

Running head: N311 Care Plan #1

N311 Care Plan #1  
Lakeview College of Nursing  
McKayla Norton

### Demographics (5 points)

<b>Date of Admission</b> 02/05/2020	<b>Patient Initials</b> MB	<b>Age</b> 05/18/1933 (86 y/o)	<b>Gender</b> Female
<b>Race/Ethnicity</b> White/Caucasian	<b>Occupation</b> Retired	<b>Marital Status</b> Widowed	<b>Allergies</b> NKA (no known allergies)
<b>Code Status</b> DNR	<b>Height</b> 5'2"	<b>Weight</b> 128 lbs	

### Medical History (5 Points)

**Past Medical History:** A-Fib, Leukocytosis, Sepsis, Acute diastolic CHF

**Past Surgical History:** Right hip surgery/replacement

**Family History:** Mother: high blood pressure, Father: high blood pressure

**Social History (tobacco/alcohol/drugs):** Pt. reports no use of tobacco or recreational drug use. Pt. states that she drinks a glass of wine at night.

### Admission Assessment

**Chief Complaint (2 points):** Sepsis

**History of present Illness (10 points):** **Onset:** Beginning of February. **Location:** in the blood. **Duration:** Pain was intermittent. Pain has gotten better with use of IV fluids and antibiotics. **Characteristics:** When sepsis had set in, the pt states she experienced some

sharp pains in her abdomen. Pt states there is no pain today. **Associated Manifestations:** Pt had experienced some diarrhea. **Relieving Factors:** None stated. **Therapeutic Treatments:** Pt was transported to Carle Hospital in Urbana where she was placed on antibiotics to try and fight sepsis.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (3 points):** Initial findings indicated pt had sepsis on arrival to the hospital.

**Secondary Diagnosis (if applicable):** Lab results indicated pt had “probable gram-negative Pneumonia”.

**Pathophysiology of the Disease, APA format (20 points):** Sepsis is a bodywide infection that overwhelms the immune system and causes severe multiorgan compromise. Bacterial sepsis is an active multiplication of bacteria in the bloodstream that can result in an overwhelming infection. Persons most affected by sepsis are older adults and infants. Pneumonia can often lead to sepsis (Capriotti, 2016). Both of which were present in the pt. “...An infectious insult triggers a localized inflammatory reaction that then spills over to cause systemic symptoms of fever or hypothermia, tachycardia, tachypnea, and either leukocytosis or leukopenia (Jacobi)”. Pt has a history of leukocytosis as stated above in past medical history.

### **Pathophysiology References (2) (APA):**

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

Jacobi, J. (2AD). *Pathophysiology of sepsis*. <https://www.ncbi.nlm.nih.gov/pubmed/11885412>

**Laboratory Data (20 points)**

**\*If laboratory data is unavailable, values will be assigned by the clinical instructor\***

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

<b>Lab</b>	<b>Normal Range</b>	<b>Admission Value</b>	<b>Today's Value</b>	<b>Reason for Abnormal Value</b>
<b>RBC</b>	<b>3.90-4.98</b>	<b>3.91</b>	<b>* Unable to obtain</b>	
<b>Hgb</b>	<b>12.0-15.5</b>	<b>11.4</b>	<b>*</b>	<b>Hgb is lowered because of a deficient number of RBC's</b>
<b>Hct</b>	<b>35-45%</b>	<b>36.35</b>	<b>*</b>	
<b>Platelets</b>	<b>140-400</b>	<b>196</b>	<b>*</b>	
<b>WBC</b>	<b>4.0-9.0</b>	<b>10.67</b>	<b>*</b>	<b>High WBC count can indicate there is an underlying problem such as an infection.</b>
<b>Neutrophils</b>	<b>40-70%</b>	<b>60.4%</b>	<b>*</b>	

<b>Lymphocytes</b>	<b>10-20%</b>	<b>2.56%</b>	<b>*</b>	<b>Lymphocytes can be low due to an infection.</b>
<b>Monocytes</b>	<b>5%</b>	<b>4.3%</b>	<b>*</b>	
<b>Eosinophils</b>				
<b>Bands</b>				

<b>Lab</b>	<b>Normal Range</b>	<b>Admission Value</b>	<b>Today's Value</b>	<b>Reason For Abnormal</b>
<b>Na-</b>	<b>135-145</b>	<b>142</b>	<b>* Unable to obtain</b>	
<b>K+</b>	<b>3.5-5.1</b>	<b>3.4</b>	<b>*</b>	
<b>Cl-</b>	<b>98-107</b>	<b>106</b>	<b>*</b>	
<b>CO2</b>	<b>22-29</b>	<b>31.2</b>	<b>*</b>	<b>CO2 can be high due to hypoventilation or lung disease.</b>
<b>Glucose</b>	<b>70-99</b>	<b>95</b>	<b>*</b>	
<b>BUN</b>	<b>6-20</b>	<b>29</b>	<b>*</b>	<b>BUN levels could be elevated due to a disease that is present.</b>

