

N441 Care Plan

Lakeview College of Nursing

Name Penny Galloway

Demographics(3points)

Date of Admission 2/2/2020	Patient Initials RP	Age 89	Gender M
Race/Ethnicity W	Occupation retired	Marital Status M	Allergies None
CodeStatus DNR	Height 5'2"	Weight 148lb 14.4 oz	

Medical History(5 Points)

Past Medical History:CAD, Alzheimers Dementia without behavioral disturbances, Gout , CHF, Spinal Stenosis, GERD, HTN, Hyperlipidemia, Diabetes Mellitus , Renal Failure

Past Surgical History: Pacemaker Replacement 12/31/2019 (past pacemaker placement was over thirty years ago)

Family History: no family history available at this time—

Social History (tobacco/alcohol/drugs): never smoked or used drugs—no smokeless tobacco)

Assistive Devices: wheelchair

Living Situation: Nursing home---wife lives in their original home

Education Level: completed high school

Admission Assessment

Chief Complaint (2 points): Reported to ED with swelling and redness around pacemaker insertion site

History of present Illness (10 points): Pt has swelling with noted tenderness erthyema around pacemaker site—Pt was seen earlier this week at Kirby medical center and was given a dose of Vancomycin WBC's were at 13000 at that time Creatinine at 1.7 and Lactic

acid 1.8 --Pt is very hard of hearing and has dementia—Pt was sent to the ED from nursing home after noted redness and swelling with tenderness was observed.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pacemaker Infection

Secondary Diagnosis (if applicable): Diabetes Mellitus

Pathophysiology of the Disease, APA format (20 points): Pt received a new pacemaker due to problems with the battery his pacemaker had been in thirty years. Pt about a month later with current admission to the ED has developed some redness and swelling to the left chest pacemaker area. Pt stated it was painful. Patient white blood cell count was elevated to 14.2. Infections can happen with any surgical procedure. The pacemaker had been in a very long time this can make it difficult for replacement and cause a compromise of tissues. The patient does have physical and mental limitations which can impair circulation and create an environment for the disease process. While the culture had no growth after one day the concern would be for a bacterial infection such as endocarditis. Overtime an infection like endocarditis can attack heart valves and spread to your lungs and even the brain through the bloodstream (Lewis, Bucher, Heitkemper, Harding, & Kwong, 2017). Any bacterial infection can be dangerous and can damage the heart, other organs and destroy tissue. The patient may not have been able to fight the infection due to being diabetic and his physical and mental decline. Diabetes is a heterogeneous disorder. Diabetes mellitus is a chronic illness of hyperglycemia that requires a lifetime of self-management behaviors due to high glucose levels characterized by cellular insulin resistance, impaired regulation of hepatic glucose production, and declining beta-cell function, eventually leading to beta-cell failure. Patients with diabetes

N403 Care Plan

need to be able to recognize the symptoms of hyperglycemia and hypoglycemia which can be complications of diabetes. Signs and symptoms of uncontrolled diabetes can include fatigue, irritability, blurred vision, and slow healing wounds (Capriotti & Frizzell, 2016). High blood glucose levels can have signs and symptoms such as confusion, diaphoresis, fatigue, blurred vision and impair the body's ability to heal. Plasma glucose can be greater than two hundred. The two main problems related to type two diabetes is insulin resistance and impaired insulin secretion. Type one and two diabetes can result in long term complications such as ketoacidosis, eye disease, wound healing problems, compromised immune system and peripheral vascular disease (Hinkle & Cheever, 2018). Most often these complications are a result of uncontrolled blood sugar levels. The patient is wheelchair bound which causes lack of circulation compared to a person walking around. Any decline in mental or physical ability or infection can cause problems with blood sugar and result in diabetes type two. A patient may receive an oral antidiabetic medication, insulin, or IV insulin w/NaCL if needed to control diabetic ketoacidosis or to control their blood glucose levels. Diet is an essential part of living with diabetes. A proper diet reduces the chances of the blood sugars becoming out of control. Proper medication administration is essential. There are several factors that can cause an elevation in glucose levels such as stress, lifestyle, or autoimmune issues. This patient has an infection that can cause an increase in his blood sugar levels and white blood cells.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J.P. (2016). *Pathophysiology Introductory Concepts and Clinical Perspectives*. Philadelphia, PA: F.A. Davis Company.

