N321 Care Plan 3

Lakeview College of Nursing

Shayla Mitchell

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2 Nov 2019	LA	81	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Widow	Sulfa drugs - hives
Code Status	**Height**	**Weight**	
Full Code	163 cm	89.400 kg	

Medical History (5 Points)

Past Medical History: Hypertension (HTN) and Diabetes

Past Surgical History: Rotator Cuff Arthropathy at right shoulder, Appendectomy, Hysterectomy, Knee Arthropathy

Family History: HTN and Diabetes

Social History (tobacco/alcohol/drugs): Denies all use

Assistive Devices: Gait belt and walker

Living Situation: Lives at home with children

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): Off balance, dizziness, low-grade fever, leukocytosis

History of present Illness (10 points): 81 year old female with previous syncope episode who presented to the E.D. Patient has had symptoms for one month. Dizziness occurs when rising from supine position. Milder symptoms when sitting up. Patient reports “feels like being pushed backwards or forward.” The patient has not fallen. She feels nauseous at times during dizziness.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Autonomic Dysfunction

Secondary Diagnosis (if applicable): Hypertension

Pathophysiology of the Disease, APA format (20 points): The autonomic nervous system (ANS) controls several basic functions such as heart rate, body temperature, breathing rate, digestion, and sensation. The ANS includes the sympathetic nervous system (SANS) and the parasympathetic nervous system (PANS) and most organs have nerves from both. The SANS usually stimulates organs. For example, it increases heart rate and blood pressure when necessary. The PANS usually slows down bodily processes. Autonomic dysfunction usually occurs when the nerves of the ANS are damaged. This condition is also known as autonomic neuropathy or dysautonomia. Diabetes and Parkinson's disease are two processes that can lead to autonomic dysfunction. Symptoms include dizziness and fainting, sweating abnormalities, bloating, diarrhea, urinary problems, and sexual problems. The treatment for autonomic dysfunction centers around treating the symptoms (Marcin, 2016). Hypertension or high blood pressure is a common condition that occurs when the force of blood against your arteries is high enough that it may eventually cause other health problems. Blood pressure is determined both by the amount of blood your heart pumps and the amount of resistance to blood flow in your arteries. The more blood your heart pumps and the narrower your arteries, the higher your blood pressure. Most people with high blood pressure have no signs or symptoms, even if blood pressure readings reach dangerously high levels. Sometimes people with high blood pressure may have headaches, shortness of breath or nosebleeds, but these signs and symptoms aren't specific and usually don't occur until high blood pressure has reached a severe or life-threatening stage. Risk factors for high blood pressure include age, race, family history, and being overweight or obese, using tobacco, too much salt in your diet, or too little potassium in your diet

("High Blood Pressure (hypertension)," 2018). Complications include heart attack, aneurysms, or heart failure.

Pathophysiology References (2) (APA):

High blood pressure (hypertension). (2018, May 12). Retrieved from https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410.

Marcin, J. (2016, May 13). Autonomic Dysfunction: Symptoms, Types, and Treatments. Retrieved from https://www.healthline.com/health/autonomic-dysfunction.

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	4.69	4.77	Within normal limits
Hgb	11.3-15.2	13.3	13.7	Within normal limits
Hct	33.2-45.3%	39.8%	40.9%	Within normal limits
Platelets	149-393	269	234	Within normal limits
WBC	4.0-11.7	13.3	10.8	High due to patient low-grade fever
Neutrophils	45.3-79.0	80.8	78.5	High due to patient low-grade fever
Lymphocytes	11.8-45.9	11.5	11.6	High due to patient low-grade fever
Monocytes	4.4-12.0%	6%	7.4%	Within normal limits
Eosinophils	0-6.3	0.8%	1.9%	Within normal limits
Bands	n/a	n/a	n/a	n/a

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal

Na-	136-145	136	136	Within normal limits
K+	3.5-5.1	3.7	3.6	Within normal limits
Cl-	98-107	100	98	Within normal limits
CO2	21-31	24	28	Within normal limits
Glucose	74-109	174	220	High due to diabetes mellitus
BUN	7-25	18	11	Within normal limits
Creatinine	0.5-0.9	0.84	0.73	Within normal limits
Albumin	3.5-5.2	4.0	n/a	Within normal limits
Calcium	8.6-10.3	8.9	9.0	Within normal limits
Mag	n/a	n/a	n/a	Within normal limits
Phosphate	n/a	n/a	n/a	Within normal limits
Bilirubin	0.3-1.0	0.8	n/a	Within normal limits
Alk Phos	35-105	73	n/a	Within normal limits
AST	0-32	12	n/a	Within normal limits
ALT	0-33	11	n/a	Within normal limits
Amylase	n/a	n/a	n/a	Within normal limits
Lipase	n/a	n/a	n/a	Within normal limits
Lactic Acid	0.5-2.0	0.9	n/a	Within normal limits

