N321 Care Plan # 2

Lakeview College of Nursing

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N321 Care Plan

Demographics (3 points)

Date of Admission 10/10/2019	**Patient Initials** RR	**Age** 90	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Widowed	**Allergies** NKA
Code Status DNR	**Height** 158 cm	**Weight** 87.9 kg	

Medical History (5 Points)

Past Medical History: Chronic kidney disease, COPD, Heart disease, hypertension, lower extremity edema, metastatic breast carcinoma, neuropathy, osteoarthrosis, varicose veins of the legs, venous insufficiency.

Past Surgical History: No past surgical history to date.

Family History: Hypertension-father (deceased), Breast cancer-mother (deceased)

Social History (tobacco/alcohol/drugs): Denies alcohol or drug use. Patient has a previous history of smoking.

Assistive Devices: walker or wheelchair

Living Situation: Patient lives at an assisted living facility, Simple Blessings.

Education Level: 8th grade.

Admission Assessment

Chief Complaint (2 points): Patient presents in ED with cough and shortness of breath.

History of present Illness (10 points): Patient lives at an assisted living facility was having trouble catching her breath while on her baseline 2L of oxygen therapy. After 24 hours EMS was called by the facility to have patient transported to Sarah Bush Emergency Department for further evaluation. Patient was placed on the monitor in the emergency room, patients O2 saturations were below normal range at 85% on 2 L of O2. CMP and BNP drawn and IV placed

in right AC. Patient does have a past medical history of COPD. Patient was admitted for further testing, with a suspected COPD exacerbation.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): COPD exacerbation

Secondary Diagnosis (if applicable): Stroke

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

Chronic obstructive pulmonary disorder (COPD) is a combination of chronic bronchitis, emphysema and hyperreactive airway disease. COPD is the third leading cause of death in the United States (Capriotti, T., & Frizzel, J.P., 2016, p. 466). Smoking is the most common reason for patients to have this diagnosis. Characteristics associated with COPD are narrowing, excessive mucus and fibrosis in the bronchioles, loss of alveolar elastic recoil, and smooth muscle hypertrophy. Excessive mucus creates obstruction to inspiratory airflow. Once a patient is diagnosed with this disease it is not curable, can only treat symptoms.

Patients with COPD first symptom is dyspnea occurring with exertion. As the disease progresses the dyspnea worsens. Patients often suffer from chronic cough, wheezing, hypoxia, cyanosis, clubbing of the fingernails, thickened nails. The couch is normally productive. Patients often present with a barrel shaped chest. With vitals signs, a nurse should be checking heart rate and Oxygen saturation for normal range, checking to see if accessory muscles are used to breath. Patients with also have prolonged exhale and pursed lip when exhaling. Because of the stress on the right ventricle, it is not uncommon for patients to experience signs of right sided heart failure, such as jugular venous distension, ascites, hepatosplenomegaly and ankle edema. Common diagnostic tests include CBC, ECG, chest x ray PFT, and ABGs.

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This patient's secondary diagnosis was acute stroke. Ischemic stroke is caused by a thrombus or embolus that loges in a cerebral artery and blocks blood flow to the brain tissue (Capriotti, T., & Frizzel, J.P., 2016, p. 750). Smoking puts patients at risk for stroke and COPD. And having COPD puts patients at risk for strokes. Patients with COPD are less likely to be prescribed beta blockers because of the respiratory depression. However, COPD symptoms can present like cardiovascular disease. Making them at higher risk for clots.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

Hinkle, J. L., Cheever, K. H., & Brunner, L. S. (2018). *Brunner & Suddarths textbook of medical-surgical nursing.* Philadelphia: Wolters Kluwer.