Hinkle, J.L., Cheever, K.H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, PA: Wolters Kluwer.

N403 Care Plan

Lewis, S. L., Bucher, L., Bucher, L., Heitkemper, M. M., & Kwong, J. (2017). *Medical Surgical Nursing: Assessment and management of clinical problems* (10th ed.). St. Louis, MO: Elsevier Inc.

Van Leeuwen, A. M., & Bladh, M.L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7ed.) Philadelphia, PA: F.A. Davis Company.

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	3.92-5.13/L	4.70	4.60	N/A
Hgb	11.6-15 g/dL	14.4	14.4	N/A
Hct	35.5-50.0%	45.6	45.2	N/A
Platelets	140-440/dL	223	190	N/A
WBC	4.00-12.00L	14.20 H	13.80H	Pt has current infection
Neutrophils	0-100/L	82.5	78.1	N/A
Lymphocytes	0.95-3.07/L	1.20	1.70	N/A
Monocytes	0.10-0.90/L	1.20H	1.20H	Pt has current infection
Eosinophils	0.03-0.48L	0.10	0.10	N/A
Bands	N/A	N/A	N/A	N/A

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145	140	141	N/A

N403 Care Plan

K+	3.5-5.1	3.8	3.9	N/A
Cl-	98-107	101	105	N/A
CO2	21-31	26	22	N/A
Glucose	70-99	248H	157H	Pt has diabetes mellitus and an infection Hinkle & Cheever (2018).
BUN	6-20	37H	33H	Pt has history of renal failure and pt received antibiotic therapy Hinkle & Cheever (2018).
Creatinine	0.50-1.20	1.42H	1.43H	Pt has history of renal failure Pt also received antibiotic therapy Hinkle & Cheever (2018).
Albumin	3.5-5.0 g/dL	N/A	N/A	N/A
Calcium	9-11 mg/dL	N/A	N/A	N/A
Mag	1.8-3.6mg/dL	N/A	N/A	N/A
Phosphate	N/A	N/A	N/A	N/A
Bilirubin	<1.2mg/dL	N/A	N/A	N/A
Alk Phos	50-160 U/L	N/A	N/A	N/A
AST	8-43 U/L	N/A	N/A	N/A
ALT	7-45U/L	N/A	N/A	N/A
Amylase	N/A	N/A	N/A	N/A
Lipase	N/A	N/A	N/A	N/A
Lactic Acid	0.5-2.0 mmol	1.5	N/A	N/A
Troponin	N/A	N/A	N/A	N/A
CK-MB	N/A	N/A	N/A	N/A

Total CK	N/A	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	1.0	N/A	N/A
PT	10.1-13.1 sec	11.6	N/A	N/A
PTT	30-45	N/A	N/A	N/A
D-Dimer	N/A	N/A	N/A	N/A
BNP	N/A	N/A	N/A	N/A
HDL	N/A	N/A	N/A	N/A
LDL	N/A	N/A	N/A	N/A
Cholesterol	N/A	N/A	N/A	N/A
Triglycerides	N/A	N/A	N/A	N/A
Hgb A1c	N/A	N/A	N/A	N/A
TSH	N/A	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	N/A	N/A	N/A	N/A
pH	N/A	N/A	N/A	N/A
Specific Gravity	N/A	N/A	N/A	N/A

N403 Care Plan

Glucose	N/A	N/A	N/A	N/A
Protein	N/A	N/A	N/A	N/A
Ketones	N/A	N/A	N/A	N/A
WBC	N/A	N/A	N/A	N/A
RBC	N/A	N/A	N/A	N/A
Leukoesterase	N/A	N/A	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	N/A	N/A	N/A	N/A
PaO2	N/A	N/A	N/A	N/A
PaCO2	N/A	N/A	N/A	N/A
HCO3	N/A	N/A	N/A	N/A
SaO2	N/A	N/A	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	N/A	N/A	N/A	N/A
Blood Culture	N/A	N/A	N/A	Culture take on 2/2 No growth 1 day
Sputum Culture	N/A	N/A	N/A	N/A
Stool Culture	N/A	N/A	N/A	N/A

