N321 Care Plan # 1

Lakeview College of Nursing

Olamide Adewole

Demographics (3 points)

Date of Admission 09/08/2020	Patient Initials R.M	Age 73	Gender F
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Married	Allergies NKDA
Code Status Full Code	Height 5'2	Weight 220lbs	

Medical History (5 Points)

Past Medical History: Edema of lower extremities, Type II Diabetes with multiple complications, Shoulder pain, Joint pain, Knee pain, Type II without complication, Dyslipidemia, Diabetic peripheral neuropathy, Chronic kidney disease Stage III, Carpal tunnel syndrome (right), Essential Hypertension, Diarrhea.

Past Surgical History: Cardiac Catheterization (02/06/17), Cardiac Surgery (06/01/2016), Stent (01/01/2020), Gallbladder Surgery (01/01/98).

Family History: Father - Heart failure, Mother - Family history of Cancer

Social History (tobacco/alcohol/drugs): Former Smoker for 22 years, Alcohol use for 10 years

Assistive Devices: None

Living Situation: Patient lives at home with her husband.

Education Level: Associate degree in Nursing

Admission Assessment

Chief Complaint (2 points): Weakness and Confusion

History of present Illness (10 points): Patient is a 73 year old female that presented to the ER on 09/08/2020. Patient complains of weakness that started on 09/07/2020, and periodic

confusion for about a week. Patient also reported bladder incontinence & urinary frequency

that started three days ago . Patient also has a history of high blood pressure, Stent placement, Diabetes Melitus, Decreased kidney function. Patient is alert and oriented.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cerebrovascular Accident, Malignant Hypertension.

Secondary Diagnosis (if applicable): High Troponin levels

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

Cerebrovascular accidents are caused by the sudden death of some brain cells due to lack of oxygen when the brain's blood flow is impaired by blockage or rupture of an artery to the brain. It is also referred to as a stroke. It is a medical emergency that requires prompt treatment, and early action can reduce brain damage and other complications. A clot or thrombus causes the blocking of the artery that leads to the brain. Which typically occurs in a blood vessel that has previously narrowed due to atherosclerosis. It can travel through the body's circulation and lodge in an artery of the brain, plugging it up and stopping blood flow, causing an embolic stroke.

Diagnosing a stroke involves getting a complete medical history and doing a thorough physical examination. Some of the tests used to diagnose a Cerebrovascular Accident include; CAT scan, MRI, and some blood tests. A CAT scan of the brain shows if there is any bleeding into the brain, this issue is treated differently than a stroke caused by a lack of blood supply. An

MRI is used to find brain tissue damages caused by either a brain hemorrhage or an ischemic stroke. Simultaneously, blood tests find increased levels of specific proteins and find an inflamed artery.

The American Stroke Association (ASA) is promoting the slogan F (face drooping) .A(arm weakening).S (speech difficulty).T (time to call 911), to improve awareness in people and activate emergency for stroke patients. The treatment ischemic stroke is to recover brain tissue by restoring blood flow as soon as possible. It consists of assessing the patient's airway, breathing, and circulation; stabilizing the patient; and completing an initial evaluation including neurologic exam, imaging, and laboratory studies.

The patient presented to the ER with generalized weakness. During the assessment, she reported feeling tired, episodes of forgetfulness, confusion, inability to move her left arm, and her head feeling “wavy” not dizzy for about twenty seconds. These reported episodes caused the provider to order a Head CT that showed no lesions or mass, and an MRI of the Brain, which offers a breakdown in the blood-brain barrier that is constituent with a stroke. The patient already had essential hypertension; with this, the provider diagnosed her with Cerebrovascular accident and Malignant hypertension. The provider ordered a CBC, CMP, Lipid panel, an MRI, And a CAT scan, which showed no organ damage signs.

Pathophysiology References (2) (APA):

Ischemic Stroke. https://www.nursingcenter.com/journalarticle?Article_ID=3488715.

William C. Shiel Jr., M. D. (2017, January 26). Definition of Cerebrovascular accident. MedicineNet. https://www.medicinenet.com/script/main/art.asp?articlekey=2676.

