

N431 Care Plan #3

Lakeview College of Nursing

Madisyn Verostko

Demographics (3 points)

Date of Admission 10/25	Patient Initials MB	Age 67	Gender F
Race/Ethnicity White	Occupation Retired, disabled (7/20/17)	Marital Status married	Allergies Abilify – confusion Ceftriaxone – itching, watery eyes
Code Status Full code	Height 162.5 cm	Weight 65.5 kg	

Medical History (5 Points)

Past Medical History:

- Anxiety
- Arthritis
- Colon cancer
- Depression
- HTN
- Hypercholesterolemia
- Bowel obstruction
- Peristomal hernia

Past Surgical History:

- Hernia repair
- Appendectomy
- Bilateral salpingoophorectomy
- Colostomy
- Hysterectomy
- Kidney stone

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- Shoulder reply
- Urostomy- stoma

Family History:

- Father – bladder cancer, colon cancer, heart attack, heart disease, HTN, skin cancer
- Mother – Alzheimer’s, dementia, DM, heart attack, heart failure, HTN
- Grandmother (maternal) – dementia, heart attack, heart disease, heart failure, HTN
- Grandfather (maternal)- heart attack, heart disease, heart failure, HTN
- Grandmother (paternal)- heart attack, heart disease, heart failure, HTN
- Grandfather (paternal)- heart attack, heart disease, heart failure, HTN

Social History (tobacco/alcohol/drugs):

- Former smoker (11/7/17), denies alcohol use or any illegal substance use

Assistive Devices:

- Glasses
- Pt wears sling on right arm

Living Situation:

- Pt lives at home with husband

Education Level:

- High school

Admission Assessment

Chief Complaint (2 points): severe shoulder pain

History of present Illness (10 points):

Pt reports to ED with severe shoulder pain. Pt had blood culture and fluid drawn from shoulder on the previous day by her primary due to pain. Pt received a call that the cultures had shown a

bacterial infection in her right shoulder and she was advised to go to the ER. Cultures showed growth of pseudomonas – pt was sent to OR from ED for shoulder washout.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): septic arthritis of shoulder

Secondary Diagnosis (if applicable): AC joint dislocation

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

Septic Arthritis

Septic arthritis is an infection where microorganisms enter the synovial membrane and often penetrates into the joint space. Infection within the joint usually occurs secondary to another infection somewhere in the body (Capriotti, 2016). In my patient, the infection is suspected to have originated from her Hickman central line in her chest. The infection can cause significant to the bones and cartilage within the joint, so prompt treatment is crucial in maintaining the joint's viability. If the infection goes untreated, joint degeneration and permanent damage can result (Capriotti, 2016).

Septic arthritis presents with great discomfort and difficulty using the affected joint. The joint may also be red, warm, swollen, and the patient may present with a fever (Mayo Clinic Staff, 2018). Diagnosis can be made by a variation of ways including joint fluid analysis, blood tests, and diagnostic imaging (Mayo Clinic Staff, 2018). Analysis of the synovial fluid can help diagnose the presence of an infection in a joint. The presence of an infection may alter the color, consistency, volume, and makeup of one's synovial fluid. This fluid can also go through additional laboratory testing to determine what organisms are causing the infection. Blood tests can detect the presence of infection within the body, whether systemic or local. X-Rays and other

imaging may be needed to assess any damage to the joint that has occurred secondary to the infection (Mayo Clinic Staff, 2018).

Treatment usually involves draining of the joint by needle aspiration followed by antibiotic therapy (Mayo Clinic Staff, 2018). My patient has had a shoulder washout and is now receiving Cefepime for treatment. Arthroscopy or open surgery may be needed if the joint needs more drainage than the needle aspiration can accomplish (Mayo Clinic Staff, 2018).

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology Introductory Concepts and Clinical Perspectives*. Philadelphia, PA: F.A. Davis Company.

Mayo Clinic Staff. (2018, December 1). Septic Arthritis. Retrieved from

<https://www.mayoclinic.org/diseases-conditions/bone-and-joint-infections/symptoms-causes/syc-20350755>.

