N321 Care Plan #2

Lakeview College of Nursing

Twila Douglas

Demographics (3 points)

Date of Admission 10/14/19	Patient Initials D.L.	Age 82	Gender Male
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Single	Allergies Losartan Latex
Code Status Full	Height 6’	Weight 260 lbs	

Medical History (5 Points)

Past Medical History: A-Fib, coronary artery disease, chronic combined systolic and diastolic heart failure, sleep apnea, hypertension, hyperlipidemia, peripheral artery disease, and restrictive lung disease

Past Surgical History: Patient’s past surgical history consist of coronary artery bypass graft, atherectomy, right and left cardiac catherization, and total hip replacement.

Family History: “No pertinent family history” listed in chart

Social History (tobacco/alcohol/drugs): Patients denies tobacco, alcohol and drug use.

Assistive Devices: Cane and occasional walker use

Living Situation: Patient currently lives alone. Patient has a daughter and granddaughter living in the area. Patient stated, “they help out when they can.”

Education Level: Higher education and no learning barriers present

Admission Assessment

Chief Complaint (2 points): Patient fell and reported feeling dizzy.

History of present Illness (10 points): 82 year old male admitted on 10/14/2019 for dizziness that caused loss of balance resulting in a fall which caused left shoulder pain and

contusions. The pain is located on the left shoulder making it difficult to extend and abduct, the pain doesn't radiate to other areas. This pain begin prior to be admitted. The pain is a steady throbbing pain that occasionally has sharpness to it. When performing activities severity of pain is increased. There has been no relief of pain prior to be admitted to hospital. The pain is constant throbbing, with activities pain becomes more sharp and severity increases. The pain is severity causing interruptions with ADL's.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Syncope

Secondary Diagnosis (if applicable):Pain

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

Syncope can result in a consequence of cerebral hypo perfusion. The brain relies on an adequate amount of blood flow to function. Syncope can result in cerebral perfusion after cessation of perfusion lasting only 3-5 seconds. Any defect occurring in the feedback system involving cardiac output, mean arterial pressure, systemic vascular resistance, intravascular volume status, and cerebrovascular resistance with intrinsic auto regulation and metabolic regulation can cause syncope (2019).

Syncope signs and symptoms consist of pale skin, tunnel vision, nausea, feeling warm, blurred vision, yawning, or hypotension, and lightheadedness. There are no specific vital signs or finding related to syncope. Imaging studies that may be helpful for patients with syncope are CT scans of the head, CT of the chest and abdomen, chest radiography, MRI, echocardiogram, and a standard 12-lead ECG. Other diagnostic procedures and testing that may also be helpful include electroencephalography, stress test, head-up tilt-table test, and carotid sinus massage. There are no specific laboratory testing that will diagnose syncope. It is essential to monitor serum glucose levels, serum electrolytes, urinalysis, total creatine kinase, complete, and blood count (2019).

It is essential to obtain a detailed account of the event, patient's medication history, and patient's personal or family medical history of cardiac disease. It is vital to perform a complete physical examination including measurement of the glucose level, detailed cardiopulmonary and neurological examination, stool guaiac examination, and assessment for signs of trauma (2019). Treatment can start at home with a rapid assessment of airway, circulation, breathing, and neurological status. Treatment options for syncope may require using intravenous access, administering glucose, oxygen therapy, pharmacological circulation support, pharmacologic or mechanical restraints, and defibrillation, or temporary pacing (2019).

Pathophysiology References (2) (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.

