

N321 Care Plan # 3

Lakeview College of Nursing

Lindsey Davis

## N321 Care Plan

**Demographics (3 points)**

<b>Date of Admission</b> 10/31/19	<b>Patient Initials</b> MK	<b>Age</b> 54	<b>Gender</b> Male
<b>Race/Ethnicity</b> Caucasian	<b>Occupation</b> Unemployed	<b>Marital Status</b> Single	<b>Allergies</b> Adhesive
<b>Code Status</b> FULL	<b>Height</b> 191 cm	<b>Weight</b> 103 kg	

**Medical History (5 Points)**

**Past Medical History:** Cervical spine injury, quadriplegia, neurogenic bladder, CHF, hypertension, obesity, hypoventilation syndrome, atrial flutter

**Past Surgical History:** Flat hip surgery (2017), colostomy, spinal fusion (1988), lithotripsy

**Family History:** Heart disease (uncle)

**Social History (tobacco/alcohol/drugs):** Denies alcohol, drug use and smoking

**Assistive Devices:** special chair, wheelchair, hooyer lift

**Living Situation:** Lives at home alone, has in home care 8hr per day.

**Education Level:** Completed high school

**Admission Assessment**

**Chief Complaint (2 points):** Patient presents in ED with what patients states is a possible urinary tract infection (UTI). Patient has a chronic foley (last changed one week ago), he states he is prone to UTIs and has had a fever and chills while at home today.

**History of present Illness (10 points):** Patient lives at home by himself and has home care assistant. Patient is brought to Sarah Bush Emergency room by a home care worker for further evaluation. Patient was brought in because he was having chills, fevers and body spasms. Patient has a supra pubic catheter that was last changed on 10/28 at home by home care workings. Patient states he has UTIs often and is certain that is what is happening. Patient was placed on

### N321 Care Plan

the monitor in the emergency room, patients O2 saturations were normal range at 93% on 2 L of O2 his normal. Urinalysis and CMP drawn, IV placed in right hand. Patient does have a past medical history of a neurogenic bladder and has been antibiotic resistance in the past. Due to patients complicated medical history patient is admitted for IV antibiotics and to monitor for complications.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (2 points):** UTI

**Secondary Diagnosis (if applicable):** Fever

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

Urinary tract infections (UTI) is an infection of the urinary tract ureter, and bladder. This infection is most common in women, but men can get it as well. Patients with UTI will normally complain of “pain and burning on urination, as well as urinary frequency and urgency. If the infection persists, the symptoms can progress to cloudy, strong-smelling urine, fever and hematuria (Capriotti, T., & Frizzel, J.P., 2016, p. 515). Some common risk factors improper perineal hygiene, tight restrictive clothing and irritation bath products, catheterization, sexual intercourse, and contraceptive diaphragms. The most common bacteria found responsible are Proteus, Pseudomonas, Staphylococcus saprophyticus, Klebsiella and Escherichia being the most common. Diagnosis UTI is very routine and easy for the patient, urinalysis and urine culture are used. The urinalysis is used to detect red blood cells, positive leukocyte esterase, and nitrates which indicate bacteria. With a urine culture if an infection is present, a colony count can be detected under a microscope this telling a provider how significant the infection is, the organism responsible. A provider would then want to know what the sensitivities are, so they can be sure to

### N321 Care Plan

provide an antibiotic the organism is not resistant too. This patient has a high fever on admission.

Presents of a fever, is normally an indicator of a stimulation of the bodies immune system. Not all fevers are bad for the body.

For this patient specific his infection was introduced through his supra pubic catheter during placement of a new catheter 3 days before admission. The patient showed visual signs of infection such as dark and cloudy urine, chills and a fever. This patient is more complicated and would be unable to feel frequency, pain with urination. So his symptoms are more late onset, making this more severe since he has the infection longer without feeling the other symptoms.

