

N431 Care Plan #1

Lakeview College of Nursing

Marianne Florido

**Demographics (3 points)**

<b>Date of Admission</b> 6/23/2020	<b>Patient Initials</b> HL	<b>Age</b> 90	<b>Gender Female</b> F
<b>Race/Ethnicity</b> African American	<b>Occupation</b> Retired	<b>Marital Status-widow</b> widow	<b>Allergies</b> Aspirin
<b>CodeStatus</b> Full	<b>Height</b> 5'5"	<b>Weight</b> 74.4	

**Medical History (5 Points)**

**Past Medical History: Arthritis, benign essential hypertension, GERD, Glaucoma,**

**Hyperlipidemia, Hypertension, Hypothyroidism**

**Past Surgical History: Hysterectomy, Cholecystectomy**

**Family History: cancer her father**

**Social History (tobacco/alcohol/drugs):Patient has not done drugs and only has drank occasionally in the past.**

**Assistive Devices: Walker/Lift chair at home/Shower chair at home**

**Living Situation: Patient lives at home with her grandson.**

**Education Level: High School**

**Admission Assessment**

**Chief Complaint (2 points):Patient fell at home. (worsening Dyspnea & fluid overload-Hypoxia with CHF.**

**History of present Illness (10 points):: 90-year-old patient had a few falls over the past few months including this fall she is being seen for today. Patient has multiple medical problems including heart failure, hypertension, osteoporosis, and severe aortic stenosis.**

**Family reported she fell getting out of chair. Patient is alert and orientated times 3 and cooperative currently. Patient did not lose consciousness and reports no symptoms**

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**associated with dizziness, light headedness, headache, back pain—patient does report more shortness of breath.**

### **Primary Diagnosis**

**Primary Diagnosis on Admission (2 points): Hypoxia with exertion, Acute on set of chronic systolic congestive heart failure**

**Secondary Diagnosis (if applicable): Secondary Hypertension**

**Pathophysiology of the Disease, APA format (20 points):** Hypoxia can happen with congestive heart failure patients because the heart no longer has enough force to carry out the requirements needed to meet the supply and demands of the body. Pulmonary edema can happen from hydrostatic pressure in the lungs. The fluid in the body can override the system creating a fluid overload. Fluid in the air sacs of the lungs prevents contact exchange between the blood and the air a patient breathes. Hypertension happens due to the increased workload of the heart. This situation can be deadly causing death of cells and hypoxia or failure of the heart. Fluid will continue to pool all over the body and eventually death occurs. Falls can result to the body's inability to keep up with the supply and demand needed for function.

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

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

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	3.80	3.84	3.46	Red blood cells can be low due to anemia, dehydration or age-related problems—resulting in hypoxia (Capriotti & Frizzell, 2016).
Hgb	13.0-16.5	11.5	10.6	Hemoglobin can be low as a result of chronic disease, immune disorders, or cancer-NSAID use, aging (osteoporosis) (Capriotti & Frizzell, 2016).
Hct	36.0-47.0	36.3	32.4	Hematocrit levels can be low due to the lack of mobility and low vitamin D levels and chronic disease (Capriotti & Frizzell, 2016).
Platelets	140-440	195	172	Decreased sue to chronic CHF (less red blood cell production due to age and reduced bone density) (Capriotti & Frizzell, 2016).
WBC	4-12.00	5.50	7.40	
Neutrophils	47.0-73.0	62.1	67.2	
Lymphocytes	18.0-42.0	24.7	19.5	
Monocytes	4.0-12.0	10.8	11.3	
Eosinophils	0.0-5.0	1.8	1.2	
Bands	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-	133-144	144	143	