Lab Correlations Reference (APA):

Hinkle, J.L. & Cheever, K. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, P.A: Wolter's Kluwer.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Influenza A & B Negative-Chest Xray

Diagnostic Test Correlation (5 points): Patient was tested for influenza when he came into the ED which is routine due to the current weather and season. Chest X ray was done to visualize the pacemaker and area of concern with infection. Culture was pulled to confirm the kind of infection.

Diagnostic Test Reference (APA):

Hinkle, J.L. & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical Surgical Nursing* (14th ed.). Philadelphia, PA: Wolter's Kluwer.

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

Home Medications (5 required)

Brand/ Generic	Albuterol (Proventil)	Vitamin D	Lasix (furosemide)	Tylenol	Tramad ol
Dose	2.5mg	400 mg	60mg	325mg	50mg
Frequency	1 x every 6 hours	1 x daily	2 x daily	2 every 4 hours as needed	2 x daily
Route	inhalation	Oral	oral	Oral	Oral
Classificatio n	Bronchodila tor	mineral	Loop diuretic	Antiinflamma tory	Nonopio id
Mechanism of Action	Binds to beta 2 adrenergic receptors in airway smooth muscle— this leads to the activation of adenylate cyclase to convert to ATP to cAMP	Mineral required to regulate calcium & phosphorus/need ed for bone structure	Lasix inhibits the reabsorption of sodium and chloride from the loop of Henle & distal renal tubule	Reduce pain / fever	Works by changin g the way the brain and nervous system respond to pain
Reason Client Taking	History of SOB/season al	Maintain D levels/ low phosphate in the blood	History of HTN	arthritis/ discomfort	Pain
Contraindic ations (2)	Hypersensit ivity can occur/obser ve closely in patients with heart failure or cardiac disease	Reduction of kidney finction/artheros clerosis / Heparin interacts w/vitamin D	Hepatic anuria, hypersensitiv ity	Stomach carcinoma, stomach ulcers	Breathi ng problem s or a blockag e in your stomach or intestine

Side Effects/ Adverse Reactions (2)	Anxiety, Nervousness	Weakness/loss of appetite	Hyponatremia (low sodium), dizziness confusion	Nausea, abdominal pain	Dizziness, night sweats
Nursing Considerations (2)	Monitor Potassium levels/Monitor patient for tolerance of medication and for side effects of medication	Can cause failure of bone calcification/ monitor D levels/ and bone deficiencies	Monitor digoxin patients may result in toxicity, skin reactions can occur due to hypersensitivity	Monitor pt for bleeding risks, monitor pt for abdominal discomfort	Respiratory problems, addiction issues
Key Nursing Assessment(s) Prior to Administration	Assess lung sounds prior to and after giving medication —monitor vitals and pulmonary function	Assess pt labs/ monitor calcium levels	Monitor daily weights, check daily I/O's -monitor ptb/p and pulse	Monitor ALT due to tylenol is hard on the liver, Monitor for effectiveness of the drug check pain scale prior to admin and after for effectiveness	Assess pain and intensity — monitor liver function tests
Client Teaching needs (2)	Pt should be sitting up to allow proper medication administration—Pt to not exceed recommended dose of medication	Eat foods high in calcium and vitamin D – regular blood tests to monitor levels	Take as directed- contact physician if adverse reaction occurs such as rash, weakness, or cramps	Take only as directed Do not take more if pain continues and is not relieved by current dosage call provider	Take exactly as directed May cause prolonged bleeding

Hospital Medications (5 required)

