# N431 Care Plan # 3

Lakeview College of Nursing

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## Demographics (3 points)

| Date of Admission | Patient Initials<br>M.K. | Age<br>90 | Gender<br>Female |
|---|---|---|---|
| **Race/Ethnicity**<br>Caucasian | **Occupation**<br>Retired | **Marital Status**<br>Widowed | **Allergies**<br>Clindamycin |
| **Code Status**<br>Full Code | **Height**<br>163 cm | **Weight**<br>64.6 kg | |

## Medical History (5 Points)

**Past Medical History:** Abdominal pain; Abducens nerve palsy; Anemia; Atrial fibrillation; Back pain; Bloating; Congestive heart failure (CHF); Chronic kidney failure (CKD); Constipation; Depression; Diabetes; Dizziness; Deep venous thrombosis (DVT); Dyslipidemia; Fall Risk; Frequent headaches; Frontal mass of brain; gastroesophageal reflux disease (GERD); Hypertension (HTN); Hypercholesterolemia; Insomnia; Major depression; On continuous anticoagulants; Tremor; Type II diabetes mellitus; Vitamin D deficiency

**Past Surgical History:**

- Insertion of Arterial Line (04/26/2019)
- Lumbar Epidural Blood Patch with Fluoroscopy (04/15/2019 and 04/26/2019)
- Eye Laser – Capsulotomy (Yag Cap) (Left) (05/23/2018 and 05/30/2018)
- Fracture closed, humerus, shaft with metal plate
- Hysterectomy

**Family History:** No qualifying data available

**Social History (tobacco/alcohol/drugs):** Former cigarette smoker: started at 18 years old and quit at 65 years of age

**Assistive Devices:** Pt uses a walker and gait belt for motility; wears dentures and hearing aid

**Living Situation:** Brookstone Nursing Home

**Education Level:** High School

## Admission Assessment

**Chief Complaint (2 points):** Difficulty swallowing

**History of present Illness (10 points):** The patient is a 90-year-old Caucasian female brought to the emergency department with difficulty swallowing and a sore throat. Her symptoms started approximately one week ago and have progressively worsened. She has a long medical history that includes abducens nerve palsy, atrial fibrillation, CHF, CKD, dyslipidemia, DVT, myasthenia gravis, and GERD that may be associated with her dysphagia. She did see her primary care provider and was given penicillin for suspected pharyngitis, which the patient states that she was unable to swallow without pain. She has not been able to tolerate a solid or liquid diet. The patient's son visited her this morning and stated that the patient's voice is hoarse compared to one week ago. The patient is on NPO status. Upon assessment, the patient displays a rounded abdomen (non-distended), slightly limited perception to hearing, but no noted acute distress. The patient has undergone a CT scan of her neck and chest x-ray for dysphagia and pharyngitis (sore throat), which reveals no acute processes. The patient is currently awaiting consultation from the ENT physician for further testing.

## Primary Diagnosis

**Primary Diagnosis on Admission (2 points):** Dysphagia, unspecified

**Secondary Diagnosis (if applicable):** Pharyngitis (sore throat)

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

Dysphagia is a medical term for difficulty swallowing (Philipsen, 2019). Swallowing is a complex action that requires the coordination of six cranial nerves, four cervical nerves, and more than 30 pairs of muscles (Philipsen, 2019). An understanding of the normal anatomy and physiology of the larynx, pharynx, esophagus, stomach, and intestine allows the healthcare

professional to identify the mechanisms of dysphagia and aspiration better, as well as synthesize compensatory strategies and preventative measures (Philipsen, 2019). Usually, the muscles in the throat and esophagus squeeze, or contract, to move food and liquids from the mouth to the stomach without complications (Philipsen, 2019). However, sometimes, food and liquids have trouble getting to the stomach, as with this patient. Dysphagia is most common in older adults, babies, and people who have problems with the brain or nervous system (Philipsen, 2019). So, we cannot rule out the possibility that this patient has had a stroke (CVA) that may attribute to her dysphagia. There is a range of conditions, factors, and diseases that contribute to dysphagia. One of the most common causes is gastroesophageal reflux disease (GERD), which occurs when stomach acid flows back into the esophagus (Philipsen, 2019). This patient has a history of GERD, and the acid reflux may be associated with her dysphagia, along with her pharyngitis. Her pharyngitis is also causing her vocal cords to become inflamed, and her son has stated that her hoarseness has worsened since last week. Patients with untreated dysphagia are at high risk of aspiration and malnutrition (Philipsen, 2019). A thorough examination is important, and successful management requires multidisciplinary collaboration, accurate diagnostic workup, and effective therapeutic strategies (Philipsen, 2019). Treatment usually depends on the cause and type of dysphagia (Philipsen, 2019). As with this patient, she has had a CT scan of her neck and a chest x-ray to show any abnormalities related to her dysphagia. No acute abnormalities have been identified, and further testing is needed. All patients should be screened for dysphagia, and a videofluoroscopy identifies the pathology and appropriate treatment (Swearingen, 2016).

**Pathophysiology References (2) (APA):**

Philipsen, B. (2019). Dysphagia – Pathophysiology of Swallowing Dysfunction, Symptoms, Diagnosis and Treatment. *Journal of Otolaryngology and Rhinology, 5:063*. doi.org/10.23937/2572-4193.1510063

Swearingen, P. L. (2016). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, psychiatric nursing care plans*. St. Louis, MO: Elsevier/Mosby.

