

N321 Care Plan # 2

Lakeview College of Nursing

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### Demographics (3 points)

Date of Admission 10-11-2019	Patient Initials LP	Age 81	Gender M
Race/Ethnicity White	Occupation Retired	Marital Status Married	Allergies Penicillin's
Code Status Full Code	Height 168cm	Weight 77kg	

### Medical History (5 Points)

Past Medical History: B-Cell Lymphoma, HTN, Hyperlipidemia, Gout, Neuropathy, Diabetes,

Non-Hodgkin's Lymphoma, Prostate Cancer, Skin Cancer, and Colon Cancer

Past Surgical History: Appendectomy, Inguinal Hernia, Train Collision with streetcar

Family History: No known family history

Social History (tobacco/alcohol/drugs): Former smoker, quit more than 30 days ago

Assistive Devices: No assistive device use

Living Situation: Lives at home with wife

Education Level: GED

### Admission Assessment

Chief Complaint (2 points): Patient complains of fever and chills

History of present Illness (10 points): Patient is an 81-year-old male who presented to the ED from the Cancer Center on 10-11-2019. He complained of fever and chills. Patient has an extensive past medical history and currently has Non-Hodgkin's Lymphoma. The patient also complained of a dull, neuropathy pain in his lower extremities rating 6 out of 10. The patient stated the pain started on 10-11-2019. He came straight to the ER from the Cancer Center. The patient did not list any aggravating factors or any methods of relief of symptoms.

## Primary Diagnosis

Primary Diagnosis on Admission (2 points): Non-Hodgkin's Lymphoma

Secondary Diagnosis (if applicable): Chronic Kidney Disease

Pathophysiology of the Disease, APA format (20 points): Non-Hodgkin's Lymphoma (NHL) is a type of cancer that originates from lymphoid tissues, mainly of lymph nodes. These are tumors that result from chromosomal translocations, infections, environmental factors, immunodeficiency states, and chronic inflammation. The clinical manifestations of Non-Hodgkin's Lymphoma vary with location, the rate of tumor growth, and the function of the organ being compromised. Signs and symptoms of lymphomas involving the bone marrow include frequent involvement and fatigue/weakness are more common in advanced stage of the disease process. Other signs include night sweats, weight loss, bone pain, shortness of breath, and enlarged lymph nodes. Diagnostic testing for NHL is CBC which may indicate thrombocytopenia, Serum chemistry studies which indicate elevated LDH. Imaging test include chest radiology, CT scan of neck, chest, and abdomen. Bone scanning, MRI of brain/spinal cord, and PET scanning. The treatment of NHL varies depending on various factors. Common therapies include radiation therapy, bone marrow transplant, radioimmunotherapy, transfusion, and antibiotics. Treatment of NHL can increase the risk of getting secondary conditions. In this case, the patient has NHL and has a secondary diagnosis of Chronic Kidney Disease (CKD). CKD is a term that encompasses all degrees of decreased renal function. Treatment of aggressive blood pressure, hyperlipidemia, and glycemic control can all halt the progression of CKD. The patient has each of the underlying issues to manage.

Pathophysiology References (2) (APA):

Arora, P. (2019, August 1). Chronic Kidney Disease Treatment & Management: Approach Considerations, Delaying or Halting Progression of Chronic Kidney Disease, Treating Pathologic Manifestations of Chronic Kidney Disease. Retrieved from <https://emedicine.medscape.com/article/238798-treatment#d1>

Vinjamaram, S. (2019, June 12). Non-Hodgkin Lymphoma. Retrieved from <https://emedicine.medscape.com/article/203399-overview#a3>.

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	4.28-5.56	3.13	3.27	Low d/t bone marrow failure r/t lymphoma
Hgb	13-17	9.3	9.7	Low d/t bone marrow failure r/t lymphoma
Hct	38.1-48.9	27.5%	28.4%	Low d/t bone marrow failure r/t lymphoma
Platelets	149-393	62	23	Extremely low d/t bone marrow failure
WBC	4-11.7	0.3	0.5	Extremely low d/t compromised immune system from various cancers and UTIs
Neutrophils	Labs Not Performed	n/a	n/a	The patient has an extremely low WBC count therefore these cannot be determined.
Lymphocytes	Labs Not Performed	n/a	n/a	n/a
Monocytes	Labs Not Performed	n/a	n/a	n/a
Eosinophils	Labs Not Performed	n/a	n/a	n/a
Bands	Labs Not Performed	n/a	n/a	n/a

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	133	140	Within normal limits
K+	3.5-5.1	3.8	3.6	Within normal limits
Cl-	98-107	100	109	Within normal limits
CO2	21-31	20	24	Within normal limits

