N431 Care Plan #2

Lakeview College of Nursing

Tayler Obenland

Demographics (3 points)

Date of Admission 11/2/19	**Patient Initials** FV	**Age** 75	**Gender** female
Race/Ethnicity caucasion	**Occupation** doesn't work	**Marital Status** Married	**Allergies** Codeine, contrast, palvix
Code Status full code	**Height** 5'3	**Weight** 275	

Medical History (5 Points)

Past Medical History: Macular degeneration, irregular heart rhythm, hypertension, diabetes mellitus, asthma, bilateral knee osteoarthritis, obstructive sleep apnea

Past Surgical History: Pacemaker insertion, exploratory of the abdomen, coronary angioplasty with stent replacement, cholecystectomy, back surgery

Family History: Mother had diabetes, father had hypertension

Social History (tobacco/alcohol/drugs): Patient doesn't drink, smoke, or do any type of drugs

Assistive Devices: Needs a walker to get up as well as assist from people

Living Situation: Lives at home with husband but looking into going into a nursing home type facility

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): Patient states she fell at home in her living room and couldn't get up

History of present Illness (10 points):.Patent is a 75 year old female who presented to OSF Heart of Mary Medical center with complaints of fall. She has a PMH significant for bilateral knee osteoarthritis, obstructive sleep apnea, diabetes mellitus, hypertension, obesity and has difficulty with mobility. She had two falls late last night while getting out of bed to go to the

bathroom. She has a history of three falls total in the last month. She has had ongoing difficulty with mobility due to her obesity and her osteoarthritis. On the ambulance ride to the hospital the ambulance struck a deer causing a backboard to fall on her which hit her in the head.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):. Fall

Secondary Diagnosis (if applicable):.Not applicable

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

Falls are a threat to the health of older adults and can reduce their ability to remain independent. Falls are a common and often overlooked cause of injury in the elderly. Chronic health conditions, loss of balance, dizziness, and an unsteady gait can cause a fall. Normal changes to our bodies as we age also make falls more likely. Visual impairment or muscle weakness may also make it more difficult for an older person to prevent a fall (Kernisan, 2018). Older people may also have weaker muscles and stiff joints, or may lose some of the feeling in their feet and legs. They're also slower to react and may have difficulty concentrating on more than one thing as they age. You can do certain things to help prevent falls as well. Some of the things that can help is making sure you get your eyes and hearing checked frequently, know the side effects of the medications you are taking, stand up slowly, use an assistive device if you are unable to get up on your own, wear non slip resistant socks and or shoes, and be careful when you are walking on wet or icy paths (Hinkle & Suddarth, 2018).

My patient presented to the ER after having a fall at her home, this was the third fall she has had in the past month. Some things that present in my patient that correlate with the information i found above is that she has osteoarthritis, she is morbidly obese, she doesnt use an assistive

device, and she can not get up on her own. When she came into the ER and they were asking her how she fell she stated that she couldn't get out of bed on her own and she fell. She felt weak and unsteady and she didn't have an assistive device as well. She also hasn't been to the doctor or an eye appointment in awhile. She couldn't tell us the last time she had gone. We talked to her about ways to prevent further falls starting out with an assistive device and she is going to a rehab facility because she can't do anything on her own and she is having a harder time trying to walk and get up on her own.

Pathophysiology References (2) (APA):

Kernisan, L. (2018, July 14). Fall Causes and Prevention . Retrieved November 10, 2019, from https://betterhealthwhileaging.net/why-aging-adults-fall/.

Hinkle, J. L., & Cheever, K. H. (2018). *Text Book of Medical Surgical Nursing* (14th ed.). Philadelphia, PA: Brunner&Suddarth.