## 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** | 3.9–5 | 3.79 | 3.96 | |
| **Hgb** | 11-15.5 | 11.4 | 11.9 | |
| **Hct** | 33.2-45.3% | 34.8 | 36.3 | |
| **Platelets** | 150-400(k) | 249 | 267 | |
| **WBC** | 5-10(k) | 12.4 | 10.2 | An elevated WBC may indicate the immune system is fighting an infection, such as pharyngitis (Riley & Ruppert, 2015). |
| **Neutrophils** | 45-80% | 78.6 | 70.0 | |
| **Lymphocytes** | 11.8-46 | 14.7 | 21.7 | |
| **Monocytes** | 4.4-12 | 5.6 | 6.2 | |
| **Eosinophils** | 0-6.3 | 0.6 | 1.5 | |
| **Bands** | < x 10^9/L | 0.5 | 0.6 | |

**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 | 130 | 138 | |
| **K+** | 3.5-5.0 | 4.2 | 3.9 | |
| **Cl-** | 98-107 | 98 | 102 | |
| **CO2** | 21-34 | 22 | 27 | |
| **Glucose** | 70-99 | 270 | 156 | Hyperglycemia can be associated with CKD (Hinkle & Cheever, 2018). |
| **BUN** | 6-20 | 14 | 10 | |
| **Creatinine** | 0.5-0.9 | 1.05 | 0.94 | Elevated creatinine levels can indicate impaired kidney function. In this patient, it can signify kidney failure since she is diagnosed to have stage 3 CKD (Hinkle & Cheever, 2018). |
| **Albumin** | 3.5-5.2 | 3.8 | N/A | |
| **Calcium** | 8.6-10.4 | 9.0 | 9.1 | |
| **Mag** | 1.6-2.4 | N/A | N/A | |
| **Phosphate** | 2.5-4.5 | N/A | N/A | |
| **Bilirubin** | <1.2 | 0.4 | N/A | |
| **Alk Phos** | 32-100 U/L | 46 | N/A | |
| **AST** | <32 | 14 | N/A | |
| **ALT** | <33 | 13 | N/A | |
| **Amylase** | 50-150 | N/A | N/A | |

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| **Lipase** | 10-140 U/L | N/A | N/A | |
| **Lactic Acid** | 0.4-2.3 | N/A | N/A | |
| **Troponin** | 0-0.4 ng/mL | 0.019 | 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 | N/A | N/A | |
| **PTT** | 23-37 | N/A | N/A | |
| **D-Dimer** | < 500ng/mL | N/A | N/A | |
| **BNP** | <100pg/mL | N/A | N/A | |
| **HDL** | > 40 | N/A | N/A | |
| **LDL** | < 100 | N/A | N/A | |
| **Cholesterol** | < 200 | N/A | N/A | |
| **Triglycerides** | < 150 | N/A | N/A | |
| **Hgb A1c** | 0-5.7 | N/A | N/A | |
| **TSH** | 0.358-3.740 | 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 |
|---|---|---|---|---|

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|---|---|---|---|---|
| **Color & Clarity** | Yellow/Clear | N/A | N/A | |
| **pH** | 4.5-8.0 | N/A | N/A | |
| **Specific Gravity** | 1.005-1.035 | N/A | N/A | |
| **Glucose** | < 0.8 mml/L | N/A | N/A | |
| **Protein** | 6.4-8.4 g/dL | N/A | N/A | |
| **Ketones** | 0.6-1.5 | N/A | N/A | |
| **WBC** | 5-10(k) | N/A | N/A | |
| **RBC** | 3.9-5.0 | N/A | N/A | |
| **Leukoesterase** | 4.5-11(k) | 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 Range | Value on Admission | Today's Value | Explanation of Findings |
|---|---|---|---|---|
| **pH** | 7.35-7.45 | N/A | N/A | |
| **PaO2** | 75-100 | N/A | N/A | |
| **PaCO2** | 35-45 | N/A | N/A | |
| **HCO3** | 22-26 | N/A | N/A | |
| **SaO2** | >92% | 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** | Straw | N/A | N/A | |
| **Blood Culture** | N/A | N/A | N/A | |

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|---|---|---|---|---|
| **Sputum Culture** | N/A | N/A | N/A | |
| **Stool Culture** | N/A | N/A | N/A | |

**Lab Correlations Reference (APA):**

Hinkle, J.L., & Cheever, K.H. (2018). *Brunner & Suddarth's Textbook of Medical Surgical Nursing (14th ed.).* Philadelphia, PA: Wolters Kluwer Health Lippincott William & Wilkins.

Normal Lab Values - Common Laboratory Values. (n.d.). Retrieved from https://www.meditec.com/resourcestools/medical-reference-links/normal-lab-values/

Riley, L., & Rupert J. (2015). Evaluation of Patients with Leukocytosis. *American Family Physician, 92*(11), 1004-1011. https://www.aafp.org/afp/2015/1201/p1004.html

## Diagnostic Imaging

**All Other Diagnostic Tests (5 points):** CT Neck and Chest x-ray (Sarah Bush, 2019).

**Diagnostic Test Correlation (5 points):**

CT Neck Soft Tissue with contrast for dysphagia: Impression:

- No acute abnormality is identified on the neck
- A symmetric right cervical lymph nodes are within normal limits for size and are nonspecific, could be reactive
- Incidentally noted right thyroid nodules measure up to 2.2 cm. Please see comment section below for follow-up recommendations
- Incidentally noted nodular density in the right lung apex measure up to 9 mm and is unchanged compared to the prior chest CT; per the previous chest CT report, this finding is unchanged since 2016, suggesting benign, no follow-up is necessary

Chest x-ray for shortness of breath with cough: Impression:

- No acute cardiopulmonary process

**Diagnostic Test Reference (APA):**

Hinkle, J.L., & Cheever, K.H. (2018). *Brunner & Suddarth's Textbook of Medical Surgical Nursing (14th ed.).* Philadelphia, PA: Wolters Kluwer Health Lippincott William & Wilkins.