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	Labs not performed	n/a	n/a	n/a
PT	Labs not performed	n/a	n/a	n/a
PTT	Labs not performed	n/a	n/a	n/a
D-Dimer	Labs not performed	n/a	n/a	n/a
BNP	Labs not performed	n/a	n/a	n/a
HDL	23-92	38	n/a	Within normal limits
LDL	<100	112	n/a	High due to hyperlipidemia
Cholesterol	<130	170	n/a	High due to hyperlipidemia
Triglycerides	0-149	102	n/a	Within normal limits
Hgb A1c	< = 6.4	7.3%	n/a	High due to diabetes mellitus
TSH	0.45-5.33	n/a	1.52	Within normal limits

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	Clear	Yellow/Clear	n/a	Within normal limits
pH	4.5-8.0	6.0	n/a	Within normal limits
Specific Gravity	1.010-1.030	1.008	n/a	Within normal limits
Glucose	0 – 0.8	Normal	n/a	Within normal limits
Protein	0-20mg/dL	Negative	n/a	Within normal limits
Ketones	Negative	Negative	n/a	Within normal limits
WBC	Negative	Negative	n/a	Within normal limits
RBC	Negative	Negative	n/a	Within normal limits
Leukoesterase	Negative	Negative	n/a	Within normal limits

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	Labs not performed	Negative	n/a	A negative urine culture means that the probability of a urine infection is low.
Blood Culture	Labs not performed	Negative	n/a	A negative blood culture means that the probability of a blood infection is low.
Sputum Culture	Labs not performed	n/a	n/a	n/a
Stool Culture	Labs not performed	n/a	n/a	n/a

Lab Correlations Reference (APA): (Medical Chart, 2 Nov 2019)

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Troponin I (0.01 g/mL), CT Brain/Head, Chest X-Ray, Echocardiogram, and MRI brain

Diagnostic Test Correlation (5 points): EKG – Normal sinus rhythm, CT Brain – No evidence of acute infarction or hemorrhage, MRI Brain – Mild diffuse parenchymal volume loss and nonspecific mild patchy cerebral white matter gliosis, Chest X-Ray – Heart size is mildly enlarged, slight elevation of hemidiaphragm

Diagnostic Test Reference (APA): (Medical Chart, November 4, 2019)

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

Home Medications (5 required)

Brand/Generic	Hydralazine	Mobic/ Meloxicam	Norvasc/ amlodipine	Antivert/ Medizine	Calcium Carbonate/Vitamin D3
Dose	10mg	7.5mg	10mg	25mg	1000unit
Frequency	TID	Daily	Daily	TID/PRN	BID
Route	PO	PO	PO	PO	PO
Classification	Antihypertensive	NSAID	Calcium Channel Blocker	Anti-histamine	Calcium Salts
Mechanism of Action	Direct vasodilator	Inhibits synthesis of prostaglandins in body tissues by inhibiting isoenzymes	Inhibits transmembrane influx of extracellular calcium ions across membranes of myocardial cells	Antihistamine with activity against nebulized histamine	Stimulates calcium and phosphate absorption
Reason Client Taking	High Blood Pressure	Arthritis	High Blood Pressure	Dizziness	Help absorb calcium and phosphorus
Contraindications (2)	Coronary artery disease Mitral valve rheumatic heart disease	Salicylate allergy CABG Surgery	Hypersensitivity CHF	Hypersensitivity	Hypersensitivity Hypercalcemia

Side Effects/Adverse Reactions (2)	Hypotension Palpitations	Indigestion Upper respiratory infection	Edema Headache	Drowsiness Constipation	Anorexia Constipation
Nursing Considerations (2)	Do not refrigerate Avoid adding drug to infusion solution	Use to lowest effective dose for shortest duration	Titrate medication slowly Can be a combination medication	May impair physical or mental abilities	Take with food Tell patient to limit sun exposure