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<b>K+</b>	<b>3.5-5.1</b>	<b>3.8</b>	<b>3.6</b>	
<b>Cl-</b>	<b>98-107</b>	<b>110</b>	<b>107</b>	
<b>CO2</b>	<b>21-31</b>	<b>26</b>	<b>27</b>	
<b>Glucose</b>	<b>70-99</b>	<b>99</b>	<b>93</b>	
<b>BUN</b>	<b>7-25</b>	<b>30 H</b>	<b>31H</b>	<b>Kidney function can be compromised due to age or medications or complications to CHF (Capriotti &amp; Frizzell, 2016).</b>
<b>Creatinine</b>	<b>0.50-1.20</b>	<b>1.51 H</b>	<b>1.63 H</b>	<b>Kidney function can be compromised due to age or medications (Capriotti &amp; Frizzell, 2016).</b>
<b>Albumin</b>	<b>3.5-5.7</b>	<b>N/A</b>	<b>N/A</b>	
<b>Calcium</b>	<b>8.6-10.3</b>	<b>8.8</b>	<b>8.6</b>	
<b>Mag</b>	<b>1.5-2.5</b>	<b>1.6-2.6</b>	<b>N/A</b>	
<b>Phosphate</b>	<b>2.5-4.5</b>	<b>N/A</b>	<b>N/A</b>	
<b>Bilirubin</b>	<b>0.0</b>	<b>N/A</b>	<b>N/A</b>	
<b>Alk Phos</b>	<b>34-104</b>	<b>N/A</b>	<b>N/A</b>	
<b>AST</b>	<b>13-39</b>	<b>N/A</b>	<b>N/A</b>	
<b>ALT</b>	<b>7-52</b>	<b>N/A</b>	<b>N/A</b>	
<b>Amylase</b>	<b>23-470</b>	<b>N/A</b>	<b>N/A</b>	
<b>Lipase</b>	<b>20-86</b>	<b>N/A</b>	<b>N/A</b>	
<b>Lactic Acid</b>	<b>300-239</b>	<b>N/A</b>	<b>N/A</b>	
<b>Troponin</b>	<b>0.000-0.040</b>	<b>.050 H</b>	<b>0.120H</b>	<b>This lab can be high due to cardiac output problems and damage happening in relation to CHF (Capriotti &amp; Frizzell, 2016).</b>

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<b>CK-MB</b>	<b>0.36</b>	<b>N/A</b>	<b>N/A</b>	
<b>Total CK</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	

Other Tests **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>INR</b>	<b>0.9-1.1</b>	<b>N/A</b>	<b>N/A</b>	
<b>PT</b>	<b>10.1-13.1</b>	<b>N/A</b>	<b>N/A</b>	
<b>PTT</b>	<b>25-36</b>	<b>N/A</b>	<b>N/A</b>	
<b>D-Dimer</b>	<b>&lt;0.5</b>	<b>N/A</b>	<b>N/A</b>	
<b>BNP</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	
<b>HDL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	
<b>LDL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	
<b>Cholesterol</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	
<b>Triglycerides</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	
<b>Hgb A1c</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	
<b>TSH</b>	<b>0.270-4.200</b>	<b>N/A</b>	<b>0.138 L</b>	<b>Thyroid function can be low due to age or autoimmune issues (Capriotti &amp; Frizzell, 2016).</b>

Urinalysis **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>5.0-9.0</b>	<b>N/A</b>	<b>N/A</b>	
<b>pH</b>	<b>5.0-8.5</b>	<b>N/A</b>	<b>N/A</b>	

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<b>Specific Gravity</b>	<b>1.001-1.035</b>	<b>N/A</b>	<b>N/A</b>	
<b>Glucose</b>	<b>Neg</b>	<b>N/A</b>	<b>N/A</b>	
<b>Protein</b>	<b>Neg</b>	<b>N/A</b>	<b>N/A</b>	
<b>Ketones</b>	<b>Neg</b>	<b>N/A</b>	<b>N/A</b>	
<b>WBC</b>	<b>Neg 0-5</b>	<b>N/A</b>	<b>N/A</b>	
<b>RBC</b>	<b>Neg 0-5</b>	<b>N/A</b>	<b>N/A</b>	
<b>Leukoesterase</b>	<b>Neg</b>	<b>N/A</b>	<b>N/A</b>	