Syncope: Practice Essentials, Background, Pathophysiology. (2019). Retrieved 23 October 2019, from https://emedicine.medscape.com/article/811669-overview

Laboratory Data (15 points)

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	**4.5 million-5.9 million cells/ mcL**	**3.84**	**None**	
Hgb	**13-17.5 gm.dL**	**13.3**	**None**	
Hct	**41.5-50.5%**	**38.8**	**None**	
Platelets	**150,000-450,000 platelets/mcL**	**266**	**None**	
WBC	**4,5000=10,000 cells/ mcL**	**9.88**	**None**	
Neutrophils	**2.0-7.0**	**4.02**	**None**	
Lymphocytes	**20-40**	**44 (abnormal)**	**None**	**Increase in lymphocyte is related to infection (Hinkle & Cheever, 2018).**

Monocytes	**2-10**	**9.7**	**None**	
Eosinophils	**1-10**	**9.6**	**None**	
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 mmol/L**	**135**	**None**	
K+	**3.5-5 mmol/L**	**4.2**	**None**	
Cl-	**95-105 mmol/L**	**97**	**None**	
CO2	**23-29 mEq/L**	**32.4 (abnormal)**	**None**	**COPD patient have a reduction in ability to exhale the CO2 adequately which cause retention of CO2 levels (Hinkle & Cheever, 2018).**
Glucose	**65-110 mg/dL**	**103**	**None**	
BUN		**51**	**None**	
Creatinine	**0.6-1.2 mg/dL**	**1.88**	**None**	**Indicates impaired kidney function or body's poor ability to clear creatinine (Hinkle & Cheever, 2018).**
Albumin	**3.4-5.4 g/dL**	**3.4**	**————**	
Calcium	**8.5-10.3**	**9.1**	**None**	
Mag	**1.5-2.5 mEq/L**	**1.7**	**None**	
Phosphate	**————**	**————**	**None**	

Bilirubin	**0-6 umol/L**	**0.3**	**None**	
Alk Phos	**50-100U/L**	**93**	**None**	
AST	**5-30 U/L**	**18**	**v**	
ALT	**5-30**	**15**	**None**	
Amylase	**——-**	**————-**		
Lipase	**————**	**———-**		
Lactic Acid	**————**	**—————**		

Other Tests 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
INR	**0.9-1.2**	**2.2(abnormal)**	**2.3**	**Patient has an abnormal reading due to blood taking longer to clot (Hinkle & Cheever, 2018).**
PT	**20-40 sec**	**24.9**	**25.8**	
PTT	**————-**	**————**		
D-Dimer	**————**	**————**		
BNP	**————-**	**———**		
HDL	**——-**	**————**		
LDL	**————**	**————**		
Cholesterol	**————**	**————**		
Triglycerides	**————**	**————**		
Hgb A1c	**————**	**————**		
TSH	**————**	**————**		

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	————————			
Blood Culture	————————			
Sputum Culture	————————			
Stool Culture	————————			

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT scans of the head, CT of the chest and abdomen, chest radiography, MRI, echocardiogram, and a standard 12-lead ECG.

Diagnostic Test Correlation (5 points): Test are correlated with diagnosis and treatment plan.

Diagnostic Test Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**Coumadin/ warfin**	**Aspirin/ acetylsalicylic acid**	**Coreg/ carvedilol**	**Lipitor / atorvastatin calcium**	**Plavix/ clopidogrel**

Dose	**5mg**	**81 mg**	**3.125 mg**	**10 mg**	**75 mg**
Frequency	**Q 1600**	**Daily**	**2X daily with meals**	**Daily**	**Daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Anticoagulant**	**Platelet aggregation**	**antihypertensive, HF treatment adjunct**	**Antihyperlipidemic**	**Platelet aggregation inhibitor**
Mechanism of Action	**Livers ability to synthesize vitamin K dependent cloning factors are interfered with it. Prevents coagulation from occurring**	**Aspirin inhibit platelets aggregation and blocks the activity of cyclooxyrgenase.**	**Reduces cardiac output and tachycardia which causes decreased peripheral vascular resistance, resulting in reduced cardiac workload and blood pressure.**	**Reduces lipoprotein levels and enhances LDL uptake and breakdown**	**Binds with ADP and prevents platelet aggregation**
Reason Client Taking	**Prevent blood clots**	**1. Prevent blood clots**	**CHF, heart diagnosis**	**To control cholesterol CAD**	**Prevent blood clots**
Contraindications (2)	**1. Hypersensitivity to warfin 2. Hemorrhage tendency**	**1. Allergy ti tartrazine dye 2. Asthma**	**1. Hypersensitivity to caspofungin 2. None**	**1. Active hepatic disease 2. Hypersensitivity to atorvastatin**	**1. Active pathological bleeding 2. Hypersensitivity to clopidogrel**