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	3.80-5.30	4.27	4.05	
Hgb	12.0-15.8	13.5	12.6	
Hct	36.0-47.0	41.0	38.8	
Platelets	140-440	161	157	
WBC	4.00-12.00	12.00	11.60	
Neutrophils	47.0-73.0	72.0	N/A	
Lymphocytes	18.0-42.0	18	N/A	
Monocytes	4.0-12.0	10.6	N/A	

Eosinophils	0.0-5.0	0.7	N/A	
Bands	1.5-8.0	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-	135-145	N/A	N/A	
K+	3.5-5.1	N/A	N/A	
Cl-	98-107	N/A	N/A	
CO2	21-31	N/A	N/A	
Glucose	70-99	N/A	N/A	
BUN	7-25	N/A	N/A	
Creatinine	.50-1.20	N/A	N/A	
Albumin	3.5-5.7	N/A	N/A	
Calcium	8.6-10.3	N/A	N/A	
Mag	1.6-2.6	N/A	N/A	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	0.2-0.8	N/A	N/A	
Alk Phos	34-104	N/A	N/A	
AST	13-39	N/A	N/A	
ALT	7-52	N/A	N/A	

Amylase	30-110	N/A	N/A	
Lipase	60-160	N/A	N/A	
Lactic Acid	0.5-2.0	N/A	N/A	
Troponin	.0-.040	N/A	N/A	
CK-MB	5-25	N/A	N/A	
Total CK	22-198	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	.9-1.1	N/A	N/A	
PT	10.1-13.1	N/A	N/A	
PTT	60-70	N/A	N/A	
D-Dimer	>500	N/A	N/A	
BNP	>125	N/A	N/A	
HDL	40-59	N/A	N/A	
LDL	100-129	N/A	N/A	
Cholesterol	>200	N/A	N/A	
Triglycerides	>150	N/A	N/A	
Hgb A1c	4-5.6	N/A	N/A	
TSH	0.4-4.0	N/A	N/A	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	clear /yellow	clear/ yellow	clear/ yellow	
pH	5.0-9.0	6.0	6.0	
Specific Gravity	1.00.-1.030	1.005	1.005	
Glucose	negative	negative	negative	
Protein	negative	negative	negative	
Ketones	negative	negative	negative	
WBC	0-5	6-10	6-10	has a possible UTI, waiting for urinalysis to come back (Sampson, 2018)
RBC	0-2	0-2	0-2	
Leukoesterase	4,500,11,000	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	5-9	N/A	N/A	
PaO2	75-100	N/A	N/A	
PaCO2	38-42	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	80-100	N/A	N/A	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	Abnormal	Abnormal	found WBC esterase, nitrite, WBC, Bacteria all in the urine. Urinalysis

				came back positive for UTI
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (APA):

Sampson, S. (2018, June 28). Causes of Leukocytes in Urine. Retrieved November 10, 2019, from https://www.medicalnewstoday.com/articles/314165.php.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): X-Ray of the knee, CT of the spine

Diagnostic Test Correlation (5 points): A CT is a rotating X-ray machines to create cross-sectional images of the body (Morrison, 2016)**.** They did a CT of the spine due to her fall and the results were clear. X-ray imaging creates pictures of the inside of your body (Weatherspoon, 2016). X-Ray of the knee due to the fall as well and the results were clear

Diagnostic Test Reference (APA):

Morrison, W. A. (2016, February 25). What is a CT. Retrieved November 10, 2019, from https://www.healthline.com/health/ct-scan.

Weatherpoon, D. (2016, December 5). Purpose of an X Ray. Retrieved November 11, 2019, from https://www.healthline.com/health/x-ray.

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

Home Medications (5 required)

Brand/Generic	naproxen (NAPROSYN)	metFORMIN (GLUCOPHAGE)	glimepiride (AMARYL)	rosuvastatin (CRESTOR)	Solifenacin (VESICARE)
Dose	500 mg	1,000 mg	2 mg	10 mg	5 mg
Frequency	BID	BID	every morning	take nightly	daily
Route	oral	oral	oral	oral	oral
Classification	anti-inflammatory	dimethylbiguanide	antidiabetic	antihyperlipidemic	antimuscarinic
Mechanism of Action	blocks cyclooxygenase, the enzyme needed to synthesize prostaglandins	promote storage of excess glucose as glycogen in the liver	stimulates insulin release from beta cells in pancreas	selective inhibitor	exerts competitive antagonistic effects at the muscarinic receptor
Reason Client Taking	osteoarthritis	she is a diabetic	for diabetes	takes for high cholesterol	because she can't control when she goes to the bathroom
Contraindications (2)	angioedema, asthma	advanced renal disease, hypersensitivity to metformin	pregnancy, diabetic coma	active liver disease, breastfeeding	gastric retention, urinary retention
Side Effects/Adverse Reactions (2)	cognitive impairment, dizziness	headache, hypoglycemia	anxiety, abnormal gait	abdominal pain, myalgia	constipation, confusion