### Pathophysiology References (2) (APA):

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

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

### Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4-6 mcl	4.77 mcl	5.26 mcl	
Hgb	11.3-15.2 g/dL	10.6 g/dL	11.7 g/dL	
Hct	33.2-45.3%	34.6 %	37.9 %	
Platelets	149-393 k/mcl	151 k/mcl	153 k/mcl	
WBC	4.0-11.7	2.7	4.9	

## N321 Care Plan

	k/mcl			
<b>Neutrophils</b>	45.3-79.0%	63.9 %	63.2 %	
<b>Lymphocytes</b>	11.8-45.9%	22.7 %	23.5%	
<b>Monocytes</b>	4.4-12.0%	9.3 %	9.5 %	
<b>Eosinophils</b>	0-6.3%	3.2%	3.2%	
<b>Bands</b>				

**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
<b>Na-</b>	135-145 mmol/L	140 mmol/L	141 mmol/L	
<b>K+</b>	3.5-5.0 mmol/L	3.8 mmol/L	3.7 mmol/L	
<b>Cl-</b>	97-107 mmol/L	95 mmol/L	93 mmol/L	patient suffers from hyperventilation syndrome, atrial flutter and CHF requiring him to wear oxygen 2 L at all times.
<b>CO2</b>	20-30 mmol/L	41 mmol/L	44 mmol/L	Patients with lung disease can see an increase in their CO2, patient suffers from CHF.
<b>Glucose</b>	70-110 mg/dL	114 mg/dL	99 mg/dL	
<b>BUN</b>	7-25 mg/dL	7 mg/dL	7 mg/dL	
<b>Creatinine</b>	0.50-0.90 mg/dL	.50 mg/dL	0.50 mg/dL	
<b>Albumin</b>	3.5-5.2 g/dL			
<b>Calcium</b>	8.6-10.3 mg/dL	8.3 mg/dL	8.5 mg/dL	
<b>Mag</b>	1.7-2.2 mg/dL	1.9 mg/dL	2.0 mg/dL	
<b>Phosphate</b>	2.5-4.5 mg/dL			

## N321 Care Plan

<b>Bilirubin</b>	0.1-1.2 mg/dL			
<b>Alk Phos</b>	35-105 unit/ L			
<b>AST</b>	0-32 intlunit/L			
<b>ALT</b>	4-33 intlunit/L			
<b>Amylase</b>	56-90			
<b>Lipase</b>	0-110			
<b>Lactic Acid</b>	6-16			

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

<b>Lab Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>INR</b>	0.9-1.2			
<b>PT</b>	11-14			
<b>PTT</b>	0-250			
<b>D-Dimer</b>	0-250			
<b>BNP</b>	<100			
<b>HDL</b>	<40			
<b>LDL</b>	>100			
<b>Cholesterol</b>	<200			
<b>Triglycerides</b>	<150			
<b>Hgb A1c</b>				
<b>TSH</b>	0.4-4.0			

N321 Care Plan

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	cloudy/ dark yellow		
pH	5.0-8.0	9.0		
Specific Gravity	1.005-1.035	1.013		
Glucose	Normal	Normal		
Protein	negative	1+		
Ketones	Negative	Negative		
WBC	<5	>100		
RBC	0-3	>100		
Leukoesterase	Negative	3+		

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture				
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

N321 Care Plan

Henry, N.J.E., Mcmicheal, M., Johnson, J., DiStasi, Ball, B.S., Holman, C., Lemon, T. (2016).

*Rn adult medical surgical nursing: review module.* Leawood, KS: Assessment Technologies

Institute.

### Diagnostic Imaging

#### All Other Diagnostic Tests (5 points):

No other diagnostic tests were completed during this admission.