Glucose	74-109	145	97	Within normal limits
BUN	7-25	37	25	Increased d/t Chronic Kidney Disease
Creatinine	0.70-1.20	1.65	1.18	Increased d/t chronic kidney disease
Albumin	3.5-5.2	3.6	n/a	Within normal limits
Calcium	8.6-10.3	8.7	8.1	Hypocalcemia d/t chronic kidney disease
Mag	Labs Not Performed	n/a	n/a	n/a
Phosphate	Labs Not Performed	n/a	n/a	n/a
Bilirubin	0.3-1.0	1.0	n/a	Within normal limits
Alk Phos	40-130	111	n/a	Within normal limits
AST	0-40	52	n/a	High d/t hyperlipidemia
ALT	0-41	54	n/a	High d/t hyperlipidemia
Amylase	Labs Not Performed	n/a	n/a	n/a
Lipase	Labs Not Performed	n/a	n/a	n/a
Lactic Acid	0.5-2.0	1.7	n/a	Within normal limits

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	Labs Not Performed	n/a	n/a	n/a
PT	Labs Not Performed	n/a	n/a	n/a
PTT	Labs Not Performed	n/a	n/a	n/a

D-Dimer	Labs Not Performed	n/a	n/a	n/a
BNP	Labs Not Performed	n/a	n/a	n/a
HDL	Labs Not Performed	n/a	n/a	n/a
LDL	Labs Not Performed	n/a	n/a	n/a
Cholesterol	Labs Not Performed	n/a	n/a	n/a
Triglycerides	Labs Not Performed	n/a	n/a	n/a
Hgb A1c	Labs Not Performed	n/a	n/a	n/a
TSH	Labs Not Performed	n/a	n/a	n/a

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	Clear	Yellow/Clear	Not performed today. Only at admission.	Within normal limits
pH	4.5-8.0	5.0	n/a	Within normal limits
Specific Gravity	1.010-1.030	1.012	n/a	Within normal limit
Glucose	0 – 0.8	Normal	n/a	Within normal limit
Protein	0-20mg/dL	1+	n/a	Within normal limits
Ketones	Negative	Negative	n/a	Within normal limits
WBC	Negative	Negative	n/a	Within normal limits
RBC	Negative	Negative	n/a	Within normal limits
Leukoesterase	n/a	n/a	n/a	n/a

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	Labs Not Performed	n/a	n/a	n/a
Blood Culture	Negative.	Not performed at admission	Negative	A negative blood culture means that the probability of a blood infection is low.
Sputum Culture	Labs Not Performed	n/a	n/a	n/a
Stool Culture	Labs Not Performed	n/a	n/a	n/a

Lab Correlations Reference (APA): (Medical Chart, October 14, 2019)

#### Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT Abdomen (UTI), Chest CT (Bronchitis)

Diagnostic Test Correlation (5 points): A CT of the abdomen allows visualization of the kidney, pancreas, liver, and other parts of the belly. This CT revealed that the patient has a UTI. A chest CT helps diagnose the cause of unexplained cough, shortness of breath, fever, chest pain, or other chest symptoms. This CT revealed that the patient has bronchitis.

Diagnostic Test Reference (APA): (Medical Chart, October 14, 2019)

Current Medications (10 points, 1 point per completed med)  
 \*10 different medications must be completed\*

Home Medications (5 required)

Brand/Generic	Lipitor/atorvastatin	Zyloprim/Allopurinol	Ativan/Lorazepam	Bactrim DS/trimethoprim	Cefdinir
Dose	20mg	300mg	0.5mg	160mg	300mg
Frequency	Daily	Daily	TID/PRN	BID	Q12H
Route	PO	PO	PO	PO	PO
Classification	Statin	Antigout	Antianxiety	Sulfonamides	Cephalosporins
Mechanism of Action	Reduces rate-limiting step in cholesterol	Inhibits the production of uric acid	Sedative hypnotic with short onset of effects	Blocks 2 consecutive steps in the biosynthesis of nucleic acid	Inhibits mucopeptide synthesis in bacterial cell wall
Reason Client Taking	Hyperlipidemia	To treat gout and hyperuricemia	To treat anxiety	Antibiotic to treat UTI	Antibiotic to treat non-Hodgkin's lymphoma
Contraindications (2)	Hypersensitivity Active liver disease	Hypersensitivity didanosine	Patients with primary depressive disorder Opioids	Hypersensitivity Hepatic impairment	Hypersensitivity Penicillin allergy
Side Effects/Adverse Reactions (2)	Myopathy Diarrhea	Nausea Vomiting	Sedation Dizziness	Anorexia Nausea	Diarrhea Nausea
Nursing Considerations (2)	Monitor liver function Monitor CPK levels for muscle tenderness	Monitor blood pressure Monitor CBC and uric acid levels during therapy	If IV form must be injected I.M. Use cautiously in elderly due to sedative adverse effect	When administering do not use NS as dilute Do not refrigerate	Store in tightly closed container Monitor for signs of hypersensitivity