<b>Creatinine</b>	<b>0.50-1.00</b>	<b>0.63</b>	<b>*</b>	
<b>Albumin</b>		<b>n/a</b>		
<b>Calcium</b>	<b>8.4-10.5</b>	<b>8.7</b>	<b>*</b>	
<b>Mag</b>		<b>n/a</b>		
<b>Phosphate</b>		<b>n/a</b>		
<b>Bilirubin</b>		<b>n/a</b>		
<b>Alk Phos</b>		<b>n/a</b>		

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

<b>Lab Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>Color &amp; Clarity</b>				<b>**No cultures completed for this pt.**</b>
<b>pH</b>				
<b>Specific Gravity</b>				
<b>Glucose</b>				
<b>Protein</b>				
<b>Ketones</b>				
<b>WBC</b>				

RBC				
Leukoesterase				

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

APA format.

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	Ph: 5.0-7.0	Ph: 5.0		
Blood Culture		n/a		
Sputum Culture		n/a		
Stool Culture		18.70		Normal ranges were not given, but admission value can indicate there is an infection in the lower digestive tract. More test could be done to determine if there is bacteria that is pathogenic or if it is just normal flora present.

Lab Correlations Reference (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

### Diagnostic Imaging

#### All Other Diagnostic Tests (10 points):

Pt. did not receive any other diagnostic tests.

#### Current Medications (10 points, 2 points per completed med)

<b>Brand/Generic</b>	<b>Cymbalta/ Duloxetine</b>	<b>Ativan/ Lorazepam</b>	<b>Lasix/ Furosemide</b>	<b>n/a</b>	<b>n/a</b>
<b>Dose</b>	<b>90mg</b>	<b>0.5mg</b>	<b>20mg</b>	<b>n/a</b>	<b>n/a</b>
<b>Frequency</b>	<b>HS</b>	<b>qd</b>	<b>qd</b>	<b>n/a</b>	<b>n/a</b>
<b>Route</b>	<b>PO</b>	<b>PO</b>	<b>PO</b>	<b>n/a</b>	<b>n/a</b>
<b>Classification</b>	<b>Antidepressant, neuropathic and musculoskeletal pain reliever</b>	<b>Anxiolytic</b>	<b>Antihypertensive/ diuretic</b>	<b>n/a</b>	<b>n/a</b>

<b>Mechanism of Action</b>	<b>Inhibits dopamine, neuronal serotonin, and norepinephrine reuptake to potentiate noradrenergic and serotonergic activity in the CNS.</b>	<b>May potentiate the effects of GABA and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in cortical and limbic areas of CNS.</b>	<b>Inhibits sodium and water reabsorption in the Loop of Henle and increases urine formation.</b>	<b>n/a</b>	<b>n/a</b>
<b>Reason Client Taking</b>	<b>Pt is taking this because for an antidepressant.</b>	<b>Pt. is taking this because of anxiety.</b>	<b>Pt. is taking this to reduce blood pressure.</b>	<b>n/a</b>	<b>n/a</b>

<b>Contraindications (2)</b>	<b>Chronic liver disease including cirrhosis, hypersensitivity to duloxetine or its components severe renal impairment.</b>	<b>Acute angle-closure glaucoma, hypersensitivity to lorazepam, psychosis.</b>	<b>Anuria unresponsive to furosemide, hypersensitivity to furosemide, sulfonamides and their components.</b>	<b>n/a</b>	<b>n/a</b>
<b>Side Effects/Adverse Reactions (2)</b>	<b>Aggression, agitation, anger, anxiety.</b>	<b>Amnesia, confusion, headache, fatigue.</b>	<b>Dizziness, blurred vision.</b>	<b>n/a</b>	<b>n/a</b>

**\*5 different medications must be completed\***

**Medications Reference (APA):**

Jones & Bartless Learning. (2020). *2020 Nurse's drug handbook* (19<sup>th</sup> ed.).

