N311 Care Plan #1

Lakeview College of Nursing

Name: Olivia Behning

3/3/2020

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
January 2020 (no exact date listed)	OC	93	female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/ nonhispanic	none	Widowed	Fentanyl, hydrocodone, lisinopril
Code Status	**Height**	**Weight**	
Full code	5'2"	139lbs (admission weight: 152 lbs)	

Medical History (5 Points)

Past Medical History: complete heart block, CAD, DJD of shoulder, exudative macular degeneration, GERD, hyperpipidemia, HTN, mild aortic rgurgutation, multiple thyroid nodules, osteoporosis (unspecified), paroxysmal atrial fibrillation(CMS-HCC), peronal history of colonic polyps, primary open angle, glaucoma both eyes at a moderate stage, primary osteoarthritis of Right knee, rotator cuff tea, arthopathy of both shoulders, S/P implantation of a Boston Scientific CRT-D system, S/P implantation of dual chamber

Past Surgical History: Right Hip surgery no other surgeries

Family History: husband deceased, hypertension on maternal side, no paternal information.

Social History (tobacco/alcohol/drugs): former smoker quit in 2008, no recreational drug use, no alcohol use for over 5 years

Admission Assessment

Chief Complaint (2 points): weakness, right lower quadrant pain (hernia).

History of present Illness (10 points): Patient presents to hospital ED January 13 following a fall at home. The fall was unintentional, the patient was experiencing right lower quadrant abdomen pain, leaned over in pain, lost her balance and was unable to catch herself. The patient

received right hip surgery at the hospital following the fall and is receiving therapy at CLV to gain movement back onto right side post-op. Patient will discharge home and will receive care for right side lower quadrant pain and will have hernia surgery once fully recovered from hip fracture. Patients wound upon arrival at CLV was well approximated and healing well. Patient is expected to have a return to baseline mobility (cane/walker).

Primary Diagnosis

Primary Diagnosis on Admission (3 points):closed intertrochanteric fracture of right hip

Secondary Diagnosis (if applicable): incarcerated hernia

Pathophysiology of the Disease, APA format (20 points): A hip fracture is most simply a break in the proximal end of the femur (Anderson, 2013). This is the top portion of the femur. This can happen at any age. Hip fractures are commonly caused by falls and bone loss that increases with age. People over the age of 65 are at a greater risk because of unsteady gait, balance, dementia, frailty, and bone loss (Anderson, 2013). The Intertrochanteric (IT) area is a specific upper part of the femur. This is where the greater and lesser trochanters and the neck of the femur attach to the hip abductor and primary hip flexor. This type of fracture is very common in elderly females with a history of bone disease and falls. They are commonly diagnosed with plain radiographs also including a traction view. Surgical fixation is the standard treatment plan. Patients are commonly encouraged to get up a moving around with aid as soon as possible after surgery. This prevents complications, a rehabilitation facility can be very helpful to help gain movement and strength back to the area. In the case of my patient she falls into the high-risk category. Being over the age of 65, having a history of osteoporosis, and having hernia pain on top of that makes her a high falls risk.

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Pathophysiology References (2) (APA)

Ahn, J., & Bernstein, J. (2010, May 3). Fractures in brief: intertrochanteric hip fractures. March 9, 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2853662/

Anderson, Julie (2013, November 27). Hip fracture. March 9, 2020. https://www.britannica.com/science/hip-fracture

Laboratory Data (20 points)
If laboratory data is unavailable, values will be assigned by the clinical instructor
ALL LABS ARE FROM HOSPITAL
ALL PINK HIGHLIGHTS= HIGHER THAN NORMAL RANGE
ALL GREEN HIGHLGIHTS= LOWER THAN NORMAL RANGE
ALL BLUE HIGHLIGHTS= SLIGHTY OUT OF RANGE BUT NOT ABNORMAL
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	3.90-4.98	3.46	3.46	This is likely due to the recent surgery and the body is still replacing and rebuilding the RBC supply.
Hgb	12.0-15.5	9.6	9.6	This is likely due to the recent surgery and the body is still replacing and rebuilding the RBC supply.
Hct	35-45	30.8	30.8	This is likely due to the recent surgery and the body is still replacing and rebuilding the RBC supply.
Platelets	140-400	AGREE	AGREE	
WBC	4.0-9.0	15.99	15.99	This is likely due to the recent surgery, and all of the inflammatory responses in play here for the slight increase in WBC.
Neutrophils	40-70	NA	NA	
Lymphocytes	10-20	17.0	17.0	
Monocytes	5	10.0	10.0	This is likely due to the recent

				surgery, and all of the inflammatory responses in play here for the slight increase in WBC.
Eosinophils	**1-4**	**1.0**	**1.0**	
Bands	**??**	**NA**	**NA**	

