N321 Care Plan # 3

Lakeview College of Nursing

Kristine Johnson

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
11-19-19	W.C.W.	75	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retail before retirement	Widowed	No known Allergies
Code Status	**Height**	**Weight**	
Full	5'4"	225.6 lbs (102.5 kg)	

Medical History (5 Points)

Past Medical History: Congestive cardiac failure, COPD, Cushing disease, Diabetes mellitus type 2, GERD, HTN, Hyperlipidemia, sleep apnea syndrome (uses oxygen, no CPAP)

Past Surgical History: Pituitary surgery, Cholecystectomy, Adrenalectomy, Hysterectomy, colonoscopy 3 times, PR Removal gallbladder, upper GI endoscopy 2 times

Family History: Father having cancer as well as mother

Social History (tobacco/alcohol/drugs): Former smoker she quit in 2007. No alcohol consumption.

Assistive Devices: ambulates with a walker or a cane.

Living Situation: lives with daughter, son-in-law, and grandchildren.

Education Level: 8th grade education level and didn't finish 9th grade

Admission Assessment

Chief Complaint (2 points): Weakness and fever

History of present Illness (10 points): Came by ambulance because of weakness and pain in hip. She fell 11-18-19 at night. Been feeling weak for past 2 days. No burning when urinating but states she has been "urinating less". She also complains of cough but also has COPD. She is on 3L oxygen at night when at home. Due to weakness she came to the ER.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute cystitis without hematuria

Secondary Diagnosis (if applicable): Urinary tract infection

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

The patient's primary diagnosis was acute cystitis without hematuria which is inflammation of the bladder and a secondary diagnosis of a urinary tract infection. Cystitis is a visceral pain that can give systemic symptoms of weakness, malaise, and nausea (Capriotti, Frizzell, 2016). The client Some signs and symptoms strong persistent urge to urinate, burning sensation while urinating, passing frequent small amounts of urine, low grade fever, and pelvic discomfort (Mayo Clinic, 2018). The client was experiencing a strong persistent urge to urinate most of the clinical time, and she had this sensation so much that it bothered her, and she would strain trying to urinate in a bed pan but was unable to. She also stated that when she did urinate before it was "a dab" of urine which is also consistent with having the cystitis and the urinary tract infection.

Causes of cystitis include bacteria such as E. coli which can be caused from wiping back to front introducing bacteria to the urethra causing the urinary tract infection. Since the client's education level is at the 8th grade level she may not know the concerns with wiping back to front. The cystitis could have been a complication due to diabetes because the client does have a medical history of diabetes mellitus (Mayo Clinic, 2018).

Diagnostic testing that is used for diagnosing cystitis include a urine analysis which was done with the client and showed abnormalities such as increases white and red blood cells and 3+ leukoesterase. Other diagnostics are cystoscopy and imaging such as an x-ray of the pelvis (Mayo Clinic, 2018). The client did also get an x-ray of the pelvis however it was done because

she fell but it could also have been used to look at the bladder if the physician wanted to also look at the bladder (Mayo Clinic, 2018). Treatment for this client would be to begin an antibiotic to treat the urinary tract infection and because they did not do a culture, they would use a broad-spectrum antibiotic. The doctor may prescribe an anti-inflammatory to reduce the cystitis or if need be there are surgical procedures to treat cystitis (Mayo Clinic, 2018).

Pathophysiology References (2) (APA):

Capriotti, T., Frizzell, J., (2016), *Pathophysiology Introductory concepts and clinical perspectives*. Philadelphia, PA, F.A. Davis Company

Mayo Clinic (2018) *Cystitis*. Retrieved from https://www.mayoclinic.org/diseases-conditions/cystitis/symptoms-causes/syc-20371306