Hospital Medications (5 required)

Brand/Generic	Aspirin	Zestril/ Lisinopril	Lovenox/ enoxaparin	Lopressor / Metoprolol	Tylenol/ acetaminophen
Dose	81mg	40mg	40mg	50mg	650mg
Frequency	Daily	Daily	Daily	Daily	Q6hr/PRN
Route	PO	PO	SQ	PO	PO
Classification	NSAID	ACE inhibitor	Anticoagulant	Beta Blocker	Antipyretic
Mechanism of Action	Inhibits synthesis of prostaglandins	Dilate arteries and veins by converting angiotensin one to angiotensin two	Inhibits factor Xa by increasing inhibition rate of clotting proteases	Blocks response to beta-adrenergic stimulation	Acts on hypothalamus to produce antipyresis
Reason Client Taking	MI, CVA Prevention	Hypertension	Prevent Blood Clots	Hypertension	Mild Pain Reliever/ Fever Reducer
Contraindications (2)	Bleeding GI ulcers Appendicitis	Pregnancy Hypersensitivity	Active bleeding Hx of HIT	Angina Sinus bradycardia	Severe active liver disease Hypersensitivity
Side Effects/Adverse	Angioedema Bronchospasm	Dizziness Cough	Hemorrhage Fever	Dizziness Headache	Angioedema Disorientation

Reactions (2)					
Nursing Considerations (2)	Take with food Assess pain before administration	Shake suspension before each use	Always assess vitals before administration Always clean site before administration	Give undiluted by direct injection Swallow whole	Do not exceed 4g/day May increase risk for bleeding

Medications Reference (APA): (Medical Chart, November 4, 2019)

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	• A/O x4 – Patient is oriented to person, place, time, and current president • Obese female • No acute distress • Patient is white, older female and she was lying in bed watching TV during my care with her.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:**	• Skin is pink, warm and dry • Temperature is 37.8˚C taken at temporal artery • Skin turgor is <3 sec • No rash, pruritis, abrasions, or open wounds

Wounds: . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	• Braden score: 20
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	• Normocephalic head shape • No ear pain, tinnitus, hearing loss, nasal congestion, sinus pain, sore throat, or swallowing difficulty • Moist oral mucosa • No exudate • No dentures or decay
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:**	• Normal sinus rhythm on EKG • No chest pain, palpitations, or orthopnea • Dizziness upon switching positions • Chest x-ray showed mildly enlarged heart • No murmurs, gallops, or rubs • Capillary refill <3 sec
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	• Bilateral clear to auscultation and percussion • No labored breathing
GASTROINTESTINAL (2 points): **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:**	• No abdominal pain, nausea, vomiting, diarrhea, constipation, melena, or hemorrhage • Active bowel sounds present upon auscultation in all four quadrants • Soft, non-distended abdomen • Heart-healthy diet • Patient needs education of diabetic diet and counting carbohydrates due to the fact that the patient's glucose is extremely high

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	• No dysuria, frequency, hematuria, or oliguria • Patient is one assist to bathroom but can go on own without help • Normal urine output
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☐**	• Normal range of motion and strength all extremities • No deformities, tenderness, or swelling • High fall risk; fall score is 85 • Up with one assist and walker • No neck, back, or joint pain
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	• No focal neuro-symptoms • DTRs +2 and symmetrical • A/O x 4 • No altered mental status • No speech problems • No sensory deficits
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):**	• The patient is Baptist and loves church and Jesus • No anxiety, depression, or suicide ideation • Cooperative, appropriate mood, and no hallucinations

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0700	70 bpm	150/70	18	37.0˚	98%
1000	72 bpm	164/70	18	37.3˚	93%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric Pain Scale	N/a	0	n/a	No pain interventions necessary
1000	Numeric Pain Scale	n/a	0	n/a	No pain interventions necessary

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 gauge
Location of IV:	Peripheral left forearm
Date on IV:	4 Nov 2019
Patency of IV:	No phlebitis, catheter present
Signs of erythema, drainage, etc.:	No signs of erythema or drainage present
IV dressing assessment:	Transparent dressing

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
2000 mL	700 mL

Nursing Care

Summary of Care (2 points)

Overview of care: During my time of care with this patient I administered her insulin SQ injection (1 unit), Lovenox SQ injection, and oral medication pass

Procedures/testing done: Chest X-ray, EKG, MRI Brain

Complaints/Issues: Patient has complaint of feeling off balance and dizzy

Vital signs (stable/unstable): Patient vitals are stable

Tolerating diet, activity, etc.: Patient is tolerating a heart, healthy diet well

Physician notifications: None

Future plans for patient: Discharge patient back home with her children

Discharge Planning (2 points)

Discharge location: Home with children

Home health needs (if applicable): Not applicable

Equipment needs (if applicable): Not applicable

Follow up plan: Patient is to attend physical therapy in the home setting

Education needs: Diabetes management and keeping blood glucose at acceptable range.