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

<b>Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Explanation of Findings</b>
<b>pH</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>PaO2</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>PaCO2</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>HCO3</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>SaO2</b>	<b>90-100</b>	<b>89</b>	<b>100</b>	<b>Pt has been on consistent O2 since admission to the hospital.</b>

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

<b>Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Explanation of Findings</b>
<b>Urine Culture</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>Blood Culture</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>Sputum Culture</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>Stool Culture</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>

**Lab Correlations Reference (APA):**

CBC and ABG's are consistent with CHF and age-related problems. Low oxygen levels of the blood and red blood cells can cause impaired gas exchange. These tests show what is occurring in relation to blood gases and the red blood cells. Red blood cell levels can show how well the cells are carrying oxygen which can help determine the reasons for low levels in such cases as CHF or other age-related conditions.

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

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.

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points): Chest Xray, Hip Xray, EKG, CT (Leg and head)**

**Diagnostic Test Correlation (5 points):** Chest X ray -is a chest film or picture which is a projection radio graph used to help diagnose certain types of conditions. These conditions could be affecting the chest or lung area. These images provide us with information to help spot different types of abnormalities or deformities. The chest Xray can help the doctor recognize normal to abnormal areas such as masses or broken bones. Chest Xray can help identify pneumonia or even TB. Lung cancers and other serious conditions can also be found.

Pulse Ox- Patient to have pulse ox level done q 4 hours to measure O2 levels. Monitor O2 levels to make sure patient is maintaining proper levels currently. Hip CT and head CT ruled out any

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fractures of the hip. EKG to help monitor the heart. No hemorrhage was found only age-related changes.

### **Diagnostic Test Reference (APA):**

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

Sorenson, M., Quinn, L., Klein, D. (2019). *Pathophysiology: concepts of human disease*. Hoboken, NJ: Pearson, Education, Inc

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

#### **Home Medications (5 required)**

<b>Brand/ Generic</b>	<b>Albuterol</b>	<b>Vitamin D</b>	<b>Metopro lol tartrate</b>	<b>Acetamin ophen</b>	<b>Bromonidine</b>
<b>Dose</b>	<b>2.5mg</b>	<b>400</b>	<b>50 mg</b>	<b>325mg</b>	<b>0.2%</b>
<b>Frequency</b>	<b>PRN</b>	<b>Once a day</b>	<b>twice daily</b>	<b>Every 6 hours</b>	<b>1 drop (3xday)</b>
<b>Route</b>	<b>airway</b>	<b>PO</b>	<b>PO</b>	<b>PO</b>	<b>eye drop</b>
<b>Classification</b>	<b>Bronchodilator Shortness of breath</b>	<b>Mineral required to regulate calcium and phosphorus/ needed for bone structure</b>	<b>Beta blocker</b>	<b>Pain</b>	<b>Glaucoma</b>
<b>Mechanism of Action</b>	<b>Works by opening up the</b>	<b>Maintain D levels/low</b>	<b>Lowers BP</b>	<b>Helps reduce</b>	<b>dilates the vessels</b>

