N311 Care Plan # 4

Lakeview College of Nursing

Name: Rece Doggett

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
09/26/19	GE	86	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Widowed	Iodine, shellfish
Code Status	**Height**	**Weight**	
Full Code	4’ 11”	150.2 lb	

Medical History (5 Points)

Past Medical History: Stroke, hypomagnesemia, Acute renal failure, AKI, COPD

Past Surgical History: Two joint replacements (08/16/2018) , Hysterectomy (1970), cataract removal w/ implant (Jan/2018), Pacemaker insertion.

Family History: No known family history.

Social History (tobacco/alcohol/drugs): No Hx of smoking, drugs, or alcohol

Admission Assessment

Chief Complaint (2 points): Short of breath, Dyspnea

History of present Illness (10 points):

On 10/22/19 a 86 YO female was admitted to Heart of Mary Medical Center (HOM) for septic shock. She was found by a nurse aide on 10/22/2019 who went into room to check in with her because she was in the assisted living section of Clark Lindsey. Client was bedridden unresponsive, but with a pulse and respirations according to chart. This had occurred from client being immobile for an extended period of time. She was then **transferred by Pro ambulance services to HOM. Client believes she was taken to hospital for bed sores, but the real reason was septic shock**. She has no memory of feeling ill or being told she was septic. She had no complaints of pain or discomfort while in HOM. **Patient was transferred from Heart of Mary to Clark Lindsey on 10/26/2019**. Bed sores were stage 3 which **takes weeks to form**. Located

on coccyx and right hip. Client does not feel pain in these areas with no aggravating factors or reliefs. Wounds are currently covered in bandages and antibiotic ointment.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Septic Shock

Secondary Diagnosis (if applicable): COPD, Pneumonia, Anemia

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

Chronic obstructive pulmonary disease is lung disease that can occur due to genetic and environmental factors. COPD is identified as poor irreversible airflow limitation cause by a combination of chronic bronchitis, emphysema, or hyperreactive airway disease. When COPD occurs, the lungs begin to lose the natural elasticity it needs for gas exchange as well as causing over expanding. This results in some air still being trapped in the lungs when you exhale.

The main cause of COPD in developed countries is due to smoking tobacco. With smoking there may be misdiagnosed COPD cases due to the lungs being less functional in general, if this occurs a more thorough evaluation is performed. Other causes of COPD may include exposure to chemical fumes, or excessive inhalation of dust.

Symptoms may include shortness of breath (especially during physical activity), wheezing, chest tightness, cyanosis in the fingers, frequent respiratory infections, lack of energy, unintended weight loss, and/or edema of the legs, feet or ankles. Risk factors for COPD include exposure to tobacco smoke including secondhand smoking, prolonged exposure to dust or chemicals, age, and genetics. COPD can cause complications such as respiratory infections, heart

problems, lung cancer, high blood pressure in lung arteries, and depression. In a physical exam you can hear a prolonged expiratory phase.

There are no treatments for COPD, but there are preventions which include avoid smoking or secondhand smoke and reducing exposure to fumes from chemicals. The client's reason for having this disease is most likely from inhaling chemicals in the environment due to having no history of smoking. A common reason for older women to get COPD is due to the fumes from cooking food. Cooking with materials that were available before the early 1980's had different preservatives and chemicals that were harmful to the lungs.

Pathophysiology References (2) (APA):

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

L. Swearingen, P. L., & Wright, J. (2018). *All-In-One Nursing Care Planning Resource: Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health*. United States: Elsevier - Health Sciences Division.

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	3.8 – 5.3	2.43		Congenital Heart Disease
Hgb	12.0 -15.8	8.2		Anemia
Hct	36.0 – 47.0	23.4		Anemia
Platelets	140 – 440	350		
WBC	4 – 12	8.80		
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-	134 – 145	137		
K+	3.6 – 5.1	3.6		
Cl-	98 – 107	98		
CO2	35 – 45	30		Hyperventilation
Glucose	70 - 100	100		
BUN	5 – 20	17		
Creatinine	0.5 – 1.5	0.5		
Albumin	3.1 – 4.3	4.3		
Calcium	8.7 - 10	8.8		
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	No Urinalysis on file			
pH				
Specific Gravity				
Glucose				
Protein				
Ketones				
WBC				
RBC				
Leukoesterase				

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	Negative	Negative		No growth in 3 days resulted 10/25
Sputum Culture				

Stool Culture				

Lab Correlations Reference (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Adult trans-esophageal echo complete – indications of Bacteremia

X-ray of chest single view portable - pulmonary vascular congestion

X-ray pelvis AP port – pulmonary vascular congestion and degenerative changes of the spine

CT of chest, abdomen, and pelvis w/out contrast

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

Medications (5 required)

Brand/Generic	Atorvastatin Lipitor	Bumetanide Bumex	Losartan Cozaar	MetFORMIN	Ondansetron Zofran
Dose	10mg Tablet	.5 and 1.0 mg tablets	50 mg Tablets	1000mg tablet	4mg Tablet
Frequency	Nightly	.5 – evening 1-breakfast	Daily	2 times/day with meals	1 Tablet PRN

Route	PO	PO	PO	PO	PO
Classification	Antihyperlipidemic	Loop diuretic	Antihypertensive	Antidiabetic	Antiemetic
Mechanism of Action	Reduces plasma cholesterol and lipoprotein levels	Inhibits reabsorption of sodium	Blocks binding of angiotensin II to receptor sites	Promotes storage of excess glucose as glycogen in the liver	Blocks serotonin receptors centrally in the chemoreceptor trigger zone
Reason Client Taking	High cholesterol	Edema caused by HF	Hypertension	Diabetic	Prevent nausea and vomitting
Contraindications (2)	Active hepatic disease, pregnancy, breastfeeding	Anuria, Hepatic coma, Electrolyte depletion	Concurrent aliskiren therapy, hypersensitivity	advanced renal disease, metabolic acidosis	Concomitant use of apomorphine, congenital long QT syndrome
Side Effects/Adverse Reactions (2)	Arrhythmias, dysuria, dyspnea, anaphylaxis	Dizziness, hypotension, nausea, muscle spasms	Dizziness, diarrhea,	Headache hypoglycemia, aplastic anemia	Agitation, arrhythmia, blurred vision, abdominal px