Also, patient needs education on how to count carbohydrates.

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. Activity	This nursing diagnosis	1.Elavuate patient's actual and	The client was very cooperative

	intolerance related to dizziness and off balance spells AEB verbal report of fatigue	was chosen because a huge symptoms of autonomic dysfunction is dizziness which can and does affect my patients ability to perform certain activities	perceived limitations or degree of deficit 2.Instruct client in energy-conserving techniques	with her care. She was able to verbalize exactly how she was feeling and was able to adjust her techniques to conserve energy such as using a chair while showering
2.	Imbalanced nutrition related to patient diagnosis of diabetes AEB patient is obese and does not manage diabetes glucose levels well	The patient is a type two diabetic and her condition is not managed properly. Her unmanaged diabetes can affect her hypertension and overall health	1. Assess patient understanding of direct relationship between hypertension and diabetes and obesity 2.Discuss necessity for decreased caloric intake and limited intake of fats, salt, and sugar as indicated.	The client was very cooperative and eager to learn about how she could contribute to her health. The nurse did provide education to the client about counting carbohydrates and following a heart-healthy diet.
3.	Risk for decreased cardiac output related to patient comorbidities AEB signs and symptoms patient is experiencing	The patient has hypertension and diabetes which can put her more at risk for decreased cardiac output and other cardiac related issues.	1. Check laboratory data (cardiac markers, complete blood cell count, electrolytes, ABGs, blood urea nitrogen and creatinine, cardiac enzymes, and cultures, such as blood, wound or secretions). 2Note presence, quality of central and peripheral pulses.	The clients labs and test were reviewed and any abnormalities were noted. The client did have a high blood pressure during care which was treated with medications.

Other References (APA): Vera, M. (2018, December 6). Hypertension Nursing Care Plans: 6 Nursing Diagnosis. Retrieved from https://nurseslabs.com/6-hypertension-htn-nursing-care-plans/.

Concept Map (20 Points):

Subjective Data

Patient rates pain 0/10 at 0700
Patient reports, “Feels like I am being pushed backwards or forward.”

Nursing Diagnosis/Outcomes

Activity intolerance related to dizziness and off balance spells AEB verbal report of fatigue
The client was very cooperative with her care. She was able to verbalize exactly how she was feeling and was able to adjust her techniques to conserve energy such as using a chair while showering
Imbalanced nutrition related to patient diagnosis of diabetes AEB patient is obese and does not manage diabetes glucose levels well
The client was very cooperative and eager to learn about how she could contribute to her health. The nurse did provide education to the client about counting carbohydrates and following a heart-healthy diet.
Risk for decreased cardiac output related to patient comorbidities AEB signs and symptoms patient is experiencing
The clients labs and test were reviewed and any abnormalities were noted. The client did have a high blood pressure during care which was treated with medications.

Objective Data

Patient vital signs at 0700
Pulse: 70
BP: 150/70
RR: 18
Temp: 37.0
O2: 98%
Patient vital signs at 1000
Pulse: 72
BP: 164/70
RR: 18
Temp: 37.3
O2: 93

Patient Information

81 y.o female
Chief complaint of feeling off balance and dizziness
Patient has hx of HTN and Diabetes

Nursing Interventions

1.Elavuate patient’s actual and perceived limitations or degree of deficit
2.Instruct client in energy-conserving techniques
. Assess patient understanding of direct relationship between hypertension and diabetes and obesity
2.Discuss necessity for decreased caloric intake and limited intake of fats, salt, and sugar as indicated.
Check laboratory data (cardiac markers, complete blood cell count, electrolytes, ABGs, blood urea nitrogen and creatinine, cardiac enzymes, and cultures, such as blood, wound or secretions).
2Note presence, quality of central and peripheral pulses.