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	4-6 mcl	3.27 mcl	3.30 mcl	patient could have an issue with anemia due to the stoke.
Hgb	11.3-15.2 g/dL	12.4 g/dL	12.3 g/dL	
Hct	33.2-45.3%	35.7 %	35.5%	
Platelets	149-393 k/mcl	225 k/mcl	164 k/mcl	
WBC	4.0-11.7 k/mcl	2.7	4.9	
Neutrophils	45.3-79.0%	88.9%	84.6%	Patient was on an antifungal for a yeast infection. And experiencing extreme stress on the body due to

				stoke
Lymphocytes	11.8-45.9%	9.1%	10.8%	patient does have breast cancer could be immunosuppression because of treatment.
Monocytes	4.4-12.0%	1.9%	4.5%	
Eosinophils	0-6.3%			
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	140 mmol/ L	143 mmol/L	
K+	3.5-5.0 mmol/L	3.6 mmol/L	3.4 mmol/L	
Cl-	98-107 mmol/L	99 mmol/L	107 mmol/L	
CO2	22-29 mmol/L	28 mmol/L	27 mmol/L	
Glucose	70-109 mg/dL	132 mg/dL	123 mg/ dL	patients with COPD are commonly prescribed steroids which can affect the blood sugar.
BUN	7-25 mg/dL	25 mg/dL	25 mg/dL	
Creatinine	0.50-0.90 mg/dL	1.24 mg/dL	0.90 mg/dL	
Albumin	3.5-5.2 g/dL	3.9 g/dL		
Calcium	8.6-10.3 mg/ dL	9.2 mg/dL	8.1 mg/ dL	
Mag	1.7-2.2 mg/dL			
Phosphate	2.5-4.5 mg/dL			
Bilirubin	0.1-1.2 mg/dL	0.8mg/dL		

Alk Phos	35-105 unit/ L	51unit/L		
AST	0-32 intlunit/L	18 intlunit/ L		
ALT	4-33 intlunit/L	9 intlunit/L		
Amylase	56-90			
Lipase	0-110			
Lactic Acid	6-16			

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	1.03		
PT	11-14	13.7		
PTT	0-250	45.5		
D-Dimer	0-250			
BNP	<100	300		
HDL	<40	54		
LDL	>100	94		
Cholesterol	<200	169		
Triglycerides	<150	105		
Hgb A1c				
TSH	0.4-4.0			

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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	yellow/clear	Straw color, clear		
pH	5.0-8.0	6.0		
Specific Gravity	1.005-1.035	1.005		
Glucose	Normal	WNL		
Protein	negative	negative		
Ketones	Negative	Negative		
WBC	<5	<1		
RBC	0-3	<1		
Leukoesterase	Negative	Negative		

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):

Henry, N.J.E., Mcmicheal, M., Johnson, J., DiStasi, Ball, B.S., Holman, C., Lemon, T. (2016). *Rn adult medical surgical nursing: review module.* Leawood, KS: Assessment Technologies Institute.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

10/11- EKG: sinus rhythm with occasional premature ventricular complex

- CT Brain/head and MRI: acute infarction (calvarium) 4.7 centimeter R cerebellar hypodensity- acute stroke
- Chest x-ray: med size esophageal, hiatal hernia/pulmonary venous congestion/mild infiltrate or atelectasis left lung base, unchanged. Cardiomegaly and mild pulmonary edema
- Carotid duplex Bilat: acute CVA less than 50% right

Diagnostic Test Correlation (5 points):

The patient had several tests done, some were to rule out other conditions and others were to see damages. EKG was done on admission to check heart rhythm. Chest x-ray was also done on admission looking for pneumonia. CT brain/head and MRI were completed after the stroke The CT is able to give a clear picture, looking for any hemorrhages within the brain. The MRI is done without contrast in order to detect what areas may have been damaged due to the stroke.

Diagnostic Test Reference (APA):

Hinkle, J. L., Cheever, K. H., & Brunner, L. S. (2018). *Brunner & Suddarths textbook of medical-surgical nursing.* Philadelphia: Wolters Kluwer.