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	4.2 - 5.2	3.85	4.06	The patient's RBC is low because she has chronic kidney disease.
Hgb	12 - 16			
Hct	37 - 47			
Platelets	150 - 250			
WBC	4.3 - 11			
Neutrophils	37 - 85%			
Lymphocytes	1 - 4%			
Monocytes	00.1 - 1%			
Eosinophils	0.00 - 0.1%			
Bands				

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 mmol/L			
K+	3.5 - 5.0 mmol/L			
Cl-	95 - 110 mmol/L			
CO2	23 - 31 mmol/L			

Glucose	**70 - 110 mg/dL**	**296**	**194**	**The patients glucose level is increased because she is diabetic**
BUN	**8 -25 mg/dL**	**31**	**25**	**The patient BUN is increased because she has chronic kidney disease**
Creatinine	**0.70 - 1.50 mg/dL**			
Albumin	**3.5 -5.0 mg/dL**			
Calcium	**8.4 - 10.3 mg/dL**			
Mag	**1.5-2.6 mg/dL**			
Phosphate	**2.5-4.5 mg/dL**			
Bilirubin	**0.2-0.8 mg/dL**			
Alk Phos	**40 -150 U/L**			
AST	**16 - 40**	**12**	**19**	**The patient has increased because she had a CVA**
ALT	**7 - 52**			
Amylase	**23 - 85 u/L**			
Lipase	**12 -70u/L**			
Lactic Acid	**7.0 - 31.4 u/ L**			

Other Tests 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
INR	**0.8 - 1.4**			
PT	**10.1 - 13.1 seconds**			
PTT				

	25-36 sec			
D-Dimer	**<0.5**			
BNP	**<100 mg/ml**			
HDL	**>60 mg/ml**	**38**	**38**	**The patient is obese which could cause her HDL to be low**
LDL	**<100 mg/ml**			
Cholesterol	**<200mg/ml**			
Triglycerides	**<150mg/ml**	**262**	**262**	**The patient triglycerides could be high because of her uncontrolled diabetes**
Hgb A1c	**<7%**			
TSH	**0.4 - 4.0mu/ L**			

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**			
pH	**4.6 - 8.0**			
Specific Gravity	**1.005 - 1.030**			
Glucose	**Negative**			
Protein	**0 -8 mg / dl**			
Ketones	**Negative**			
WBC	**0 - 4**			
RBC	**0 - 2**			
Leukoesterase	**Negative**			

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	**Negative**			
Blood Culture	**Negative**			
Sputum Culture	**Negative**			
Stool Culture	**Negative**			

Lab Correlations Reference (APA):

Todd, J. C., & Sanford, A. H. (1948). ***Clinical diagnosis by laboratory methods*****. Saunders.**

Diagnostic Imaging

All Other DiagnosticTests (5 points):

CT Scan Head Without Contrast (09/08/2020):Result; Base of the skull appears intact. No fracture seen. No replacement lesions are seen. Calvarium appears intact and no Linear or depressed skull fractures are seen. Mild thickening of the inner table is seen in suggests hyperostosis frontalis internal changes.

MRI Brain Without Contrast (09/08/2020); Results - There is identified on the diffusion-weighted images evidence of an area of acute breakdown in the blood-brain barrier the high posterior right parietal deep white matter and this is consistent with what is Subacute stroke. no

hemorrhoid is seen. Increase signal on T2 - weighted imaging is noted. Mild decrease signal on T1 - weighted imaging is noted

Diagnostic Test Correlation (5 points): Patient presented to the ER with generalized weakness, During the assessment, she reported feeling tired,episodes of forgetfulness, confusion, inability to move her left arm, and feeling “wavy” not dizzy. Which caused the provider to order a Head CT which showed no lesions or mass, and a MRI of the Brain which shows a breakdown in the blood-brain barrier which is constituent with a stroke.

Diagnostic Test Reference (APA):

Todd, J. C., & Sanford, A. H. (1948). Clinical diagnosis by laboratory methods. Saunders.

