N311 Care Plan 3

Lakeview College of Nursing

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Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
9-24-2019	AR	93	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Married	Clonidine, Amlodipine, Atorvastatin
Code Status	**Height**	**Weight**	
DNR	5’2”	115lbs	

Medical History (5 Points)

Past Medical History: Anemia, Back pain, Depression, Hypotension and a history of falls.

Past Surgical History: Hysterectomy and dental surgery.

Family History: Patients sister had breast cancer, her daughter and aunt were both diabetic.

Social History (tobacco/alcohol/drugs): Patient never consumed alcohol, smoked or did any illegal drugs.

Admission Assessment

Chief Complaint (2 points): Right shoulder pain

History of present Illness (10 points): The patient fell at home on September 18, 2019. After two days of the pain getting worse, she went to the hospital via ambulance. The location of her pain was in her upper right arm as well as her face. The pain before treatment was very severe, and she told me, "it just never stops hurting." The patient described the pain as a throbbing and burning sensation that never stopped. Trying to move the arm at all resulted in the pain getting worse, and her face hurt when she attempted to speak. Before admission to the hospital, she used over the counter pain medications and an ice pack. For treatment, the doctors did a CT and Xray and recommended admission to a rehabilitation facility.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Fractured right Humerus

Secondary Diagnosis (if applicable): N/A

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

The humerus is the long bone within your upper arm. It spreads from your shoulder to your elbow, where it joins with the ulna and radius bones of your forearm. A humerus fracture refers to any break in this bone.

Any hard blow or injury to your arm can result in a humerus fracture. For example, my patient stated she was trying to use the bathroom in the middle of the night and failed to use her walker. She said she became unbalanced when trying to turn on the lights and ended up falling forward. In doing so, she put out her right hand to try to soften the fall. Unfortunately, in doing so, she fractured it and also hit her head on the side of her sink's cabinet.

Treating a humerus fracture depends on many different factors, including the type of fracture and whether there are any loose bone fragments according to our pathophysiology book. To determine the best treatment for the patient, the doctor will start by taking an X-ray of their arm. They may also have you do some movements with your arm. This will help them determine what kind of fracture you have and whether you have any other injuries.

Pathophysiology References (2) (APA):

Capriati, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: 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	3.50-5.20	3.57		
Hgb	11-16	12		
Hct	34-47%	36%		
Platelets	140-400	23		
WBC	4-11	6.81		
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	139		
K+	3.5-5.1	4.1		
Cl-	98-107	106		

CO2	**21.0-32.0**	**26.0**		
Glucose	**60-99**	**88**		
BUN	**7-18**	**14**		
Creatinine	**.55-1.02**	**.77**		
Albumin	**3.4-5.4**	**3.9**		
Calcium	**8.5-10.1**	**9.0**		
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		**n/a**		**My patient did not have a urinalysis lab report.**
pH		**n/a**		
Specific Gravity		**n/a**		
Glucose		**n/a**		
Protein		**n/a**		
Ketones		**n/a**		
WBC		**n/a**		
RBC		**n/a**		

Leukoesterase		**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		**n/a**		
Blood Culture		**n/a**		
Sputum Culture		**n/a**		
Stool Culture		**n/a**		

Lab Correlations Reference (APA):

Swearingen, P., & Wright, J. (n.d.). *All-in-one Nursing Care Planning Resource*. Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Ct Facial bones without contrast on 9-20-2019.

Findings – Acute right nasal bone fracture

XR shoulder right Ap/Grashey/Y=View on 9-20-2019.

Findings – Acute Fracture involving the right humeral neck.

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

Medications (5 required)

Brand/Generic	**Amlodipine**	**Dextrose 40%**	**Fentanyl**	**Lovastatin**	**Meloxicam**
Dose	**2.5mg**	**15g**	**25mcg**	**10mg**	**7.5mg**
Frequency	**At bedtime**	**PRN**	**PRN**	**Daily**	**Daily**
Route	**Mouth**	**Mouth**	**Iv Push**	**Mouth**	**Mouth**
Classification	**Pyrazine**	**Monosaccharide**	**Opioid**	**Mevinic acid derivative**	**Oxicam Derivative**
Mechanism of Action	**Inhibits sodium reabsorption in distal convoluted tubules.**	**Prevents protein and nitrogen loss, promotes glycogen**	**Binds to the opioid receptor site in the CNS.**	**Interferes with the hepatic enzyme and reduces formation of**	**Blocks cyclooxygenase and prevents inflammatory response.**

		deposition.		mevanic acid.	
Reason Client Taking	**Hypokalemia**	**Type 2 Diabetes**	**Pain**	**Cholesterol**	**Osteoarthritis**
Contraindications (2)	**Hypersensitivity to amiloride & Impaired renal function**	**Anuria & diabetic coma**	**Asthma & Intolerance**	**Breastfeeding & Pregnancy**	**Asthma & nasal polyps**
Side Effects/Adverse Reactions (2)	**Confusion & Dry mouth**	**Fever & Dehydration**	**Amnesia & Anxiety**	**Chills & Pain**	**Chest pain & UTI**