Brand/ Generic	Bisacodyl	Vancomycin	0.9 sodium chloride	Ondansetron/ Zofran	Zosyn/ Piperacillin
Dose	10mg	750mg	65ml/hr	4mg	3.375g
Frequency	1 x daily	125 ml/hour every 12	Cont.	Every 12 hours	25ml/hr Every 8
Route	oral	IV	IV	By mouth	IV
Classification	laxative	antibiotic	Fluid therapy	Antiemetic	Broad spectrum antibiotic
Mechanism of Action	Soften stool/increases intestinal activity	Tx for infections to kill bacteria causing infections	To increase fluid volume	Blocks serotonin receptors centrally in the chemoreceptor trigger zone	Tx for bacterial infections binds to bacteria cell wall
Reason Client Taking	Stool softener	infection	Mild dehydration	Nausea	Infection/ prior to surgery admin
Contraindications (2)	Abdominal pain/GI bleed	Allergy to corn, hypersensitivity	Fluid overload/ complications due to heart failure	Prior use of apomorphine/ congenital long QT syndrome	Allergic reactions, allergies to cephalosporins
Side Effects/ Adverse Reactions (2)	Loose stools, abdominal pain	Wheezing, hives	Monitor for s/s of fluid overload Monitor of decreased lung sounds	Shortness of breath-serotonin syndrome	Pain, reddness, insomnia
Nursing Considerations (2)	Monitor pt stools, monitor bowel sounds	Monitor for hypersensitivity, rash, urticaria Monitor for anaphylaxis	Monitor lung sounds and look for signs of fluid overload such as edema	place disintegrating tablet under the tongue immediately after opening package—know that if hypokalemia or hypomagnesemia is present	Pt may experience severe stomach pain, monitor liver levels

				correct imbalances prior to administration	
Key Nursing Assessment(s) Prior to Administration	Monitor effectiveness of drug, Assess pt for hyperactive bowel activity	Monitor for red man syndrome Observe for sudden hypotension Trough will be pulled to monitor levels Check for corn allergy	Lung sounds, I/O's, daily weights	Monitor for hypokalemia and hypomagnesemia prior to administration	Kidney function needs clearance, obtain a history prior to administration
Client Teaching needs (2)	Take to avoid constipation Take daily to maintain soft stools	This drug may interact with over the counter medications, drug may cause kidney problems	Do not remove iv access, educate pt on the importance of iv fluid intake	Contact provider if adverse reaction occurs such as abdominal pain or discomfort, temporary blindness can occur	Drink plenty of water due to the medication can be hard on the kidneys, take as directed be aware of side effects such as stomach pain or ill feeling due to bacteria die off

Medications Reference (APA):this drug may interact

Jones & Bartlett. (2019). *Nurse's Drug Handbook* (18th ed.). Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient was alert and oriented x 2 pt had no apparent distress and was resting comfortably in bed-Patient's wife is at beside.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Patients skin was pink and warm to the touch with moderate dry areas of the lower arms. Skin turgor was less than 2 seconds with no bruises or wounds. Left upper pacemaker pocket area was red and swollen with 2 plus edema to the area. No drainage present area is tender to the touch. Pt is very limited Braden score of 13.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Atraumatic- No drainage from his nose –lips are facial features are within normal limits. Head, neck and ears are symmetrical with large hearing impairment. Patient has dentures but does not always wear them—currently they are out at this moment. .</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>.S1 ad S2 are present with no S3 or other murmurs noted at this time. All peripheral pulses are intact (2+noted upon palpation) and cap refill of less than 3 seconds is noted—for all extremities. Pt is resting with no distress or pain at this time. Pt is able to voice pain when you verbalize with him. Patient states he is in no pain at this time. Patient is 100 percent</p>

