N321 Care Plan #2

Lakeview College of Nursing

Hope Dykes

Demographics (3 points)

Date of Admission 02/18/20	Patient Initials KH	Age 49	Gender F
Race/Ethnicity W/C	Occupation Unemployed	Marital Status M	Allergies Azithromycin, Sulfa, Lanolin
Code Status FULL	Height 4'11"	Weight 177 lbs	

Medical History (5 Points)

Past Medical History: Turner Syndrome, Hx of Stroke, Acute Kidney Injury (7/2019), Asthma, COPD, Chron's Disease

Past Surgical History: Tonsillectomy, Cholecystectomy, Tumor Removal

Family History: Mother= Diabetes; No other significant family hx.

Social History (tobacco/alcohol/drugs): Smoked ¼ ppd until 1992. Has not smoked since then. Reports no other use of alcohol, tobacco, or any illegal drugs.

Assistive Devices: Cane, Walker, Grab Bars around Home to help with Balance.

Living Situation: Lives with room mate and husband.

Education Level: Developmental and cognitive impairment. Low ability to communicate. Understands at about a 3rd grade level (per pt chart).

Admission Assessment

Chief Complaint (2 points):Nausea and vomiting

History of present Illness (10 points):Patient was "throwing up a whole lot" for 4 days. After 4 days of nausea and vomiting, she went to her PCP. He ordered labs to be drawn. Before she got her results, while her husband was driving her home, she began to throw up again. She said "I wasn't holding anything down. I felt real sick." When I asked if anything hurt at that time, she said not that she could remember. She could not remember taking

any medications at that time to help with the nausea. Due to cognitive difficulties, the patient had difficulty understanding and answering questions fully. She also has hearing loss in both ears, so conversation was difficult. Toward the end of our interview, the occupational therapist came in and told her she would have to stay another day. The patient became very emotional and started crying. She asked me to go call her doctor and tell him she was not staying because she was "all better". At that point, the patient's primary nurse came in and took over.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):Acute Kidney Injury

Secondary Diagnosis (if applicable):N/A

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

Patient was "throwing up a whole lot" for 4 days. After 4 days of nausea and vomiting, she went to her PCP. He ordered labs to be drawn. Before she got her results, while her husband was driving her home, she began to throw up again. He decided to drive her to the Emergency department where she was admitted for acute kidney injury (AKI).

The term AKI is used to represent a large spectrum of renal disorders. It is diagnosed when there are acute changes in urine output and/or serum creatinine. AKI usually presents within a few hours or a few days. Some causes include a lack of blood flow to the kidneys from hypotension, severe blood loss or diarrhea, burns, major surgery, allergic reactions, and organ failure of the heart or liver. In other cases, the kidneys are directly damaged due to sepsis, damage to the vessels leading to the kidneys, and cancer. Signs and symptoms can include confusion, nausea, fatigue, swelling around the eyes, and

chest pain. Complications of the disorder can also include seizure and coma in severe cases. Repeated cases of AKI increase the risks of kidney failure, heart disease, and stroke. Diagnostic tests include urine tests and output measurements, creatinine, BUN, potassium, GFR, ultrasound, and kidney biopsy (National Kidney Foundation, 2019).

My patient had Turner Syndrome, which can lead to malformation of the kidneys. She has suffered from kidney issues in the past. She was hospitalized last July for the same problem. The patient's BUN and creatinine were high on admission, and the GFR was measuring very low at an 11. Her CT scan showed a malformation of the kidneys with a renal cortical cyst. Together, the labs and diagnostic tests indicate failure of the kidneys to filter waste from the blood appropriately. These labs were still bad at the end of my shift. As a result, the physician decided to keep the patient hospitalized for further observation.

