N311 Care Plan #

Lakeview College of Nursing

Name

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
09/30/19	E.W.	102	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Widowed	Pineapple, bananas, sulfas
Code Status	**Height**	**Weight**	
DNR	4' 11"	79 lb.	

Medical History (5 Points)

Past Medical History: Severe Right hip osteoarthritis, Pneumonia, dysphagia, mild cognitive impairment

Past Surgical History: Bilateral L hip hemiarthroplasty

Family History: Maternal - Hypertension

Social History (tobacco/alcohol/drugs): Hx of smoking tobacco

Admission Assessment

Chief Complaint (2 points):Hip pain, fall

History of present Illness (10 points):Patient admitted to facility after a fall at home causing px in the hip. The pain began immediately after the fall. It is located on the left hip and does not spread or radiate anywhere else. Patient was unable to walk on her own after the fall, but there are no other associated signs/symptoms. Patient did not take any medications because she was unable to access them due to the injury. Client has been diagnosed with Osteoarthritis in the past which may have contributed to the fall.

~~**Osteoarthritis**~~

Primary Diagnosis

Primary Diagnosis on Admission (3 points):Hip Fracture

Secondary Diagnosis (if applicable):Mild cognitive impairment

Pathophysiology of the Disease, APA format (20 points): Osteoarthritis also known as OA commonly occurs in individuals older than 50. Those who have had excess weight or stress on joints, or trauma also may be affected by this. OA is a slow and progressive, degenerative, and inflammatory disease. The pressure on the joint wears away the cartilage. Inflammation occurs as cytokines which have inflammatory mediators. Metalloproteases (an enzyme that works with a metal) are released into the joint and degrade the cartilage. Cartilage begins to lose elasticity and bone will strip the protective cartilage contacts against the opposing surfaces. Erosion of damaged cartilage in OA joints can progress until it exposes the underlying bone. OA can damage any joints, but usually effect hands, knees, hips, and spine. This disease can usually be managed, and the damage is irreversible. The disease is caused by the cartilage wearing away at the joints. As the cartilage begins to wear, the bone may end up rubbing on bone. Symptoms of osteoarthritis include pain, stiffness, tenderness, loss of flexibility, grating sensation, bone spurs, and swelling. Risk factors include aging, obesity, history of sports, trauma over joints, and heavy physical labor. Complications of OA are chronic inflammation of the joints and chronic pain of the joints.

Pathophysiology References (2) (APA):

Osteoarthritis - Symptoms and causes. (2019, Maddy 8). Retrieved October 2, 2019, from https://www.mayoclinic.org/diseases-conditions/osteoarthritis/symptoms-causes/syc-20351925

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. United States: 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	3.8-5.3	3.0		
Hgb	12.0-17.0	8.8		
Hct	38 – 51%	26%		
Platelets	140 – 440	280		
WBC	4.0-12.0	11.8		
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-	**138-146**	**138**		
K+	**3.5 – 4.9**	**4.6**		
Cl-	**98-109**	**102**		
CO2	**23-27**	**29**		
Glucose	**23-99**	**85**		
BUN	**8-26**	**25**		
Creatinine	**0.6-1.3**	**0.7**		
Albumin	**3.5-5.7**	**4.5**		
Calcium	**1.12-1.32**	**1.14**		
Mag				
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	**Lab Data Unavailable**			
pH	**Lab Data Unavailable**			
Specific Gravity	**Lab Data Unavailable**			
Glucose	**Lab Data Unavailable**			

Protein	**Lab Data Unavailable**			
Ketones	**Lab Data Unavailable**			
WBC	**Lab Data Unavailable**			
RBC	**Lab Data Unavailable**			
Leukoesterase	**Lab Data Unavailable**			

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	**Lab Data Unavailable**			
Blood Culture	**Lab Data Unavailable**			
Sputum Culture	**Lab Data Unavailable**			
Stool Culture	**Lab Data Unavailable**			

Lab Correlations Reference (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. United States: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

CT on right hip without contrast for trauma – nondiagnostic x-ray. Evidence of osteoarthritis in hips as well as previous breaks or trauma.