Sarah Bush Lincoln Hospital (2019). *Cerner Database*. Unpublished internal document.

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

**Home Medications (5 required)**

| **Brand/Generic** | **Neurontin (gabapentin)** | **Zofran (ondansetron)** | **Xarelto (rivaroxaban)** | **Lipitor (atorvastatin)** | **Glucophage (metformin)** |
|---|---|---|---|---|---|
| **Dose** | 300 mg capsule | 4 mg = 2 mL Injectable | 10 mg | 20 mg tablet | 500 mg tablet |
| **Frequency** | Once daily | Every 6 hours PRN | Once daily | Once daily | BID |
| **Route** | PO | IV | PO | PO | PO |
| **Classification** | Anticonvulsant | Antiemetic | Anticoagulant | Lipid-lowering agent | Antidiabetic |
| **Mechanism of Action** | Inhibits the rapid firing of neurons associated with seizures. | Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in | Acts as selective factor X inhibitor that blocks the active site of factor Xa, inactivating the cascade of coagulation. | Inhibits 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase, an enzyme which is responsible for catalyzing an early step in the synthesis of | Decreases hepatic glucose production. Decreases intestinal glucose absorption. Increases sensitivity to insulin. Therapeutic |

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| | | the intestine. | Therapeutic Effects: Prevention of blood clots and subsequent pulmonary emboli following knee/hip replacement surgery. | cholesterol. Therapeutic Effects: Lowering of total and LDL cholesterol and triglycerides. Slightly increases HDL cholesterol. Reduction of lipids/cholesterol reduces the risk of myocardial infarction and stroke sequelae. Slows the progression of coronary atherosclerosis with resultant decrease in coronary heart disease– related events. | Effects: Maintenance of blood glucose. |
| **Reason Client Taking** | Reduce tremors | Reduce nausea | Prevent DVT | Reduce dyslipidemia and hypercholesterolemia | Management of type II diabetes mellitus |
| **Contraindications (2)** | 1) Hypersensitivity<br><br>2) Anaphylaxis | 1) Concomitant use of morphine.<br><br>2) Congenital long QT syndrome | 1) Active major bleeding<br><br>2) Severe renal impairment | 1) Active liver disease<br><br>2) Unexplained persistent elevations in AST and ALT | 1) Metabolic acidosis<br><br>2) Dehydration |
| **Side Effects/Adverse Reactions (2)** | 1) Agitation<br><br>2) | 1) Dystonia<br><br>2) Torsade's de pointes | 1) Syncope<br><br>2) Muscle spasm | 1) Amnesia<br><br>2) Peripheral edema | 1) Abdominal bloating |

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| | Abnormal vision | | | | 2) Lactic acidosis |
| **Nursing Considerations (2)** | 1) Administer initial dose at bedtime to minimize adverse reactions.<br><br>2) Don't exceed 12 hours between doses on a three-times-a-day schedule. | 1) Place disintegrating tablet or oral soluble film on patient's tongue immediately after opening package. It dissolves in seconds.<br><br>2) Use calibrated container or oral syringe to measure dose of oral solution. | 1) Discontinue at least 24 hr prior to surgery and other interventions. Restart as soon as hemostasis has been reestablished.<br><br>2) If rivaroxaban must be discontinued for other than bleeding, consider replacing with another anticoagulant; discontinuation increases risk of thrombotic events. | 1) Do not confuse Lipitor with Loniten or Zyrtec.<br><br>2) Avoid grapefruit and grapefruit juice during therapy; may increase risk of toxicity. | 1) When combined with oral sulfonylureas, observe for signs and symptoms of hypoglycemic reactions (abdominal pain, sweating, hunger, weakness, dizziness, headache, tremor, tachycardia, anxiety).<br><br>2) Withhold metformin before or at the time of studies requiring IV administration of iodinated contrast media and for 48 hr after study. |
| **Key Nursing Assessment(s)/Lab(s) Prior to Administration** | 1) May cause false-positive readings when testing for urinary protein with Ames | 1) Monitor ECG in patients with hypokalemia, hypomagnesemia, HF, bradyarrhythmias, or patients | 1) May cause elevated serum AST, ALT, total bilirubin and GGT levels. | 1) Evaluate serum cholesterol and triglyceride levels before initiating, after 2– 4 weeks of therapy, and | 1) Monitor serum glucose and glycosylated hemoglobin periodically during therapy to evaluate |