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**	**140**	
K+	**3.5-5.1**	**3.6**	**3.6**	
Cl-	**98—107**	**106**	**106**	
CO2	**22-29**	**27.4**	**27.4**	
Glucose	**70-99**	**103**	**103**	**Only slightly high probably from a recent meal.**
BUN	**6-20**	**13**	**13**	
Creatinine	**0.50-1.00**	**0.68**	**0.68**	
Albumin	**3.5-5.2**	**3.5**	**3.5**	
Calcium	**8.4-10.5**	**9.8**	**9.8**	
Mag	**1.7-3.4**	**NA**	**NA**	
Phosphate	**2.5-4.5**	**NA**	**NA**	
Bilirubin	**0.0-1.2**	**NA**	**NA**	
Alk Phos	**??**	**NA**	**NA**	

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				**no cultures completed for this patient**
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				**no cultures completed for this patient**
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA): NA

Diagnostic Imaging

All Other Diagnostic Tests (10 points): NA

Current Medications (10 points, 2 points per completed med)
5 different medications must be completed

Medications (5 required)

Brand/ Generic	**Aspirin, acetylsalicylic acid (ASA)**	**Heparin**	**Losartin postassium/ Cozaar**	**Omeprazole/ Prilosec**	**Metoprolol succinate ER/ Toprol XL**
Dose	**81 mg**	**5,000 Units**	**25 mg**	**20 mg**	**50 mg**
Frequency	**daily**	**Q8**	**daily**	**daily**	**daily**
Route	**PO**	**SubQ**	**PO**	**PO**	**PO**
Classification	**NSAID, anti-inflammatory, antipyretic**	**anticoagulant**	**antihypertensive**	**antiulcer**	**Antianginal/ antihypertensive**
Mechanism of Action	**Blocks activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis. Prostaglandins are important for inflammato**	**Binds with antithrombin III, enhancing the inactivation of thrombin, extends clotting time**	**Blocks binding of angiotensin II to receptor sites in tissues. The inhibiting effects of angiotensin II lowers blood pressure**	**Interferes with gastric acid secretion by inhibiting the proton pump which blocks the exchange of Hydrogen and Potassium keeping**	**Inhibits stimulation of beta receptor sites, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand. Which helps**

	ry response			**additional HCl from forming**	**relieve angina and decrease blood pressure**
Reason Client Taking	**Pain, and arthritis**	**Immobility post-op**	**HTN**	**HX of GERD**	**HTN**
Contraindications (2)	**Active bleeding or coagulation disorders, current or recent GI bleed**	**History of thrombocytopenia, inability to monitor coagulation parameters**	**GFR less than 60 ml/min, concurrent aliskiren therapy**	**Concurrent therapy with rilpivirine containing products, hypersensitivity to the drug**	**Acute heart failure, cardiogenic shock, AV block**
Side Effects/ Adverse Reactions (2)	**CNS depression, prolonged bleeding time**	**Hemorrhage, dyspnea, anaphylaxis**	**Hypotension, angioedema, thrombocytopenia**	**Hypoglycemia, abdominal pain, neutropenia**	**CVA, arrythmias**

Medications Reference (APA):

Jones and Bartlett Learning. 2020 Nurse's Drug Handbook. 19th ed., Jones & Bartlett Learning, 2020.

Nurses are aware on contraindication between Aspirin and Heparin and are closely monitoring the effects to ensure safety of the patient

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Alert and oriented x4** **Not distressed** **Well kept, clean, and appropriately dressed**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**-Skin is pink, warm and dry, no pallor present** **-Temperature is 98.2 F** **- normal turgor 2+** **- no rashes, no bruises** **-had a small stage 1 sore on bottom and received treatment and dressings, the sore has since resolved and is no longer present** **- Surgical wound is well approximated, lesion is closed, minimal scarring present** **- Braden:22, not at risk** **- no drains present**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**-no limitations in head and neck mobility, head and neck are symmetrical** **- no hearing aids or hearing impairments, free from discharge** **- symmetrical EOM, wears glasses, and has moderate glaucoma in both eyes, uses a magnifying glass with glasses to read** **-nose symmetry no deviation** **-dentures are cleaned and properly placed** .
CARDIOVASCULAR: **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 present and normal, no murmurs, gallops, or rubs in S3 and S4. Capillary refill was less than three seconds on fingers and toes. Peripheral pulses 2+, no neck vein distention, no sign of edema, blood pressure:143/68(right arm), pulse: 61**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Respirations are 18, and oxygen saturation is at 95% on room air. No accessory muscle use, breath sounds are even with unlabored, symmetrical, no wheezing or crackles present.**
GASTROINTESTINAL: **Diet at home:** **Current Diet**	**-Regular diet at home** **-regular diet at CLV** **-5'2"**