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

Medications (5 required)

Brand/Generic	**fentaNYL**	**HYDROcodone – aceetometaphine**	**Bisacodyl**	**Cholecalciferol**	**Acetaminophen**
Dose	**25 mcg/hr Patch**	**5-325mg tablets**	**10mg suppository**	**50,000 Unit Capsule**	**325mg tablet**
Frequency	**72H for 16 days**	**PRN**	**PRN**	**Twice daily**	**2 tablets every 6H PRN**
Route	**Topically – patch**	**PO**	**Rectal~~Rectal~~**	**PO**	**PO**

Classification	Opioid	Semisynthetic opioid	Laxative	Vitamin	Nonopioid analgesic
Mechanism of Action	Binds to opioid receptors	Binds to opioid receptors	Stimulates bowel movements	Absorption in GI tract	Blocks proglandin production
Reason Client Taking	Px	Px	Regulate bowel movements	Regulate bowel movements	Px
Contraindications (2)	Hypersensitivity to opioids, opioid nontolerance	Asthma, hypercarbia, hypersensitivity to opioids	Appendicitis, bowel obstruction, Bleeding from rectum	Liver disease, High phosphate levels in blood	Hypersensitivity to drug or components, severe hepatic impairment
Side Effects/Adverse Reactions (2)	Anxiety, confusion, delusions, blurred vision, bradycardia	Abdominal pain, hot flashes, seizures, hypotension	Cramping, nausea, diarrhea, muscle cramps	Muscle weakness, bone pain	Anxiety, insomnia, stridor, abdominal pain,

Medications Reference (APA):

Assessment

Physical Exam (18 points)

GENERAL: **Alertness: AO x2 (Name, place)** **Orientation:** **Distress: No distress visible** **Overall appearance: Appropriate**	Pt was unable to say what the date/month was.

INTEGUMENTARY: **Skin color: Pink** **Character: dry** **Temperature: warm** **Turgor: >3 seconds** **Rashes: Age spots** **Bruises: None visible** **Wounds: ~~abrasion on l side of chest~~None visible** **Braden Score: 13 Moderate Risk** **Drains present: Y☐ N ☒** **Type:**	
HEENT: **Head/Neck: Normal cephalic** **Ears: No visible drainage appropriate shape** **Eyes: Sclera white, atrophy of the iris** **Nose: Septum medial, no drainage visible** **Teeth: Few teeth missing, no dentures.**	**.**
CARDIOVASCULAR: **Heart sounds: S1 and S2 audible, but lightly** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: +12-radial** **Capillary refill: >3 seconds** **Neck Vein Distention: Y ☐ N ☒⊟** **Edema Y ☐ N ☒⊟** **Location of Edema: N/A**	**~~.~~Patient has a weak pulse and was difficult to auscultate.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒⊟** **Breath Sounds: Location, character**	**.**
GASTROINTESTINAL: **Diet at home: N–ormal** **Current Diet: Normal** **Height: 4' 11"** **Weight: 79lbs.** **Auscultation Bowel sounds: Borborygmi** **Last BM: Early morning – not specified** **Palpation: Pain, Mass etc.: N/A** **Inspection: No lesions or masses** **Distention: None** **Incisions: None**	**~~.~~While auscultating client's abdomen the stomach had a consistent growl, with no pauses in peristalsis.**