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| | N-Multistix SG dipstick test; use sulfosalicylic acid precipitation procedure.<br><br>2) May cause leukopenia. | taking concomitant medications that prolong the QT interval.<br><br>2) May cause transient elevation in serum bilirubin, AST, and ALT levels. | 2) Assess for signs of bleeding and hemorrhage (bleeding gums; nosebleed; unusual bruising; black, tarry stools; hematuria; fall in hematocrit or BP; guaiac-positive stools); bleeding from surgical site. Notify healthcare professional if these occur. | periodically thereafter.<br><br>2) Monitor liver function tests prior to initiation of therapy, and as clinically indicated. If symptoms of serious liver injury, hyperbilirubinemia, or jaundice occurs, discontinue atorvastatin and do not restart. May also cause elevated alkaline phosphatase and bilirubin levels. | effectiveness of therapy. May cause false-positive results for urine ketones.<br><br>2) Patients who have been well controlled on metformin who develop illness or laboratory abnormalities should be assessed for ketoacidosis or lactic acidosis. Assess serum electrolytes, ketones, glucose, and, if indicated, blood pH, lactate, pyruvate, and metformin levels. If either form of acidosis is present, discontinue metformin immediately and treat acidosis. |
| **Client Teaching needs (2)** | 1) Tell patient taking gabapentin extended- | 1) Advise patient to use calibrated container or oral syringe | 1) Instruct patient not to drink alcohol or take other | 1) Instruct patient to take medication as directed. Take missed doses as | 1) Instruct patient to take metformin at the same time |

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| | release tablet to swallow the tablet whole and not chew, crush, or split the tablets.<br><br>2) If patient experiences difficulty breathing or swelling of lips, throat, or tongue, to seek immediate emergency treatment and notify prescriber as drug will need to be discontinued. | to measure oral solution.<br><br>2) Advise patient to immediately report signs of hypersensitivity, such as rash. | Rx, OTC, or herbal products, especially those containing aspirin or NSAIDs, or to start or stop any new medications during rivaroxaban therapy without advice of health care professional.<br><br>2) Advise female patients to notify health care professional if pregnancy is planned or suspected or if breast feeding. | soon as remembered more than 12 hrs since missed dose; omit and take next scheduled dose. Do not double up on missed doses. Advise patient to avoid drinking more than one quart of grapefruit juice per day during therapy. Medication helps control but does not cure elevated serum cholesterol levels.<br><br>2) Advise patient that this medication should be used in conjunction with diet restrictions (fat, cholesterol, carbohydrates, alcohol), exercise, and cessation of smoking. | each day, as directed. Take missed doses as soon as possible unless almost time for next dose. Do not double doses. Instruct parent/caregiver to read the Medication Guide prior to use and with each Rx refill; new information may be available.<br><br>2) Encourage patient to follow prescribed diet, medication, and exercise regimen to prevent hyperglycemic or hypoglycemic episodes. |

**Hospital Medications (5 required)**

| **Brand/Generic** | **Colace (docusate)** | **Lovenox (enoxaparin)** | **Novolog (insulin aspart)** | **Protonix (pantoprazole)** | **Morphine (morphine sulfate)** |
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| **Dose** | 100 mg capsule | 90 mg subQ | Medium dose via sliding scale | 40 mg = 10 mL IV push | 1mg = 0.5 mL IV push |
| **Frequency** | BID | Q12H | PRN | Once daily | Q2H PRN |
| **Route** | PO | SubQ | SubQ | IV | IV |
| **Classification** | Stool softener | Anticoagulant | Antiulcer | Antiulcer | Opioid analgesic |
| **Mechanism of Action** | Promotes incorporation of water into stool, resulting in softer fecal mass. May also promote electrolyte and water secretion into the colon. Therapeutic Effects: Softening and passage of stool. | Potentiates the inhibitory effect of antithrombin on factor Xa and thrombin. Therapeutic Effects: Prevention of thrombus formation. | Inhibits the hydrogen-potassium-adenosine triphosphatase enzymes in gastric parietal cells. | Inhibits the hydrogen-potassium-adenosine triphosphatase enzymes in gastric parietal cells. | Binds with and activates opioid receptors (mainly mu receptors) in brain and spinal cord to produce analgesia and euphoria. |
| **Reason Client Taking** | Relieve constipation | Prevent DVT | Reduce GERD symptoms | Reduce GERD symptoms | Relieve severe pain |

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| **Contraindications (2)** | 1) Abdominal pain<br><br>2) Nausea | 1) Hypersensitivity to benzyl alcohol<br><br>2) Active, major bleeding | 1) Acute interstitial nephritis<br><br>2) Bronchospasm | 1) Acute interstitial nephritis<br><br>2) Bronchospasm | 1) Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment.<br><br>2) Respiratory depression |
| **Side Effects/Adverse Reactions (2)** | 1) Throat irritation<br><br>2) Diarrhea | 1) Dizziness<br><br>2) Constipation | 1) Confusion<br><br>2) *Clostridium difficile* associated with diarrhea | 1) Confusion<br><br>2) *Clostridium difficile* associated with diarrhea | 1) Ataxia<br><br>2) Atelectasis |
| **Nursing Considerations (2)** | 1) Do not confuse Colace with Cozaar. Do not confuse Dulcolax (docusate sodium) with Dulcolax (bisacodyl). Do not confuse Kaopectate Stool Softener (docusate calcium) with Kaopectate (bismuth subsalicyla | 1) Do NOT confuse Lovenox with Levemir.<br><br>2) Cannot be used interchangeably (unit for unit) with unfractionated heparin or other low-molecular-weight heparins. | 1) Don't give within 4 weeks of testing for *Helicobacter pylori* because may lead to false-negative results.<br><br>2) Expect to monitor PT/INR during therapy if patient takes an oral anticoagulant. | 1) Don't give within 4 weeks of testing for *Helicobacter pylori* because may lead to false-negative results.<br><br>2) Expect to monitor PT/INR during therapy if patient takes an oral anticoagulant. | 1) Store morphine at room temperature.<br><br>2) Be aware that ER forms of morphine aren't interchangeable. |