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	3.50-5.20	4.35	N/A	
Hgb	11.0-16.0	12.1	N/A	
Hct	34.0-47.0	40.0	N/A	
Platelets	140-400	302	N/A	
WBC	4.00-11.00	5.41	N/A	
Neutrophils	1.60-7.70	2.16	N/A	
Lymphocytes	1.00-4.90	2.44	N/A	
Monocytes	0.00-1.10	0.55	N/A	
Eosinophils	0.00-0.50	0.19	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	139	N/A	
K+	3.5-5.0	4.4	N/A	
Cl-	98-107	104	N/A	
CO2	22.0-30.0	28.3	N/A	
Glucose	60-99	107	N/A	The client is a diabetic which can cause her to have a higher casual blood glucose level.
BUN	7-18	24	N/A	The client is unable to urinate which is causing the kidneys not to function properly causing a high BUN.
Creatinine	0.60-1.30	1.85	N/A	The increased creatinine can be due to the cystitis because the body is not able to expel the waste.
Albumin	3.4-5.0	3.0	N/A	The inflammation of the cystitis could decrease the albumin, or the infection could be causing the albumin to be low.
Calcium	8.5-10.1	9.1	N/A	
Mag	N/A	N/A	N/A	
Phosphate	N/A	N/A	N/A	
Bilirubin	N/A	N/A	N/A	
Alk Phos	N/A	N/A	N/A	
AST	15-37	27	N/A	
ALT	12-78	17	N/A	
Amylase	N/A	N/A	N/A	

Lipase	N/A	N/A	N/A	
Lactic Acid	N/A	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	0.9-1.1 ratio	2.4	N/A	The INR is on the normal range of 2.0-3.0 because she is on coumadin.
PT	N/A	N/A	N/A	
PTT	12.1-14.9 sec	26.9	N/A	The PTT would be elevated because she is on a blood thinner.
D-Dimer	N/A	N/A	N/A	
BNP	N/A	N/A	N/A	
HDL	N/A	N/A	N/A	
LDL	N/A	N/A	N/A	
Cholesterol	N/A	N/A	N/A	
Triglycerides	N/A	N/A	N/A	
Hgb A1c	N/A	N/A	N/A	
TSH	N/A	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	Colorless-yellow	yellow	N/A	
pH	5.0-8.5	7.0	N/A	
Specific Gravity	1.000-1.030	1.020	N/A	

Glucose	Neg	Neg	N/A	
Protein	Neg	Neg	N/A	
Ketones	Neg	Neg	N/A	
WBC	0-5 HPF	25-50	N/A	The white blood cell count could be elevated because of the infection.
RBC	0-4 HPF	10-15	N/A	The combination of the cystitis and the UTI could cause blood in the urine and being on a blood thinner could cause more bleeding than normal.
Leukoesterase	Neg	3+	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	N/A	N/A	N/A	
Blood Culture	N/A	N/A	N/A	
Sputum Culture	N/A	N/A	N/A	
Stool Culture	N/A	N/A	N/A	

Lab Correlations Reference (APA):

Capriotti, T., Frizzell, J., (2016), *Pathophysiology Introductory concepts and clinical perspectives*. Philadelphia, PA, F.A. Davis Company

Diagnostic Imaging

All Other Diagnostic Tests (5 points): XR Chest PA/LAT, XR of pelvis

Diagnostic Test Correlation (5 points): Indicate fall pain in the pelvis, and determine if cough was pneumonia

Diagnostic Test Reference (APA):

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

Home Medications (5 required)

Brand/Generic	Albuterol sulfate (Ventolin)	Tylenol w/ codeine (acetaminophen-codeine)	Lipitor (atorvastatin)	Cortef (hydrocortisone)	Trazodone (Oleptro)
Dose	2.5 mg	30 mg	20 mg	10 mg	100 mg
Frequency	RT 4 times a day	PRN	Daily	Twice daily	At bed time
Route	Nebulizer/ PO	PO	PO	PO	PO
Classification	Beta-2 agonist	Analgesic /antitussive	Dyslipidemia	Systemic corticosteroid	Serotonin Modulator
Mechanism of Action	Relaxes airway smooth muscles	Regulates heat and provide pain relief	Inhibits cholesterol synthesis	Inhibits multiple inflammatory cytokines	Inhibits serotonin reuptake
Reason Client Taking	Aid in breathing due to cough and COPD	Pain relief	Reduce cholesterol levels	Prevent Addison's disease	Insomnia
Contraindications (2)	Hypersensitivity Allergy to milk proteins	Hypersensitivity Respiratory depression	Pregnancy Myopathy	Cerebral malaria Systemic fungal infection	Hypersensitivity MI, acute recovery
Side Effects/Adverse Reactions (2)	Throat irritation cough	Drowsiness Lightheadedness	URI Headache	Cushingoid appearance Hirsutism	Somnolence Xerostomia
Nursing Considerations (2)	Monitor BP Be aware of sound alike medications like acebutolol	Monitor for respiratory depression and monitor BP	Monitor Cr. at baseline Monitor CK and compare to baseline	Monitor electrolytes get Chest X-ray if prolonged	Assess for suicidal thoughts Monitor for unusual behavior