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	3.8-5.41 M/uL	3.67	3.08	Decreased RBCs suggest active bleeding (Van Leeuwen & Bladh, 2017). Pt may be bleeding into shoulder joint.
Hgb	11-15.5 g/dL	10.2	8.3	Decreased hemoglobin levels suggest active bleeding (Van Leeuwen & Bladh, 2017). Pt may be bleeding into shoulder joint.
Hct	33.2%-45.3%	30.2	25.6	Decreased hematocrit levels suggest active bleeding (Van Leeuwen & Bladh, 2017). Pt may be bleeding into shoulder joint.

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Platelets	150- 450 K/uL	412	317	
WBC	4.8 – 10.8 K/uL	14.6	13.2	
Neutrophils	45-80 %	77	74.1	
Lymphocytes	11.8-46 %	14.2	15.4	
Monocytes	4.4-12 %	7.4	9.1	
Eosinophils	0 – 6.3 %	0.4	0.8	
Bands	0-5 %	0	0	

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	135	
K+	3.5- 5.1 mmol/L	4.4	3.8	
Cl-	98 – 107 mmol/L	99	107	
CO2	35- 45 mmol/L	26	20	CO2 levels are decreased in anxiety due to hyperventilation, where too much CO2 is being exhaled. CO2 is also decreased in dehydration, which my patient also presents with (Van Leeuwen & Bladh, 2017).
Glucose	70-99 mg/dl	109	112	Glucose is elevated in acute stress situations as well as trauma by the release of catecholamines and glucagon (Van Leeuwen & Bladh, 2017). The patient's body is under acute stress due to the infection in the shoulder and body.
BUN	6-20	31	25	Elevated BUN without the elevation of Creatinine, suggests dehydration (Van Leeuwen & Bladh, 2017).
Creatinine	0.5 -1.2 mmol/L	1.01	0.8	

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Albumin	3.5-5.2 g/L	3.5	N/A	
Calcium	8.6 – 10.4 mg/dl	9.1	7.8	
Mag	1.6 – 2.4 mmol/L	N/A	N/A	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	0 – 1.2 umol/L	0.5	N/A	
Alk Phos	44-147 U/L	79	N/A	
AST	0-32 U/L	16	N/A	
ALT	0-33 U/L	15	N/A	
Amylase	23-85	N/A	N/A	
Lipase	23-85	N/A	N/A	
Lactic Acid	0.5-1 mmol/L	0.8	N/A	
Troponin	0.0-0.4 ng/mL	N/A	N/A	
CK-MB	5-25 IU/L	N/A	N/A	
Total CK	22-198 U/L	N/A	N/A	

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	0.86 – 1.14	N/A	N/A	
PT	11.9 – 15 sec.	N/A	N/A	
PTT	23- 37 sec.	N/A	N/A	
D-Dimer	< 0.4 or	N/A	N/A	

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	<250			
BNP	< 100	N/A	N/A	
HDL	>60	N/A	N/A	
LDL	100-129	N/A	N/A	
Cholesterol	.< 200	N/A	N/A	
Triglycerides	< 150	N/A	N/A	
Hgb A1c	4-5.6%	N/A	N/A	
TSH	0.4 – 4.0	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	Yellow / Clear	N/A	N/A	
pH	4.5- 8	N/A	N/A	
Specific Gravity	1.005-1.025	N/A	N/A	
Glucose	< 130 mg/d	N/A	N/A	
Protein	< 150 mg/d	N/A	N/A	
Ketones	None	N/A	N/A	
WBC	<2-5 /hpf	N/A	N/A	
RBC	< 2 /hpf	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

Arterial Blood Gas **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal	Value on	Today's	Explanation of Findings
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	Range	Admission	Value	
pH	7.32-7.43	N/A	N/A	
PaO2	20-49 mmHg	N/A	N/A	
PaCO2	41-51 mmHg	N/A	N/A	
HCO3	24-28 mEq/ L	N/A	N/A	
SaO2	70-75%	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	Negative- < 10,000	N/A	N/A	
Blood Culture	Negative	Positive	Positive	Gram negative Bacilli found growing in 2/2 sites. Pt is receiving antibiotic therapy for infection.
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (3 ed.). Philadelphia, PA: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- No diagnostic imaging has been performed on this patient

Diagnostic Test Correlation (5 points):

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Not applicable

Diagnostic Test Reference (APA):

Not applicable

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

Home Medications (5 required)