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| | te).<br><br>2) Assess color, consistency, and amount of stool produced. | | | | |
| **Key Nursing Assessment(s)/Lab(s) Prior to Administration** | 1) Assess for constipation indications<br><br>2) Assess for abdominal distention, presence of bowel sounds, and usual pattern of bowel function. | 1) Monitor CBC, platelet count, and stools for occult blood periodically during therapy. If thrombocytopenia occurs, monitor closely. If hematocrit decreases unexpectedly, assess patient for potential bleeding sites.<br><br>2) Special monitoring of clotting times (aPTT) is not necessary in most patients. Monitoring of the aPTT may be | 1) May cause hypomagnesium prior to and periodically during therapy.<br><br>2) May cause abnormal liver function tests, including elevated AST, ALT, alkaline phosphatase, and bilirubin. | 1) May cause hypomagnesemia. Monitor serum magnesium prior to and periodically during therapy.<br><br>2) May cause abnormal liver function tests, including elevated AST, ALT, alkaline phosphatase, and bilirubin. | 1) May elevate plasma amylase and lipase levels.<br><br>2) If an opioid antagonist is required to reverse respiratory depression or coma, naloxone is the antidote. Dilute the 0.4-mg ampule of naloxone in 10 mL of 0.9% NaCl and administer 0.5 mL (0.02 mg) by direct IV push every 2 min. For children and adults weighing 40 kg, dilute 0.1 mg of naloxone in |

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| | | considered in certain patient populations (such as obese patients or patients with renal insufficiency). | | | 10 mL of 0.9% NaCl for a concentration of 10 mcg/mL and administer 0.5 mcg/kg every 2 min. Titrate dose to avoid withdrawal, seizures, and severe pain. |
| **Client Teaching needs (2)** | 1) Advise patients that laxatives should be used only for short-term therapy. Long-term therapy may cause electrolyte imbalance and dependence.<br><br>2) Instruct patients with cardiac disease to avoid straining during bowel movements | 1) Advise patient to report any symptoms of unusual bleeding or bruising, dizziness, itching, rash, fever, swelling, or difficulty breathing to health care professional immediately.<br><br>2) Instruct patient not to take aspirin, naproxen, or ibuprofen without consulting health care professional | 1) Instruct patient in proper use of inhaler, nebulizer, or nasal spray and to take medication as directed. Take missed doses as soon as possible unless almost time for the next dose; space remaining doses evenly during the day. Do NOT double dose.<br><br>2) Advise patients that rinsing mouth after using an inhaler, good oral hygiene, and sugarless gum or candy may minimize | 1) Instruct patient to swallow tablets whole and not to chew or crush them.<br><br>2) Instruct patient to take 30 minutes before a meal. | 1) Urge patient not to break, chew, or crush ER capsules and tablets to avoid rapid release and possibly toxicity.<br><br>2) Instruct patient to notify provider about worsening or breakthrough pain. |

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| | (Valsalva maneuver). | while on enoxaparin therapy. | dry mouth. A health care professional should be notified if stomatitis occurs or if dry mouth persists for more than 2 weeks. | | |

**Medications Reference (APA):**

2019 Nurse's Drug Handbook (18th ed.). (2019). Jones & Bartlett Learning.

Up-to-Date Drug Information. (2019). Retrieved from https://www.drugguide.com/ddo/

## Assessment

**Physical Exam (18 points)**

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| **GENERAL (1 point):**<br>**Alertness:** A&Ox4; Pt is alert and oriented to person/place/time/current situation.<br>**Orientation:** A&Ox4; Pt is alert and oriented to person/place/ time/current situation<br>**Distress:** No acute distress<br>**Overall appearance:** Appears stated age | A&Ox4; Pt is alert and oriented to person/place/time/current situation. The patient has an unsteady gait and requires a gait belt and walker for mobility. Pt states that she has had her current flu shot. |
| **INTEGUMENTARY (2 points):**<br>**Skin color:** Pink<br>**Character:** PWD<br>**Temperature:** Warm<br>**Turgor:** Appropriate for age<br>**Rashes:** No noted rashes<br>**Bruises:** No noted bruises<br>**Wounds:** No noted wounds<br>**Braden Score:** 18 | Skin is PWD (pink, warm and dry) and intact. Skin turgor is appropriate for age. No noted lesions or rashes. Braden Score of 18 indicates mild risk for developing pressure ulcers. |

