		110	could be caused by dehydration
CO2	21-31 mmol/L		25	
Glucose	74-109 mg/dL		96	
BUN	7-25 mg/dL		22	

Creatinine				
Albumin	0.50 - 0.90 mg/dL		1.46	could be dehydration or impaired kidney functions
Calcium	3.5 - 5.2 g/dL		4.0	
Mag	8.6 - 10.3 mg/dL		9.0	
Phosphate	1.7 - 2.2 mg/dL		1.8	
Bilirubin	2.5 - 4.5 mg/dL		1.0	could be impaired nutrition or dehydration
	0.3 - 1.0 mg/dL		0.4	
Alk Phos	35 - 105 int'l unit/L		40	

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	<del>cloudy</del> yellow	cloudy yellow	urine could be cloudy due to dehydration
pH	5.0 - 8.0	5.0	5.0	
Specific Gravity	1.005 - 1.034	1.040	1.040	could be high due to dehydration or infection
Glucose	Normal	normal	normal	
Protein	Negative	Negative	Negative	
Ketones	Negative		Negative	
WBC	< 5		1	
RBC	0-3		0	
Leukoesterase	Negative		Negative	

**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	negative		No growth	
Blood Culture	negative		No growth	
Sputum Culture	negative		No growth	
Stool Culture	negative		No growth	

Lab Correlations Reference (APA): Sarah Bush Lincoln Health Center (2019).  
 Reference Range. (lab values). Matteson, IL.  
 Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Cholesterol	120-200	150	150	150	150
Triglycerides	<150	100	100	100	100
HDL	>40	50	50	50	50
LDL	<100	70	70	70	70
Glucose	70-100	90	90	90	90
Hemoglobin A1c	<5.7	5.5	5.5	5.5	5.5
Iron	50-150	100	100	100	100
TIBC	200-300	250	250	250	250
Transferrin Sat	20-50	30	30	30	30
Albumin	3.5-5.0	4.0	4.0	4.0	4.0
BUN	7-20	10	10	10	10
Cr	0.6-1.2	0.8	0.8	0.8	0.8
UA	<30	20	20	20	20
Ca	8.5-10.5	9.5	9.5	9.5	9.5
P	2.5-4.5	3.5	3.5	3.5	3.5
Alb	3.5-5.0	4.0	4.0	4.0	4.0
AST	0-40	20	20	20	20
ALT	0-40	20	20	20	20
ALP	40-120	80	80	80	80
GGT	0-40	20	20	20	20
PT	11-14	12	12	12	12
PTT	25-35	30	30	30	30
INR	0.8-1.2	1.0	1.0	1.0	1.0
WBC	4,000-11,000	8,000	8,000	8,000	8,000
RBC	4.2-5.4	4.5	4.5	4.5	4.5
Hgb	12-16	13	13	13	13
Hct	37-47	40	40	40	40
MCV	87-101	90	90	90	90
MCH	27-34	30	30	30	30
MCHC	32-36	33	33	33	33
RDW	11.5-14.5	13	13	13	13
Platelets	150,000-400,000	250,000	250,000	250,000	250,000

Medications Reference (APA): Valleron and A.H. Saunders; (A. & Q. (2019). Davis's drug guide for nurses. Philadelphia, PA: F.A. Davis Co.

Current Medications (10 points, 2 points per completed med)  
 \*5 different medications must be completed\*

Medications (5 required)

Brand/Generic	Norco Hydrocodone	Keppra levetiracetam	Nitroglycerin Nitrostat	Furosemide Lasix	Bisacodyl Dulcolax
Dose	5-326mg	250mg	0.4mg	20mg	10mg
Frequency	Prn Q4H	BID	Prn Q5min	Qam	Prn daily
Route	PO	PO	sublingual	PO	Suppository
Classification	Analgescic	anti convulsant	Antianginal	antihypertensive loop diuretic	laxative
Mechanism of Action	opiate receptors	inhibits voltage-dependent Na <sup>+</sup> type 2 ch	forms nitric oxide	Diuretic	Irritating the smooth muscle in intestine
Reason Client Taking	chron. x pasm	Seizure	chest pain	BLE edema	constipation
Contraindications (2)	Hypersensitivity respiratory depression	Hypersensitivity	Hypersensitivity severe anemia	Hypersensitivity hypotensive coma	intestinal obstruction inflammatory bowel diseases
Side Effects/Adverse Reactions (2)	Drowsiness serotonin syndrome	CNS depression Hypertension	dizziness passing out	constipation Diarrhea	abdominal cramping vomiting

Medications Reference (APA): Valler and A.H., Sanoski, C.A. & Quiring, C. (2019). Davis's drug guide for nurses. Philadelphia, PA: F.A. Davis company.

