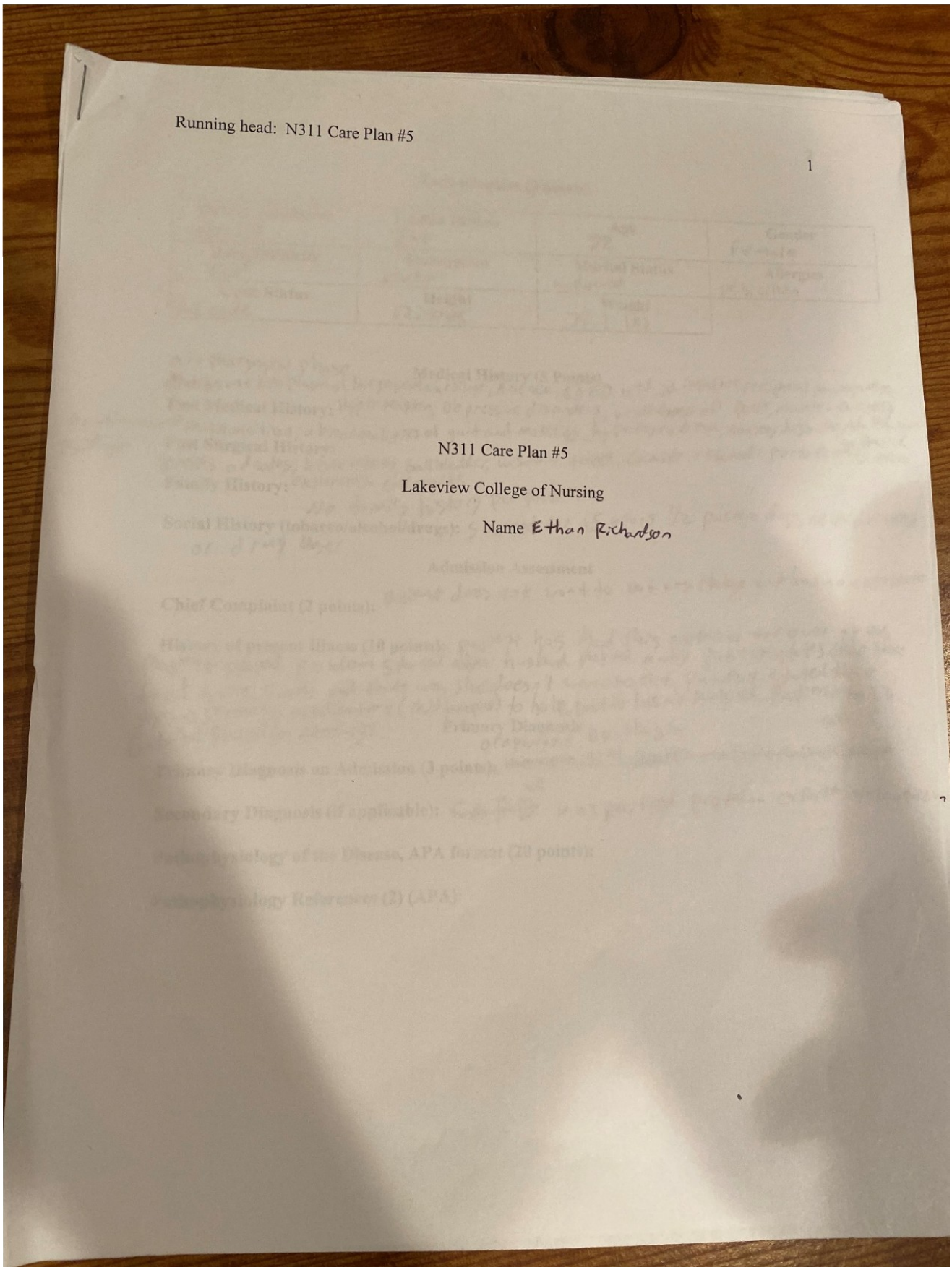
N311 Care Plan #5



Running head: N311 Care Plan #5

N311 Care Plan #5

Lakeview College of Nursing

Name Ethan Richardson

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
10/11/19	JW	72	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
white	teacher	widowed	penicillin
Code Status	**Height**	**Weight**	
Full code	62 inches	79.1 lbs	