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

Home Medications (5 required)

Brand/Generic	**Aspirin**	**Atorvastatin**	**Benazepril**	**Carvedilol**	**Furosemide**
Dose	**81mg**	**80mg**	**40mg**	**12.5mg**	**20mg**
Frequency	**QD**	**QD**	**Q2D**	**QD**	**QD**
Route	**P.O**	**P.O**	**P.O**	**P.O**	**P.O**
Classification	**Anti-inflammatory**	**Antihyperlipidemic**	**Antihypertensive**	**Heart failure treatment adjunct**	**Diuretic**
Mechanism of Action	**blocks the activity of cyclooxygenase, the enzyme thats is needed for prostaglandin**	**reduces plasma cholesterol and lipoprotein levels**	**Prevent conversion of angiotensin I to angiotensin II**	**Reduces cardiac output and tachycardia causes vasodilation**	**inhibits sodium and water absorption in the loop of Henle and increases urine formation**
Reason Client Taking	**to reduce pain**	**To control lipid levels**	**To control hypertension**	**To control hypertension**	**To control heart failure, and renal failure**
Contraindications (2)	**Lovastatin St. John Wort**	**MOA inhibitor therapy, pressor agents**	**ACE inhibitors, Renal impairment**	**Asthma,Steven johnson syndrome**	**ACE Inhibitors, propranolol**
Side Effects/Adverse Reactions (2)	**Peripheral edema, Alopecia**	**Anxiety, Blurred vision**	**Anxiety, Hyperglycemia**	**Asthenia, Dizziness**	**Arrhythmias, orthostatic hypotension**
Nursing Considerations (2)	**Tell patient to monitor glucose level,**	**Monitor patient liver function, obtain**	**monitor blood pressure with patient**	**Monitor blood glucose because the**	**obtain patient weight before**

	instruct patient to report signs of infection	**baseline blood pressure and heart rate before starting therapy**	**lying down, monitor urine output and BUN**	**drug alters blood glucose. Avoid stopping drug abruptly because it might cause worse MI**	**and during therapy. use cautiously in patient with hepatic cirrhosis**

Hospital Medications (5 required)

Brand/Generic	**Amlodipine**	**Lisinopril**	**Clopidogrel**	**Atorvastatin**	**Glimepiride**
Dose	**5mg**	**40mg**	**75mg**	**80mg**	**4mg**
Frequency	**QD**	**QD**	**QD**	**QD before bed**	**Q2D**
Route	**P.O**	**P.O**	**P.O**	**P.O**	**P.O**
Classification	**Antianginal**	**Antihypertensive**	**Platelet aggregator**	**Antihyperlipidemic**	**Antidiabetic**
Mechanism of Action	**Binds to dihydropyridine and nondihydropyridine cell membrane**	**May reduce blood pressure by inhibiting conversion of**	**Binds to adenosine diphosphate receptors on the surface of activated platelets**	**reduces plasma cholesterol and lipoprotein levels**	**Stimulates insulin release from beta cells in pancreas**

		angiotensin I to angiotensin II.			
Reason Client Taking	**to treat chronic stable angina**	**To treat hypertension**	**to reduce thrombotic embolic event**	**To control lipid levels**	**To control blood glucose in diabetes**
Contraindications (2)	**ACE inhibitors, Beta Blockers**	**Concurrent use of aliskiren, ACE inhibitors**	**Peptic ulcer disease, intracranial hemorrhage**	**MOA inhibitor therapy, pressor agents**	**Diabetic coma, Ketoacidosis**
Side Effects/Adverse Reactions (2)	**Dizziness, dry mouth**	**Confusion, Constipation**	**Abdominal pain, Confusion**	**Anxiety, Blurred vision**	**Abnormal gait, dermatitis**
Nursing Considerations (2)	**monitor blood pressure while adjusting dosage, assess patient frequently for chest pain**	**monitor patients for anaphylaxis, notify the prescriber if the patient has a persistent nonproductive cough.**	**Avoid clopidogrel in patient who have a a genetic variation in CYP2CI9, use cautiously in patient with severe hepatic or renal disease**	**Monitor patient liver function, obtain baseline blood pressure and heart rate before starting therapy**	**monitor fasting glucose levels to determine response to glimepiride. Monitor patient closely for allergic response**