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| **Drains present: Y☐ N ☒**<br>**Type:** | |
| **HEENT (1 point):**<br>**Head/Neck:** Head is normocephalic and atraumatic. Trachea is midline<br>**Ears:** Did NOT check TMs. Slightly limited perception. Pt wears hearing aid<br>**Eyes:** PERRLA and EOMI bilaterally<br>**Nose:** No noted deviated septum, polyps or turbinates.<br>**Teeth:** Pt wears dentures | Patient has no palpable lymph nodes. Head is normocephalic and atraumatic. Eyes are PERRLA and EOMI bilaterally. Did NOT check TMs. Patient has slightly limited perception, and is hard of hearing. Pt wears hearing aid. No noted deviated septum, polyps or turbinates. Moist mucus membranes, no noted exudate, lesions, erythema around the head and neck. Trachea is midline. Pt wears dentures. |
| **CARDIOVASCULAR (2 points):**<br>**Heart sounds:**<br>**S1, S2, S3, S4, murmur etc.**<br>**Cardiac rhythm (if applicable):** RRR<br>**Peripheral Pulses:** dorsalis pedis 2+ bilaterally<br>**Capillary refill:** <3 seconds upper and lower extremities bilaterally<br>**Neck Vein Distention: Y ☐ N ☒**<br>**Edema Y ☐ N ☒**<br>**Location of Edema:** | S1, S2, and murmur detected. No noted gallops, or rubs. Capillary refill less than 3 seconds. 2+ pedal pulses bilaterally. No noted deformities. No noted edema. |
| **RESPIRATORY (2 points):**<br>**Accessory muscle use: Y☐ N ☒**<br>**Breath Sounds: Location, character** | Lungs CTA bilaterally. No noted wheezes, rhonchi, or crackles. |
| **GASTROINTESTINAL (2 points):**<br>**Diet at home:** Regular<br>**Current Diet:** NPO<br>**Height:** 163 cm<br>**Weight:** 64.6 kg<br>**Auscultation Bowel sounds:** Present in all four quadrants<br>**Last BM:** Morning of 11/06/19<br>**Palpation: Pain, Mass etc.:** Pt states headache pain (8/10).<br>**Inspection:** No noted lesions or rashes<br>**Distention:** No noted distention<br>**Incisions:** No noted incisions<br>**Scars:** No noted scars<br>**Drains:** No noted drains<br>**Wounds:** No noted wounds | I did not palpate abdomen. Bowel sounds present in all four quadrants. Patient is NPO. |

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| **Ostomy: Y ☐ N ☒**<br>**Nasogastric: Y ☐ N ☒**<br>**Size:**<br>**Feeding tubes/PEG tube Y ☐ N ☒**<br>**Type:** | |
| **GENITOURINARY (2 Points):**<br>**Color:** Yellow<br>**Character:** Yellow color, no foul odor<br>**Quantity of urine:** 150 mL<br>**Pain with urination: Y ☐ N ☒**<br>**Dialysis: Y ☐ N ☒**<br>**Inspection of genitals:** I did not inspect genitals<br>**Catheter: Y ☐ N ☒**<br>**Type:**<br>**Size:** | Patient ambulated with assistance and urinated 3 times this morning. |
| **MUSCULOSKELETAL (2 points):**<br>**Neurovascular status:** All 4 extremities are atraumatic, well developed, and move without difficulty (MAEW). No noted edema.<br>**ROM:** Intact in the upper and lower extremities bilaterally and moves without difficulty<br>**Supportive devices:** Walker and gait belt<br>**Strength:** 5/5 in upper and lower extremities bilaterally<br>**ADL Assistance: Y☒ N ☐**<br>**Fall Risk: Y ☒ N☐**<br>**Fall Score:** 50<br>**Activity/Mobility Status:** Patient is able to ambulate and walk to the restroom with assistance.<br>**Independent (up ad lib) ☐**<br>**Needs assistance with equipment ☒**<br>**Needs support to stand and walk ☒** | Patient uses a walker and gait belt at the nursing home. Hand grips equal bilaterally. DTRs intact. ROM intact in the upper and lower extremities bilaterally, 5/5 musculoskeletal strength in upper and lower extremities bilaterally and moves without difficulty (MAEW). No noted edema. Patient is a fall risk as evidence by Morse Fall Scale of 50. Patient is able to ambulate and walk to the restroom with assistance. |
| **NEUROLOGICAL (2 points):**<br>**MAEW: Y ☒ N☐**<br>**PERLA: Y ☒ N☐**<br>**Strength Equal: Y ☒ N ☐ if no -**<br>**Legs ☐ Arms ☐ Both ☐**<br>**Orientation:** A&Ox4<br>**Mental Status:** A&Ox4<br>**Speech:** Normal | Patient is A&Ox4. She is able to orient person/place/time/current situation. Muscle strength and sensation intact in upper and lower extremities bilaterally. No noted nuchal rigidity or meningeal signs. |

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| **Sensory:** Intact<br>**LOC:** Normal | |
| **PSYCHOSOCIAL/CULTURAL (2 points):**<br>**Coping method(s):** Talking with friends and playing BINGO on Saturdays, Tuesdays, and Thursdays.<br>**Developmental level:** Appropriate for age<br>**Religion & what it means to pt.:** Patient is a Christian, and treats others with kindness.<br>**Personal/Family Data (Think about home environment, family structure, and available family support):** Pt lives at a nursing home with friends. Pt has a concerned son who visits frequently. | Patient's coping method is talking with her friends and playing BINGO. Patient states that she is of Christian faith and practices kindness towards others. Patient is widowed and resides at a nursing home where she feels safe among her friends. She has a concerned son who visits with her frequently. |

**Vital Signs, 2 sets (5 points)**

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| 0730 | 96 | 128/73 | 18 | 36.4 C | 94% |
| 1000 | 74 | 122/65 | 16 | 36.5 C | 96% |

**Vital Sign Trends:**

**Pain Assessment, 2 sets (2 points)**

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| 0730 | 8 out of a 10 (10 pain scale) | Headache across forehead | Severe | Throbbing | Morphine |
| 1000 | 0 out of a 10 (10 pain scale) | N/A | N/A | N/A | N/A |

**IV Assessment (2 Points)**

| IV Assessment | Fluid Type/Rate or Saline Lock |
|---|---|
| **Size of IV:** 22 gauge<br>**Location of IV:** Right forearm<br>**Date on IV:** 11/05/2019<br>**Patency of IV:** Patent, no phlebitis/infiltration present, infusing without difficulty<br>**Signs of erythema, drainage, etc.:** No noted signs of erythema, drainage, etc.<br>**IV dressing assessment:** Clean, dry, and intact | 0.9% NS IV solution 75 mL IV drip |