Medical History (5 Points)

Past Medical History: oropharyngeal phase Malignant neoplasm of laryngeal cartilage, Anemia, COPD, UTI, idiopathic peripheral neuropathy, Hypertension, Depressive disorders, unsteadiness of feet, muscle weakness, protein-calorie malnutrition, abnormalities of gait and mobility, hypothyroidism, Anxiety disorder, Adult failure Dysphagia to thrive

Past Surgical History: tonsils adenoides, histo ectomy, Gallbladder, wisdom teeth, Cancer related: ports feeding tubes

Family History: exploratory Cadoracts

No family history per patient

Social History (tobacco/alcohol/drugs): Smoked for 15 years 1/2 pack a day, never drinker, or drug user

Admission Assessment

Chief Complaint (2 points): patient does not want to eat anything and has no appetite

History of present Illness (10 points):. patient has had this problem for over a year. Patient stated problem started after husband passed away. Patient states that the food here sucks and thats why she doesn't want to eat. Patient stated that she was placed on medication (mirtazapine) to help, but it has not helped. Patient has a G-tube placed for feedings.

Primary Diagnosis on Admission (3 points):. ~~Unspecified protein-calorie malnutrition~~ oropharyngeal Dysphagia OR

Secondary Diagnosis (if applicable):. ~~COPD~~ OR unspecified protein calorie malnutrition

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

Pathophysiology References (2) (APA):

Pathophysiology of Oropharyngeal Dysphagia

There are numerous underlying causes, including stroke and other neurologic conditions, local trauma and muscle damage, and a tumor or swelling that partially obstructs the passage of food (Saunders 2003). The condition can range from mild discomfort, such as a feeling that there is a lump in the throat, to a severe inability to control the muscles needed for chewing and swallowing (Saunders 2003).

Dysphagia can seriously compromise the nutritional status of a patient (Saunders 2003). Temporary measures such as tube feeding and parenteral nutrition can remedy the immediate problem, but long-term goals for rehabilitation must focus on helping the patient recover the ability to swallow sufficient amounts of food and drink to assure adequate nutrition (Saunders 2003).

Measures intended to accomplish the goal of oral feeding are implemented only after determining the particular techniques that are most helpful for the individual patient (Saunders 2003). In general, placing the patient in an upright position, providing a pleasant and calm environment, being sure the lips are closed as the patient begins to swallow, and preparing and serving foods of the proper consistency are all helpful techniques (Saunders 2003). Stroke victims who have difficulty swallowing should be turned, or should turn their heads, to the unaffected side to facilitate swallowing (Saunders 2003). If dry mouth is a problem, there are artificial salivas available to moisten and lubricate the mouth (Saunders 2003). When drinking fluids, dysphagic patients should sip the liquid in small amounts (Saunders 2003).

Esophageal dysphagia dysphagia caused by an abnormality in the esophagus, such as a smooth muscle disorder that interferes with peristalsis or an obstruction from external compression or a stricture (Saunders 2003). Oropharyngeal dysphagia is caused by difficulty in

initiating the swallowing process, so that solids and liquids cannot move out of the mouth properly (Saunders 2003).

References

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition. 2003 by Saunders, an imprint of Elsevier, Inc. All rights reserved.

N311 Care Plan #5

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 M/mcL		5	
Hgb	13.0-17.0 g/dL		15	
Hct	38.1-48.9%		41%	
Platelets	149-393 K/mcL		200	
WBC	4.0-11.7 K/mcL		13	
Neutrophils	2.4-8.4 x10^3/mcL		10	patient has a UTI
Lymphocytes	0.8-3.7 x10^3/mcL		2	patient has a UTI
Monocytes	4.4-12.0%		11	
Eosinophils	0.0-6.3%		3	
Bands	45.3-79.0		60	

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		140	
K+	3.5-5.1 mmol/L		4.5	
Cl-	98-107 mmol/L		102	
CO2	21-31 mmol/L		26	
Glucose	74-106 mg/dL		84	