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

No other diagnostic test were completed during this admission

#### Diagnostic Test Reference (APA):

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

#### Home Medications (5 required)

<b>Brand/Generic</b>	tramadol/ ultram	colace/ docusate	baclofen/ ozobax	raNITidine/ zantac	Mirabegron/ Myrbetriq
<b>Dose</b>	50mg	100 mg	25mg	150mg	25mg
<b>Frequency</b>	q 4 hrs	daily	BID	Daily	Daily
<b>Route</b>	Oral	Oral	Oral	Oral	Oral (chew)
<b>Classification</b>	Opioids	stool softener	muscle relaxant	Histamine-2	Antispasmodics

## N321 Care Plan

<b>Mechanism of Action</b>	It works by changing the way the brain and nervous system respond to pain.	lowers the surface tension at the oil-water interface of the feces	exact mechanism of action is unknown	Selectively antagonize histamine H2 receptors	Selectively stimulates beta-3 adrenergic receptors, relaxing bladder smooth muscle
<b>Reason Client Taking</b>	Patient was experiencing pain.	Patient help with patients constipation	to help patients muscles relax	To prevent heartburn	To prevent urinary retention
<b>Contraindications (2)</b>	acute alcohol, addiction history	avoid abrupt withdrawal, caution if renal impairment	heart failure, severe PVD	Porphyria Caution if hepatic impairment	SBP >180 DBP >110 Caution hepatic impairment
<b>Side Effects/Adverse Reactions (2)</b>	seizures, respiratory depression	hypersensitivity, GI bleed	fatigue, dizziness	Nausea, constipation	Angioedema Hallucinations
<b>Nursing Considerations (2)</b>	check vital signs regularly and BP watch for hypotension	monitor cardiac rhythm at baseline, behavior changes	monitor blood pressure and heart rate	Monitor CR Stand slowly caution for dizziness	Monitor BP

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	Oxybutynin/ Ditropan	enoxaparin/ lovenox	furosemide / lasix	Zofran/ onansetron	Venlafazine/ effexor
<b>Dose</b>	5 mg	40 mg	80 mg	4 mg	25 mg
<b>Frequency</b>	TID	daily	daily	PRN (q8hr)	daily
<b>Route</b>	oral	Sq	oral	oral	oral

## N321 Care Plan

<b>Classification</b>	antispasmodics	anticoagulant	diuretics	anti nausea/vomiting	non-steroidal aromatase inhibitor
<b>Mechanism of Action</b>	antagonizes acetylcholine at muscarinic receptors; relaxes bladder smooth muscle, inhibits involuntarily.	binds to antithrombin and accelerates activity	inhibits loop of henle and proximal and distal convoluted tubule	selectively antagonizes serotonin 5-HT <sub>3</sub> receptors	inhibits enzymatic androgen conversion to estrogen
<b>Reason Client Taking</b>	To help with bladder spasms	patient is at risk for PE or DVT due to inactivity	pt has history of edema in the lower extremities	Pt take for nausea	antidepressant
<b>Contraindications (2)</b>	urinary retention, glaucoma	hepatic impairment, coagulation disorder	diabetes mellitus, electrolyte imbalances	QT prolongation, bradycardia	avoid abrupt withdrawal, no alcohol use
<b>Side Effects/Adverse Reactions (2)</b>	angioedema, dizziness	hemorrhage, thrombocytopenia	hypokalemia, electrolyte imbalance	ECG if electrolyte abnormalities, CHF	suicidality, seizures
<b>Nursing Considerations (2)</b>	Monitor electrolyte imbalances	monitor CBC, and platelet	monitor BUN and	CK levels and LFTs	Cr at baseline, lipid panel

**Medications Reference (APA):**

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

**Physical Exam (18 points)**

<b>GENERAL (1 point):</b> <b>Alertness:</b> <b>Orientation:</b> <b>Distress:</b> <b>Overall appearance:</b>	Patient appeared tired, was laying with blankets over his head while listening to music, however easy awoken by conversation. Patient know where he was, who he was, the date and the president. A&O x4. Overall patient seem comfortable at this time, only request was for a
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## N321 Care Plan