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	<b>airways/bronchodilation</b>	<b>phosphate in the blood</b>		<b>pain and inflammation</b>	
<b>Reason Client Taking</b>	<b>Shortness of breath</b>	<b>Reduction in kidney function/ atherosclerosis/ Heparin interacts with vitamin D –u need to eat a diet rich in calcium &amp; vitamin D when on heparin</b>	<b>Prevent Strokes  Hypertension, bradycardia, acute heart failure</b>	<b>Pain and joint soreness due to age</b>	<b>Open angle glaucoma</b>
<b>Contraindications (2)</b>	<b>Use caution if the pt has hypothyroidism , or seizure disorder, or heart disease</b>	<b>Weakness/ loss of appetite</b>	<b>Risk for orthostatic hypotension bradycardia</b>	<b>Hemorrhage or liver failure</b>	<b>closed angle glaucoma, injury or trauma of the eye</b>
<b>Side Effects/ Adverse Reactions (2)</b>	<b>Nausea, Nervousness-</b>	<b>Deficiency can cause failure of bone calcification/ monitor D levels/monitor bone deficiencies</b>	<b>Monitor BP, dizziness , AV block</b>	<b>hypersensitivity, liver failure</b>	<b>Irritation, redness, burning, compromised vision</b>
<b>Nursing Considerations (2)</b>	<b>Use caution if the pt has hypothyroidism , or seizure disorder, or heart disease</b>	<b>Eat food high in calcium and vitamin D Regular blood tests to monitor levels</b>	<b>Check pulse rate/to be above 60 monitor BP</b>	<b>S/s of bleeding, patient safety</b>	<b>Insert eye drops properly- patient education, one eye drop administration</b>
<b>Key Nursing Assessment(s) /Lab(s) Prior to</b>	<b>Lung assessment, and pulse ox</b>	<b>Vitamin D levels, altered metabolism</b>	<b>Monitor BP, vertigo, feelings</b>	<b>Liver test, pain scale</b>	<b>Assess eye for irritation/complication, tip head back/</b>

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<b>Administration</b>			<b>of dizziness, monitor pulse rate, patient education</b>		<b>5 rights medication administration</b>
<b>Client Teaching needs (2)</b>	<b>Med Admin of how to use inhaler /Wait 5 min in between inhalers/prime unit before use</b>	<b>To report excessive drowsiness which could be a sign of low vitamin D levels, Take in the morning for maximum absorption</b>	<b>Tell pt to take their BP (pulse) before taking medication Take w/ meals as directed, avoid driving</b>	<b>Pt to let staff know when in pain, pt to tell staff if stomach irritation occurs</b>	<b>take as directed, follow up with provider</b>

**Hospital Medications (5 required)**

<b>Brand/ Generic</b>	<b>Bisacodyl</b>	<b>Lovenox</b>	<b>Lactobacillus</b>	<b>Norco</b>	<b>Hydralazine</b>
<b>Dose</b>	<b>10mg</b>	<b>30mg</b>	<b>50 million cap</b>	<b>5-325mg</b>	<b>50mg</b>
<b>Frequency</b>	<b>1 X daily</b>	<b>1 X daily</b>	<b>1 daily</b>	<b>As needed/prn</b>	<b>3 times daily</b>
<b>Route</b>	<b>Oral</b>	<b>Sub Q</b>	<b>Oral</b>	<b>oral</b>	<b>oral</b>
<b>Classification</b>	<b>-Softens stool/Increases intestinal activity</b>	<b>Blood thinner Decreases clotting ability/thins blood</b>	<b>Restore Good bacteria For stomach</b>	<b>Narcotic/ Pain reliever</b>	<b>Blood pressure medication</b>