Nursing Considerations (2)	avoided with patients with recent MI, use with extreme caution in patients with recent GI bleeding	don't give if they have severe renal impairment, take with food	increased risk of dying from cardiovascular disease, use cautiously in patients with G6PD deficiency	increased risk of hepatotoxic effects, increased serum transaminase	moderate hepatic impairment, anaphylactic reactions
Key Nursing Assessment(s)/Lab(s) Prior to Administration	look at blood and platelet panels, checks lung sounds frequently	look at their GFR, check blood sugar often	check blood sugars often, monitor closely for allergic reactions	lipid panel and liver function	LOC, check if patients bladder symptoms are improving
Client Teaching needs (2)	do not exceed the recommended dose, take this drug with food	take exactly as prescribed, avoid alcohol when taking this medication	take before the first meal of the day, do not skip doses or increase dose without a doctor's order	report signs and symptoms of myopathy, report signs and symptoms of liver injury	report signs and symptoms of angioedema, may cause constipation

Hospital Medications (5 required)

Brand/Generic	acetaminophen (TYLENOL)	enoxaparin (LOVENOX)	ceftriaxone (ROCEPHIN)	ezetimibe (ZETIA)	levothyroxine (SYNTHROID)
Dose	650mg	40mg	1g	10mg	137mcg
Frequency	every 4	every 12	once a day	daily	every

	hours PRN	hours			morning before breakfast
Route	oral	subcu	intravenous	oral	oral
Classification	analgesic	low molecular weight heparin	antibiotic	antihyperlipidemic	thyroid supplement
Mechanism of Action	reduces pain	coagulation inhibitor	exhibits bactericidal activity by the inhibition of bacterial wall synthesis	reduces blood cholesterol	Thyroid hormones exert their physiologic actions through control of DNA transcription and protein synthesis
Reason Client Taking	mild or severe pain for her knee	DVT precautions	possibility of UTI	high cholesterol	hypothyroidism
Contraindications (2)	severe hepatic disease, hypersensitivity to acetaminophen	active major bleeding, hypersensitivity to heparin	hypersensitivity to cephalosporins, concurrent administrations of calcium containing IV solutions	active liver disease, pregnant or nursing mothers	acute MI, inability to swallow capsules
Side Effects/Adverse Reactions (2)	pruritus, headache	confusion, congestive heart failure	diarrhea, renal failure	diarrhea, upper respiratory infection	diarrhea, fatigue
Nursing Considerations (2)	risk of hepatic injury, severe hypovolemia	use enoxaparin with caution, don't give by IM injections	hemolytic anemia, use caution in patients with a history of allergies	not recommended in patients with severe hepatic impairment, increase the	underlying cardiovascular disease, new or worsening cardiac

				risk of myopathy	abnormalities
Key Nursing Assessment(s)/Lab(s) Prior to Administration	monitor fever, and monitor pain	do an EKG, monitor for DVT	do a CBC, check fevers	check liver function labs, and check cholesterol	can do an EKG, check HR and BP
Client Teaching needs (2)	unsafe to take more than 4000mg in 24 hours, take with a full glass of water	notify the provider if bleeding, teach patients to give shots at home	report severe diarrhea, other superinfection signs and symptoms should be monitored	may cause abdominal pain, report arthralgias	do not suddenly discontinue this medication, take on an empty stomach

Medications Reference (APA):

Jones, & Bartlett. (2018). *Nurse's Drug Handbook* (17th ed.). Burlington, MA: Jones & Bartlett Learning .

