N321 Care Plan # 1

Lakeview College of Nursing

Teah Rasche-Hill

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
1/20/2020	JT	81	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Divorced	Amlodipine, Besylate, Levofloxacin, Loratadine, Penicillin, Olmesartan Medoxomil-HCTZ
Code Status	**Height**	**Weight**	
Full Code	5'3	192 lb 3.9oz	

Medical History (5 Points)

Past Medical History: Depression, Dyslipidemia, Generalized OA, Hypertension, Multiple Thyroid nodules, peptic ulcer, and pulmonary emboli

Past Surgical History: Cataract Removal

Family History: Mother (deceased)- Breast cancer

Father(deceased)- Arthritis and Congestive Heart Failure

Brother- Prostate cancer and skin cancer

Social History (tobacco/alcohol/drugs): Never smoked, used smokeless tobacco, or drank alcohol.

Assistive Devices: Hand walker

Living Situation: Living alone until she fell at home.

Education Level: Unknown

Admission Assessment

Chief Complaint (2 points):Fall

History of present Illness (10 points):JT is an 81-year-old female who presents to the emergency department after falling outside of her house she just bought. Client states that she

wasn't use to her new house and slipped and fell. Laid outside in nine-degree weather for thirty minutes before realizing no one could hear her. She army crawled into her house to get her cell phone and called 911. Client reports having a headache, right shoulder pain, as well as right hip pain. She landed on concreate when she fell but did not have a LOC, not dizziness, lightheadedness. No history of prior falls. Client denies any PMH of respiratory, cardiac, or neurological issues.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Right shoulder and hip fracture due to fall.

Secondary Diagnosis (if applicable):.

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

Weak muscles, slow reflexes, weakness due to age, decreased bone strength, medications, anemia, and cardiovascular disease all contribute to falls of an older adult which in turn causes hip fractures. Yearly 250,000 older adults (65 or older) suffer a hip fracture causing hospitalization. Older adults who suffer a hip fracture display delirium from stress, trauma, pain, sleep deprivation, and unfamiliar surroundings. Exercise is necessary to help build up muscle to protect from reoccurring falls as well as building strength in fractured hip.

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* (14th ed.). 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				
Hgb				
Hct				
Platelets				
WBC	**4-12mcl**	**12.60mcl**		Due to recent fall causing stress & inflammation.
Neutrophils	**47-73%**	**90.7 %**		Increase physical stress to right side of body. Trauma from fractured hip & shoulder.
Lymphocytes	**18.0-42.0%**	**6.2%**		Client is taking Tessalon perles for cough/cold and lymphocytes could be low due to this infection.
Monocytes	**4.0-12.0%**	**2.6%**		Low number on monocytes in blood is due to lymphocytopenia.
Eosinophils				
Bands				

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-				
K+	**3.5-5.1 mmol/L**	**3.0 mmol/L**		Client just endured a recent trauma from falling and fracturing her right shoulder and hip.

Cl-				
CO2				
Glucose	**70-99 mg/dL**	**181 mg/dL**		Due to acute stress response from recent fall.
BUN				
Creatinine				
Albumin				
Calcium				
Mag				
Phosphate				
Bilirubin				
Alk Phos				
AST				
ALT				
Amylase				
Lipase				
Lactic Acid				

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	**2.0-3.0**	**2.6**	**2.8**	They're not in an abnormal range

				but are getting closer to an abnormal range so wanted to keep an eye on it. Client is taking Warfarin and two different doses and could be the reason why it is elevated.
PT		**30.6**	**32.8**	They're not in an abnormal range but are getting closer to an abnormal range so wanted to keep an eye on it. Client is taking Warfarin and two different doses and could be the reason why this is elevated.
PTT				
D-Dimer				
BNP				
HDL				
LDL				
Cholesterol				
Triglycerides				
Hgb A1c				
TSH				

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				
pH				
Specific Gravity				
Glucose				
Protein				
Ketones				

WBC				
RBC				
Leukoesterase				

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):

Kee, J. L. F. (2017). *Pearson handbook of laboratory & diagnostic tests with nursing implications*. Boston: Pearson.

Hinkle, J. L., Cheever, K. H., & Brunner, L. S. (2018). *Brunner & Suddarths textbook of medical-surgical nursing* (14th ed.). Philadelphia: Wolters Kluwer.

Normal ranges were pulled from EPIC.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1/20/2020: CT Head/Brain w/o contrast

Impression: No acute intracranial abnormality

CT Cervical Spine w/o contrast

Impression: Nondisplaced right side superior pubic rami fracture. No significant traumatic injury seen to the pelvis.