Side Effects/Adverse Reactions (2)	**1. Bleeding 2. Red or brown urine**	**1. Confusion 2. CNS depression**	**1. Asthenia 2. Anxiety**	**1. Amnesia 2. Abnormal dreams**	**1. Confusion 2. Depression**
Nursing Considerations (2)	**1. Monitor patient with hepatic impairment closely for bleeding 2. Monitor INR and lab levels**	**1. Don't crush time release or controlled released aspirin tablet unless directed 2. Ask about tinnitus**	**1. Monitor for possible histamine reaction 2. Watch for flush skin and asses patient**	**1. Know not to be used in patients taking cyclosporine 2. Use cautiously in patients who consume substantial amounts of alcohol**	**1. Obtain blood cell counts 2. Monitor for signs of bleeding**

Brand/Generic	**Norco / hydrocodone**	**Morphabond/ morphine**	**Zofran / onadansetron injection**	**Tylenol / acetaminophen**	**Miralax/ polyethylene glycol**
Dose	**5.325 mg**	**4 mg**	**4 mg**	**500 mg**	**17 g**
Frequency	**PRN Q 4hrs**	**PRN Q 4hrs**	**PRN Q 8hrs**	**PRN Q 4hrs**	**1x Daily**
Route	**Oral**	**I.V. push**	**I.V. push**	**Oral**	**Oral**

Classification	**Analgesic**	**analgesic**	**Antiemetic**	**antipyretic, nonopiod analgesic**	**Laxative**
Mechanism of Action	**Binds with opiod receptors to produce pain relief**	**Brain and spinal cord produces euphoria and analgesic.**	**Reduces nausea and vomitting by small intestine from releasing serotonin**	**Acts directly on temperature regulating center in the hypothalamus and interfere with pain impulse in the peripheral nervous system**	**Increases amount of water in the intestinal tract which then stimulate bowel movements.**
Reason Client Taking	**Pain in shoulder**	**For pain related to fall**	**Nausea**	**Pain in shoulder**	**Prevent constipation**
Contraindications (2)	**1. Acute or severe bronchial asthma 2. Hypersensitivity to morphine**	**1. Hypersensitivity to montelukast 2. Patients with upper airway obstructions**	**1. Hypersensitivity to zofran 2. Concomitant use of apomorphine**	**1. Hypersensitivity to acetaminophen 2. Sever hepatic impairment**	**1. Hypersensitivity to miralax 2. Breast feeding women**
Side Effects/Adverse Reactions (2)	**1. Dizziness 2. Lightheadness**	**1. Agitation 2. Confusion**	**1. Agitation 2. Anxiety**	**1. Fatigue 2. Agitation**	**1. Increased sweating 2. Upset stomach, bloating, gas**

Nursing Considerations (2)	**1. Should not be given to patient with impaired consciousness** **2. Use extreme caution when administer hyrdrocodone to patient with significant COPD.**	**1, use extreme caution when administering morphine to patient with conditions associated with COPD.** **2. Use morphine with extreme caution in patients who may be at risk for carbon dioxide retention**	**1. Place tablet under tongue** **2. Monitor patient closely for sign and symptoms of hypersensitivity to zofran**	**1. Use cautiously in patient with hepatic impairment** **2. Monitor renal function in patient on long term therapy**	**1. Monitor stool** **2. Encourage fluid intake**

Hospital Medications (5 required)

Medications Reference (APA):