Brand/Generic	Norvasc Amlodipine	Zanaflex tizanidine	Paxil Paroxetine	Roxanol morphine	Docusate sodium (Colace)
Dose	5 mg	2 mg	20 mg	10 mg = 5 mL	100 mg
Frequency	Daily	BID	Daily	TID	daily
Route	PO	PO	PO	PO	PO
Classification	Calcium channel blocker	Alpha-2 adrenergic agonist	SSRI	Narcotic, opioid analgesic	OTC stool softener
Mechanism of Action	Inhibits influx of extracellular calcium into vascular smooth muscle and MI cells	Acts on nerves in spine to reduce muscle spasms	Inhibits reuptake of serotonin	Opiate agonist	Mixes stool fat and water
Reason Client Taking	HTN	To relax muscles, relieve pain	Anxiety	Pain	Colostomy, hx of bowel obstruction
Contraindications (2)	Heart failure	Hepatic impairment	Use of MAOI Hypersensitivity	GI obstruction	Fecal impaction appendicitis

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	pregnancy	hypersensitivity		Acute or severe asthma	
Side Effects/Adverse Reactions (2)	Edema dizziness	Dry mouth asthenia	Insomnia Agitation	Drowsiness Euphoria	Diarrhea abd. cramps
Nursing Considerations (2)		Use before ADLs Gradually reduce does as indicated	Monitor for serotonin syndrome Monitor for suicidal thoughts	Monitor for hypotension Monitor for respiratory depression	Assist pt to bathroom as needed monitor for dehydration due to diarrhea
Key Nursing Assessment(s)/Lab(s) Prior to Administration	BP periodic LFTs	Aminotransferase levels Renal function at baseline	Liver enzymes Na levels	Blood pressure RR	Electrolytes hydration status (BUN)
Client Teaching needs (2)	Report s/sx of Stevens-Johnson's d/c if become pregnant	Can take with or without food Be careful changing positions	Educate on increased risk for suicidal thoughts Do not ingest alcohol	Increase fluid intake to prevent constipation Do not operate heavy machinery	d/c if nausea/vomiting occur increase fluids

Hospital Medications (5 required)

Brand/Generic	Zofran ondansetron	Dilaudid hydromorphone	Maxioime cefepime	Narcan Naloxone hydrochloride	Tylenol acetaminophen
Dose	4 mg = 2 mL	0.5 mg = 5 ml	2000 mg	0.4 mg – 1 mL	1000 mg = 2 tab
Frequency	Q 6 hr PRN	Q2 hr PRN	Q 12 hr	Q2m PRN	Q 6 hr PRN
Route	IV push	IV push	IV PB	IV push	PO
Classification	antiemetic	Opioid	Cephalosporin	Opioid antagonist	Antipyretic/ non-opioid analgesic
Mechanism of	Selective 5-	Opioid agonist	Bactericidal	Antagonizes	Inhibits the

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Action	HT3 receptor antagonist		cell wall synthesis	opioid effect	synthesis of prostaglandins that may serve as mediators of pain and fever, primarily in the CNS
Reason Client Taking	nausea	Pain	Pseudomonas is right shoulder (septic arthritis)	Prescribed in case of opioid OD	Pain
Contraindications (2)	Taking apomorphine hypersensitivity	Severe respiratory depression Asthma	Corn allergy Hypersensitivity to cephalosporins	Hypersensitivity to the drug Hypersensitivity to any drug components	Hepatic impairment Severe malnutrition
Side Effects/Adverse Reactions (2)	Dizziness headache	Light headedness Sedation	Localized reaction diarrhea	Body aches Convulsions (r/t abrupt withdrawal)	Nausea headache
Nursing Considerations (2)	Monitor for anaphylaxis Monitor for serotonin syndrome	Monitor for addiction Monitor for constipation	Protect from light Infuse over light	Continue to monitor for withdrawal effects Monitor vitals	Monitor temp/pain Document when last dose was given
Key Nursing Assessment(s)/Lab(s) Prior to Administration	ECG BP	RR BP	ALT level WBC	NA	Liver enzymes Cr at baseline
Client Teaching needs (2)	May impair thinking or reactions OD sx – loss of vision, lightheadedness, severe constipation	Educate on addiction properties of this drug Avoid driving when taking this medication	May cause AMS Take full course	Educate on signs of opioid OD Educate family on administration	Take recommended dose on label OD can cause liver damage or death