Pathophysiology References (2) (APA):

National Kidney Foundation. (2019). ***Acute Kidney Injury (AKI).***

https://www.kidney.org/atoz/content/AcuteKidneyInjury

Mayo Clinic. (2017, November 18). ***Turner Syndrome.*** https://www.mayoclinic.org/diseases-conditions/turner-syndrome/symptoms-causes/syc-20360782

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.40-5.80			
Hgb	13-16.5			
Hct	38.0-50.0 %			
Platelets	140-440			
WBC	4.00-12	16.44	WNL	Elevated WBC can be an indicator of Chronic Kidney Disease (CKD).
Neutrophils	40-60%			
Lymphocytes	20-40%			
Monocytes	0.2-1.0			
Eosinophils	1-4%			
Bands	0-4%			

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-	133-144			
K+	3.5-5	3.3	3.1	Pt takes Pot Chloride daily at home, which would indicate a past hx of hypokalemia.
Cl-	98-107			
CO2	21.31			
Glucose	70-99	171		The patient has Type 1 Diabetes. Although normally well controlled, AKI puts stress

				on the body, which can increase blood sugar.
BUN	**7-25**	**53**	**26**	**An elevated BUN indicates protein in the blood that is normally removed by the kidneys. This number rises when the kidneys are not functioning well.**
Creatinine	**0.50-1.20**	**53**	**26**	****These were marked as high due to acute kidney injury. If 2 or more tests are high, it may indicate chronic kidney disease.**
Albumin	**3.5-5.3**			
Calcium	**8.8-10.2**			
Mag	**1.6-2.6**			
Phosphate	**2.5-4.5**			
Bilirubin	**<0.5**			
Alk Phos	**39-104**			
AST	**13-39**			
ALT	**7-52**			
Amylase	**23-85**			
Lipase	**0-160**			
Lactic Acid	**0.5-1**			

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

****All WNL for my pt**

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR				
PT				
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	**Yellow and Clear**	Yellow and Clear		
pH	**5.0-9.0**			
Specific Gravity	**WNL**			
Glucose	**Neg**			
Protein	**Neg**			
Ketones	**Neg**			
WBC	**Neg**			
RBC	**Neg**			
Leukoesterase	**Neg**			

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			
Blood Culture	N/A			
Sputum Culture	N/A			
Stool Culture	N/A			

Lab Correlations Reference (APA):

National Kidney Foundation. (2019). *Acute Kidney Injury (AKI).*

https://www.kidney.org/atoz/content/AcuteKidneyInjury

Mayo Clinic. (2018, December 22). *Creatinine test.* https://www.mayoclinic.org/tests-procedures/creatinine-test/about/pac-20384646

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT Test of Kidney and Abdomen showed horseshoe kidneys fused at lower midline pole. Rounded 3cm posterior mid pole left renal cortical cyst. Non-obstructing 0.9cm mid pole left renal calculus.

Diagnostic Test Correlation (5 points): In patients with Turner Syndrome, which my pt presented with, the kidneys can be malformed. Malformation of the kidneys can lead to inadequate blood flow which can lead to Acute Kidney Injury.

Diagnostic Test Reference (APA):

National Kidney Foundation. (2019). *Acute Kidney Injury (AKI).*

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https://www.kidney.org/atoz/content/AcuteKidneyInjury

Mayo Clinic. (2017, November 18). ***Turner Syndrome.*** https://www.mayoclinic.org/diseases-conditions/turner-syndrome/symptoms-causes/syc-20360782

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

Home Medications (5 required)

Brand/Generic	**Albuterol Inhaler**	**Atenolol**	**Budesonide DR particles**	**Potassium Chloride**	**Ambien/ Zolpidem**
Dose	**1 puff**	**25mg**	**6mg**	**10mEq**	**5mg**
Frequency	**QID prn**	**qd**	**qd**	**BID**	**qhs**
Route	**Inhaled**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Bronchodilator**	**Beta Blocker**	**Steroid**	**Metal Halide**	**Sedative**
Mechanism of Action	**Relax the smooth muscles in bronchioles**	**Slow down the cardiac rhythm so the heart can relax**	**Reduces inflammation in the digestive tract.**	**Raises potassium levels in the blood.**	**Activates GABA neurotransmitters to slow down the brain.**
Reason Client Taking	**COPD**	**Hx of Stroke ?? Not sure…**	**Chron's Disease**	**Hypokalemia**	**Insomnia Preventions**
Contraindications (2)	**Hypertension, Coronary Artery Disease**	**Asthma, COPD **I would question the use of this med for this pt.**	**Hypertension, Diabetes**	**Renal Impairment, Diabetes**	**Liver disease. Renal impairment.**
Side Effects/Adverse Reactions (2)	**Headache, Nervousness**	**Headache, Weakness**	**Heartburn, Nausea**	**Diarrhea, Stomach Pain**	**Headache, Dry Mouth**
Nursing Considerations	**These are for acute attacks**	**Monitor HR and BP**	**Capsules may be**	**Do not take diuretics**	**Do not drink alcohol while**