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** awake and alert **Orientation:** orient and can talk **Distress:** no distress **Overall appearance:** clean overall appearacne	patient was alert and oriented, was awake and could answer all of our questions while we were in there. She showed no distress and her overall appearance was clean and well hygiene
INTEGUMENTARY (2 points): **Skin color:** white **Character:** dry **Temperature:** 98.6	skin color is caucasian and it was very dry. The temperature was 98.6. Skin turgor was a quick response. Patient has no rashes but did have a bruise on her right hip and her right knee. She

Turgor: quick response **Rashes:** no rashes **Bruises:** a bruise on her right hip and right knee **Wounds:** has a cut on her right shin **Braden Score:** 15 **Drains present: Y☐ N ☐** **Type:** IV in her left upper arm	has a wound on her right shin. Drain is present in her left upper arm but there is nothing running in it right now. Braden score for the patient
HEENT (1 point): **Head/Neck**:everything is symmetric bilaterally **Ears:** pink auricle, pearly grey TM **Eyes:** sclera is white, conjunctiva is pink, PERRLA **Nose:** no deviated septum **Teeth:** clean, missing some	head and neck on this patient was clean, everything was symmetric bilaterally. Her ears had a pink auricle, with a pearly grey ™. Eyes had a white sclera, conjunctiva was pink, PERRLA, no deviated septum in the nose, her teeth were clean but she had some of them missing
CARDIOVASCULAR (2 points): **Heart sounds:** S1 and S2 were clear **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** normal sinus rhythm **Peripheral Pulses:**2+ pulses in all extremities **Capillary refill:**less than three seconds **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	heart sounds were clear, had a S1 and S2 heart sounds, no S3 or S4 sounds as well as no murmur. Cardiac rhythm is normal sinus rhythm. Peripheral pulses were 2+ in all extremities. Capillary refill was less than three seconds. No neck vein distention and no edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	No accessory muscles were used, her breath sounds were clear in the front and back exam
GASTROINTESTINAL (2 points): **Diet at home:** regular **Current Diet** diabetic diet **Height:** 5’3 **Weight:** 275 **Auscultation Bowel sounds:** were hyperactive **Last BM:** last night **Palpation: Pain, Mass etc.:** no masses or pain **Inspection:** **Distention:**none **Incisions:**none	diet at home is regular and her current diet at the hospital is a diabetic diet. Her height is 5’3 and weighs 275. Bowel sounds were hyperactive and her last bowel movement was last night. No masses or pain during palpation. No distention or incisions. No scars but has a wound on her right shin. Has an IV in her left upper arm but has nothing running it in at the moment. No ostomy or NG feeding tube

Scars:none **Drains:** IV in left arm **Wounds:** on her right shin **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	
GENITOURINARY (2 Points): **Color:**yellow **Character:**clear **Quantity of urine:** was not measured **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** pink and moist **Catheter: Y ☐ N ☐** **Type:** **Size:**	patient has clear yellow urine. The amount was not measured, she has being used pads and depends but they were not weighed. No pain with urination and no catheter. Her genitals were pink and clean.
MUSCULOSKELETAL (2 points): **Neurovascular status:** LOC **ROM:** all extremities **Supportive devices:** walker **Strength:** weak **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** 34 **Activity/Mobility Status:** needs assistance **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient is alert and oriented, has LOC. ROM in all extremities. needs a walker to get up out of bed and walk anywhere.Needs help with ADL's and is a fall risk, her score is 34. She needs assistance when she gets up as well as needs her walker to even stand.Has weak strength
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** alert **Mental Status:** is awake and can understand everything **Speech:** clear speech **Sensory:** is in tact **LOC:** oriented	Patient has MAEW, PERRLA, strength is equal in both sides but she is weak. She is alert and oriented and can understand and talk to us about everything that is going on. Her speech is clear and her sensory is intact.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):**likes to talk about things	Patients coping method is she likes to talk about it, she has a highschool degree and for her religion she doesn't really prefer one. She lives

Developmental level: highschool degree **Religion & what it means to pt.:**doesn't prefer one **Personal/Family Data (Think about home environment, family structure, and available family support):**	with her husband in her home and is getting discharged to a nursing home facility.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
2357	80	148/84	18	98.4 oral	94 room air
0700	69	141/86	18	98.6 oral	98 room air

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	5	right knee	not severe	a dull ache	put a warm towel on it
1100	7	right knee	a little more severe	throbbing pain	gave tylenol

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:** right upper arm **Date on IV:**10/3/2019 **Patency of IV:** not running **Signs of erythema, drainage, etc.:** dry, no redness, no itching **IV dressing assessment:** had tegaderm on it, date and time	nothing running at the time