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<b>Mechanism of Action</b>	<b>Stool softener</b>	<b>Blood thinner</b>	<b>probiotic</b>	<b>Pain relief/ works in the brain to change the way your body responds to pain</b>	<b>Lowers blood pressure/doesn't affect heart rate</b>
<b>Reason Client Taking</b>	<b>To soften stools/avoid straining</b>	<b>Due to fall and patient not getting up and moving right now</b>	<b>Restore natural flora in the stomach</b>	<b>Pain associated to age related problems/arthritis</b>	<b>hypertension</b>
<b>Contraindications (2)</b>	<b>Abdominal pain, GI bleed</b>	<b>Excessive bleeding, aneurysm</b>	<b>Diarrhea/intestinal gas</b>	<b>Hypersensitivity, hepatotoxicity, respiratory depression</b>	<b>Low blood pressure Dizziness, syncope</b>
<b>Side Effects/Adverse Reactions (2)</b>	<b>Monitor pt stools/for diarrhea, Nausea</b>	<b>Monitor for bleeding and B/P/risk of falls due to blood loss</b>	<b>Do not give in patients with yeast sensitivities or weakened immune systems</b>	<b>Nausea or vomiting can occur, intolerance to pain medications due to age</b>	<b>Weakness, low blood pressure,</b>
<b>Nursing Considerations (2)</b>	<b>Taken for constipation to avoid straining, monitor stools for effectiveness</b>	<b>Educate on S/S of bleeding/Bruising/GI Bleed/ Observe for unusual bleeding/complcations of low blood pressure, pt safety</b>	<b>Dairy products &amp; yogurt contain lactobacillus education, take prior to eating</b>	<b>Monitor respiratory status of patient, monitor for hypersensitivity</b>	<b>Monitor vitals, Up with assistance, I/O's, patient safety</b>
<b>Key Nursing Assessment(s)/ Lab(s) Prior to</b>	<b>Pt does not have an allergy to drug, 5</b>	<b>Skin assessment for signs of excessive</b>	<b>Take with water, Pt should take sitting up</b>	<b>Pulse ox, respiratory status</b>	<b>Vitals, I/O's, distal pulses</b>

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<b>Administration</b>	<b>rights, Pt not having diarrhea</b>	<b>bruising</b>			
<b>Client Teaching needs (2)</b>	<b>Pt to report signs of bowels not moving, Pt to report cramping or excessive diarrhea to provider</b>	<b>Pt safety, pt to use call light to ask for assistance when getting up, Pt to report any signs and symptoms for bleeding /patient to remain free from falls during the hospital stay</b>	<b>Take prior to eating/ Patient to take according to medication regimen</b>	<b>Opioid pain medication/tell your doctor if you plan to stop/ Can be habit forming</b>	<b>Medication education to monitor blood pressure at home , avoid orthostatic hypotension with proper measures</b>

**Medications Reference (APA):**

Burlington: Jones & Bartlett Learning. 2018 *Nurse's Drug Handbook*. (2018). 17th ed.

Burlington:MA

**Assessment**

**Physical Exam (18 points)**

<b>GENERAL (1 point): Alertness: Alert and orientated Orientation:X3</b>	<b>Pt is sitting up in bed orientated times 3, Pt showing no distress at this time. Pt states she is doing well. Pt speaks good English with</b>
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<p><b>Distress: None noted</b>  <b>Overall appearance: cheerful and cooperative</b></p>	<p><b>normal tone. Pt MAEW for current age and condition. Strength is bilateral and equal. Pt follows commands with no restrictions. Pt has no signs of neurological deficit.</b></p>
<p><b>INTEGUMENTARY (2 points):</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor: Normal</b>  <b>Rashes: N/A</b>  <b>Bruises: N/A</b>  <b>Wounds: N/A</b>  <b>Braden Score: 20</b>  <b>Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Type:</b></p>	<p><b>Pt is African American skin average in color. Skin is fair to dry. Normal elasticity warm to touch. No signs of lesions or wounds. Pt complained of sore bottom. Slight redness to coccyx area foam dressing applied- Pt repositioned to relieve pressure. No open areas. No drainages. Patient states that she is just stiff from being in bed. No rashes normal skin turgor. Hair is gray in color. Braden Scale 20</b></p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p><b>Head is or normal shape with no apparent deviations. Hair is gray. Ears have no drainage or discomfort, tympanic membrane pearly gray. PEERLA within normal limits. Patient does have glaucoma which she takes eye drops for daily. Patient has glasses but only for reading. Pt eyes show no discharge. Pupils are hazy in color but pt states she can still see just fine. No deviation of the septum, turbinate equal bilaterally. No rhinorrhea. No complaints of congestion or nose bleeds. Oral mucosa is pink and moist with no discharge. Patient is missing some teeth but appropriate due to age. Patient states she is able to eat just fine.</b></p>
<p><b>CARDIOVASCULAR (2 points):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses: Regular no abnormalities</b>  <b>Capillary refill: WNL</b>  <b>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Location of Edema:</b>  <b>Lower legs and right arm (right arm edema was due to her landing on her side during fall but no broken bone just swelling)</b></p>	<p><b>Placement auscultated x5 for heart sounds. Pt has normal S1 and S2 no abnormalities, no murmurs, no thrills. Pt has normal cardiac rhythm with Regular cap refill, 2 plus swelling and edema of lower extremities and right arm. Pt is on heart monitor. Radial pulses and pedal pulse 2+ . Negative for any vein distention. Pillow placed to raise right arm above the heart to reduce swelling.</b></p>