(2)	**only. Do not use more than prescribed.**	**before and after. This can mask symptoms of hypoglycemia.**	**opened and sprinkled on applesauce. Take immediately after mixing. Do take with grapefruit juice.**	**while on this medication. Do not take NSAIDs while on this medication.**	**using this medication! Do not take with anti-depressants.**

Hospital Medications (5 required)

Brand/Generic	**Zofran/ Ondansetron**	**Paxil/ Paroxetine**	**Potassium Chloride**	**Atenolol**	**Lovenox/ Enoxaparin**
Dose	**4mg**	**30mg**	**10mEq**	**25mg**	**30mg**
Frequency	**Q12h prn**	**qd**	**BID**	**qd**	**qd**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Sub-q**
Classification	**Antiemetic**	**Antidepressant (SSRI)**	**Metal Halide**	**Beta Blocker**	**Anitcoagulant**
Mechanism of Action	**Blocks serotonin to prevent nausea and vomiting.**	**Slows the brain's absorption of Seratonin to enhance mood.**	**Raises potassium in the blood**	**Slows down the cardiac rhythm so the heart can relax**	**Prevents platelets from forming clots**
Reason Client Taking	**Nausea/ Vomiting**	**Depression**	**Hypokalemia**	**Hx of Stroke ?? Not sure…**	**DVT prevention**
Contraindications (2)	**Allergic reactions in the past, Antidepressants**	**Thyroid Disease, Breastfeeding**	**Renal Impairment, Diabetes**	**Asthma, COPD **I would question the use of this med for this pt.**	**Liver Disease, NSAIDs or other blood thinners**
Side Effects/Adverse Reactions (2)	**Headache, Tachycardia**	**Loss of Appetite, Increased Sweating**	**Diarrhea, Stomach Pain**	**Headache, Weakness**	**Hair Loss, Increased Bruising/ Bleeding**
Nursing Considerations	**Do not use in patients with**	**This medication**	**Do not take diuretics**	**Monitor HR and BP before**	**Use bleeding precautions**

(2)	**liver failure.** **Report any falls or dizziness to your PCP while on this medication.**	**may lower sex drive.** **Report hallucinations to PCP while on this medication.**	**while on this medication.** **Do not take NSAIDs while on this medication.**	**and after.** **This can mask symptoms of hypoglycemia .**	**like electric razors and soft toothbrushes.** **Report any falls or injuries to PCP.**

Medications Reference (APA):

Elsevier. (2020). *Patient education by Elsevier.*

https://patienteddirect.elsevier.com/#/ibservice?clientid=54081639

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Overall appearance normal for pt. Alert to person and place. Did not know time or current events.** **Pt showed flat affect during the beginning of physical exam. When primary nurse came in to tell her she would not be discharged, pt became very frustrated and emotional. She was crying, cussing, and yelling words that did not make sense. -+**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 17** **Drains present: Y☐ N ☒** **Type:**	**Braden Scale=17** **Skin had redness around face.** **Arms were swollen and pale from edema.**
HEENT (1 point): **Head/Neck:** **Ears:**	**Head was large for body. Neck showed kyphosis. Pt had hearing difficulties in both**