Hospital Medications (5 required)

Brand/Generic	NaCl infusion	Acetaminophen (Tylenol)	Atenolol (Tenormin)	Lofibra (fenofibrate)	Triamcinolone (Kenalog)
Dose	100 mL/hr	650 mg	100 mg	160 mg	0.1%
Frequency	Continuous	Every 4 hrs	Daily	Daily	2 times daily
Route	IV	PO	PO	PO	Topical
Classification	sodium/ saline	analgesic	antianginals	Dyslipidemia: Fibrates	corticosteroid
Mechanism of Action	Replace fluids and restore NaCl	Direct action on hypothalamic heat regulating center	Selectively antagonizes beta-1 adrenergic receptors	Inhibits triglyceride synthesis and stimulates catabolism of triglyceride-rich lipoproteins	Inhibit inflammatory cytokines, produces multiple glucocorticoid and mineralocorticoid effects
Reason Client Taking	Fluid loss	Reduce fever	Chest pain	Lower cholesterol	Reduce redness and moisture under breast and folds
Contraindications (2)	Hypersensitivity Fluid overload	Hypersensitivity Caution in liver dysfunction	Hypersensitivity Sinus bradycardia	Hypersensitivity Breast feeding	Hypersensitivity Caution if skin infection
Side Effects/Adverse Reactions (2)	Diarrhea Nausea	Nausea rash	Bradycardia hypotension	ALT and AST elevation Abnormal LFTs	Burning Pruritus
Nursing Considerations (2)	Monitor I/O's Monitor Sodium and chloride labs	Cr. at baseline Do not exceed 4 grams	Cr. at base line Monitor BP and HR	Monitor LFTs Monitor CBC	Monitor ACTH stimulation tests if HPA axis suppression risk Monitor skin

Medications Reference (APA):

Jones & Bartlett Learning. (2019) *2019 Nurse's Drug Handbook, eighth edition.* Burlington, MA, Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented Gel nail polish Well groomed responsive
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	"age spots" from sun damage Legs- swollen, red/dermatitis Braden scale: 13 Slight skin turgor No bruising Discoloring on back No drains
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Farsighted Can see nearsighted with glasses Dentin good Ears moist and pink Sclera white no redness Conjunctiva moist and pink
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:**	Strong S1 and S2 Cap refill: 5-10 secs Edema in legs lower calf Strong peripheral pules bilaterally No neck vein distention
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Clear lung sounds Client coughed a few times with no sputum
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet**	No distention, incisions, scars, drains, wounds Hyperactive bowel sounds in LRQ and URQ Hypoactive in ULQ, LLQ

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:**	Skin on abdomen is dry and flaky Current diet: cardiac and diabetic diet Home diet: "balanced" H: 5'4" W: 225.6 No ostomy No NG No feeding tubes
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Last urination "a dab" in AM No dialysis No pain with urination No catheter
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** ☐	Equal strength bilaterally in hands and feet Hands are +2 Feet are weak but equal Full ROM in arm Little to no range of motion in legs Uses a Cane and walker Fall risk 30
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:**	Neuropathy in legs Little to no sensation in feet Little PERLA Strength equal in hands and equal in feet but feet are weaker Talks clear and response appropriately

Mental Status: **Speech:** **Sensory:** **LOC:**	
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):**	Sit a cry, 8th grade education, Christian, daughter and son, husband passed away 9 years ago, lives w/ daughter, never a dull moment in home life, family is supportive, no pets unless grandchildren visit.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
4:24 pm	72	91/53	16	97.7 F Temporal	96 Nasal canula 0.5L
5:22pm	71	95/53	14	97.3 F Temporal	95 Nasal Canula 0.5L

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
2.38 pm	6	R. Side and back	Hurts a lot	Dull	Given Tylenol with codeine
5:22pm	8	Butt	Moderate	Achy	Pain medication at 6pm

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	R. antecubital Dry, clean, and intact 22G Peripheral IV

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
400 mL	**0 mL**

Nursing Care

Summary of Care (2 points)

Overview of care: 2 aid assist to use a bed pan or ambulate with walker if tolerable. Manage pain and monitor I/O's.