Scars: None Drains: None Wounds: None Ostomy: Y ☐ N ☒ Nasogastric: Y ☐ N ☒ Size: Feeding tubes/PEG tube Y ☐ N ☒ Type:	
GENITOURINARY: Color: Light Yellow Character: Clear Quantity of urine: Voided 2 times during shift Pain with urination: Y ☐ N ☒ Dialysis: Y ☐ N ☒ Inspection of genitals: Yes Catheter: Y ☐ N ☒ Type: Size:	
MUSCULOSKELETAL: Neurovascular status: Appropriate for age ROM: Limited in extremities especially hips Supportive devices: Sit-to-stand Strength: Overall weak ADL Assistance: Y☒ N ☐ Fall Risk: Y ☒ N☐ Fall Score: High Activity/Mobility Status: Limited Independent (up ad lib) ☐ Needs assistance with equipment ☒ Needs support to stand and walk ☐	-Patient is at an old age and is becoming weaker. She has expressed ADL are becoming more difficult.
NEUROLOGICAL: A&O x2 (name place) MAEW: Y ☐ N☒ PERLA: Y ☒ N☐ Strength Equal: Y ☐ N ☒ if no - Legs ☒ Arms ☐ Both ☐ Orientation: Understands and follows commands Mental Status: Slightly confused Speech: Slightly slurred Sensory: Pt has feeling throughout body	-Client moves upper extremities well for her age. Lower extremities are limited w/ ROM.

LOC: None recently	
PSYCHOSOCIAL/CULTURAL: **Coping method(s): Watching TV, Church** **Developmental level: Well—** **Religion & what it means to pt.:** **Christian – Significant importance** **Personal/Family Data (Think about home environment, family structure, and available family support): Client did not want to discuss. Sister does visit from time to time according to aide.**	**.**

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0855	81	102/71	14	98.1	96

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0855	0/10	Hips	5	Aching	Spoke to Nurse

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
75% of breakfast, 8oz of water, 8oz of grape juice	Urinated x2 during shift.

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	Rational • Explain why the nursing diagnosis was chosen	Intervention (2 per dx)	Evaluation • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. —Chronic px due to osteoarthritis as evidence by client verbal expression of pain and guarding near hip.	Client has many px medications on chart. During physical assessment patient was cautious around hips.	1.—Review expectation of pain relief with client. 2.—Explore clients need, time, and schedule for medications and the medications they use daily.	Client's expression of relief or verbalizing the pain is no longer present. Allowing the client to be more independent and moving and functioning on her own.
2. —Client at risk for spiritual distress related to sociocultural deprivation as evidence by inability to participate in church activities and searching for spiritual strength.	Client has had limited communication with friends and family from church while at the facility. Verbal expression is a good method of clarification and allows you to have a better understanding.	1. —If client is unable to write, then give them a recorder or phone to record thoughts or call friends. 2.—Discuss with the client how they have coped in the past and it had helped them.	Client should show reduced stress and the ability to cope easier. Having a feeling of self-connectedness, comfort, and peace. Patient may possibly state that they feel better and are more positive/happy.

Other References (APA):

Concept Map (20 Points):

Subjective Data

Client complaining of pain in left hip rated 5/10. Client has expressed her passion for religion and the meaning it has in her life.

Nursing Diagnosis/Outcomes

Client experiencing chronic px due to osteoarthritis as evidence by client verbal expression of pain and guarding near hip.
Client at risk for spiritual distress related to sociocultural deprivation as evidence by inability to participate in church activities and searching for spiritual strength.

Objective Data

Client's labs were almost all within the normal ranges. Turger and capillary refill are rapid with <3 second response time. Heart and lung sounds are clear with no wheezes, crackles, or murmers. Patient is prescribed several pain medications. Vitals are as follows Pulse 81, BP 102/71, Respirations 14, Temp 98.1 temporal, and O2 sat as 96%.

Patient Information

102 YO female admitted to facility on 04/30/2019 for a hip fracture. Client is 4ft 11in and 79lbs. She is a widow with a code status of DNR.

Nursing Interventions

1(a). Review expectation of pain relief with client.

1(b). Explore clients need, time, and schedule for medications and the medications they use daily.
2(a). If client is unable to write, then give them a recorder or phone to record thoughts or call friends.

2(b). Discuss with the client how they have coped in the past and it had helped them.