Eyes: **Nose:** **Teeth:**	**ears. Nose was large and distorted toward right side of face. Pt had full dentures.**
CARDIOVASCULAR (2 points): **Heart sounds: N/A (Unable to complete) S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): N/A** **Peripheral Pulses: N/A** **Capillary refill: N/A** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☒ N ☐** **Location of Edema: Bilaterally hands, arms, feet, legs**	**Pt had severe edema bilaterally on hands, feet, arms, and legs. I was unable to hear heart sounds as pt was informed she was remaining in the hospital during my exam and became very emotional.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Pt had normal breath sounds. Lungs clear on auscultation.**
GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current Diet: Mechanical Soft** **Height: 4'11"** **Weight:177 lbs** **Auscultation Bowel sounds: Hyperactive** **Last BM: During shift** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	**Bowel sounds were hyperactive.** **Pt was frustrated with mechanical soft diet.** **Pt had BM during shift. It was soft and formed.** **No tubes or drains present.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:**	**Fecal and urinary incontinence.** **Pt wears adult diapers and had an incontinence pad under her in bed. She shows no signs of discomfort or strain when voiding.**

Catheter: Y ☐ N ☐ **Type:** **Size:**	
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** ☒	**Pt uses cane and walker at home. Physical therapy told her to continue with only walker upon discharge.** **Pt needed assistance getting up from bed and walking across the room with her cane. She made it about 15 feet before she could not stand up anymore and returned to bed.** **Pt was a fall risk due to unsteady gait, mobility deficit, and weakness.** **Fall Risk=10**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Pt was awake and alert, but had cognitive impairment and hearing difficulties in both ears. Speech was very limited.** **Both arms showed contracture and were unable to be straightened at the elbow.**
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):**	**Impaired developmental level.** **Pt lives with husband and roommate. Pt has an in-home nurse 3 days/week who helps her bathe and dress herself.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1500	77	128/80	18	97.0 F Temp	100%
1700	74	122/78	20	97.2 F Temp	100%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1500	***No nonverbal signs present.**	**N/A**	**N/A**	**N/A**	**N/A**
1700	***No nonverbal signs present.**	**N/A**	**N/A**	**N/A**	**N/A**

****Primary nurse said pt did not understand pain scale or Wong Baker faces scale.**

Nonverbal signs were charted as negative.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g **Location of IV: Left radial** **Date on IV: 2/18/20** **Patency of IV: Unknown** **Signs of erythema, drainage, etc.: N/A** **IV dressing assessment: Good, sterile tape strips and tegaderm over site.**	N/A. Pt had existing IV removed at the beginning of my shift, and there were no fluids hung yet or ordered when I left.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
360mL	**2 urine, 1 stool**

Nursing Care

Summary of Care (2 points)

Overview of care: Tried to provide emotional support for patient when she was sad and angry about having to stay over. I spoke facing the patient at all times due to her hearing difficulties, and I spoke slowly and clearly. I adjusted my language to include simple terms when I could tell she did not have a very large vocabulary.

Procedures/testing done: Labs, Urine Culture, CT scan

Complaints/Issues: N/A

Vital signs (stable/unstable): VS were stable during my shift with the patient.

Tolerating diet, activity, etc.: The patient was frustrated she was on a mechanical soft diet. She mentioned when they brought her tray she was "sick of mashed potatoes". She thought since she had held down one meal, she should be allowed to eat like she did prior to admission at home.

Physician notifications: N/A

Future plans for patient: The patient may need to consider a group home placement if she becomes more ill and her husband can no longer care for her. I did not meet her husband, so it is hard to gauge how competent he is in caring for her at home. She mentioned he usually drove her around but would be unable to pick her up from the hospital the following day due to his own health concerns. The patient has an in-home nurse 3 days a week who helps her bathe and dress herself. She mentioned her husband does the shopping and handles the money.

Discharge Planning (2 points):

Discharge location: Home or Group Home, depending on situation at discharge

Home health needs (if applicable): Husband will need educated on what signs to look for in terms of kidney failure, stroke, and heart disease as these are all increased risks for the patient.

Equipment needs (if applicable): The patient has a cane, walker, and grab bars at home. The physical therapist recommended she use the walker exclusively and stop using her cane.

Follow up plan: The patient will need to return for follow-up labs with her PCP.