<p><b>GENERAL:</b> Alertness: Orientation: Distress: Overall appearance:</p>	<p>And OX1, catheter pain, well-groomed</p>
<p><b>INTEGUMENTARY:</b> Skin color: NFR Character: warm dry Temperature: warm to touch Turgor: poor Rashes: none Bruises: none Wounds: none Braden Score: 12 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>skin warm to touch, skin color NFR, skin dry and intact, patient scored a 12 on the braden scale for predicting pressure ulcers, which is high risk.</p>
<p><b>HEENT:</b> Head/Neck: Ears: Eyes: Nose: Teeth: 6 top front teeth</p>	<p>oral mucosa moist and intact, no obvious or likely cavities noted. patient only has 6 top front teeth.</p>
<p><b>CARDIOVASCULAR:</b> Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: noted Capillary refill: slow 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>Regular cardiac rhythm noted and regular heart sounds, no edema noted, peripheral pulses noted. capillary refill noted as slow. S1 and S2 noted. no murmur noted. pulses +2 equal and bilateral for extremities.</p>
<p><b>RESPIRATORY:</b> Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>non-labored non-obstructive regular respirations. breath sounds regular lungs clear to auscultation bilaterally</p>
<p><b>GASTROINTESTINAL:</b> Diet at home: regular, regular Current Diet regular, regular Height: 65 inches Weight: 126.8 lbs Auscultation Bowel sounds:</p>	<p>patient only eats bread with jelly and milkshakes for every meal. last BM was 10/7/19 and was described as small and soft. bowel sounds were active and normal.</p>

Last BM: 10/21/19  
 Palpation: Pain, Mass etc.:

Inspection:  
 Distention: none  
 Incisions: none  
 Scars: none  
 Drains: none  
 Wounds: none

Ostomy: Y   
 Nasogastric: Y   
 Size: N/A  
 Feeding tubes/PEG tube Y   
 Type: N/A

GENITOURINARY:  
 Color: yellow/clear  
 Character: normal smell  
 Quantity of urine:  
 Pain with urination: Y  N   
 Dialysis: Y  N   
 Inspection of genitals:  
 Catheter: Y  N   
 Type: Foley catheter  
 Size:

pain with urination related to catheter, patient states, "My catheter hurts so much." Catheter was first placed on 11/17/19. Catheter site is cleaned and flushed daily per discussion with nurse.

MUSCULOSKELETAL:  
 Neurovascular status:  
 ROM: partial  
 Supportive devices: wheelchair  
 Strength: weak  
 ADL Assistance: Y  N   
 Fall Risk: Y  N   
 Fall Score: 55  
 Activity/Mobility Status: chair fast  
 Independent (up ad lib)   
 Needs assistance with equipment   
 Needs support to stand and walk

partial ROM in both arms. pain noted in patients feet when she tried to move them.

NEUROLOGICAL:  
 MAEW: Y  N   
 PERLA: Y  N   
 Strength Equal: Y  N  if no - Legs  
 Arms  Both   
 Orientation:  
 Mental Status: A and O X/

ROM is impaired by pain in bilateral legs. strength is weak in the legs. A and O X. speech was slow and seemed labored. pupils were reactive to light but slightly sluggish.