**Intake and Output (2 points)**

| Intake (in mL) | Output (in mL) |
|---|---|
| 225 mL (IV fluids) | 150 mL (urine) |

**Nursing Care**

**Summary of Care (2 points)**

**Overview of care:** The patient in room #410 stayed in her room throughout the day. She did ambulate three times to go to the restroom, and she required assistance. She was on NPO status and did not eat or drink. She complained of hunger and of having a headache, which she rated as an 8/10 on a 0-10 pain scale. She had a 22 gauge IV in her right forearm and was on normal saline. The nurse and I monitored the patient frequently and administered her medication promptly. She did not show any signs of acute distress, and her vital signs remained stable throughout my time with her. The patient spent most of the morning watching the Hallmark channel on the television. After she had received morphine for her headache, she rated her pain at 0/10. The patient had a CT scan of her neck and a chest x-ray before my time with her, and both tests identified no acute abnormalities. The patient was still waiting to see the ENT specialist for further testing when I finished with my clinical. The hospitalist met with the patient

before I left, and reassured her that the ENT specialist would arrive shortly to meet with her. The ENT specialist will examine the patient's mouth and throat in greater detail. I anticipate the patient will require videofluoroscopy to identify the pathology of her dysphagia and to help determine the appropriate treatment before discharge. I also expect the patient will be on a pureed diet after getting off NPO status, and to monitor her risk for aspiration and swallowing ability. Impaired ability to swallow is a major concern due to the risk of aspiration pneumonia, difficulty with nutrition, and difficulty with administration of medications. The patient's son will help his mother return to Brookstone Nursing Home at the appropriate time.

**Procedures/testing done:** CT scan of her neck and chest x-ray

**Complaints/Issues:** Hunger and headache

**Vital signs (stable/unstable):** Stable

**Tolerating diet, activity, etc.:** The patient used the restroom three times. The patient is NPO.

**Physician notifications:** ENT specialist scheduled to meet with patient for further testing

**Future plans for patient:** We are currently awaiting an ENT specialist to determine future action. I anticipate a videofluoroscopic assessment (videofluoroscopy) to be done. Medications to prevent GERD from entering the esophagus are prescribed, as well as antibiotic drugs for infections in the pharynx, larynx, and throat, if present.

**Discharge Planning (2 points)**

**Discharge location:** Brookstone Nursing Home

**Home health needs (if applicable):** Assistance with ambulation and drug compliance

**Equipment needs (if applicable):** Gait belt and walker

**Follow up plan:**

- Successful management of dysphagia requires multidisciplinary collaboration that includes an ENT specialist, rehabilitation nurse, occupational therapist, speech pathologist, dietician, physician, radiologist, and language therapist who work together (Philipsen, 2019).
- Follow-up appointment to determine the effectiveness of interventions.

**Education needs:**

Managing secretions:

- Preferred position is Semi-Fowlers (head of bed at 30 degrees or greater, unless contraindicated) (Hinkle & Cheever, 2018).
- If management of secretions is a significant problem, have suction set-up available at bedside (Hinkle & Cheever, 2018).
- Perform aggressive oral care and respiratory assessment every four (4) hours and as needed, to include suctioning of the posterior pharynx (Hinkle & Cheever, 2018).
- Assess stability and patency of airway (Hinkle & Cheever, 2018).

Medications:

- Drug compliance
- Consider alternative routes for PO medications, if unable to swallow (Hinkle & Cheever, 2018).
- If oral route for medications is utilized, check patient's mouth for pocketing after medication administration (Hinkle & Cheever, 2018).
- If patient is on thickened liquids, use this consistency when administering medications (Hinkle & Cheever, 2018).

Nutrition:

- Position patient upright 90 degrees during feeding (Hinkle & Cheever, 2018).
- Small, frequent meals, with small bites for easier chewing and swallowing (Hinkle & Cheever, 2018).
- The patient should remain at 90 degrees for 30 minutes after meals (Hinkle & Cheever, 2018).
- Check patient's mouth for pocketing of food or incomplete swallowing (Hinkle & Cheever, 2018).
- If feeding tube is present and patient is receiving continuous feedings, check tube position every four (4) hours and as needed. If patient is receiving intermittent feedings, check tube position before each feeding. Note that NG and ND tube feedings are generally not recommended if gag reflex is absent (Hinkle & Cheever, 2018).
- If the patient is receiving NG feedings in addition to oral feedings, it may be helpful to stop tube feedings for 1 to 2 hours prior to oral feeding to help stimulate the appetite (Hinkle & Cheever, 2018).

**References:**

Hinkle, J.L., & Cheever, K.H. (2018). *Brunner & Suddarth's Textbook of Medical Surgical Nursing (14th ed.).* Philadelphia, PA: Wolters Kluwer Health Lippincott William & Wilkins.