<p><b>INTEGUMENTARY (2 points):</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds:</b>  <b>Braden Score:</b>  <b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>sprite.</p> <p>Patients skin is pink, dry and warm. Patients stomach and back appear well moisturized, and no rashes detected. Lower extremities have no pitting edema, and no varicose veins present. Nails normal for ethnicity. Cap normal less than 3 seconds. Skin turgor was normal, 1 second of tenting. Two wounds were noted on assessment, break down of the sacrum area and right hip. The sacrum is stage 3, extending into the subcutaneous tissue layers, needed to be packed. Serousanguinous drainage present, moderate amount, abd dressing pad applied. The right hip was a stage 1 only loss of only superficial skin with a reddening of the area.</p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>Head and Neck appear in normal limits. No jugular vein distention, no carotid bruit, no lymphadenopathy. Ear are within normal limits, pearly grey tympanic membrane. Patient denies the use of glasses. Nose appears normal, no deviation, turbinates inspected. Patient has no dentures, and no cavities noted at this time. .</p>
<p><b>CARDIOVASCULAR (2 points):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input type="checkbox"/>  <b>Edema</b> Y <input type="checkbox"/> N <input type="checkbox"/>  <b>Location of Edema:</b></p>	<p>Regular rate and rhythm, S1 and S2 are normal no murmurs/rubs/or gallops, point of maximal intensity non displaced. Capillary refill was normal within 3 seconds. No edema noted on patient. pulses normal 3+ bilaterally.</p>
<p><b>RESPIRATORY (2 points):</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>Patient does sound clear in upper and lower lungs bilaterally upon auscultation. No rales/rhonchi/wheezes, no egophany, no tactile fremitus. Patient does require 2L of oxygen at all times to maintain normal oxygen saturations.</p>
<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at home:</b>  <b>Current Diet</b>  <b>Height:</b>  <b>Weight:</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</b>  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b></p>	<p>Patient does not follow any special diets at an assisted living facility. Patient continues normal diet in the hospital. Weight is 191 kg and height is 191 cm making the BMI 29 placing this patient in the obeses category for his height. Normal bowel sounds normal in all four quadrants (sounds heard within 1 minute). resonant to percussion, soft, non-distended and non-tender, no rebound or guarding. no hepatomegaly. no</p>

## N321 Care Plan

<p><b>Distention:</b>  <b>Incisions:</b>  <b>Scars:</b>  <b>Drains:</b>  <b>Wounds:</b>  <b>Ostomy:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Nasogastric:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Size:</b>  <b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>palpable masses. Patient does have an ostomy, was changed, stoma was pink/red and most skin around stoma was dry and intact with no irritation. voiding with no difficulties In the lower quadrants a supra pubic catheter was in place, sick in the area was pink, none tender and dry. Patient had no complaints at either locations.</p>
<p><b>GENITOURINARY (2 Points):</b>  <b>Color:</b>  <b>Character:</b>  <b>Quantity of urine:</b>  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Dialysis:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b>  <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b> supra pubic catheter indwelling  <b>Size:</b> 20 Fr (changed 10/31)</p>	<p>Patient's urine is light yellow to clear. No visible sediment, no foul smell. Patient has been urine incontinent during this admission.</p>
<p><b>MUSCULOSKELETAL (2 points):</b>  <b>Neurovascular status:</b>  <b>ROM:</b>  <b>Supportive devices:</b>  <b>Strength:</b>  <b>ADL Assistance:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Fall Risk:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Fall Score:</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b> <input type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>Patient reports no pain, no signs of pallor, pulse 3+ is within normal range on all extremities. Paresthesia or paralysis, is noted on patient from midchest down. Patient is a quadriplegic. Patient is able to complete passive ROM on lower extremities with my help. Patient can complete most exercises of upper extremities with active ROM. Patient does use a hooyer lift to be moved with 2 assistance. Fall score is 55. Fall precautions alarm on, with pt positioned with push button call light, side rails up on top half of the bed. Patient is on air mattress.</p>
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW:</b> Y <input type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input type="checkbox"/> N <input type="checkbox"/> if no -  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b>  <b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b></p>	<p>Patients pupils were equal, round, and reactive to light when assessing with pen light. Patient was orientated to person, place, time and situation. Patients level of consciousness was within normal limits, patient was easily arousable. Patient has no movement below the armpit. Patients speech was clear and easy to understand.</p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b></p>	<p>Patient enjoys talking with siblings and care partners. Patient got through 12th grade. Patient</p>