N311 Care Plan #5

BUN	7-25 mg/dL		13	
Creatinine	0.70-1.20 mg/dL		0.90	
Albumin	3.5-5.2 g/dL		4.2	
Calcium	8.6-10.3 mg/dL		9	
Mag	1.7-2.2 mg/dL		1.9	
Phosphate	2.5-4.5 mg/dL		3.2	
Bilirubin	0.3-1.0 mg/dL		0.6	
Alk Phos	35-105 int unit/L		70	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences an contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	yellow clear		yellow hazy	UTI
pH	5.0-8.0		7.0	
Specific Gravity	1.005-1.034		1.020	
Glucose	normal		normal	
Protein	negative		negative	
Ketones	negative		negative	
WBC	<= 5		64	UTI
RBC	0-3		5	UTI
Leukoesterase	negative		3+	UTI

N311 Care Plan #5

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		>100,000 cfu/mL methicillin-Resistant staphylococcus aureus	patient has a UTI
Blood Culture	negative		negative	
Sputum Culture	negative		negative	
Stool Culture	negative		negative	

Sarah Bush Lincoln Health Center (2019). Reference Range. (Lab values). Mattoon IL.

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (10 points): Radiology Fluoroscopy

Reason for exam: difficulty Swallowing

Procedure: RF video swallow study

Indications: difficulty swallowing

Impression: There is evidence of significant laryngeal penetration and aspiration with thin consistency, nectar thickened consistency, Honey thickened consistency, and applesauce consistency.

abnormal: Abnormal results would be anything outside of a full shallow at the barium.

Citation: Center for Devices and Radiological Health. (n.d.) Fluoroscopy. Retrieved from HTTPS://www.fda.gov/radiation-emitting-products/medical-x-ray-imaging/fluoroscopy

N311 Care Plan #5

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

Medications (5 required)

Brand/Generic	clonazepam Klonopin	Symbicort Budesonide-Formoterol Fumarate	Albuterol Sulfate HFA Pro air	hydroxyzine Vistaril	Remeron mirtazapine
Dose	0.5mg	2 puffs	2 puffs	10 mg	15mg
Frequency	BID	BID	QAH	TID	HS
Route	G-tube	inhale	inhale	G-tube	PO
Classification	Anticonvulsant Benzodiazepine	corticosteroid	Beta$_2$ Agonist	Antiemetic Histamine Antagonist	antidepressant Alpha-2 antagonist tetracyclic
Mechanism of Action	ability to enhance the activity of GABA; relaxes smooth muscle	relaxes bronchial smooth muscle	relaxes bronchial smooth muscle	competes with histamine for H_1-receptor	antidepressant
Reason Client Taking	Anxiety ~~wheezing~~	wheezing	wheezing	itching	depression and hunger
Contraindications (2)	Hypersensitivity liver disease	Hypersensitivity allergenic cross-reactivity	Hypersensitivity allergenic cross reactivity	Competes with histamine for H_1-receptor sites	Hypersensitivity linezolid
Side Effects/Adverse Reactions (2)	fatigue common cold symptoms	pharyngitis abdominal pain	vomiting back pain	dry mouth fatigue	increased hunger weight gain

Medications Reference (APA):

Valler and A.H. Sanoski; C.A. & Quiring C. (2019). Davis's drug guide for nurses. Philadelphia, PA: P.A. Davis Company.

N311 Care Plan #5

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** A and O x3 **Orientation:** **Distress:** non-distressed **Overall appearance:** clean well-kept	A and O x3, well groomed, non-distressed relaxed and comfortable
INTEGUMENTARY: **Skin color:** NFR **Character:** dry **Temperature:** warm **Turgor:** delayed turgor **Rashes:** none **Bruises:** none **Wounds:** none **Braden Score:** 22 **Drains present:** Y☐ N☒ **Type:** N/A	All skin is warm and dry to touch. Skin color is NFR. Skin turgor was slightly delayed when assessed. Patients Braden score was assessed as 22 for predicting pressure ulcers. No edema present.
HEENT: Normocephalic **Head/Neck:** **Ears:** **Eyes:** perrla **Nose:** **Teeth:**	Patient wears reading glasses, oral mucosa is moist and intact no obivous or visable cavities noted. Pupils are equal and reactive to light.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** present, strong 3+ **Capillary refill:** less than 3 seconds **Neck Vein Distention:** Y☐ N☒ **Edema** Y☐ N☒ **Location of Edema:** N/A	S_1 and S_2 noted, no S3 or S4 noted. peripheral pulses present and strong. All peripheral pulses were present and 3+. Capillary refill was less than 3 seconds. No edema noted.
RESPIRATORY: **Accessory muscle use:** Y☐ N☒ **Breath Sounds: Location, character**	Non-labored non-obstructive regular respirations. breath sounds regular. Lungs clear to auscultation bilaterally