<p>Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema: left upper chest pacemaker pocket area</p>	<p>paced at this time.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Pt is currently not using accessory muscles— Breathing sounds are clear bilaterally and in all lobes—no distress is noted at this time. Pt is currently on room air. Breath Sounds: Location, character</p> <p>ET Tube: Size of tube:N/A Placement (cm to lip):N/A Respiration rate:N/A FiO2:N/A Total volume (TV):N/A PEEP:N/A VAP prevention measures:N/A</p>	<p>Pt is currently not using accessory muscles Breathing sounds are clear bilaterally in all lobes Pt shows no signs of distress or shortness of breath. Pt is currently on room air. HOB at 30 degrees</p>
<p>GASTROINTESTINAL (2 points): Diet at home: mechanical Current Diet diabetic Height: 5’2” Weight:148lb Auscultation Bowel sounds: Last BM: Yesterday Palpation: Pain, Mass etc.:no pain or masses noted Inspection: Distention:no distention Incisions:No incisions Scars:No Scars Drains: No drains Wounds:No wounds Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Pt is on mechanical soft diet in the nursing home but is currently NPO for surgery Diabetic diet Bowel sounds in all four quadrants Pt had a bowel movement yesterday. No pain or abdominal distention No prior abdominal surgeries. Pt has no vomiting or diarrhea.</p>
<p>GENITOURINARY (2 Points): Color:yellow Character:clear</p>	<p>Pt lives at a nursing home where he is full care due to physical disabilities-Pt is on a mechanical soft diet. Wife states pt does</p>

<p>Quantity of urine:Inc x 2 Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size: CAUTI prevention measures:</p>	<p>normally use a urinal but is using briefs currently due to infection and illness. No abdominal distention. Bowel sounds all four quadrants. NO wounds No diarrhea Abdomen is soft</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM:Limited Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: High risk 34 Activity/Mobility Status: Y Needs assistance with equipment Y Needs support to stand and walk Y</p>	<p>Pt is alert x2 pt is a full 2 person assist Pt does have dementia and needs assistance with ADLS –Pt is a fall risk of 34 and Sepsis Score of 4 –Decreased ROM ability due to arthritis Supportive device is a wheelchair –Fall score is high of 34</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status:Alert x 2 Speech:mildly impaired Sensory:pt does have impaired hearing LOC: alert oriented x2</p>	<p>Pt can move extremities but is limited. Strength is equal in both hands-pt does has some mental decline and has delayed response with direction cues. Pt does respond to name and stimulation. PERRLA is intact with no deficiencies noted-Pt does have difficulty hearing</p>
<p>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):</p>	<p>): Pt does well with favorite music to help him relax wife is at beside as much as possible. Family does pray and is christian faith. Wife lives in close to the facility her husband lives in due to her inability to not long care for his needs at home Wife states their children are also very supportive.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
900	88	104/67 (arm)	37	97.4 oral	99 room air
1000	96	97/61 (arm)	36	98.0 oral	98 room air

--	--	--	--	--	--

Vital Sign Trends/Correlation: Pt was on room air with no distress noted. Pt would have a slight elevation in blood pressure when repositioned. This elevation could be due to pain from infection or due to status of dehydration and antibiotic therapies—pt was scheduled for surgery at 1pm today.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
900	0-10	N/A	N/A	Pt denies any pain	N/A
1000	0-10	N/A	N/A	Pt denies any pain	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 Location of IV: 1 right AC Date on IV: 2/2/2020 Patency of IV: flushed with saline - Signs of erythema, drainage, etc.: none IV dressing assessment: dry and intact	0.9 NS was running prior to surgery along with Zosyn pt currently waiting for surgery today –waiting on physician rounding
Other Lines (PICC, Port, central line, etc.)	N/A
Type: Size: Location: Date of insertion: Patency: Signs of erythema, drainage, etc.: Dressing assessment: Date on dressing: CUROS caps in place: Y <input type="checkbox"/> N <input type="checkbox"/> CLABSI prevention measures:	N/A

Intake and Output(2 points)

Intake (in mL)	Output (in mL)
IV 2,158	Inc. X 2

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was waiting on surgery on the pacemaker site. The patient was observed by the nurse throughout the shift. Patient was sleeping most of the morning due to surgery scheduled at one in the afternoon. Dr Reddy to perform a pacemaker surgery to removed infected tissue around pacemaker pocket of left upper chest. Vitals were done and patient turned q 2 hours with extra pillow to elevate infected left upper chest pacemaker pocket. Vitals were stable at this time with no complaints of pain. Pt was given antibiotic Zosyn through IV prior to surgery.

Procedures/testing done: Influenza was done in ED and were negative-Chest Xray was done but results were not back yet—and culture was taken in ED which showed no growth after one day.

Complaints/Issues: Patient was resting comfortably and had negative complaints about the CCU nurses or physician. Wife stated she was thankful for all his medical care and treatment.