Philipsen, B. (2019). Dysphagia – Pathophysiology of Swallowing Dysfunction, Symptoms, Diagnosis and Treatment. *Journal of Otolaryngology and Rhinology, 5:063*. doi.org/10.23937/2572-4193.1510063

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

| **Nursing Diagnosis**<br>• Include full nursing diagnosis with "related to" and "as evidenced by" components | **Rational**<br>• Explain why the nursing diagnosis was chosen | **Intervention (2 per dx)** | **Evaluation**<br>• How did the patient/family respond to the nurse's actions?<br>• Client response, status of goals and outcomes, modifications to plan. |
|---|---|---|---|
| **1.** Ineffective airway clearance related to pharyngitis as evidence by the patient's progressing hoarse voice. | The patient was prescribed penicillin for her pharyngitis prior to admission. The patient's report states that she was unable to swallow the penicillin tablet without pain. The patient's son stated that her hoarseness had gotten worse over the past week. Also, dysphagia makes it difficult for the patient to | **1.** Place the patient in a semi-Fowlers position using pillows to facilitate lung expansion.<br><br>**2.** Encourage increased fluid intake to decrease the viscosity of secretions. | ***** The patient is cooperative and agrees with interventions.<br><br>* Prior to discharge, the patient will understand that a semi-Fowler's position will enable her to breathe easier, and the increases in fluids enable her to expectorate sputum effectively. |

| | | | |
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| | swallow liquids or solids. | | |
| **2.** Impaired swallowing related to acid reflux as evidence by her diagnosis of GERD. | The patient was admitted for dysphagia, and has a history of GERD. | **1.** Provide oral care before feeding. Clean and insert dentures before each meal.<br><br>**2.** For impaired swallowing, use a dysphagia team composed of a rehabilitation nurse, speech pathologist, dietitian, physician, and radiologist who work together. | ***** The patient is cooperative and agrees with interventions.<br><br>* Prior to discharge, the patient will understand that optimal oral care promotes appetite and eating, and that good oral care helps prevent aspiration pneumonia. The dysphagia team can help the patient learn to swallow safely and maintain a good nutritional status. |
| **3.** Acute pain related to pharyngitis as evidence by patient complaining of pain when swallowing. | The patient was prescribed penicillin for her pharyngitis prior to admission. The patient's report states that she was unable to swallow the penicillin tablet without pain. Also, dysphagia makes it difficult for the patient to swallow liquids or solids. | **1.** Assess pain characteristics using a 1-10 pain scale.<br><br>**2.** Suggest diversional activity such as watching a video, reading a book or listening to music. | ***** The patient is cooperative and agrees with interventions.<br><br>* Prior to discharge, the patient will understand that the assessment of her pain experience is the first step in planning pain management strategies. The most reliable source of information about the pain is the patient. Descriptive scales such as a 0-10 pain scale can be utilized to distinguish the degree of pain. The patient spent much of the morning watching the Hallmark channel as a diversional activity. |
| **4.** Risk for aspiration related to dysphagia as | | **1.** Elevate the head of bed to 30 to 45 degrees while feeding the patient | ***** The patient is cooperative and agrees with interventions. |

| | | | |
|---|---|---|---|
| evidence by impaired swallowing. | | and for 30 to 45 minutes afterward if feeding is intermittent. Turn off the feeding before lowering the head of bed. Patients with continuous feedings should be in an upright position.<br><br>**2.** Assess level of consciousness. | * Prior to discharge, the patient will understand that upright positioning reduces aspiration by decreasing reflux of gastric contents. She will also understand that the primary risk factor of aspiration is a decreased level of consciousness. |

**Other References (APA):**

Hinkle, J.L., & Cheever, K.H. (2018). *Brunner & Suddarth's Textbook of Medical Surgical Nursing (14th ed.).* Philadelphia, PA: Wolters Kluwer Health Lippincott William & Wilkins.

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):**

## Subjective Data

Pain when swallowing
Difficulty breathing
Difficulty swallowing
Increased work to swallow

## Nursing Diagnosis/Outcomes

Impaired swallowing related to acid reflux as evidence by her diagnosis of GERD.
**Outcome:** Patient verbalizes appropriate maneuvers to prevent choking and aspiration: positioning during eating, type of food tolerated, and safe environment.
Impaired swallowing related to acid reflux as evidence by her diagnosis of GERD.
**Outcome:** Patient displays ability to safety swallow, as evidenced by absence of aspiration, no evidence of coughing or choking during eating/drinking, no stasis of food in oral cavity after eating, ability to ingest foods/fluids.
Acute pain related to pharyngitis as evidence by patient complaining of pain when swallowing.
**Outcome:** Patient uses pharmacological and nonpharmacological pain-relief strategies.
Risk for aspiration related to dysphagia as evidence by impaired swallowing.
**Outcome:** Patient swallows and digests oral, nasogastric, or gastric feeding without aspiration.

## Objective Data

Drooling
Hoarseness in voice
Coughing
Pharyngitis

## Patient Information

A 90-year-old female nursing home resident was brought to the emergency department (ED) for dysphagia and pharyngitis on 11/05/19. She has a long medical history that includes abducens nerve palsy, atrial fibrillation, CHF, CKD, dyslipidemia, DVT, myasthenia gravis, and GERD that may be associated with her dysphagia.

## Nursing Interventions

* Place the patient in Fowler's or semi-Fowler's position using pillows to facilitate lung expansion.
* Encourage increased fluid intake to decrease the viscosity of secretions.
* Provide oral care before feeding. Clean and insert dentures before each meal.
* For impaired swallowing, use a dysphagia team composed of a rehabilitation nurse, speech pathologist, dietitian, physician, and radiologist who work together.
* Assess pain characteristics using a 1-10 pain scale.
* Suggest diversional activity such as watching a video, reading a book or listening to music.
* Elevate the head of bed to 30 to 45 degrees while feeding the patient and for 30 to 45 minutes afterward if feeding is intermittent. Turn off the feeding before lowering the head of bed. Patients with continuous feedings should be in an upright position.
* Assess level of consciousness.