Procedures/testing done: CBC, UA, INR, and PT, chest and pelvis X-ray

Complaints/Issues: weakness, unable to urinate, back pain

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: tolerating regular diabetic diet. Low to no activity level.

Physician notifications: N/A

Future plan for patient: Improve pain management and education of peritoneal care to prevent UTIs.

Discharge Planning (2 points)

Discharge location: Back home with daughter and son-in-law.

Home health needs (if applicable): Remove any objects or rugs that could increase the likelihood of falling and aid ambulating to the bathroom.

Equipment needs (if applicable): Continue to use walker and or cane if possible. Maybe have a wheel chair accessible when she feels to weak to walk.

Follow up plan: Make a follow up appointment to check if she is having persistent back pain after pain management changes.

Education needs: Educate the client about proper peritoneal care to prevent UTI's and tell her about nonpharmacological pain management methods.

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. Urinary retention related to being unable to void as evidenced by not being able to urinate	The client had a persistent sensation of needing to void and she said when she had it was very little.	1. Monitor I/O's and teach the client the importance of letting the nurse know if she voided 2. Monitor weight gain	The patient was upset about not being able to provide an output but continued to try voiding in a bed pan and told the aids about the liquids she consumed. The client also allowed the nurse to take her weight and the clients daughter readily assisted.
2. Impaired physical mobility related to weakness as evidence by her increased pain when	The client was unwilling to use a walker or cane to walk to the bathroom because she could move her legs.	1. Try providing passive range of motion and teach the daughter how to continue the exercise 2.Assess strength periodically	The client complied with the passive range of motion after the nurse explained the benefits and the daughter took notes. The client also allowed the nurse to check her strength in her legs.

being aided to move			
3. Risk for imbalanced fluid volume related to increased intake of fluids as evidence by not being able to void.	The client was unable to urinate during the clinical time while also consuming liquids. UTIs do cause a sensation if needing to but she physically could not.	1. Teach the client signs of fluid imbalance. 2 Teach the client symptoms of UTIs.	The client was unwilling to listen to the nurse about the UTI causing a sensation of needing to urinate frequently. The client was willing to listen to the nurse about knowing the early signs and symptoms of fluid imbalance like irregular heart rate and fatigue.
4. Chronic Pain related to her back as evidence by high pain scores of 6 and 8.	Every time she had to be moved on her side she would be vocally in pain until she was back on her back and sat upright.	1. administer Tylenol-codeine when client complains about pain. 2. Assess pain 30-40 mins after administration.	The client took the medication a told the nurse her pain went from an 8 to a 5. The nurse told her to notify her about the pain before it becomes severe again and the client called her 3 and a half hours later.
5. Risk for pressure ulcers related to not being able to move on her own as evidence by being in bed and not moving to keep from stimulating	If the client is unable to get up or move on her own during the time at the hospital and continued at home the lack of mobility will increase the risk of pressure sores and her refusal to reposition.	1. Use pillows to reposition the client every 2 hours. 2. Teach the client the purpose of repositioning and how it prevents pressure sores.	The client initially refused the repositioning, but the daughter helped in encouraging so the client allowed the nurse and aid to repositioning every 2 hours and after a while the client felt it helpful.

the pain.			

Other References (APA):

Swearingen, P., (2019) *All-in-One Nursing Care Planning Resource*. Fifth edition. St. Louis, MI, Elsevier

Concept Map (20 Points):


Subjective Data
Pain on a scale of 0-10: 6-8
Client states when she urinated it was a "dab"
Nursing Diagnosis/Outcomes
Urinary retention related to being unable to void as evidenced by not being able to urinate
Impaired physical mobility related to weakness as evidence by her increased pain when being aided to move
Risk for imbalanced fluid volume related to increased intake of fluids as evidence by not being able to void.
Objective Data
When client was being turned, she moans and grimaced
Clients BP: 95/53
Was on nasal cannula with oxygen at 0.5L
Patient Information
Female
75-year-old
PMH of COPD
Widowed
Lives with daughter's family
Nursing Interventions
Monitor I/O's and teach the client the importance of
etting the nurse know if she voided
ry providing passive range of motion and teach the
aughter how to continue the exercise
Teach the client symptoms of UTIs.