Education needs: The patient will need to be educated on when to call PCP. She would likely do better with a pamphlet with pictures on it than a lot of text.

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

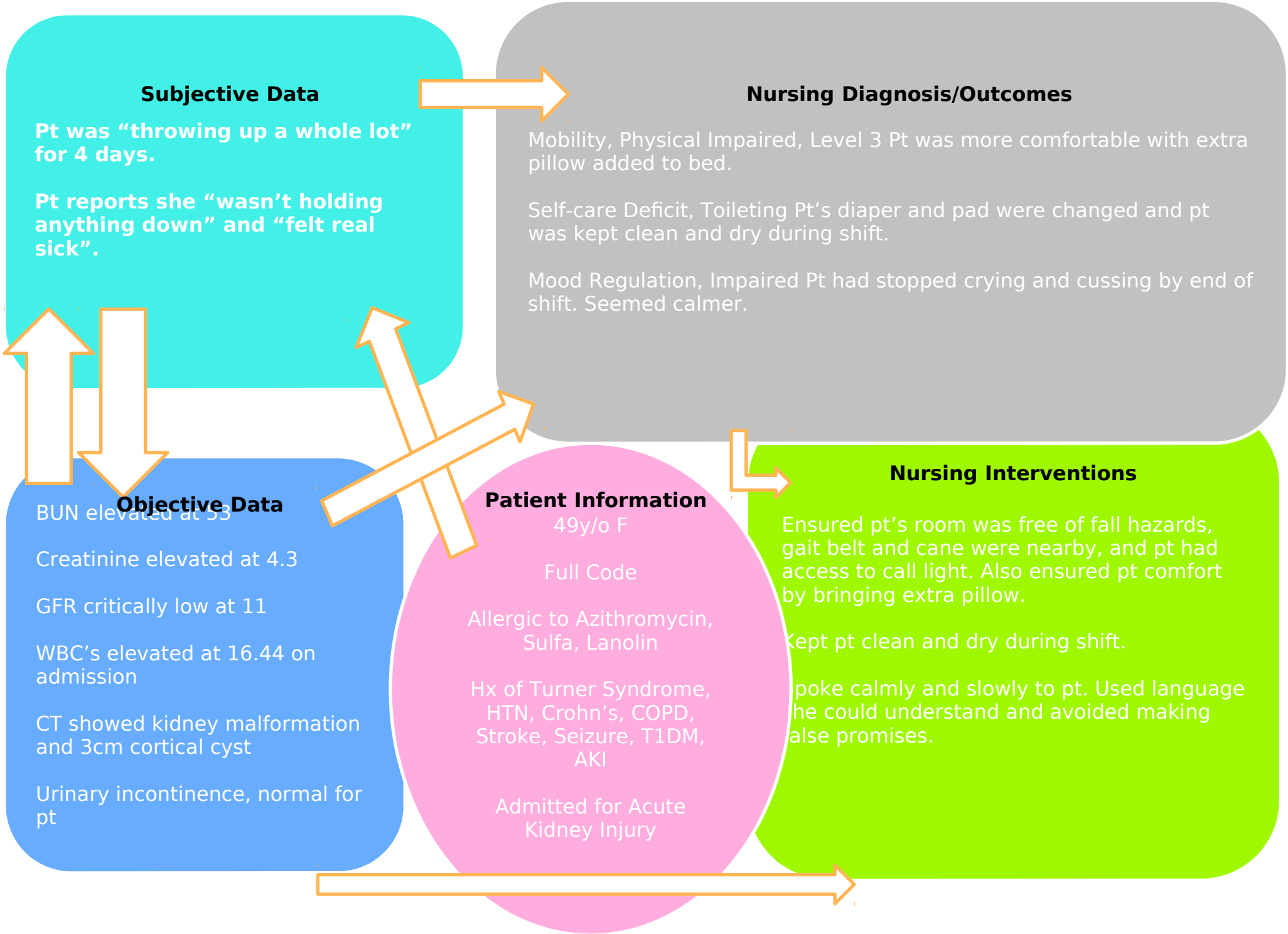
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Mobility: Physical, Impaired, Level 3 related to joint stiffness and contractures as evidenced by patient's inability to straighten arms, legs, or spine.	**Patient was unable to get out of bed without assistance. Once up, she was able to walk across the room with a cane. Physical therapist used a gait belt to help her along. She showed difficulty turning and inability to stand up straight.**	**1.Ensure that the patient's room is safe. This includes call light within reach, cane nearby, gait belt available for staff, and bed in low position.** **2. Assist pt to find comfortable position, including pillows under arms and legs when requested.**	**The patient appreciated being asked if she had her call light. She seemed unaware of the other room modifications, but staff appreciated the gait belt hung near the door and cane nearby.** **Patient seemed to appreciate extra pillow for arm that looked uncomfortable.**
2. Self-care deficit, Toileting related to inability to carry out proper toilet hygiene as evidenced by altered cognitive	**This was a concern as patient had both urinary and bowel incontinence. Keeping her clean and dry can protect skin integrity and health in the hospital and at**	**1. Keep adult diaper and pad under pt clean and dry. Check on diapers and pads whenever in the room, at least every hour. Change when needed.** **2. Ensure pt has proper support at home to care for total**	**Pad was checked at least every hour during my shift. Diaper was changed twice following bowel movements.** **Pt reports she has a husband who helps at home in addition to an in-home nurse 3 days a week who checks on her and helps her bathe and**

