

# N210 Fundamentals of Nursing Care Plan

(Lindsey Davis)

(January 31, 2019)

**Patient Demographics ( / 5 Points)**

Age: 48 Gender: F

Place of Residence: Clark-Lindsey

Code Status: unknown

Date of Admission: 1/12/19

Hospital Day #: 14

**Social History ( / 5 Points)**

Marital status: unknown

Occupation: unknown

Tobacco use: Former Smoker (last smoke 60yrs ago)

Alcohol use: unknown

**Past History ( / 5 Points)**

Past Medical History:

Anemia, Chronic atrial fibrillation, Chronic combined systolic and diastolic heart failure, COPD, Essential hypertension, hypothyroidism, Lymphoma in remission, Parkinson, Pneumonia Chronic, CHF

Past Surgical History:

Placement of cardiac pacemaker 11/24/18, Cathlab procedure 1/10/19, echocardiogram 1/6/19

Allergies:

NKA, NKDA

**History of Present Illness ( / 15 Points)**

Subjective Complaint **3 points**

Unknown Unable to assess client, due to being in

PT. \_\_\_\_\_

Present Health Information (PHI): **5 points**

Unknown unable to assess client, due to being in

PT. \_\_\_\_\_

Medical Diagnosis/Acute Problem(s): **3 points**

Unknown due to not having access to electronic medical chart. \_\_\_\_\_

Current Treatments: **4 points**

Unknown due to not having access to electronic medical chart



<b>Vital Signs: 1 point</b> T: 98.4F P: 88 RR: 18 O2Sat: 98 BP: 150/90 98	<b>Pain: 1 point</b> Rating: /10 Characteristics: unable to assess client	<b>Intake &amp; Output: 2 points</b> Previous 24 hour balance: unknown Balance since admission: unknown
<b>NEUROLOGICAL: 2 points</b> MAE: Y N PERLA: Y N Strength Equal: Y N if no - Legs Arms Both Orientation, Mental Status, Speech, Sensory, LOC  <b>EENT:</b> Ears: Eyes: Nose: Teeth:	<b>GASTROINTESTINAL: 2 points</b> Diet at home: _____ Current Diet: _____ Height: _____ Weight: _____ Auscultation: _____ Last BM, character & freq of stools _____ Palpation: Pain, Mass etc _____ Inspection: distention, incisions, scars, drains, wounds Ostomy: Y N Nasogastric: Y N Feeding tubes/PEG tube Y N Type: _____	
<b>MUSCULOSKELETAL: 2 points</b> Neurovascular status, ROM, Supportive devices/strength  ADL Assistance Y N Fall Risk: Y N Activity/Mobility Status: Needs assistance with equipment Needs support to stand and walk	<b>GENITOURINARY: 2 points</b> Color, character, quantity of urine, Pain : Y N Describe: _____ Dialysis Y N Inspection of genitals: Catheter: Y N Type _____	
<b>CARDIOVASCULAR: 2 points</b> 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 _____	<b>PSYCHOSOCIAL/CULTURAL: 2 points</b> Coping methods: _____ Educational level: _____ Developmental level: _____ Ethnicity: _____ Religion & what it means to pt. _____ Occupation (previous if retired) _____ Personal/Family Data (Think about home environment, family structure, and available family support) Do you feel safe at home? Y N	
<b>RESPIRATORY: 2 points</b> Accessory muscle use: Y N Breath Sounds: Location, character _____	<b>INTEGUMENTARY: 2 points</b> Skin color, character, turgor, rashes, bruises, wounds: character, drainage, approximation etc. Braden scale: _____. Also date & location of IV's	

Below information is unknown due to no assessment.

**The Nursing Process ( \_\_\_\_\_ / 25 points)**

<b>Nursing Diagnosis #1 (Physical): <u>3 points</u> ___</b>	
<b>Outcome Planning: 3 points</b>	
<b>Nursing Interventions: 3 points</b>	<b>Client Responses to Interventions: 3.5 points</b>
1. Not enough information collected to answer	1. Not enough information collected to answer
2.	2.
3.	3.
4.	4.
5.	5.
<b>Evaluation (client progress):</b>	

<b>Nursing Diagnosis #2 (Safety): <u>3 points</u> ___</b>	
<b>Outcome Planning: 3 points</b>	
<b>Nursing Interventions: 3 points</b>	<b>Client Responses to Interventions: 3.5 points</b>
1. Not enough information collected to answer	1. Not enough information collected to answer
2.	2.
3.	3.
4.	4.
5.	5.
<b>Evaluation (client progress):</b>	

<b>Category</b>	<b>5 points</b>	<b>2 point</b>	<b>0</b>	<b>Points Earned</b>
<b>Demographics</b>	Obtained and recorded all data as required.	Missing data.	Not Done	
<b>Category</b>	<b>5 points</b>	<b>2 point</b>	<b>0</b>	<b>Points Earned</b>
<b>Social History</b>	Obtained and recorded all data as required.	Missing data.	Not Done	
<b>Category</b>	<b>5 points</b>	<b>2 points</b>	<b>0</b>	<b>Points Earned</b>
<b>Past History</b>	Obtain and recorded all data as required.	Missing data.	Not Done	
<b>Category</b>	<b>15 points</b>	<b>5 points</b>	<b>0</b>	<b>Points Earned</b>
<b>History of Present Illness</b>	Obtained and recorded all data as required. Demonstrated thorough and concise exploration into events surrounding the client's presentation to the hospital. Also included any and all relevant medical diagnosis or acute problems and appropriate current treatments.	Missing or limited data provided, minimal guidelines met.	Not done	
<b>Category</b>	<b>25 points</b>	<b>15 points</b>	<b>0</b>	<b>Points Earned</b>
<b>Pathophysiology</b>	Correctly identified the medical diagnosis or acute problem. Thoroughly and concisely described the pathophysiology (in the student's own words). Successfully able to relate pathophysiology to the disease process exhibited by the actual client. Include APA citations as required.	Missing or limited data provided, minimal guidelines met.	Not done	
<b>Category</b>	<b>20 points</b>	<b>10 points</b>	<b>0</b>	<b>Points Earned</b>
<b>Physical Assessment</b>	Complete head to toe assessment. Includes vital signs, pain scale, and intake and output as required. Must be the student's clinical assessment, NOT what is documented in the EMR.	Missing or limited data provided, minimal guidelines met.	Not done	
<b>Category</b>	<b>25 points</b>	<b>15 points</b>	<b>0</b>	<b>Points Earned</b>
<b>The Nursing Process</b>	Includes 2 relevant client problems, 2 correctly written NANDA approved nursing diagnosis, and 5 nursing interventions for each diagnosis.	Missing or limited data provided, minimal guidelines met.	Not done	

Total Points: \_\_\_\_\_/100