Medications Reference (APA):

2019 Nurses drug handbook (18th ed). (2019). Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Pt appears to be in pain and discomfort by dull expression. Pain is confirmed upon pt's verbalization of pain. Pt remains calm, appropriate, and cooperative. Pt is A&O4.</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>Braden score: 18</p> <p>Skin color is appropriate for ethnicity, pink, warm, and dry. Skin is rarely moist. Turgor is loose. Open area on sacrum. Bottom is red but blanchable. Bottom is left open to air with cream applied as needed. No rashes, bruises, or wounds noted.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck symmetry noted. Pt wears glasses. Vision and hearing are intact. No septum deviation or nasal polyps noted. Oral mucosa is pink, moist, and intact. No abnormalities noted.</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"/></p>	<p>Pt is normal sinus rhythm on telemetry. Heart sounds auscultated x5, S1 and S2 noted. No murmurs, gallops, or rubs noted. Dorsalis pedis and radial pulses graded 3+ normal. Cap refill is normal at <3 seconds. No neck vein distention or edema noted.</p>

<p>Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>SpO2 99 on RA. Respiratory rate normal and breathing is unlabored. Breath sounds auscultated anteriorly x4 and posteriorly x7. All lung fields clear. Lung aeration is equal. No evident use of accessory muscles.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: regular Current Diet regular Height: 162.5 Weight: 65.5 Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input checked="" type="checkbox"/> N <input 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 flat, soft, non-distended. Bowel sounds auscultated in upper abdomen. Colostomy present on left side of abdomen. Stool is yellow/brown and loose.</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>Pt has urostomy on right side of abdomen. Stoma is pink and moist. Urine is yellow- clear with sediment. Urine odor is normal. No difficulties voiding.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score:</p>	<p>Morse score: 45 Musculoskeletal strength is equal bilaterally, graded 5/5. Full active ROM. Pt is up ad lib with standby assist. Pt performs ADLs with minimal to no assistance. Provides self-care and cares for both ostomies. Pt wears sling on right arm to support affected shoulder.</p>

Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/>	
NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:	Pt is able to MAEW with the exception of right arm/shoulder due to infection and pain. PERLA noted. Strength equal bilaterally. Pt is A&O4. Pt speaks English at a normal pace. Speech is clear and coherent. Sensory perception is intact.
PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): N/A Developmental level: Full Religion & what it means to pt.: Christian Personal/Family Data (Think about home environment, family structure, and available family support):	Pt comes from home with husband. Husband present at bedside. Pt is Christian.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0740	69	142/65	20	37.2	99
1150	66	116/54	16	38.1	95

Vital Sign Trends:

Initial blood pressure reading at 0740 is elevated due to morning meds not yet administered (antihypertensive) and pts pain may be contributing to elevated bp reading. Temperature reading at 1150 shows slight fever, due to pt's active infection.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

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1105	Numeric	Right shoulder	8/10	N/a	N/a
1500	numeric	Right shoulder and left chest (attempted PICC removal)	10/10	Sharp	Nurse administered Dilaudid

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 Location of IV: right forearm Date on IV: 10/28 Patency of IV: patent and flushes well Signs of erythema, drainage, etc.: no signs of infiltration, phlebitis, or erythema evident IV dressing assessment: transparent dressing- clean, intact, and dry	Saline locked

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
639.99 mL	1100 mL

Nursing Care

Summary of Care (2 points)

Overview of care:

Pt continues to c/o pain in right shoulder. Rates her pain 10/10. Pt remains calm, appropriate, and cooperative. Pt up to bathroom during my shift, performed ostomy care. Pt receiving Cefepime IVPB q 12 hr.

Procedures/testing done:

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Attempted to remove PICC line from chest, unsuccessful. Surgeon attempted to remove PICC at bedside as well, unsuccessful. Pt to go to special procedures next day for removal.

Complaints/Issues:

Pt reports persistent, severe shoulder pain. Pt verbalizes significant pain following surgeon's attempt of PICC removal. Dilaudid administered for pain at 1500.

Vital signs (stable/unstable):

Vital signs stable. Slightly elevated temperature due to infection in shoulder joint and in blood.

Tolerating diet, activity, etc.:

Pt performed self-care of ostomies.