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

Home Medications (5 required)

Brand/Generic	tramadol/ ultram	Gabapentin /neurotin	metoprolol/ Lopressor	Fluconazole/ Diflucan	Cyancobalamin / Vitamin B12
Dose	50mg	300 mg	100mg	200mg	1,000mg
Frequency	q 4 hrs	2x daily	daily	daily	2x daily
Route	PO	PO	PO	PO	PO
Classification	Opioids	anticonvulsants	beta blocker	antifungal	vitamins
Mechanism of Action	It works by changing the way the brain and nervous system respond to pain.	Decrease abnormal excitement in the brain.	Working by blocking the hormone epinephrine	inhibiting fungal cell membrane ergosterol synthesis.	essential component and participant in physiologic systems and reactions
Reason Client Taking	Patient was experiencing pain.	Patient was placed on this after having stroke to help with neuropathic pain condition.	to help with premature ventricular complex	to treat patients yeast infection.	To help patients recover from stroke.
Contraindications (2)	acute alcohol, addiction history	avoid abrupt withdrawal, caution if renal impairment	heart failure, severe PVD	prolonged QT intervals, liver problems	If patient has renal failure or respiratory infection
Side Effects/Adverse Reactions (2)	seizures, respiratory depression	depression, dizziness	fatigue, dizziness	headache diarrhea	Headache/ swelling

Nursing Considerations (2)	check vital signs regularly and BP watch for hypotension	monitor cardiac rhythm at baseline, behavior changes	monitor blood pressure and heart rate	monitor LFTs, Cr at baseline	Monitor labs closely for toxicity, renal failure.

Hospital Medications (5 required)

Brand/Generic	acetylsalicylic acid/bayer	enoxaparin/ lovenox	furosemide / lasix	Lipitor/ atorvastatin	Anastrozole/ arimidex
Dose	81 mg	40 mg	40 mg	20 mg	1 mg
Frequency	daily	daily	daily	daily	daily
Route	oral	Sq	oral	oral	oral
Classification	antiplatelet	anticoagulant	diuretics	dyslipidemia	non-steroidal aromatase inhibitor
Mechanism of Action	reducing platelet aggregation	binds to antithrombin lll and accelerates activity	inhibits loop of henle and proximal and distal convoluted tubule	inhibiting cholesterol synthesis	inhibits enzymatic androgen conversion to estrogen
Reason Client Taking	Patients past history of DVT/PE blood thinning medication	patient is at risk for PE or DVT due to inactivity	pt has history of edema in the lower extremities	patient has high cholesterol	patient has breast cancer
Contraindications (2)	GI bleed, uncontrolled hypertension	hepatic impairmen, coagulation disorder	diabetes mellitus, electrolyte imbalances	alcohol, renal impairment	pregnancy or breastfeeding
Side Effects/Adverse Reactions (2)	DIC, GI perforation/ulcer	hemorrhage, thrombocytopenia	hypokalemia, electrolyte imbalance	tendon rupture, acute renal failure	nausea/ vomiting, hot flashes
Nursing Considerations (2)	monitor drug serum levels and Cr	monitor CBC, and platelet	monitor BUN and	CK levels and LFTs	monitor body mass and lipids

Medications Reference (APA):

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Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook.* Burlington, MA.**Assessment**

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient appeared tired, falling asleep during meeting however was easy awaken by conversation. Patient know where she was, who she was, the date and the president. A&O x4. Overall patient seem comfortable at this time.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patients skin is pink, dry and warm. Patients stomach and back appear flaky, however no rashes detected. Lower extremities have pitting edema +2, varicose veins present. Skin turgor was normal, 1 second of tenting. Five bruises were found three on left arm and two on right arm all due to IV starts an infiltrated IV site. One wound was found on assessment, break down of the sacrum area, getting close to stage 2. Braden scale of 11.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and Neck appear in normal limits. No jugular vein distention, no carotid bruit, no lymphadenopathy. Ear are within normal limits, pearly grey tympanic membrane. Patient wears glasses for farsightedness. Nose appears normal, no deviation, turbinates inspected. Patient has no dentures, and no cavities noted at this time. .
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	Regular rate and rhythm, S1 and S2 are normal no murmurs/rubs/or gallops, point of maximal intensity non displaced. Capillary refill was normal within 2 seconds. +2 edema in the lower extremities.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Patient presents with a barrel chest. Has diminished lung sounds in lower lobes bilaterally. Patient does sound clear in upper lungs bilaterally about auscultation. No rales/rhonchi/wheezes, no egophany, no tactice fremitus. Patient does require 2L of oxygen at all times to maintain normal oxygen saturations.
GASTROINTESTINAL (2 points):	Patient does not follow any special diets at an