N311 Care Plan #5

GASTROINTESTINAL: **Diet at home:** Regular Regular **Current Diet** Regular mechanical texture **Height:** 62 inches **Weight:** 29.1 lbs **Auscultation Bowel sounds:** **Last BM:** 10/21/19 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** N/A **Incisions:** N/A **Scars:** legs, stomach, **Drains:** N/A **Wounds:** N/A **Ostomy:** Y ☐ N ☒ **Nasogastric:** Y ☐ N ☒ **Size:** N/A **Feeding tubes/PEG tube** Y ☒ N ☐ **Type:** G-tube	Diet at home is Regular Regular and diet in the facility is Regular mechanical texture and Regular consistency. Patient is on External feeding QID of 240mL of jevity. Bowel sounds are present and active.
GENITOURINARY: **Color:** yellow/clear **Character:** **Quantity of urine:** **Pain with urination:** Y ☐ N ☒ **Dialysis:** Y ☐ N ☒ **Inspection of genitals:** **Catheter:** Y ☐ N ☒ **Type:** N/A **Size:** N/A	No pain with urination. Patient said that she has yellow and clear urine.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** walker **Strength:** bilateral equals strength **ADL Assistance:** Y ☒ N ☐ Partial walker use **Fall Risk:** Y ☐ N ☐ **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ no **Needs assistance with equipment** ☑ yes **Needs support to stand and walk** ☐	Bilateral equal strength in all extremities. patient is at a moderate risk of a fall based on the Morse Fall assessment. patient stated she has no pain or numbness in the body.

N311 Care Plan #5

NEUROLOGICAL: **MAEW:** Y ☒ N ☐ **PERLA:** Y ☒ N ☐ **Strength Equal:** Y ☒ N ☐ **if no -** **Legs** ☐ **Arms** ☐ **Both** ☐ **Orientation:** A and O x3 **Mental Status:** **Speech:** **Sensory:** **LOC:**	ROM is normal in all extremities speech is clear. pupils were equal and reactive to light. patient is A and O x3.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** appropriate for age **Religion & what it means to pt.:** ~~catholic~~ **Personal/Family Data (Think about home environment, family structure, and available family support):**	"How can I cope with living in this place" patient has two daughters that come and see her everyday. patient catholic and prayes daily. developemental level is appropriate for age

Vital Signs, 1 set (5 points)