Medications Reference (APA):

Learning, J. B. (2018). *2019 Nurse's Drug Handbook* (18th ed.). United States of America: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Client AO x 3 (name date place) No acute distress noted and is well dressed
INTEGUMENTARY: Skin color: Character: Temperature:	Skin pink dry and warm. Bed sores covered on right hip and coccyx. Other than that there are no bruises, rashes, lesions, or wounds present.

Turgor: Rashes: Bruises: Wounds: . Braden Score: 14 Moderate risk Drains present: Y☐ N ☒ Type:	
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	Head and neck: Normocephalic w/out obvious abnormalities. External ear canals AU Eyes: Cornea clear, conjunctiva pink, EOM intact PERRLA Nose: septum midline slight drainage from O2 Teeth: has no teeth uses dentures
CARDIOVASCULAR: 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: Feet and Ankles	S1 and S2 audible with pacemakers sounds. Pulses 2+ throughout Cap refill <3 seconds
RESPIRATORY: Accessory muscle use: Y☒ N ☐ Breath Sounds: Location, character	Client leans forward to breath. Lung sounds clear w/ auscultation bilaterally w/ Ronchi in lower r lung
GASTROINTESTINAL: Diet at home: Low sodium Current Diet: Low sodium Height: 4’ 11” Weight: 152lb Auscultation Bowel sounds: Normoactive Last BM: Around 0820 Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y ☐ N ☒ Nasogastric: Y ☐ N ☒ Size:	No abnormalities with inspection, auscultation, and palpations. Scarring on upper abdomen, but no wounds

Feeding tubes/PEG tube Y ☐ N ☒ Type:	
GENITOURINARY: Color: Yellow Character: Clear Quantity of urine: Once during shift Pain with urination: Y ☐ N ☒ Dialysis: Y ☐ N ☒ Inspection of genitals: Catheter: Y ☐ N ☒ Type: Size:	Genitals normal. Bed sore on coccyx with bandage over it.
MUSCULOSKELETAL: Neurovascular status: Normal ROM: very limited Supportive devices: Wheelchair, gait belt Strength: Weak ADL Assistance: Y☒ N ☐ Fall Risk: Y ☒ N☐ Fall Score: High risk Activity/Mobility Status: Independent (up ad lib) ☐ Needs assistance with equipment ☒ Needs support to stand and walk☒	.
NEUROLOGICAL: MAEW: Y ☐ N☒ PERLA: Y ☒ N☐ Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐ Orientation: Mental Status: Speech: Sensory: LOC:	Client has limited ROM and overall minimal strength. She struggles to hold herself up and needs extensive help. No disorientation or distress noted and no LOC. Speaks clearly
PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available	Client is a Methodist and has 4 sons with 4 daughter-in-laws. She has 8 granddaughters all of which visit weekly. She also has a tablet which they upload pictures without having to be present so she can stay updated with her family.

family support):	

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0831	78	108/51	20	98.2 Temporal	95% 2L O_2

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0835	0/10	None	0	No px	No interventions.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
360mL Liquids and 90% of breakfast	Voided x1 during shift

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. Activity Intolerance	Related to restricted mobility as evidence by multiple bed sore	1.Assess ROM to view client's ability to perform prescribed	Goal met during shift. Client was willing to be mobile during shift and became increasingly

	present	exorcises 2.Teach prescribed exorcises to increase muscle strength.	active towards 2nd half of shift. She was also willing to do prescribed exorcises.
2. Dyspnea	Related to COPD as evidence by low O2 sat and client stating “I need to sit down I am out of breath."	1. Auscultate lungs every 2-4 hours 2.monitor pulse ox to keep above 88%	Goal met during shift. No changes in lung sounds were noted from beginning to end of shift. Client was still SOB, but O2 sat stayed where it needed to be and was above expected range.

Other References (APA):

L. Swearingen, P. L., & Wright, J. (2018). *All-In-One Nursing Care Planning Resource: Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health*. United States: Elsevier - Health Sciences Division.

Concept Map (20 Points):

Subjective Data

Client stated she was admitted to renewal floor for recovery for bed sores. She has no px or palpitations. Client says she gets SOB easily.

Nursing Diagnosis/Outcomes

Activity Intolerance - Goal met during shift. Client was willing to be mobile during shift and became increasingly active towards 2nd half of shift. She was also willing to do prescribed exorcises.

Dyspnea - Goal met during shift. No changes in lung sounds were noted from beginning to end of shift. Client was still SOB, but O2 sat stayed where it needed to be and was above expected range

Objective Data

Client full code with vitals as follows
T – 98.2 Temporal
P - 78
R - 20
BP – 108/51
O2 – 95 on 2L of Oxygen
Px – 0/10
Abnormal labs of RBC, Hgb, Hct, and CO2

Patient Information

86 YO white, widowed, and retired F client admitted to Clark Lindsey for sepsis.

Nursing Interventions

Activity Intolerance -1.Assess ROM to view client's ability to perform prescribed exorcises

2.Teach prescribed exorcises to increase muscle strength.

Dyspnea - 1. Auscultate lungs every 2-4 hours

2.monitor pulse ox to keep above 88%