2019 Nurse's drug handbook.

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: Alert X4** **Orientation: Oriented X3** **Distress: None** **Overall appearance: Well and stable**	
INTEGUMENTARY (2 points): **Skin color: Pale** **Character: contusion on left shoulder, few bed bug bites** **Temperature:Warm** **Turgor: less than 3 seconds** **Rashes: none** **Bruises: bruises on shoulder** **Wounds: None** **Braden Score: 21** **Drains present: Y☐ N ☐ X** **Type: N/A**	

HEENT (1 point): **Head/Neck: Head normocephalic, glasses for vision, oral mucosa moist, neck non tender, no JVD, and no bruises** **Ears: Left and right hearing aidess, tympanic membrane pearly gray and intact, no drainage or cerumen present** **Eyes: Glasses, PERRLA** **Nose: No polyps, septal deviation,** **Teeth: WDL dental appliance**	.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc. s1,s2 no s3** **Cardiac rhythm (if applicable):irrgulary, irregular** **Peripheral Pulses: present +2** **Capillary refill: less than 3 seconds** **Neck Vein Distention: Y ☐ N ☐ X** **Edema Y ☐ N ☐X** **Location of Edema: none** **N/A**	.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐X** **Breath Sounds: Location, character rhonchi, no rales,** **Decreased breath sounds at bases**	.

GASTROINTESTINAL (2 points): **Diet at home: Not eating much due to having no one to cook for him.** **Current Diet: Regular diet** **Height: 6'** **Weight:260** **Auscultation Bowel sounds: bowel sounds active in all four quadrants** **Last BM: 10/13/1019** **Palpation: Pain, Mass etc.:Soft, non distended, no mass, no pain** **Inspection:** **Distention: no** **Incisions: none** **Scars: none** **Drains: none** **Wounds:none** **Ostomy: Y ☐ N ☐ X** **Nasogastric: Y ☐ N ☐X** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐X** **Type:**	.
GENITOURINARY (2 Points): **Color: N/A** **Character: N/A** **Quantity of urine: N/A** **Pain with urination: Y ☐ N X☐** **Dialysis: Y ☐ N X☐** **Inspection of genitals: no** **Catheter: Y ☐ N ☐X** **Type:** **Size:**	

MUSCULOSKELETAL (2 points): **Neurovascular status: WDL** **ROM: ROM with all extremities** **Supportive devices: cane and occasional walker use** **Strength: weaker than normal due to pain and fall** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y X☐ N☐** **Fall Score: 25** **Activity/Mobility Status: up with assist** **Independent (up ad lib) no** **Needs assistance with equipment yes X** **Needs support to stand and walk yes X**	.
NEUROLOGICAL (2 points): **MAEW: Y ☐☒ N☐** **PERLA: Y ☐☒ N☐** **Strength Equal: Y ☐ N ☐ X if no -left side weakness due to shoulder pain** **Legs ☐ Arm s ☐ Both ☐☒** **Orientation:X3** **Mental Status: alert and stable** **Speech:clear** **Sensory:normal** **LOC: Alert and oriented**	.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): Relaxing and watching television** **Developmental level: Patient is positive about being able to get therapy for shoulde.** **Religion & what it means to pt.: Catholic and everyone should have someone to pray to.** **Personal/Family Data (Think about home environment, family structure, and available family support): Patient is divorced and lives alone. Patient has a daughter and granddaughter that can help out, if needed.**	.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
14:22	**72**	**115/56**	**18**	**97.5 F**	**94% room air**
17:06	**65**	**130/68**	**18**	**97.5 F**	**95% room air**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
14:22	**6**	**Left shoulder**	**9**	**Steady throbbing, with occasional sharpness**	**Administer Norco**
15:37	**5**	**Left shoulder**	**9**	**Steady throbbing pain**	**Position changes and use of pillows to be more comfortable in bed**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 **Location of IV: left antecubital** **Date on IV: 10/14/19** **Patency of IV: Patent** **Signs of erythema, drainage, etc.: None present** **IV dressing assessment: clean, dry and intact**	None