## N321 Care Plan

<b>Coping method(s):</b> <b>Developmental level:</b> <b>Religion &amp; what it means to pt.:</b> <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b>	is christian. And loves to listen to country music or watch netflix to relax.
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**Vital Signs, 2 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1146	60	100/62	18	36.6 C	96%
1359	60	142/81	20	36.2 C	95%

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

Time	Scale	Location	Severity	Characteristics	Interventions
1000	0				
1340	0				

**IV Assessment (2 Points)**

IV Assessment	Fluid Type/Rate or Saline Lock
<b>Size of IV:</b> <b>Location of IV:</b> <b>Date on IV:</b> <b>Patency of IV:</b> <b>Signs of erythema, drainage, etc.:</b> <b>IV dressing assessment:</b>	20 gauge Right peripheral 11/3/19 Right IV has line attached and infusing Right AC dry, clean and intact. Dressing was allusive, no phlebitis or infiltration present, catheter patent.

**Intake and Output (2 points)**

Intake (in mL)	Output (in mL)
300 mL	4600 mL

## N321 Care Plan

**Nursing Care****Summary of Care (2 points)**

**Overview of care:** Patient was admitted for possible UTI. Patient has indwelling supra pubic catheter.

**Procedures/testing done:** CBC, BMP, Urinalysis

**Complaints/Issues:** Patient presented in the ED with fever and chills

**Vital signs (stable/unstable):** patient has fever of 102.1f

**Tolerating diet, activity, etc.:** Patient is tolerating diet. Patient allowed me to do range of motion exercises.

**Physician notifications:** No notifications necessary.

**Future plans for patient:** Patient will finish antibiotic tomorrow, to clear UTI and return home tomorrow.

**Discharge Planning (2 points)**

**Discharge location:** Patient discharged to home tomorrow.

**Home health needs (if applicable):** Just normal 8 hours patient has already been receiving.

**Equipment needs (if applicable):** No new equipment needed.

**Follow up plan:** Follow up outpatient with pcp.

**Education needs:** Educate patient signs and symptoms of UTI and how home health can care for supra pubic catheter.

## N321 Care Plan

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

<b>Nursing Diagnosis</b> ● Include full nursing diagnosis with “related to” and “as evidenced by” components	<b>Rational</b> ● Explain why the nursing diagnosis was chosen	<b>Intervention (2 per dx)</b>	<b>Evaluation</b> ● How did the patient/family respond to the nurse’s actions? ● Client response, status of goals and outcomes, modifications to plan.
<b>1.</b> Functional urinary incontinence as evidenced by neurogenic bladder related to UTI.	Patient has neurogenic bladder and has an indwelling catheter to prevent his incontinence since he is a quadraplegic also leading to his incontinence.	<b>1.</b> Assess the home, acute care, or long term care environment for accessibility to toileting facilities.  <b>2.</b> Assess the client for coexisting or premorbid urinary incontinence.	Patient is unable to make changes due to limited home care help and having to take care of himself 16 hours a day.
<b>2.</b> At risk for infection related to supra pubic catheter as evidence by UTI.	Patient has in dwelling catheter, without proper care, infection is very easily introduced into the body.	<b>1.</b> Sterile technique used during catheter replacement  <b>2.</b> Daily catheter cleaning.	Goals to teach patient how to clean catheter daily so, he can make sure home health staffing if doing it properly.
<b>3.</b> At risk for activity intolerance as evidenced by always needing O2 and need assistance.	Patient requires O2 at all times.	<b>1.</b> Assess the client daily for appropriateness of activity and bed rest.  <b>2.</b> When getting a client up, observe for symptoms of intolerance such as nausea, pallor, dizziness, visual dimming, and impaired	Patient understand importance up getting up to a chair or sitting up in bed.