### Assessment

<p><b>GENERAL: Pt appears pleasant.</b> <b>Alertness: A&amp;O x4</b> <b>Orientation: Oriented to person, time, place, and current events.</b> <b>Distress: No acute distress.</b> <b>Overall appearance: Well groomed.</b></p>	
<p><b>INTEGUMENTARY:</b> <b>Skin color: White, normal for race.</b> <b>Character: Appears hydrated, clean.</b> <b>Temperature: Warm.</b> <b>Turgor: Rapid recoil.</b> <b>Rashes: None noted.</b> <b>Bruises: None noted.</b> <b>Wounds: None noted.</b> <b>Braden Score: 18</b> <b>Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b> <b>Type:</b></p>	<p><b>Pt. received an 18 Braden Score due to needing assistance with a walker and needing assistance to reposition. Pt. spends most of the day sitting in a chair or lying in bed. Pt. also stated she gets weak if staff does not ambulate her enough.</b></p>

**HEENT:**

**Head/Neck:** Head and Neck symmetrical. No lesions or rashes noted.

**Ears:** Auricle was pink, moist, with no rashes or lesions noted.

**Eyes:** Pt uses glasses to help with near vision. Upon inspection, sclera was white, cornea was clear, conjunctiva was pink with no lesions or discharge noted.

**Nose:** Septum midline. No drainage or bleeding noted.

**Teeth:** Pt has natural teeth on top and on bottom.

**CARDIOVASCULAR:**

**Heart sounds:** S1, S2 Clear with no gallops, murmurs, or rubs.

**Cardiac rhythm (if applicable):**

**Peripheral Pulses:** 81bpm

**Capillary refill:** 4 seconds

**Neck Vein Distention:** Y  N  **Edema** Y  N

**Location of Edema:** N/A

<p><b>RESPIRATORY:</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds:</b> Nonlabored breathing. Crackles noted on the Right Lobe.</p>	<p>Pt. has a history of Pneumonia which would explain the crackles noted.</p>
<p><b>GASTROINTESTINAL:</b>  <b>Diet at home:</b> Regular Diet.  <b>Current Diet:</b> Regular  <b>Height:</b>  <b>Weight:</b>  <b>Auscultation Bowel sounds:</b> Present in all four quadrants post-prandial.  <b>Last BM:</b> Yesterday morning.  <b>Palpation:</b> No pain or masses noted on palpation.  <b>Inspection:</b> No lesions or rashes noted.  <b>Distention:</b> No distention.  <b>Incisions:</b> No incisions noted.  <b>Scars:</b> No scars noted on abdomen.  <b>Drains:</b> No drains present.  <b>Wounds:</b> No wounds present on abdomen.  <b>Ostomy:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Nasogastric:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Size:</b>  <b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b> N/A</p>	<p>.</p>

**GENITOURINARY:**

**Color: Clear- Light Yellow**

**Character: Pt reports no cloudiness or sediment in urine.**

**Quantity of urine: Pt voided one time prior to my arrival.**

**She did not have to void while with me.**

**Pain with urination: Y  N**

**Dialysis: Y  N**

**Inspection of genitals: N/A**

**Catheter: Y  N**

**Type:**

**Size:**

**MUSCULOSKELETAL:**

**Neurovascular status: Pt has no neurovascular deficits noted.**

**ROM: ROM is good. Pt can get up and out of chair/wheelchair unassisted, but chooses to use a walker, due to feeling weak after sitting or lying down for some time.**

**Supportive devices: Wheelchair and walker present just for stability. Pt. states she uses walker more than wheelchair.**

**Strength: Good, equal bilaterally.**

**ADL Assistance: Y  N**

**Fall Risk: Y  N**

**Fall Score: 25 (Low in current environment, not absent due to recent injury)**

**Activity/Mobility Status:**

**Independent (up ad lib)**

**Needs assistance with equipment X**

**Needs support to stand and walk**

Pt. scores as a low fall risk because of use of an assistive device and for experiencing some generalized weakness in the lower extremities. Pt. should be considered a Stand By Assist to make sure she does not fall.

<p><b>NEUROLOGICAL:</b>  <b>MAEW:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/>  <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b> Oriented to person, time, place, and current events.  <b>Mental Status:</b> Good.  <b>Speech:</b> Good.  <b>Sensory:</b> Glasses present and hearing aids in both ears present.  <b>LOC:</b> Alert.</p>	<p>Pt. has some trouble moving upper extremities due to shaking. Although her shakiness was present, it did not appear that she had any weakness strength wise when assessed.</p>
<p><b>PSYCHOSOCIAL/CULTURAL:</b>  <b>Coping method(s):</b> Pt. states that she uses the help of family to cope.  <b>Developmental level:</b> No deficits noted.  <b>Religion &amp; what it means to pt.:</b> Pt. stated that she grew up very religious but has strayed away from her beliefs and no longer attends church or reads the bible.  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b> Pt. states she lives with daughter, and it is helpful for her having her daughter there for support or if any assistance is needed doing ADLs.</p>	<p>.</p>