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1,660 ml	410 ml

Nursing Care

Summary of Care (2 points)

Overview of care: patient was very compliant and wanted to help herself, she has right hip and knee pain, was giving pain medications to help her pain and she is starting to feel better

Procedures/testing done: had a X-Ray of knee that was clear and a CT of the spine that came back clear

Complaints/Issues: she had no complaint today besides her knee pain that is getting better once she had her medications

Vital signs (stable/unstable): vital signs were stable throughout her stay

Tolerating diet, activity, etc.: she is on a diabetic diet, she can get up with assist, gait belt and walker, got up to get into the chair while I was in clinical

Physician notifications: she can not get up or walk on her own, she needs assistance with her ADL's.

Future plans for patient:get her leg and hip feeling better, then sending her to a nursing home facility for future help

Discharge Planning (2 points)

Discharge location: location is still trying to be figured out before discharge

Home health needs (if applicable): needs assistance when she gets out of bed, needs a walker if she is going to be getting out of bed

Equipment needs (if applicable): will need a walker and assistance when getting up or moving

Follow up plan: make sure she comes in monthly to get check ups

Education needs: needs to make sure she takes all of her medications, make sure she follows her diabetic regimen for food and diet, needs to make sure she has a walker to get up

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.
risk for falls related to not being able to get up on her own as evidenced by her telling us she needs help getting up	this nursing diagnosis was chosen because since she can't get up on her own she is at risk for falls and that could hurt her even worse	**1.** put the bed all the way to the ground **2.** put a bed alarm on for the patient so they can't get out of bed without help	The patient was happy with the idea on the bed being to the floor and the bed alarm being on due to the fact she is prone to falls, she met the goals and outcomes and didn't get up without asking for help.
risk for infection related to not being able to shower as evidence by seeing dirt in places she can't reach on her own	this nursing diagnosis was chosen because without showering infection can lead to more problems	**1.** make sure she gets bathed daily **2.** put a skin barrier powder in the crevices where bacteria tend to grow	The patient liked the idea of getting bathed daily and the use of powder to prevent infection. They used the powder and did the daily bath and there was no infection so the goal was met.
impaired skin integrity related to not being able to get up as evidence by finding red marks on her joints from not	this nursing diagnosis was chosen because skin integrity can lead to wound infections	**1.** Turn the patient every 2 hours **2**. put pillows under certain pressure points to protect the skin from breakdown	The patient started feeling better after we turned her every 2 hours and gave her extra padding to protect her skin, the goal and outcome were met because the redness started going away and no more spots appeared.

being able to move			
activity intolerance related to being morbidly obese as evidence by her stating she hasnt gotten up on her own in awhile	this nursing diagnosis was chosen because without activity she can weaken her muscles	**1.** try to get the patient up and out of bed at least daily if not twice a day **2.** get her an assistive device to help her get up	The patients interventions and outcomes were met because we got her up out of bed and into a chair at least once a day and she used a walker to help her stand
5. self care deficit related not being able to do her ADL's on her own as evidence by her stating she can't do anything on her own.	This nursing diagnosis was chosen because with her not being able to do things on her own she can't take care of herself.	**1.** get her help to doing her daily ADL's **2.** make sure she goes into a rehab facility to get the help she needs	The patient was willing to go to a rehab facility to get the help that she needs.

Other References (APA):

Vera, M. (2019, February 3). Nanda Nursing Diagnosis . Retrieved November 10, 2019, from https://nurseslabs.com/nursing-diagnosis/.

Concept Map (20 Points):

Patient Information

Came into the emergency room for falls, had 3 in the past month

Subjective

couldn't get up on her own

she was morbidly obese

she stated she was feeling weak

Objective

older age (older than 65)

N431 Care Plan

white race

housebound status

heavy weight

Nursing diagnosis

-risk for falls related to not being able to get up on her own as evidenced by her telling us she needs help getting up
-risk for infection related to not being able to shower as evidence by seeing dirt in places she can't reach on her own
-activity intolerance related to being morbidly obese as evidence by her stating she hasnt gotten up on her own in awhile