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
480	350

Nursing Care

Summary of Care (2 points)

The patient was admitted following being dizzy and having a fall this afternoon. The patient complained of left shoulder pain. The patient has a contusion on the left shoulder. The physician had X-Ray of the shoulder and elbow, MRI, cardiac monitoring, and echocardiogram done. The results are still pending. The main complaint on the visit is dizziness and pain. The patient has been feeling tired and dizzy. Currently, the patient has pain related to the fall caused by being dizzy. Vital signs are presented stable, BP 115/56, pulse 72, respiratory 18, temperature 97.5F and 94% room air. The patient is currently on a regular diet since being admitted to the hospital. The patient's diet consists of missing meals due to not having someone to help prepare the meals. The patient can walk but is not active. The physician wants to monitor labs and enzyme levels. The results of the diagnostic test will determine the plan for treatment. The physician recommended a therapy consult to assist with the healing of his shoulder.

Discharge Planning (2 points)

Discharge location: Discharge will be to Heritage for therapy for left shoulder.

Home health needs (if applicable): N/A patient is unable to have home health due to having bed bugs in home.

Equipment needs (if applicable): N/A

Follow up plan: Follow up on shoulder will depend on the results from the diagnostic test. Patient will have follow up after therapy to see if improvements were made and to assess the left shoulder.

Education needs: Patient was educated on bed bugs and how to prevent them and how to get rid of the current ones. Patient was educated onto importance of diet and nutritional needs as they relate to his diagnosis. Patient was also education on fall safety and ways to avoid falls.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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

1. Fall R/T dizziness AEB syncope	**The nursing diagnosis was chosen due to patient stated gelling "dizzy & tired" which was related to his fall.**	**1. Respond to call light as soon as possible** **2. Move items used by the patient within easy reach, such as call light, urinal, water and telephone.**	• **Patient responding great to nurse responding as soon as possible and making items available for easy access.** • **Goals and outcomes was complete and client responded well**
2. Acute pain R/T pain emerging from trauma	**The nursing diagnosis was chosen for left shoulder pain caused from fall.**	**1. Acknowledge reports of pain immediately** **2. Provide rest periods to promote relief, relaxation and sleep.**	• **Patient responded well to the actions. Patient pain was acknowledge immediately and rest was provided when needed.** • **Client responded well and goals and outcomes were obtained.**
3. Disturbed sleep paterns R/T abnormal physiological symptoms (dyspnea at night) AEB sleep apnea	• **The Nursing diagnosis was chosen because patient stated having difficulty breathing when sleeping. Patient has a history of sleep apnea and other diagnosis that can contribute to the nursing diagnosis chosen.**	**1. The nurse will discourage caffeine or large meal intake 2 hours prior to bed.** **2. Evaluate timing or effects of medications that can disrupt sleep.**	**1. Patient was alone, with no family present, patient responded well to nursing actions.** **2. Client responded well, and modifications were made to fit patient.** **Goals and outcomes were obtained**

Other References (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.

Concept Map (20 Points):

Subjective Data

- Shoulder pain
- Itching from bed bug
- Pain from bed bug bites
-

Nursing Diagnosis/Outcomes

Ineffective tissue perfusion R/T decreased in peripheral blood circulation AEB syncope

- Patient will have increase in peripheral blood circulation

Decreased cardiac output R/T to the disturbance of blood flow to the heart muscle AEB syncope

- Increase in cardiac output

-
- BP 140/82, pulse 79, temp 97.9, respirations 20, 97 % room air
- Obesity
- Contusion on L shoulder
- Bed

Patient Information

- 82 year old
- Full code
- latex and losartan allergy
- Divorced
- Lives alone

Nursing Interventions

- **Prevent injury**
- **Monitor for changes in level of consciousness**
- **Educate patient to change position slowly**
- **Promote adequate fluid intake**
- **Monitor vitals signs regularly**
- **Assess changes in skin color**
- **Administer medications, as prescribed**