**Physical Exam (18 points)**

**Vital Signs, 1 set (5 points)**

<b>Time</b>	<b>Pulse</b>	<b>B/P</b>	<b>Resp Rate</b>	<b>Temp</b>	<b>Oxygen</b>
<b>1200</b>	<b>81</b>	<b>142/86</b>	<b>16</b>	<b>97.1 F</b>	<b>96%</b>

**Pain Assessment, 1 set (5 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
<b>1200</b>	<b>0/10</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>

**Intake and Output (2 points)**

<b>Intake (in mL)</b>	<b>Output (in mL)</b>
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<p><b>240mL Orange Juice. Pt. had oatmeal and a banana. Pt. ate about 75% of her meal—not able to finish all of the oatmeal. When asked why she hadn’t ate it all, pt stated she was full.</b></p>	<p><b>Pt. voided 1x during my shift—unable to measure it because pt. went to the bathroom on her own, and no hat was present to measure urine.</b></p>
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**Nursing Diagnosis (15 points)**  
**\*Must be NANDA approved nursing diagnosis\***

<p><b>Nursing Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> </ul>	<p><b>Rational</b></p> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<p><b>Intervention (2 per dx)</b></p>	<p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• How did the patient/family respond to the nurse’s actions?</li> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul>
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<p><b>1. Generalized weakness in extremities related to prolonged laying or sitting as evidence by pt using a walker or wheelchair to ambulate.</b></p>	<p><b>Pt. described weakness during hospital stay and some at the ECF. Although able to move with only a SBA, we want to strengthen the pts. ability to ambulate without feeling the need to sit down and rest as often as she is and to be able to walk longer distances.</b></p>	<p><b>1. Pt will participate in ROM exercises during physical therapy (that was ordered by the doctor) and on her own. Exercises will be approved by a physical therapist after assessing pt and figuring out the best course of action to strengthen all extremities.</b> <b>2. Pt should have walker and wheelchair near by at all times in case of emergency or episodes of weakness occur.</b></p>	<p><b>Pt. agreed that ROM and physical therapy has improved her strength. Pt feels safer with a walker or wheelchair near by, but also is gaining confidence to walk without it. Goals were met.</b></p>
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<p><b>2. Pt. states she has had some diarrhea while in the hospital and at the ECF related to unknown as evidence by watery stool witness after pt uses the restroom.</b></p>	<p><b>Although pt did not have any formal complaint, diarrhea was mentioned during her assessment with me. This caught my attention because it is likely the pt may have C.diff after experiencing sepsis due to inflammation in the gut or colon.</b></p>	<p><b>1. If pt is experiencing diarrhea, that means the pt is losing fluids and can become dehydrated. A plan to measure strict I/Os should be implemented to make sure pt is getting adequate fluid intake.</b></p> <p><b>2. Weight should be measured daily. This is also a useful indicator of fluid balance. If pt is losing weight, this is an indicator that fluid replacement is not happening and adjustments need to be made.</b></p>	<p><b>Pt and staff agreed that measuring strict I/Os and daily weight would be beneficial to learn if fluid output is greater than intake. A C.diff sample was ordered to be collected to try and determine if this is why the pt was experiencing watery stools. Will follow up with pt's nurse Tuesday to see what the results were. Goal is in progress.</b></p>
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**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*.

**Concept Map (20 Points):**

### Subjective Data

Pt. reports:  
"I grew weak at the hospital because they did not walk me enough."  
  
"I have been having diarrhea that is very watery."

### Patient Information

86 y.o female with a history of A.Fib, Leukocytosis, sepsis, acute diastolic CHF and RIGHT hip surgery/replacement. Admitted for Sepsis and probable pneumonia. Pt. has no history of drug or alcohol abuse.

### Nursing Diagnosis/Outcomes

**Generalized weakness to extremities: Pt to do ROM and attend physical therapy (as ordered by the doctor) and keep assistive devices within reach. Pt has stated that ROM has helped her become stronger and able to move extremities better.**

**Diarrhea: Measure strict I/Os and weigh pt daily.**  
**Documentation has shown that pt I/Os are about equal. Goal is still in progress to**

### Objective Data

Lymphocytes were low due to an infection. Hgb was low due to a deficient number of RBCs. WBCs were elevated due to an underlying problem. BUN and CO2 were elevated because a disease was present.

### Nursing Interventions

Keep walker and wheelchair within arms reach.  
Practice ROM to help become more stable and strong.

Measure pt's I/Os and weigh daily to keep track of fluid balance.