Nursing interventions

1. put the bed all the way to the ground

2. put a bed alarm on for the patient so they can't get out of bed without help

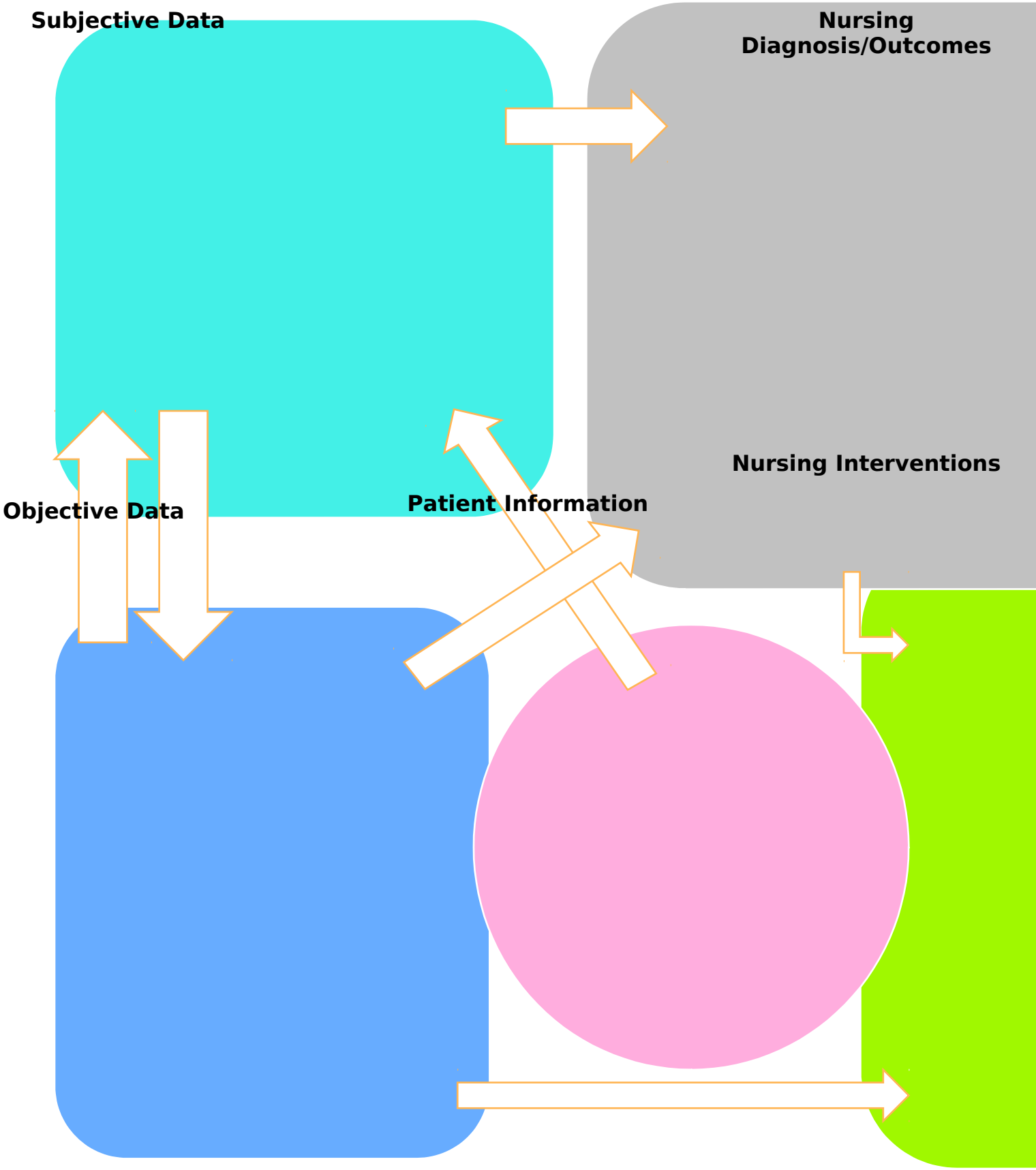
1. make sure she gets bathed daily

2. put a skin barrier powder in the crevices where bacteria tend to grow

1. try to get the patient up and out of bed at least daily if not twice a day

2. get her an assistive device to help her get up

I couldn't get the concept map to work online so I typed it out instead


Subjective Data
Nursing Diagnosis/Outcomes
Nursing Interventions
Objective Data
Patient Information