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:**	**-139lbs** **- bowel sounds are normoactive in all four quadrants** **-hernia present in right lower quadrant painful upon palpation** **-no distention or incisions** **-last BM: 3/2/2020 in the evening** **-no ostomy or tubes**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**-yellow, not cloudy but clear, no pain with urination, no measurable output, no dialysis, genitalia is normal in color, temp, no abnormal odors.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: moderate** **Activity/Mobility Status:** **Independent (up ad lib) 1Assist w/GB+ walker☐** **Needs assistance with equipment- limited assitance☐** **Needs support to stand and walk-need help upon standing but walks with steady gait on own☐**	**-Normal ROM** **-Strength in both upper and lower extremities** **-Strength in both arms, legs weaker (right side limited pain with therapy)** **-Up with gaitbelt and walker, 1-person assist to stand and walk** **-Moderate Fall risk due to previous fall and mobility impairment**
NEUROLOGICAL: **MAEW: Y ☒ N☐**	**-Moves all extremities well, right leg slower to lift from sitting position**

PERLA: Y ☒ N☐ **Strength Equal: Y ☐ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**-Perla yes** **- strength equal in arms, right leg weaker than left** **-Cognitive of space, time, and location,** **-Articulative speech** **-Mature and cognitive** **-Alert** **-No major focal neurological deficits**
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Copes by reading and talking with family** **Mature** **Lutheran goes to church regularly and prays** **Adult children visit regularly, husband is deceased**

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	**61 BPM**	**143/68**	**18**	**98.2 F**	**95%**

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1147	**Numeric, 0-10**	**NA, right lower quadrant of abdomen with movement or palpation**	**0/10, 3/10 with movement**	**Tender, throbbing when pain presents**	**Frequent position changes, PRN pain medication, distractions (reading, tv, activities)**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
-no measurable fluid intake, 100% of breakfast	**Have urinated 2 times unmeasured output**

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

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. **Acute pain related to incarcerated hernia and post-op hip surgery as evidenced by pain with mobility**	**I chose this because the patient was very guarded upon inspection of the hernia and being post-op from hip surgery there is still some soreness. Although she was not currently experiencing pain. She had been and would be upon movement.**	1. Use distraction as an alternative therapy (reading, TV, activities) to keep pain level below the patients tolerable level of pain (stated at a 3/10) 2. Help the patient Q2 or as frequent as needed to change positions to ensure	**Intervention #1 GOAL MET, the patient was reading a doing activities most of the day and was consistently keeping her pain level below a 3/10** **Intervention #2 GOAL MET, although the patient can make small shifts on her own I was able to assist in placing a pillow behind her back and under her right leg while sitting to relieve the stress on that side of her body (right hip fracture and right side hernia)** **Intervention #3 NOT MET, patient did not express the need for pain relief medications at this**

		comfort and relieve the pain in that specific area 3. **I would also administer any PRN pain medications, reminding the patient of the option when passing daily meds and when they can have more as needed.**	**time pain was 0/10 after therapy we used alternative therapy method #1 and #2 to relieve mild aching. Will reevaluate Q4 to ensure patient receives adequate pain releief**
2. **Impaired physical mobility related to hip fracture as evidenced by difficulty walking on own**	**Patient is doing well will therapy although is still having trouble walking on own. Uses walker and assistance from CNA or nurse to get up. So she still has some impaired mobility**	**1. Perform range of motion exercises to exercise joints** **2.Place items within reach of the patient to help promote independence and ensure safety**	**#1** **GOAL MET, patient did some ROM exercises in ankles, wrists, arms, and knees** **#2** **GOAL MET** **All items are on night stand and bed side table are within reach at all times, including call light.**

Other References (APA):

Concept Map (20 Point

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Subjective Data

Pt states: " I have trouble walking to the bathroom and with therapy because my side starts to hurt really bad, and I really don't want to fall again. It helps when I sit in the chair with pillows to prop me up and lean me off of the right side where my hernia and hip repair is."

Nursing Diagnosis/Outcomes

Acute pain related to incarcerated hernia and post-op hip surgery as evidenced by pain with mobility
Goal met- patient was distracted and not in pain
Goal met- nurse repositioned patient using pillows
Goal not met- pain meds not given, but patient was educated on PRN meds available, and nurse offers reminders/ pain assessment throughout the day
Impaired physical mobility related to hip fracture as evidenced by difficulty walking on own
Goal met- patient performed ROM exercises
Goal met- personal belongings within reach

Objective Data

Chief complaint is: weakness, and Right lower quadrant abdominal pain
Vital signs:
BP- 143/68 (right arm)
RR-18
P-61 BPM
T- 98.2 F
O2%- 95 (room air)

Patient Information

Patient is at CLV rehab unit receiving therapy after a fall resulting in a fractured hip and surgery. Patient also has a hernia in right lower quadrant and is going to seek repair after rehabilitation.

Nursing Interventions

Use distraction as an alternative therapy (reading, TV, activities) to keep pain level below the patients tolerable level of pain (stated at a 3/10
Help the patient Q2 or as frequent as needed to change positions to ensure comfort and relieve the pain in that specific area
I would also administer any PRN pain medications, reminding the patient of the option when passing daily meds and when they can have more as needed.
Perform range of motion exercises to exercise joints
2.Place items within reach of the patient to help promote independence and ensure safety

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