Vital signs (stable/unstable): Vitals were stable throughout the day with no changes noted at this time.

Tolerating diet, activity, etc.: Patient was NPO due to surgery

Physician notifications: The physician Dr. Reddy was scheduled to do surgery on this patient at 1pm today to clean area around pacemaker due to infection of the pacemaker pocket of the left upper chest.

Future plans for patient: Patient will continued to be monitored after surgery for infection and bleeding precautions. Pt vitals will be taken and comfort care post surgery will be observed.

Discharge Planning (2 points)

Discharge location: Pt will return to nursing home facility

Home health needs (if applicable): pt is full care at this time and will remain in need of assistance with daily care needs

Equipment needs (if applicable): wheelchair

Follow up plan: The patient will follow up with doctor one week following discharge and will need to be monitored for signs and symptoms of infection-treatment orders and changes will be followed up with per nursing care facility.

Education needs: The patient will need to be educated on the limited range of motion due to post surgery of the pacemaker pocket. Patient post op teaching will be given to the nurse when discharge occurs. This information will include activity limitations, ordered therapies per doctor's orders and post surgical treatments. Physician orders will be given to patient and to nursing home facility upon discharge.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Intervention (2 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Pt at risk for activity intolerance due to fatigue from infection</p>	<p>Pt due to dementia and physical disabilities may have difficulty regaining movement post surgery</p>	<p>1.ROM activities as tolerated</p> <p>2. Schedule rest periods to allow proper recovery time</p>	<p>Pt was currently waiting for surgery. Pt wife felt he would get better after surgery was performed. Pt responded positively to words of encouragement to getting better and regaining his independence –pt to see physical and occupational therapy after surgery</p>
<p>2. Pt at risk for skin breakdown due to impaired physical immobility</p>	<p>Pt not moving as he normally does due to infection in pacemaker pocket of left shoulder— altered condition and altered circulation</p>	<p>1. assess skin and assist pt in turning q 2 hours to ensure comfort</p> <p>Proper Pillow placement and positioning to reduce pressure on boney prominences</p> <p>Click here to enter text.</p>	<p>Patients wife was understanding to the importance of turning and repositioning at this time-Pt ed on the importance of circulation and skin care-pt to remain free from signs of infection</p>
<p>3. Pt at risk for</p>	<p>As evidence by</p>	<p>1.Glucose</p>	<p>Pt glucose level to remain</p>

unstable glucose	uncontrolled glucose and high blood sugar	monitoring 2. monitor pt for signs and symptoms of low or high blood glucose	within normal range-pt and pt family to understand the importance of diet and the reasons blood glucose levels can change during the infection and treatment process
4. Risk for ineffective renal perfusion	Patient has increased age with decreased mobility and kidneys may not be able to tolerate the large amounts of antibiotic	1. Monitor patient for signs and symptoms of fluid imbalance 2. Monitor lung sounds and edema relate to fluid overload	Pt was unable to drink due to NPO for surgery however IV had been running prior to provide proper hydration-due to the effect of the kidneys during antibiotic treatment
5. Risk for falls	Patient has dementia and can be a risk for falls due to mental decline	1. Place patient close to nurses station 2. Monitor patient with bed alarm and remind pt to use call light	Pt education on call light also instructed wife to call if she needed anything pt was currently sleeping bed alarm was on and call light within reach -pt's wife verbalized understanding

Other References (APA):

Swearington, P. (2018). *All-In-One Nursing Care Planning Resource*. [S.I.]:Mosby. St.

Louis, Missouri: Mosby, Inc.

Concept Map (20 Points):

Subjective data
Pt presented to ER with pain and redness and swelling of the left pacemaker pocket Pt exhibiting signs of infection Pt has limited range of motion of the left upper chest shoulder area due to discomfort- Pt states it hurts to move it.