functioning and impaired mobility.	**home.**	**incontinence so she can be kept clean after discharge.**	**change clothes. I was unable to get an answer as to whether or not she was changed regularly on days her nurse was not at her home.**
3. Mood Regulation, Impaired due to chronic illness and anxiety as evidenced by inability to sleep and emotional tantrums.	**Pt takes zolpidem to help her sleep at night. She had a very flat affect, then became very emotional during my shift. Her outbursts included cuss words and crying.**	**1. Keep a calm tone of voice and speak directly to pt during shift. Use simple words and phrases the pt can understand to lessen anxiety from not knowing what is going on.** **2Avoid making promises to the pt. Pt believed based on conversation with provider, she was going home as long as she did not throw up her lunch. She was able to hold her lunch down but was then told she would have to stay due to bad lab results.**	**Pt seemed receptive to slow, calm speech,** **Pt was told her primary nurse would contact her physician to come talk to her about staying overnight at least an extra night. Pt stopped crying when the nurse explained to her that she would need to stay at least until her labs stabilized. She seemed calmer after being given more information.**

Other References (APA):

Wilkinson, J. M., & Barcus, L. (2017). ***Pearson nursing diagnosis handbook : NANDA-I diagnoses, NIC interventions, NOC outcomes*****. Pearson.**

C**oncept Map (20 Points):**


Subjective Data
Pt was “throwing up a whole lot” for 4 days.
Pt reports she “wasn’t holding anything down” and “felt real sick”.
Nursing Diagnosis/Outcomes
Mobility, Physical Impaired, Level 3 Pt was more comfortable with extra pillow added to bed.
Self-care Deficit, Toileting Pt’s diaper and pad were changed and pt was kept clean and dry during shift.
Mood Regulation, Impaired Pt had stopped crying and cussing by end of shift. Seemed calmer.
Objective Data
BUN elevated at 53
Creatinine elevated at 4.3
GFR critically low at 11
WBC’s elevated at 16.44 on admission
CT showed kidney malformation and 3cm cortical cyst
Urinary incontinence, normal for pt
Patient Information
49y/o F
Full Code
Allergic to Azithromycin, Sulfa, Lanolin
Hx of Turner Syndrome, HTN, Crohn’s, COPD, Stroke, Seizure, T1DM, AKI
Admitted for Acute Kidney Injury
Nursing Interventions
Ensured pt’s room was free of fall hazards, gait belt and cane were nearby, and pt had access to call light. Also ensured pt comfort by bringing extra pillow.
Kept pt clean and dry during shift.
Spoke calmly and slowly to pt. Used language she could understand and avoided making false promises.

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