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<p><b>RESPIRATORY (2 points):</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds:</b> Location, character</p>	<p>Pt has Normal lung sounds No Crackles No rhonchi , Pt shows no signs of distress. No accessory muscle use during breathing. No deviations. Pt denies shortness of breath but does state that she does have shortness of breath at home sometimes. Minor wheezing noted on left side patient does have an albuterol order but has no signs of discomfort. Patient currently on room air. Pt states she feels better and is not normally on oxygen at home. Pt does have PRN oxygen order as needed currently at 2 liters.</p>
<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at home:</b>  <b>Current Diet Regular</b>  <b>Height:</b>  <b>Weight:</b>  <b>Auscultation Bowel sounds:</b> all 4 noted  <b>Last BM:</b> today at 2pm  <b>Palpation:</b> Pain, Mass etc.:  <b>Inspection:</b>              <b>Distention:</b> Abdominal              <b>Incisions:</b> none              <b>Scars:</b> 2 past surgical scars visible  <b>Hysterectomy and gallbladder</b>              <b>Drains:</b> N/A              <b>Wounds:</b> N/A  <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></p>	<p>Pt current regular diet. Pt states food tastes better now. Pt denies alcohol use except for a few times socially. No abnormal distention. Bowel sounds in all four quadrants. No tenderness. No masses. No ostomy. No nasogastric tubes. No wounds. Pt has no signs of distress no diarrhea, no constipation, no bloating or irritability. Last bowel movement today at 2pm.</p>
<p><b>GENITOURINARY (2 Points):</b>  <b>Color:</b> yellow  <b>Character:</b> Clear  <b>Quantity of urine:</b>400ml  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Dialysis:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b>  <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>              <b>Type:</b>              <b>Size:</b></p>	<p>Pt uses bedside commode Urine clear no odor, no urgency, no dysuria. Patient denies pain. No irregularities or discharge. Output 400ml No dialysis or catheter. Lower Pelvic area no abnormalities only redness on bottom Female genitalia within normal limits no discharge or lesions. Patient is on I&amp;O's</p>
<p><b>MUSCULOSKELETAL (2 points):</b>  <b>Neurovascular status:</b>  <b>ROM:</b> within normal limits</p>	<p>. Pt exhibits normal active ROM bilaterally, Patient states she fell at home “slipped out of the chair” .Pt is a fall risk. Pt needs help to</p>