Diet at home: **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	assisted living facility. Patient continues normal diet in the hospital. After being evaluated by speech, patient was placed on thickened liquids, for risk of aspiration. Weight is 87.9 kg and height is 158 cm making the BMI 35.2 placing this patient in the obeses category for her height. Normal bowel sounds normal in all four quadrants (sounds heard within 1 minute). resonant to percussion, soft, non-distended and non-tender, no rebound or guarding. no hepatomegaly. no palpable masses. No incisions, scars, drains or wounds noted.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient's urine is light yellow to clear. No visible sediment, no foul smell. Patient has been urine incontinent during this admission.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient reports no pain, no signs of pallor, paresthesia or paralysis, pulse is within normal range. Patient is able to complete passive ROM on lower extremities. Patient can complete most exercises upper body extremities with active ROM. Patient does use a walker or wheelchair. Fall score is 60. Does need a one assist when getting up.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -**	Patient was up with one assist. Patients pupils were equal, round, and reactive to light when assessing with pen light. Patient was orientated to person, place, time and situation. Patient spoke

Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	clearly without any impairment. Patients level of consciousness was within normal limits, patient was easily arousable.
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):**	Patient enjoys talking with family and friends for comfort. Patient got through 8th grade and then became a factory worker. Patient denies any religions beliefs. Patients family structure includes her children, two sons and one daughter.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1145	73	143/70	18	36.9 C	94%
1345	83	130/74	18	37.0 C	96%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1000	0				
1340	0				

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	20 gauge Right peripheral 10/12 Right IV has line attached and infusing Right AC dry, clean and intact. Dressing was allusive, no phlebitis or infiltration present,

	catheter patent.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
1666 mL	1685 mL

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was admitted for what was thought to be a COPD exacerbation. On day two of admission, the patient had an acute stroke.

Procedures/testing done: CBC, BMP, Urinalysis, EKG, CT brain/head, chest xray, and carotid duplex bilate

Complaints/Issues: Patient presented in the ED with shortness of breath and a cough.

Vital signs (stable/unstable): patient had a low O2 saturation upon arrival to the ED.

Tolerating diet, activity, etc.: Patient is tolerating diet. Patient is up one assist with walker, has little activity.

Physician notifications: No notifications necessary.

Future plans for patient: Patient discharged back to assisted living will follow up at scheduled appointment times.

Discharge Planning (2 points)

Discharge location: Patient discharged back to assisted living facility.

Home health needs (if applicable): no.

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Equipment needs (if applicable): no.

Follow up plan: Follow up outpatient with pcp.

Education needs: Educate patient signs and symptoms of COPD exacerbation.

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

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 gas exchange related to COPD as evidenced by 2L of O2 needed at all times.	Good oxygenation is important for all parts of the body, to prevent complications.	**1.** Monitor RR, depth, and ease of respiration, what for use of accessory muscles. **2.** Auscultate breath sounds	Client verbalized understanding, she should wear 2L of oxygen at all times.
2. At risk for infection as evidenced by wound on sacrum.	Skin integrity is important for elderly.	**1.** Assess skin for color, moisture, texture, and turgor. **2.** Encourage fluid intake	Goals for patient are to get up to restroom hourly to prevent incontinence.
3. At risk for activity intolerance as evidenced by always needing O2 and need	If the patient is going to get up hourly to use the bathroom, activity tolerance is important.	**1.** Assess the client daily for appropriateness of activity and bed rest. **2**. When getting a client up, observe for	Patient understand importance to activity.

assistance.		symptoms of intolerance such as nausea, pallor, dizziness, visual dimming, and impaired consciousness, as well as change in vitals	

Other References (APA):

Ladwig, G. B., & Ackley, B. J. (2011). *Mosbys Guide to Nursing Diagnosis.* Elsevier Health Sciences.

Concept Map (20 Points):

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