X-ray Chest single view

Impression: Mild Cardiomegaly

X-ray & 3 more views right

Impression: A linear lucency of the distal margin of the second middle Phalanx which could be due to nondisplaced fracture.

X-ray hip 2-3 views w/pelvis unilateral right

Impression: No acute bony findings

X-ray shoulder complete right

Impression: Acute comminuted fracture of the right humeral head. No dislocation seen.

Diagnostic Test Correlation (5 points):

All of these CT and X-rays were done due to the client coming into ED from a fall. They were seeing if there were any breaks, fractures, or injury to organs through these CT scans and X-rays. They also did a CBC blood draw to check and see what was elevated or low in her body. From the fall her WBC were elevated due to her inflammation and infection in her body which

correlates with her X-rays that show fracture to the right humeral head and right side superior pubic rami fracture.

Diagnostic Test Reference (APA):

Kee, J. L. F. (2017). *Pearson handbook of laboratory & diagnostic tests with nursing implications*. Boston: Pearson.

These test results were obtained through OSF Epic system

Current Medications (10 points, 1 point per completed med)

10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/ Generic	**Vitamin D3**	**Omega 3 Fish Oil**	**Diovan/ hydrochlorotniazide/ Valsartan**	**Tocopheral/ Vitamin E**	**Warfarin/ Coumadin**
Dose	**1000 Unit**	**1000mg**	**80-12.5 mg**	**200 unit Capsule**	**5mg- M-Sat 7.5 mg- Sunday**
Frequency	**1 unit Daily**	**1000 mg Daily**	**1 tablet Daily**	**1 capsule Daily**	**Daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Vitamin**	**Vitamin**	**Antihypertensive**	**Vitamin**	**Anticoagulant**
Mechanism of Action	**Helps your body to absorb calcium.**	**Is to help with differed organs in the body such as heart, kidney, and brain.**	**Blocks the hormones angiotensin II from coming together and binding at the receptor sites. This reduces blood pressure and renal reabsorption of sodium.**	**Antioxidant preventing free radical reaction with the cell membranes.**	**The liver's ability to synthesize Vitamin K is reduced while taking to help reduce clotting factor.**
Reason Client	**Client is taking it**	**Client is taking it because of**	**Client is taking this**	**Help promote**	**Client is taking because**

Taking	**due to age and having weak bones.**	**her pulmonary embolism.**	**because she has hypertension.**	**eye health and the client had cataract surgery in the past.**	**she has a history of pulmonary embolism.**
Contraindications (2)	**1.Kidney stones 2.Sarcoidosis**	**1.Can keep blood from clotting. 2. Excessive bleeding**	**1.Simultaneous aliskiren therapy in diabetic clients. 2.Hypersensitivity to Diovan**	**1.Bleeding 2. weakness**	**1.Malignant or severe hypertension. 2. Severe uncontrollable bleeding**
Side Effects/ Adverse Reactions (2)	**1.Chest pain 2.Constipation**	**1.Nosebleeds 2.Loose stools**	**1.Acute renal failure 2.Increased incidence of viral infection.**	**1.Stomach cramps 2.Bruising**	**1.Weakness 2. Jaundice**
Nursing Considerations (2)	**1.Client should avoid taking antacids while taking Vitamin D3. 2. Taking this medication while pregnant could harm unborn baby.**	**1. Make sure client is not taking more than recommended dose. It can cause serious side effects if taking in excess amounts. 2. Taking fish oil along**	**1.Check clients BP often. 2. Make sure to get routine potassium levels checked as they can be elevated due to the blocking of aldosterone secretion.**	**1.Make sure the client needs to be taking this and that it is benefiting her health. 2. Make sure to tell client that there could be some bruising and bleeding occur while**	**1.Woman at childbearing age must have a negative pregnancy test before starting this medication. 2. You will need to give heparin or enoxaparin with oral warfarin for 3 days at least before taking warfarin only.**

		with BP medications can cause BP to go too low.		**taking this vitamin.**	

Hospital Medications (5 required)