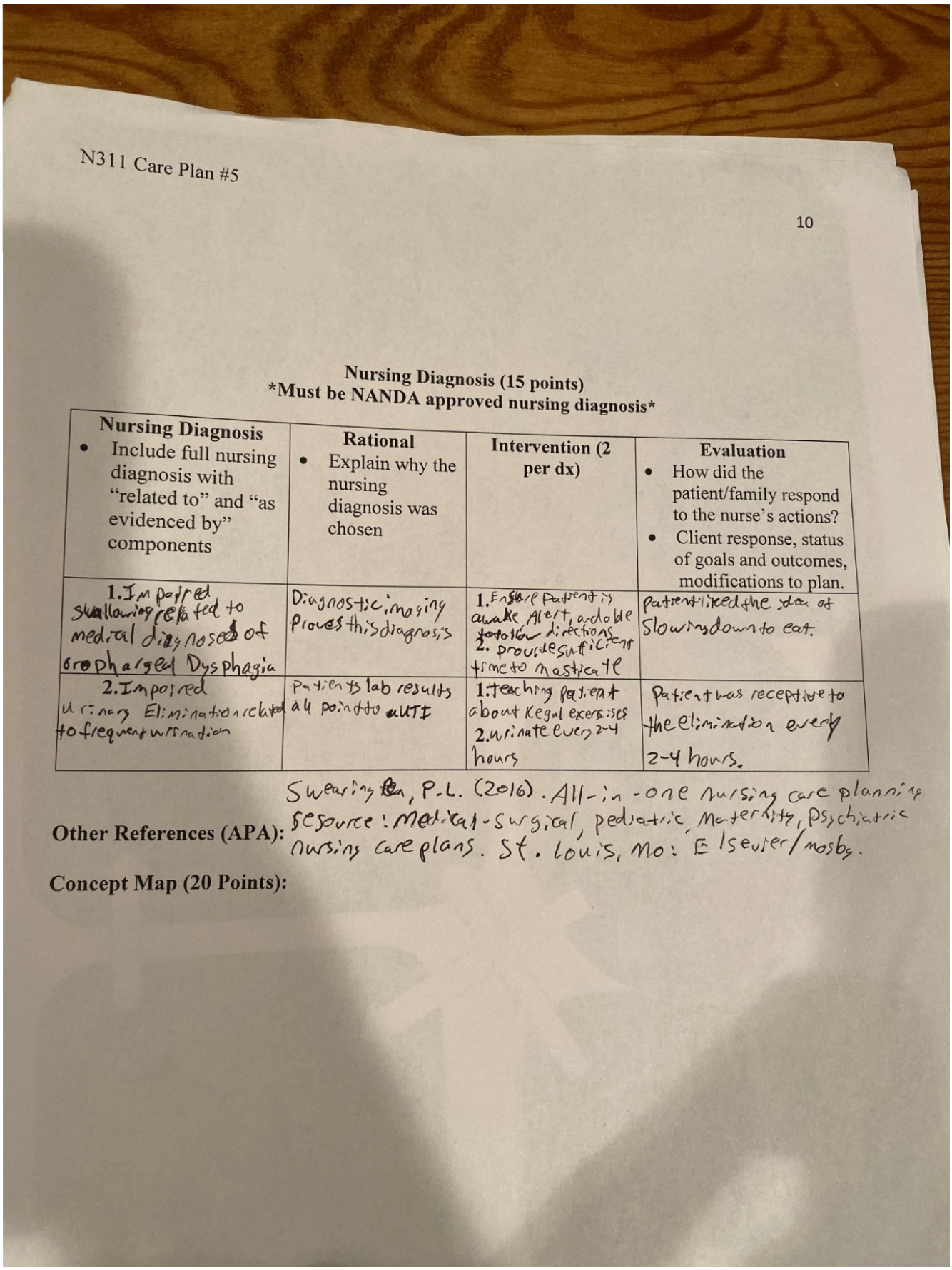
Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0820	82	118/62	18	98°F	100%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0750	0-10	whole Body	0 out of 10	none	none