Medications Reference (APA):

2019 Nurse's Drug Handbook (Eighteenth ed.). (2019). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL: **Alertness: a/o x3** **Orientation: x3** **Distress: no distress** **Overall appearance: normal, happy**	
INTEGUMENTARY: **Skin color: Pinkish** **Character: dryness** **Temperature: warm to touch** **Turgor: < 3** **Rashes: no** **Bruises: no** **Wounds: no** **Braden Score: 14** **Drains present: Y☐ N ☒** **Type:**	

HEENT: **Head/Neck: symmetrical, no defect** **Ears: clear, no drainage, HoH on rs** **Eyes: sclera white, no drainage, PERRLA** **Nose: no debris or drainage. symmetrical** **Teeth: healthy and intact**	.
CARDIOVASCULAR: **Heart sounds: Normal S1 & S2** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: Bilateral equal 3+** **Capillary refill: < 3** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:** **Lower left calf**	.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**No abnormal breath sounds. Normal breath sounds auscultated throughout.**
GASTROINTESTINAL: **Diet at home: Normal** **Current Diet - Low sodium** **Height: 5' 2"** **Weight:115lbs** **Auscultation Bowel sounds: Normal bowel sounds auscultated.** **Last BM: Last night 10-21-2019** **Palpation: Pain, Mass etc.: no** **Inspection: clear** **Distention: no** **Incisions: no** **Scars: no** **Drains: no** **Wounds: no** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	.

GENITOURINARY: **Color: yellowish** **Character: clear** **Quantity of urine: n/a** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: n/a** **Catheter: Y ☐ N ☒** **Type:** **Size:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM: needs assistance on rs.** **Supportive devices: Walker** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 114** **Activity/Mobility Status:** **Independent (up ad lib) ☐ NO** **Needs assistance with equipment - yes** **Needs support to stand and walk - Yes**	**Pt is stronger on her left side due to fractured right shoulder. Currently doing physical therapy to regain strength.**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☒ Both ☐** **Orientation: x3** **Mental Status: x3** **Speech: clear** **Sensory: n/a** **LOC: no**	.
PSYCHOSOCIAL/CULTURAL: **Coping method(s): Religion** **Developmental level: N/a** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Patient has a very kind family that visits her every week. The pt is also a Christian and likes to read her bible and say prayers in her free time. Once finished with therapy, she will be returning to her apartment in an assistive living facility.**

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0940	78	128/88	16	97.3F	99%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0945	**5**	**Right shoulder**	**Not severe.**	**Pt stated it feels like "it is burning."**	**Asked the pt if she would like pain medication but refused.**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
220 ml of Coffee & milk.	**n/a**

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	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions?

by" components			• Client response, status of goals and outcomes, modifications to plan.
Acute pain related to injury as evidenced by pt stating "it feels like a burning pain."	**The patient has stated the fracture is still causing her pain.**	**1. Administration of pain medication** **2. Assistance with her right-side weakness.**	**I offered pain medication when the patient rated her pain a 5. She refused. Goal not met.** **I offered assistance with dressing and eating, and she agreed. Goal met.**
Decreased mobility related to pain as evidenced by the patient not being able to move her right arm.	**The patient is unable to move her right arm and has difficulty completing activities of daily living.**	**1. Assist the patient with ADL.** **2.Instruct the patient to use assistive devices to keep her body aligned correctly.**	**I helped the patient get up and walk to the bathroom. She can walk fine but needs some help sitting down. Goal met.** **The patient has a supportive sling for her right arm. I assisted her with putting it on and she stated, "it feels a little better." Goal met.**

Concept Map (20 Points):


Subjective Data
Patient stated, “My right shoulder burns and itches.”
Patient stated, “I cannot lift my right arm at all without pain.”
Nursing Diagnosis/Outcomes
Acute pain related to injury as evidenced by pt. stating “it feels like a burning pain.”
Goal met.
Decreased mobility related to pain as evidenced by the patient not being able to move her right arm.
Goal met.
Objective Data
Vitals all within normal ranges. Lab results all within normal ranges and patient seems to be happy with care we are providing.
Patient Information
The patient is a 93-year-old white woman. About two months ago she was hospitalized for a fall. She fractured her right shoulder and has had difficulty regaining strength on her right upper side.
Nursing Interventions
1.Increasing her fluid consumption
2.Assistance with ADLs
3.Using her supportive sling
4.Therapy
5.Pain medications PRN
6.Checking vitals every 4 hours