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<p><b>Supportive devices: walker</b>  <b>Strength: equal</b>  <b>ADL Assistance: Y X N <input type="checkbox"/></b>  <b>Fall Risk: Y X N <input type="checkbox"/></b>  <b>Fall Score:</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b>  <b>Needs assistance with equipment Y</b>  <b>Needs support to stand and walk Y</b></p>	<p><b>stand and support. Pt states at home family does assist with mobility and errands. Grandson lives with her full time.</b>  <b>No clubbing noted, no effusions, no cyanosis – positive for myalgias right hip –currently no neck or back pain,</b></p>
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW: Y X N <input type="checkbox"/></b>  <b>PERLA: Y X N <input type="checkbox"/></b>  <b>Strength Equal: Y X N <input type="checkbox"/> if no -</b>  <b>Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/></b>  <b>Orientation: X3</b>  <b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b></p>	<p><b>Pt is sitting up in bed orientated time 3, Pt showing no distress at this time. Pt speaks good English with normal tone. PT MAEW for current age and condition. Strength is bilateral and equal. Pt follows commands with no restrictions. Pt has no signs of neurological deficit- Braden Scale 20 No headache, no gross focal neurological defects. No cranial nerve deficits.</b></p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b>  <b>Coping method(s):</b>  <b>Developmental level:</b>  <b>Religion &amp; what it means to pt.:</b>  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p><b>Pt states slightly tired from being in the hospital and states her grandson takes very good care of her and a daughter that is currently her POA</b>  <b>High school education</b>  <b>African American</b>  <b>Very happy with family very supportive</b></p>

**Vital Signs, 2 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1300	78	128/76	20	98.0	100
1500	76	126/74	18	97.9	100

**Vital Sign Trends:**

**Vital Sign Trends: Patient had stable vitals during my clinical and denied pain at this time.**

**Patient was on a heart monitor blood pressure was within normal range.**

**Pain Assessment, 2 sets (2 points)**

Time	Scale	Location	Severity	Characteristics	Interventions
1300	0	N/A	N/A	N/A	Pt denies pain at this time
1400	0	N/A	N/A	N/A	Pt denies pain at this time

**IV Assessment (2 Points)**

IV Assessment	Fluid Type/Rate or Saline Lock
<b>Size of IV:</b> <b>Location of IV:</b> <b>Date on IV:</b> <b>Patency of IV:</b> <b>Signs of erythema, drainage, etc.:</b> <b>IV dressing assessment:</b>	Patient currently did not have an IV—The staff had to many unsuccessful attempts at the time of my clinical-Pt was to receive a central line but staff waiting for it to be scheduled

**Intake and Output (2 points)**

Intake (in mL)	Output (in mL)
120+120+300=540 ml	400ml

**Nursing Care**

**Summary of Care (2 points)**

**Overview of care:):** Patient is very interactive with staff. Patient has a good support system. Patient seems satisfied with care. Patient not in any pain nor does she show signs of discomfort. Patient breathing unlabored and he showed no signs of distress throughout the day. Vitals are stable. Pt abnormal labs are consistent with diagnosis and past medical history. Patient oxygen levels stayed within normal ranges. No labored breathing or difficulty as this time. Patient very cooperative with care and looking forward to returning home with family.

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**Procedures/testing done:** Labs and Xray of the hip and chest—were all clear of any abnormalities or fractures.

**Complaints/Issues:** Patient had no complaints at this time.

**Vital signs (stable/unstable):** Vital signs were stable throughout the clinical time I was there. Patient did have heart monitor and vitals were within normal ranges.

**Tolerating diet, activity, etc.:** Patient on regular diet.

**Physician notifications:** Patient to follow up with provider.

**Future plans for patient:** Patient will probably return home since x-rays were negative for any fracture. Family is very active with care of their mother and grandmother.

### **Discharge Planning (2 points)**

Patient will need medication administration education along with caregivers (grandson and daughter). Patient should be evaluated to see if she qualifies for continued home therapy and care assistance. Patient currently does not drive states grandson and family will provide transportation. Patient does currently qualify for home health services such as in home assistance with bath or ambulation skills which will be helpful until she regains her strength. Patient currently has an oxygen concentrator at home in case she needs it. Neither patient nor family members smoke. Home and in public oxygen use safety precaution education will be helpful at this time. Family education on throw rugs, shower chairs, grab bars, and other assistive devices to reduce the chances of patient falls.

**Discharge location:** Home Preferably as requested per family-Home rehab services

**Home health needs (if applicable):** Patient has current home healthcare and family members that attend to help her with her daily routines.