Brand/ Generic	**Norco/ Hydrocodone**	**Tesslon Benzonate**	**Senokot**	**Warfarin/ Coumadin**	**hydroCHLOR Othiazide**
Dose	**10-325 mg**	**100 mg**	**8.6-50 mg**	**5 mg**	**12.5 mg**
Frequency	**1 tablet every 4 hrs PRN**	**3 times daily PRN**	**2 times daily**	**Every evening**	**Daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Semisynthetic opioid agonist**	**Non-narcotic antitussive**	**laxative**	**Anticoagulant**	**Antihypertensive, diuretic**
Mechanism of Action	**It will bind to the opioid to activate the receptors to reduce pain and give relief.**	**Sedates stretch receptors in lung tissue, pleura, respiratory tract, reducing activity and cough.**	**Helps keep water in the intestines so that stool can be soft and move to make a bowel movement.**	**The liver's ability to synthesize Vitamin K is reduced while taking to help reduce clotting factor.**	**Promotes the movement of chloride, water, and sodium to nephron's distal convoluted tubule which decreases blood pressure.**
Reason Client Taking	**Client has a right hip and shoulder fracture and is in a lot of pain.**	**Client has a cough.**	**Client is taking Norco which is causing her to be constipated and hasn't**	**Client is taking because she has a history of pulmonary embolism**	**Client has hypertension and while in hospital has had elevated BP.**

			had a bowel movement in 3 days.		
Contraindications (2)	**1.Acute or severe bronchial asthma 2. Respiratory depression**	**1.Dysphagia 2.Hypersensitivity**	**1.Gastrointestinal (GI) obstruction or perforation 2.Ulcerative colitis.**	**1.Cerebral or dissecting aneurysm. 2.Pericarditis**	**1.Renal Failure 2.Anuria**
Side Effects/Adverse Reactions (2)	**1.Dry mouth 2.Constipation**	**1.Constipation 2. hallucinations**	**1.Rectal bleeding 2.Kidney inflammation**	**1.Angina 2.Anemia**	**1.Insomnia 2.Dehydration**
Nursing Considerations (2)	**1. This medication can become habit forming so make sure the client takes it only while needed and only how prescribed. 2. Can cause constipatio**	**1.Asses the frequency of cough. 2. Don't let client break, crush, chew, or let dissolve in mouth. It can anesthetize mouth and throat causing risk of choking.**	**1. Client can become dependent on laxative to have a bowel movement. 2. medication may cause a change in urine color to pink, red, violet, yellow, or brown.**	**1.Avoid giving I.M. injections to clients who are on warfarin therapy. 2.Make sure to monitor INR and assess for therapeutic effects.**	**1.You want to give this medication in the morning or evening to avoid nocturia. 2. What to make sure to do routine vitals, weight, fluid intake and output, and serum levels of electrolytes and especially potassium.**

	n so make sure to inform client and add a stool softener if necessary.				

Medications Reference (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The Client is Alert and Oriented x3 and is in no apparent distress. Her overall appearance is well. She is well groomed female who has fallen and fractured her right shoulder and hip.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 17** **Drains present: Y☐ N ☒** **Type:**	Clients skin is pallor and dry and has a temperature of 98.1 degrees Fahrenheit. Turgor is 1+ and she has multiple moles on her back. Her whole right side of her body shoulder down is bruised due to recent fall. No rashes or wounds besides her bruising on her right side.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:**	Head is normal cephalic with no vein distention on neck. PERRLA was done and noted. Nose was moist pink with turbinate's noted, no polys

Nose: **Teeth:**	visualized. Septum is midline and no sinus tenderness with percussion. Client has her own teeth and were stained yellow with light plaque buildup.
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:**	S1 and S2 noted in all 5 areas with normal rhythm and rate. No murmur, gallop, or rub heard. I did peripheral pulse on left radial pulse and was strong. Capillary refill was less than 3 seconds. No edema noted.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Lungs clear when auscultated. Breath sounds noted in all locations no wheezing or crackles heard.
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:**	Client has no restrictions on her diet while at the hospital and lives and home by herself and eats a balanced diet. She is 5'3 and 193lb 3.9oz. Abdomen is soft/obese, non-distended, and bowel sounds present in all four quadrants. Client hasn't had a bowel movement since she has been admitted to the hospital. No pain or masses noted while palpating abdomen. No drains, scars, wounds, distention, incisions noted.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒**	Her urine is a yellow/amber color with no other distinct characteristics. She is frequently going to the bathroom with no problem emptying her bladder. The nurse I followed didn't have me measure how many mL of urine output she was giving.