Physician notifications:

Dr. Green and hospitalist notified regarding PICC line. PICC line was ordered to be removed by hospitalist. Upon unsuccessful removal, Dr. Green was consulted.

Future plans for patient:

Pt to go to special procedures for PICC line removal. Pt to finish antibiotic therapy in hospital.

Continue to monitor infection.

Discharge Planning (2 points)

Discharge location:

Pt to be discharged home with husband.

Home health needs (if applicable):

Pt may need home health to perform self-care r/t limited mobility of shoulder.

Equipment needs (if applicable):

None indicated at this time.

Follow up plan:

Pt will need follow up regarding shoulder infection. Additional fluid/blood draws to evaluate the presence of infection. Possible follow up X-Ray to determine damage done to shoulder joint. Pt will also need another central/peripheral line inserted at some point to continue TPN at home. Physical therapy may be needed after discharge.

Education needs:

Pt should be educated on early signs and symptoms of infection so that she knows when to get prompt medical attention.

Nursing Diagnosis (15 points)

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

Nursing Diagnosis <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	Rational <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Intervention (2 per dx)	Evaluation <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain r/t septic arthritis of the shoulder AEB pt rates pain 10/10	Pt continues to rate pain 10/10 and unmanaged by pain medication.	1. Apply ice to affected joint as indicated 2. Have pt wear sling as prescribed by doctor	Goal met – pt wears sling as directed to. Reports mild relief while wearing sling.
2. Impaired physical mobility r/t septic arthritis of the shoulder AEB extremely limited ROM	Pt cannot move right shoulder. This can alter many activities of daily living.	1. Help support patient as she walks without taking away independence 2. consider using a cane if additional support is needed	Goal met- pt is ambulating well with only standby support. Nurse to continue assisting as needed.
1. Self-care deficit r/t septic arthritis of the shoulder AEB	Pt cannot use right shoulder which limits her dominant hand’s	1. Suggest in home care to assist with care needs	Goal met- pt is considering in home care. Needs will be evaluated closer to discharge to

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limited ROM in shoulder	ability to perform self-care. This is crucial for this patient as she has two ostomies to care for.	2 help patient learn techniques of self-care using her non-dominant hand	determine care needs at home. Pt is performing self-care well at this time.
2. Risk for falls r/t pain and limited ROM	Pt cannot use or move right shoulder at all. This can throw off her balance and keep her from using her right arm for support while walking.	1. Make sure pt has call light and calls for help at all times 2. Ensure bed alarm is on	Goal met- pt uses call light each time she needs help. Bed alarm is on and working.

Other References (APA):

Concept Map (20 Points):

Subjective Data

- Pt rates pain 8-10/10 consistently
- Pt expresses great discomfort after surgeon's attempt at removing PICC

Nursing Diagnosis/Outcomes

- **Acute pain r/t septic arthritis of the shoulder AEB pt rates pain 10/10 → manage pt's pain. Pain goal = 0/10 by discharge.**
- **Impaired physical mobility r/t septic arthritis of the shoulder AEB extremely limited ROM → maintain/increases shoulder ROM. Perform ROM exercises as able. Refer to physical therapy after discharge.**
- **Self-care deficit r/t septic arthritis of the shoulder AEB limited ROM in shoulder → help pt perform self-care. Assess needs upon discharge to determine if in-home care is needed.**
- **Risk for falls r/t pain and limited ROM → turn on bed alarm, give pt call light (fall precautions).**

Objective Data

- Pt bp reading was elevated during morning vitals
- Pt has slightly elevated temperature during afternoon vitals
- Pt blood cultures showed growth of gram negative bacilli
- Pseudomonas found in right shoulder joint
- Glucose level elevated
- RBCs, Hct, Hgb, CO2 decreased on blood work

Patient Information

- 67 years old
- female
- white
- husband at bedside
- septic arthritis of right shoulder
- pt has colostomy and urostomy

Nursing Interventions

- **Apply ice to affected joint as indicated**
- **Have pt wear sling as prescribed by doctor**
- **Help support patient as she walks without taking away independence**
- consider using a cane if additional support is needed
- **Suggest in home care to assist with care needs**
- **help patient learn techniques of self-care using her non-dominant hand**
- **Make sure pt has call light and calls for help at all times**
- **Ensure bed alarm is on**

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