Speech: Sensory: LOC:	
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):	2 kids. No other responses to questions given.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0715	82 bpm	152/72	18 rr	97.8°F	98%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0715	0-10	folly catheter	7-10	Sharp	told nurse

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL	

Nursing Diagnosis (15 points)

**\*Must be NANDA approved nursing diagnosis\***

<b>Nursing Diagnosis</b> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with "related to" and "as evidenced by" components</li> </ul>	<b>Rational</b> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<b>Intervention (2 per dx)</b>	<b>Evaluation</b> <ul style="list-style-type: none"> <li>• How did the patient/family respond to the nurse's actions?</li> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul>
1. Acute pain in bladder related to Catheter, AEB Patient stating "My catheter hurts so much."	Patient was in visible pain when explaining to us that she is having pain in her catheter.	1. Analgesics (control pain) 2. Breathing exercises	Patient wanted analgesic medication, and nurse was agreeable to this.
2. Imbalanced nutrition less than body requirements related to impaired food intake. AEB patient only eats milkshakes and jelly covered bread.	Patient is on comfort feeding and does not eat other nutrients.	1. Diet changes 2. encourage patient to eat more foods and higher protein ones	Patient did not want anything besides jelly and toast and a milkshake.

Swearingen, P. L. (2016). All-in-one nursing care planning resource.

**Other References (APA):**

Medical-surgical pediatric, Maternity, psychiatric nursing care plans, St. Louis, MO: Elsevier/Mosby.

**Concept Map (20 Points):**

### Subjective Data

- Patient stating "my pain is a 7 out of 10"
- Patient stating "my catheter hurts so much"

### Objective Data

- Patient observed crying during jelly on toast and misshakes
- Patient's blood pressure is 152/72 which is high
- observed grimace on face when talking about her pain at catheter site
- patient not eating any of the food the other patients were eating

### Nursing Diagnosis/Outcomes

- Diagnosis:** Acute pain in bladder related to catheter, AEB patient stating "my pain is a 7 out of 10"
- Outcomes:** patient's pain was decreased after Analgesic medication was administered.
- Diagnosis:** Imbalanced nutrition less than body requires related to impaired food digestions
- Outcomes:** patient did not want to eat anything else besides those foods.
- Diagnosis:** Activity intolerance in first entry to endear, completed desired needs
- Outcomes:** patient needs to adapt lifestyle to energy level

### Patient Information

- Admitted for palliative care
- 71 years old
- female
- catheter placed on 11/17/18
- 16 FR catheter
- patient has pain in catheter site

### Nursing Interventions

- Assessing client's level of pain
- Collaborating with medical team for medication to relieve pain
- Educating patient on how medications work to help relieve pain
- Teaching patient about breathing exercises to help relieve pain

### Morse Fall Risk Assessment

Risk Factor	Scale	Points	Patient's Score
History of Falls	Yes	25	25
	No	0	0
Secondary Diagnosis (Two or more medical Diagnoses)	Yes	15	15
	No	0	0
Ambulatory Aid	Furniture	30	0
	Crutches/Walker/Cane	15	0
	None/Bedrest/Wheelchair/Nurse	0	0
IV/Saline Lock	Yes	20	0
	No	0	0
Gait/Transferring	Impaired	20	0
	Weak	10	0
	Normal/Bed Rest/Immobile	0	0
Mental Status	Forgets limitations	15	15
	Oriented to own ability	0	0

Total Score: 45

**High Risk** = 45 and higher  
**Moderate Risk** = 25-44  
**Low Risk** = 0-24

(From Morse, J. M. (1997). Preventing Patient Falls. Thousand Oaks: Sage.)



**BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK**

Patient's Name: AC      Evaluator's Name: Esther Richardson      Date of Assessment: 10/8

	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment				
<b>SENSORY PERCEPTION</b> ability to respond meaningfully to pressure-related discomfort	Unresponsive (does not moan, frown, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/4 of body.	Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	3			
<b>MOISTURE</b> degree to which skin is exposed to moisture	Constantly Moist Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	Very Moist Skin is moist, but not always moist. Linen must be changed at least once a shift.	Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	Rarely Moist Skin is usually dry, linen only requires changing at routine intervals.	2			
<b>ACTIVITY</b> degree of physical activity	Bedfast Confined to bed.	Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours.	2			
<b>MOBILITY</b> ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance.	Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Slightly Limited Makes frequent though slight changes in body or extremity position independently.	No Limitation Makes major and frequent changes in position without assistance.	2			
<b>NUTRITION</b> usual food intake pattern	Very Poor Never eats a complete meal. Rarely eats more than 1/4 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	Probably Inadequate Rarely eats a complete meal and generally eats only about 1/4 of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	2			
<b>FRICTION &amp; SHEAR</b>	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.		1			
Total Score					12			

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