Type: **Size:**	
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 8+** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Client has limited ROM as she has fractured her right shoulder and right hip. She is very strong on her left side as she can get up with assistance to go to bathroom. She is using a supportive device a hand walker to help give extra support to her left side that is having to do most of the work. She is a fall risk, so she does need assistance with getting up to go to the bathroom, wipe, and pull pants up and down. Gait belt is used for all lift and walking with client.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Client was admitted because of recent fall and right hip and shoulder fracture. Strength in all extremities is not there. Her mental status is strong along with her speech and sensory. She was able to understand all that was happening and never had a 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):**	Client is coping with her fall well. She is reluctant to go to a nursing hope to get therapy and would like to stay in the hospital to get care. She is educated and understands the steps that need to be taken for her fractures to heal. She is divorced and lives at home alone, but her son was up to visit with her throughout the day. She is getting ready to move and son will move her belongings to help her out.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
2:18 pm	**78**	**181/74**	**17**	**98.1 degrees Fahrenheit**	**95**
5:30 pm	**76**	**144/81**	**16**	**98.0 degrees Fahrenheit**	**94**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
2:18pm	**2**	**Hip/whole right side**	**Increases when active**	**Doesn't hurt as bad when stable in chair.**	**Client is getting Norco every 4 hrs PRN. Waiting to get next dose.**
4:30 pm	**5**	**Hip/whole right side**	**Increased because I lifter her to go to the bathroom**	**Increase pain while moving from chair to commode to back.**	**Client is getting her pain medication (Norco) in 30 minutes.**

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:**	Pt refused IV so no assessment was needed.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
840mL	Two voids unknown amount due to staff not measuring.

Nursing Care

Summary of Care (2 points)

Overview of care: Client was a very understanding older adult female who was hospitalized due to recent fall that resulted a right hip and shoulder fracture. No surgery was done, and physical therapy was set while in assisted living facility. While in the hospital client was a fall risk and needed assistance with moving to bed to couch, couch to bed, chair to toilet. She had routine care from nurse, doctor, and case worker. Assisted living was picked out and plan for discharge was in the works. Vitals where done routinely, medications were given at set times, hygiene was done throughout the day.

Procedures/testing done: No testing was done while in my care.

Complaints/Issues: No complaints or issues.

Vital signs (stable/unstable): Vitals were stable besides her BP was elevated 181/74 but got order from physician for BP medication and it started to go down 144/81. Rest were within normal range.

Tolerating diet, activity, etc.: Client is not on a diet and is managing activity to get up and go to bathroom quite well. She does have an issue of sleeping at night since she is a side sleeper and can't do that right now with the fractured hip.

Physician notifications: Physician came into room while I was there to discuss her future plans. Client had many questions on what the insurance was going to pay. Physician sat down and discussed what they had told him. When a question couldn't be answered he personally called back insurance company to make sure he heard correctly what would be covered and what wouldn't.

Future plans for patient: Client was starting plans to go to an assisted living facility in Tuscola in the next day or two. She will be getting routine therapy to help with her fractured hip and shoulder.

Discharge Planning (2 points)

Discharge location: Client had plans for discharge in the next day and would be moving into an assisted living facility in Tuscola for the next month. Client agreed upon this and was ready to start her therapy.

Home health needs (if applicable): Client will need to be in an Assisted living facility for at least the next month to get adequate therapy for her fractured hip and shoulder.

Equipment needs (if applicable): Client was using a hand walker while in my care and was using it well for some left side stability. She will need to use this or a cane in the coming month to keep a stable balance and reduce the chance of another fall.

Follow up plan: I didn't see that there were any follow up plans in the notes.

Education needs: Client had already had education given on falls and safety tips to protect herself from falls in the future.

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. Constipation related to pain	This nursing diagnosis was chosen because	1.Started the client on senokot to help produce a bowel	Client took her first dose of senokot in the morning and later that night was

	medication (Norco) given as evidence by no bowel movement since prior to admission 3 days prior.	the client was complaining that she couldn't have a bowel movement and that she was worried. I asked her how long it has been, and she started "before she was admitted to the hospital." She has been admitted for 3 days.	movement. 2.Client is on a well-balanced diet while in the hospital.	going to get her second dose. She was happy to start taking something to help produce a bowl movement. She was really worried about not having a regular bowel movement. She was informed that a well-balanced diet will help with healthy regular bowel movements and was when she ordered dinner it was well balanced with fruit, vegetables, meat, milk, and water.
2.	Risk for fall related to right hip and shoulder fracture as evidence by recent fall.	Client has a fractured hip and shoulder on her right side. Makes it hard for her to get up and walk. Uses a hand walker for help but still is at risk for another fall due to her injuries.	1. Client is a put on the fall risk while in the hospital. She can't get up and move around unless assisted by a hospital staff. She has a gait belt to help support her while she is up moving around. 2.Client also has a hand walker assisted device to keep her stable and help lift herself up when moving from chair to bed or chair to bathroom.	Client and family were very understanding of the steps taken to prevent another fall. She kept her call light next to her and would call when needing assistance. She was very good a using her hand walked and loved how supportive it was on her left side.
3.	Sleep deprivation related to hip fracture as evidence by not sleeping well in bed.	One of the first things the client told me was that she isn't getting much sleep because she is a side sleeper and can't do that since she fractured her right shoulder and	1.Offered to give client more pillows for while in bed. Help her get more comfortable and have more support for better sleep. 2.Have client sleep in chair for better support of her hips and	Client was given options to help better her sleeping while in the hospital. Client wasn't very responsive to ideas. She really misses sleeping on her side and want to be able to do that again.