**Equipment needs (if applicable):** Patient has necessary equipment at home

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**Follow up plan:** Patient to follow up with provider in a week and patient to attend or have home care for any rehabilitative services—home care as scheduled

**Education needs:** Patient needs to be more clear on safety concerns and asking for help when needing assistance to ensure patient safety to avoid future falls.

**Nursing Diagnosis (15 points)**

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

<b>Nursing Diagnosis</b> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> </ul>	<b>Rational</b> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<b>Intervention (2 per dx)</b>	<b>Evaluation</b> <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>
<b>1. Pt at risk for Ineffective breathing pattern/related to ineffective inspiration and expiration occurring with chronic airflow limitations</b>	<b>Respiratory instability related to CHF</b>	<b>1.1.Oxygen PRN 2.Check Pulse Ox</b>	<b>Pt to show stable vitals and oxygen levels Pt to have no respiratory distress with care</b>
<b>2. Patient at risk for Activity intolerance related to imbalance between oxygen supply and demand</b>	<b>Oxygen levels to remain stable during activity</b>	<b>1. Pt to tolerate light mobility without signs of distress/allow extra time for adjustment to repositioning/safety  2.Stand by 2 assists with walk patient to be able to walk to bathroom 10 feet without distress wheezing or fatigue</b>	<b>Pt to be able to increase activity to complete tasks as tolerated daily</b>
<b>3. Self-care deficit related</b>	<b>ROM activities as</b>	<b>1. Pt goal to assist with ROM’s</b>	<b>Pt to perform ROM’s with</b>

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<p><b>to fatigue from the increased work of breathing</b></p>	<p><b>tolerated to improve mobility</b></p>	<p><b>without exhaustion or fatigue</b>  <b>2. Pt to have therapy consult to improve mobility</b></p>	<p><b>increased mobility</b></p>
<p><b>4. Chronic low self-esteem related to chronic illness</b></p>	<p><b>As evidenced by CHF and lack of activity</b></p>	<p><b>1.Pt to meet with social service for coping skills</b>  <b>2. Pt to have positive attitude toward health improvement/increasing social interaction</b></p>	<p><b>Pt to exhibit positive expression with completing tasks</b>  <b>Pt to interact with home activity as tolerated daily</b></p>

**Other References (APA):**

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

Sorenson, M., Quinn, L., Klein, D. (2019). *Pathophysiology: concepts of human disease*.  
 Hoboken, NJ: Pearson, Education, Inc

**Concept Map (20 Points):**

### Subjective Data

Pt is 90 years old states fatigue, weak, unable to stand or walk very far, unsteady gait, fell at home-Pt has CHF, extensive prior medical history, and hypoxia.

### Nursing Diagnosis/Outcomes

Pt at risk for fall due age related decreased activity and glaucoma- Pt to have side rails up and alarm on while in bed—Pt to remain free of falls while in the hospital undergoing treatment  
Pt at risk for ineffective breathing pattern that does not provide adequate ventilation-Pt to use incentive spirometer and oxygen as needed -Pt to maintain adequate oxygen levels  
Pt at risk for fluid volume overload due to congestive heart failure. Pt to maintain adequate fluid intake in regards to I/O'S-Pt to not show signs of respiratory distress.

### Objective Data

Older patient in no apparent pain -right arm edema from fall—2 plus edema on legs-age related difficulties such as walking with a steady gait-pt currently takes eye drops for glaucoma

### Patient Information

90 year old patient -fell at home (this has been the third fall in a matter of weeks) Pt lives w/grandson and has home care.Past history CHF, Hypertension, fluid overload, shortness of breath

### Nursing Interventions

Vitals, I/O's, daily weights, turning, and positioning monitoring for signs and symptoms of pain (pain scale), teach non pharmacologic therapeutic pain options, swelling, and decreased mobility. Safety precautions to avoid falls. Pillows placed under arm to help reduce swelling-(restricted fluid intake)—Pt has home care services when at home -Patient education on medications.

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