## N321 Care Plan

		consciousness, as well as change in vitals	
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**Other References (APA):**

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

**Concept Map (20 Points):**

N321 Care Plan

**Subjective Data**

No smoking, alcohol or drug use  
Pain  
Living situation  
Education level

**Nursing Diagnosis/Outcomes**

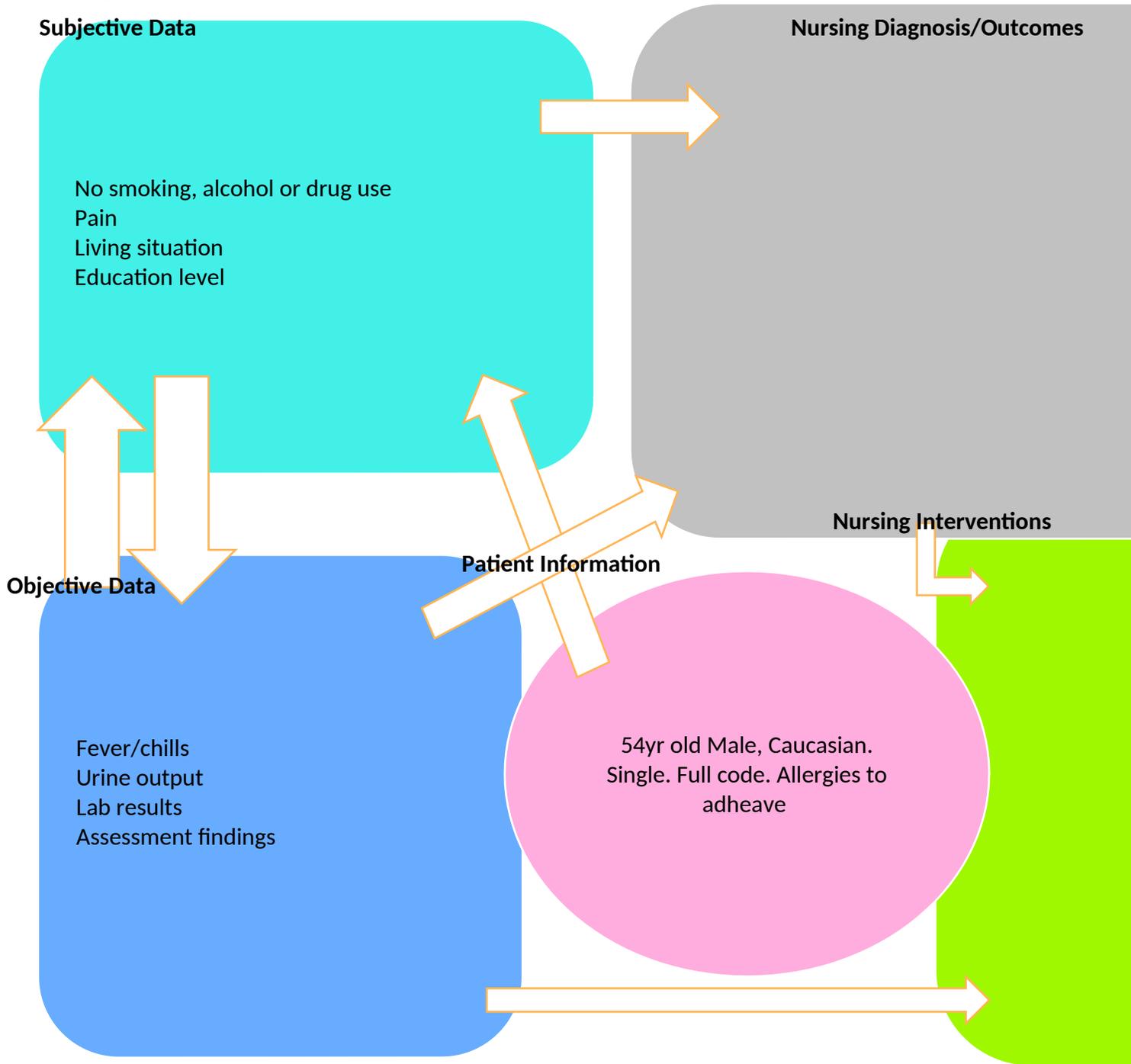
**Objective Data**

Fever/chills  
Urine output  
Lab results  
Assessment findings

**Patient Information**

54yr old Male, Caucasian.  
Single. Full code. Allergies to  
adheave

**Nursing Interventions**



N321 Care Plan

N321 Care Plan