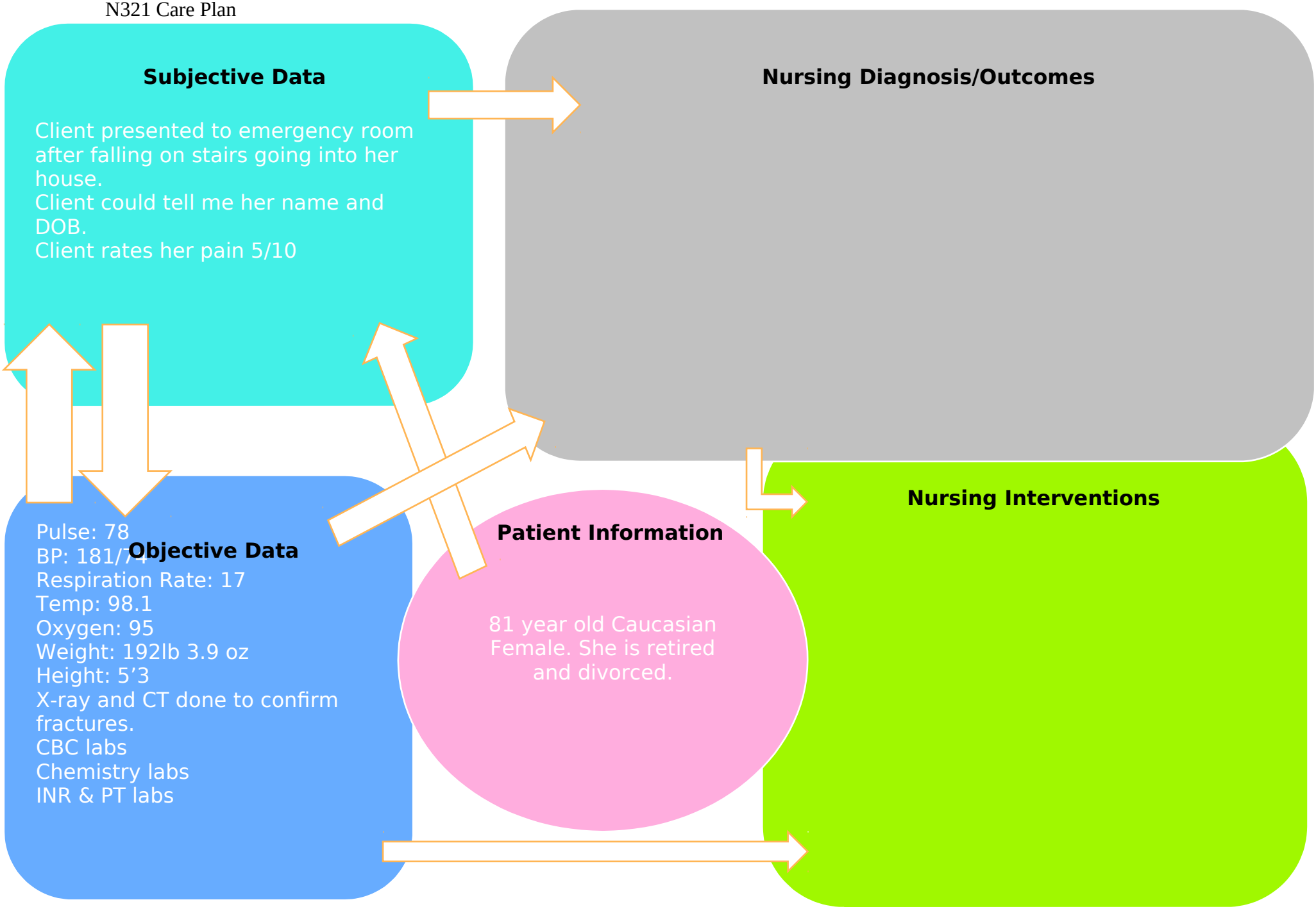
	hip.	shoulder. Have a pillow placed underneath her right arm for extra support.	

Other References (APA):

Swearingen, P.L., & Wright, J. D. (2019). ***All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health.*** **St.Louis, MO: Elsevier.**

Concept Map (20 Points):

N321 Care Plan



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