Nursing Diagnosis/Outcomes

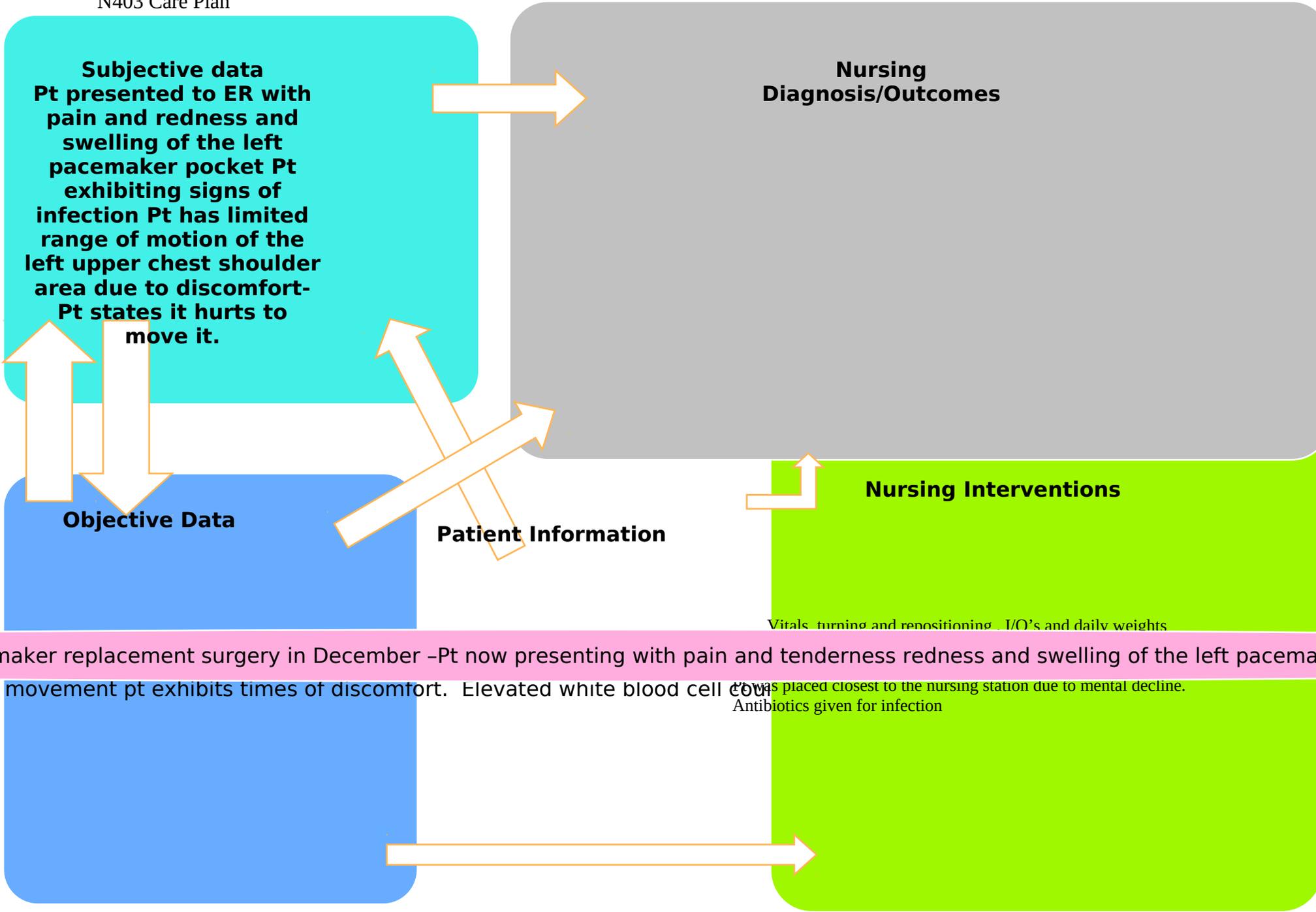
Objective Data

Patient Information

Nursing Interventions

Vitals, turning and repositioning, I/O's and daily weights

pacemaker replacement surgery in December -Pt now presenting with pain and tenderness redness and swelling of the left pacemaker pocket. Limited range of movement pt exhibits times of discomfort. Elevated white blood cell count. Pt was placed closest to the nursing station due to mental decline. Antibiotics given for infection.



N403 Care Plan

N403 Care Plan