Hospital Medications (5 required)

Brand/Generic	Gabapentin /Neurontin	Heparin/Heparin	Zohydro/Hydrocodone	Vancocin/Vancomycin	Protonix/pantoprazole
Dose	300mg	500 units (5mL)	325mg	1.5mg	40mg
Frequency	HS	PRN	Q6H	Daily	Daily
Route	PO	IV push	PO	PO	PO
Classification	GABA Analogs	Anticoagulants	Opioid	Glycopeptides	Proton pump inhibitor
Mechanism of Action	Structurally related to neurotransmitter GABA	Binds with antithrombin iii enzyme which inhibits thrombin	Opioid receptor agonist	Inhibits cell-wall biosynthesis	Binds to H+/K+ exchanging ATPase in gastric parietal cells
Reason Client Taking	For nerve pain	To provide with anticoagulation	Pain	Neutropenia Fever	GERD
Contraindications (2)	Hypersensitivity Increased CPK levels	History of HIT Uncontrolled, active bleeding	Opioid receptor antagonist and respiratory depressant	Hypersensitivity	Hypersensitivity Concomitant administration with rilpivirine containing products
Side Effects/Adverse Reactions (2)	Ataxia Dizziness	Heparin-induced thrombocytopenia Mild pain	Nausea Vomiting	Nausea Abdominal pain	Headache Abdominal pain
Nursing Considerations (2)	Give drug with food to prevent GI upset	Given SQ in the abdomen or IV push	Do not crush or chew capsule, take whole with enough water to ensure complete swallowing	Rapid IV administration may result in flushing, pruritis, hypotension, erythema, and urticaria	Tablet should not be chewed or crushed Administer before meals

Medications Reference (APA): (Medical Chart, October 14, 2019)

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point):  Alertness:  Orientation:  Distress:  Overall appearance:</p>	<p>A/O x 4  No diaphoresis, fevers, chills, weight changes, or change in appetite  No signs of distress  Patient appears very fatigue from his illness</p>
<p>INTEGUMENTARY (2 points):  Skin color:  Character:  Temperature:  Turgor:  Rashes:  Bruises:  Wounds: .  Braden Score:  Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  Type:</p>	<p>Skin is pink, warm, and dry  38.0°C (Tympanic) 39.3°C (Tympanic max)  No rashes, lesions, pruritis, or nodules  No open wounds on upper or lower extremities  No bilateral, lower or upper extremity edema</p>
<p>HEENT (1 point):  Head/Neck:  Ears:  Eyes:  Nose:  Teeth:</p>	<p>PERLA present  Nose is midline without signs of rhinorrhea or epistaxis  Oral mucosa is moist  Tongue is midline without obvious edema  Throat is non-erythematous  Hearing is appropriate bilateral</p>
<p>CARDIOVASCULAR (2 points):  Heart sounds:  S1, S2, S3, S4, murmur etc.  Cardiac rhythm (if applicable):  Peripheral Pulses:  Capillary refill:  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>Sinus rhythm on telemetry  Radial pulses, dorsalis pedis pulses bilateral 3+ normal  Capillary refill &lt; 3sec  No murmurs, clicks, or rubs</p>
<p>RESPIRATORY (2 points):  Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  Breath Sounds: Location, character</p>	<p>Lungs are clear to auscultation bilaterally  Respirations are appropriate and non-labored  No obvious retractions or accessory muscle use</p>

<p>GASTROINTESTINAL (2 points):  Diet at home:  Current Diet  Height:  Weight:  Auscultation Bowel sounds:  Last BM:  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>Abdomen rounded, soft, non-tender  Neutropenic diet  Height: 168cm  Weight: 77kg  Bowel sounds are normoactive in all 4 quadrants  Last BM not known</p>
<p>GENITOURINARY (2 Points):  Color:  Character:  Quantity of urine:  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:  Size:</p>	<p>No difficulties voiding, frequency, urgency, or dysuria with voiding</p>
<p>MUSCULOSKELETAL (2 points):  Neurovascular status:  ROM:  Supportive devices:  Strength:  ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/>  Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/>  Fall Score:  Activity/Mobility Status:  Independent (up ad lib) <input type="checkbox"/>  Needs assistance with equipment <input type="checkbox"/>  Needs support to stand and walk <input type="checkbox"/></p>	<p>Weak gait  Up with one assist  No assistive device uses  Moves all extremities (upper and lower) symmetrically 5/5 bilaterally  Fall score: 45</p>
<p>NEUROLOGICAL (2 points):  MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p>	<p>Morse scale: 45 (Oriented to own ability)  No focal neurological deficits or paresthesia noted</p>

Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:	Patient has appropriate and symmetric sensation to touch in upper and lower extremities, bilaterally A/O x4 No slurred speech noted
PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	No obvious memory deficits Mood is pleasant Affect is appropriate Patient is cooperative with student examination Patient did not specify what religion means to him Family support comes from wife

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	68bpm	124/72mmH g	20beats/min	37.2°c	95%
1000	70bpm	141/81mmH g	18 beats/min	36.0°c	96%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric pain scale	Lower extremities	5	Dull	Acetaminophen and Gabapentin
1000	Numeric pain scale	Lower extremities	3	Dull	Acetaminophen and Gabapentin

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 gauge
Location of IV:	Right upper chest
Date on IV:	10-11-2019
Patency of IV:	No complications. Port is intact.
Signs of erythema, drainage, etc.:	No signs of erythema or drainage
IV dressing assessment:	Transparent dressing

### Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1708 mL	2075 mL

### Nursing Care

#### Summary of Care (2 points)

Overview of care: Patient is being treated for fever and chills. Monitoring patient platelet count closely for need of transfusion.

Procedures/testing done: Abdominal CT, Chest CT, Chest X-Ray

Complaints/Issues: Fever and Chills, Neuropathy Pain in lower extremities bilaterally

Vital signs (stable/unstable): Stable with peaked SBP

Tolerating diet, activity, etc.: Patient tolerates neutropenic diet well

Physician notifications: Notify physician if SBP is >180 or DSP is >90

Future plans for patient: Monitor for transfusion then discharge

#### Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): n/a

Equipment needs (if applicable): n/a

Follow up plan: Continue to treat for neutropenic fever and send home on antibiotic therapy

Education needs: Education related to chronic kidney disease, gout, neutropenic fever, and diabetes management

### Nursing Diagnosis (15 points)

\*Must be NANDA approved nursing diagnosis and listed in order of priority\*

<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, <b>modifications to plan.</b></li> </ul>
1. Unstable blood glucose r/t T2DM AEB, elevated blood glucose level	The patient is a diabetic with an extensive list of comorbidities. All of which, T2DM can have a negative effect on them all if not controlled.	1. assess patient blood glucose before meals and before bedtime 2. Assess feet for temperature, pulses, color, and sensation	The patient’s glucose was highly elevated at time of admission. After medication the levels dropped to an acceptable range.
3. Infection r/t UTI AEB patient has positive labs for UTI	The patients abdominal CT revealed a positive UTI	1.. Encourage the client to void every 2-3 hrs. 2.Encourage increased fluid intake to 2-3L/day 1.	The client was able to urinate on a regular basis to help prevent retention thus causing bacteria buildup. The client was very cooperative however, some fatigue was hindering full engagement in activity.
<b>3.</b> Risk for bleeding r/t thrombocytopenia AEB extremely low platelet count	The patient has a really low platelet count and is under close observation for bleeding	1. 1. monitor vital signs especially BP and heart rate 2. evaluate the use of any medications that affect hemostasis	The client was cooperative with regularly checked vital signs. The BP was abnormal but not enough to notify the provider. The client is taking medications that can interfere with hemostasis, but the client has severe comorbidities.

Other References (APA): Vera, M. (2019, September 18). 13 Nursing Diagnosis. Retrieved from <https://nurseslabs.com/diabetes-mellitus-nursing-care-plans/>.

Concept Map (20 Points):



**Subjective Data**

Patient rates pain 5/10 at 0700  
Patient states "The pain is dull and aching in my feet"  
Patient reports fever and chills

**Nursing Diagnosis/Outcomes**

Unstable blood glucose r/t T2DM AEB, elevated blood glucose level  
The patient's glucose dropped to an acceptable level after administration of medication  
Infection r/t UTI AEB patient has positive labs for UTI  
The patient is on antibiotic therapy for UTI, but no further labs have been completed to determine if the UTI is still present  
Risk for bleeding r/t thrombocytopenia AEB extremely low platelet count  
The patient is being monitored closely for signs of bleeding and platelet count drop

**Objective Data**

Patient vital signs at 0700  
Pulse: 68  
BP: 124/72  
Resp: 20  
Temp: 37.2  
O2: 95  
Patient vital signs at 1000  
Pulse: 70  
BP: 141/81  
Resp: 18  
Temp: 36  
O2: 96

**Patient Information**

81 yo male  
Fever and Chills  
Patient has hx of gout,  
hyperlipidemia, non-Hodgkin's  
lymphoma, diabetes  
Droplet, Granulocytopenic Precautions

**Nursing Interventions**

Assess patient blood glucose before meals and before bedtime  
Assess feet for temperature, pulses, color, and sensation  
Encourage the client to void every 2-3 hrs.  
Encourage increased fluid intake to 2-3L/day  
Monitor vital signs especially BP and heart rate  
Evaluate the use of any medications that affect hemostasis