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
237 mL	voids self



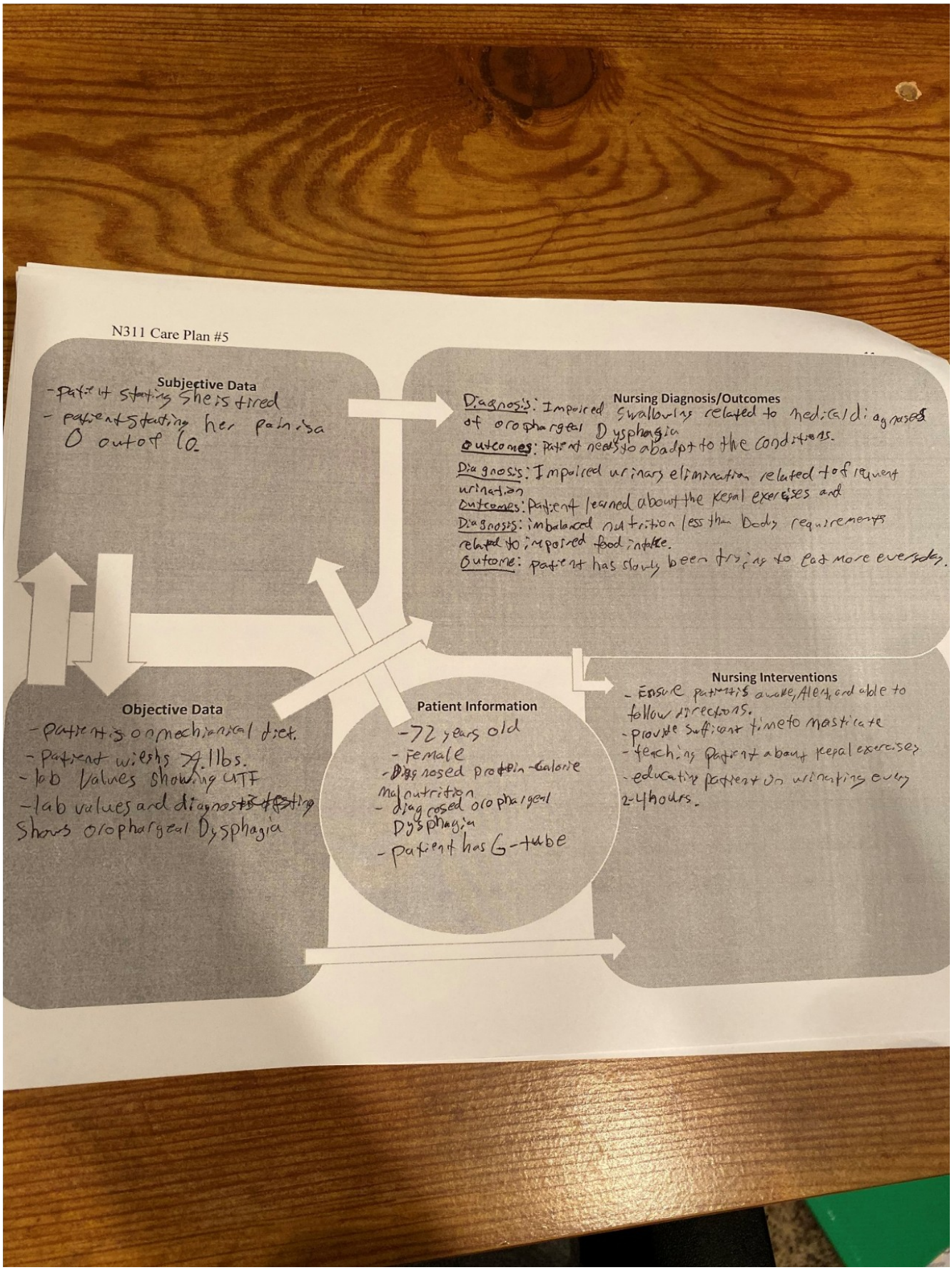
N311 Care Plan #5

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. Impaired swallowing related to medical diagnoses of oropharyngeal Dysphagia	Diagnostic imaging proves this diagnosis	1. Ensure patient is awake Alert, and able to follow directions 2. provide sufficient time to masticate	patient liked the idea of slowing down to eat.
2. Impaired Urinary Elimination related to frequent urination	Patients lab results all point to a UTI	1. Teaching patient about Kegal exercises 2. urinate every 2-4 hours	Patient was receptive to the elimination every 2-4 hours.

Other References (APA): Swearingen, P.L. (2016). All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, psychiatric nursing care plans. St. Louis, Mo: Elsevier/mosby.

Concept Map (20 Points):


N311 Care Plan #5
Subjective Data
- Patient stating She is tired
- patient stating her pain is a 0 out of 10.
Nursing Diagnosis/Outcomes
Diagnosis: Impaired Swallowing related to medical diagnosed of oropharyngeal Dysphagia
Outcomes: Patient needs to adapt to the conditions.
Diagnosis: Impaired urinary elimination related to frequent urination
Outcomes: Patient learned about the kegal exercises and
Diagnosis: imbalanced nutrition less than Body requirements related to; impaired food intake.
Outcome: patient has slowly been trying to eat more everyday.
Objective Data
- patient is on mechanical diet.
- Patient weighs 74.1lbs.
- lab values showing UTI
- lab values and diagnostic testing Shows oropharyngeal Dysphagia
Patient Information
-72 years old
- female
- Diagnosed protein-Calorie malnutrition
- diagnosed oropharyngeal Dysphagia
- patient has G-tube
Nursing Interventions
- Ensure patient is awake, Alert, and able to follow directions.
- provide sufficient time to masticate
- teaching patient about kegal exercises
- educating patient on urinating every 2-4 hours.