Medications Reference (APA):

Jones & Bartlett Learning. (2019). ***2019 Nurse's drug handbook*****.**

Assessment

Physical Exam (18 points)

GENERAL (1 point):	

Alertness: **Orientation:** **Distress:** **Overall appearance:**	**Alert** **Oriented to person, place, time, and situation** **Shows no sign of distress** **Well-groomed, looks appropriate for age**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	 **Normal for race** **Warm and dry** **Warm** **Intact** **No rashes** **No bruises** **No open wounds** **22** **No drains present**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 **Normal cephalic, and atraumatic** **outer ear looks normal** **No drainage from the eyes, PERRLA and extraocular movement present.** **Pink and Moist** **Oral mucosa pink and moist, missing some teeth, no sores.**.
CARDIOVASCULAR (2 points): **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:**	. **Strong** **No murmurs, gallops, or rubs.** **Sinus Brady** **Strong** **Less than 3** **No neck vein distension** **No Edema**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	. **No use of accessory muscle use** **Clear and unlaboured**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:**	. **Diabetic Diet** **Diabeitc Diet** **5'2** **220** **Active bowel sounds in all 4 quadrants** **09/09/2020** **No pain or masses detected upon palpation** **Abdomen intact without incisions or scars**

Distention: **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	**No distension** **No Incision** **No Scars** **No Drains** **No Wound** **No Ostomy** **No Nasogastric** **No Feeding tubes**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	 **Yellow** **Clear and free of particles** **310ml** **No pain with urination** **No dialysis** **N/A** **No catheter**
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☐**	. **Intact** **Full active ROM** **No use for supportive devices** **Equal strength on all extremities** **No ADL assistance needed** **No** **8** **Independent**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	. **Yes** **Yes** **Yes** **Both** **Oriented X4** **Competent** **Clear** **No sensory deficits** **Alert**
PSYCHOSOCIAL/CULTURAL (2 points):	.

Coping method(s):	**Effective**
Developmental level:	**Appropriate for age**
Religion & what it means to pt.:	**N/A**
Personal/Family Data (Think about home environment, family structure, and available family support):	**Patient has significant family support system**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:03 am	**55**	**150 /62**	**15**	**97.9**	**98%on room air**
9:47am	**60**	**166/60**	**18**	**97.8**	**96% on room air**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
7:03am	**0 - 10**				
9:47	**0 - 10**				

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	**20 gauge**
Location of IV:	**Right Forearm**
Date on IV:	**09/08/2020**
Patency of IV:	**IV still patent**
Signs of erythema, drainage, etc.:	**No signs of erythema, drainage**
IV dressing assessment:	**Dry and intact**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

210	**310**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient diabetic and would require accu - checks before meals. Patients rate pain level zero on a scale of 0 to 10. Patient is independent, alert, and oriented to place, time, day.

Procedures/testing done:

While hospitalized, this patient received a CT Scan of her Head without contrast, MRI Brain without Contrast to confirm that she had a CVA

Complaints/Issues: No complaints for right now

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc; Patient will continue with her regular diabetic diet, while monitoring blood sugar before meals. Patients may participate in normal activities as tolerated.

Physician notifications: No notifications

Future plans for patient; Patient would continue to monitor blood sugar, and would watch out for signs of a Stroke

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): N/A

Equipment needs (if applicable):N/A

Follow up plan: The patient would continue with insulin therapy, and she would watch out for signs of a Stroke

Education needs: Patient would need education on how to control her diabetes,

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. Decreased functional ability due to neuromuscular impairment with limited use of upper limbs, as evidence of the patient complaint of her inability to move her left arm	**Patient complained at the ED about her inability to move her left arm**	**1. Assess for subluxation of the shoulder** **2. Recommend wearing well-fitting shoes**	**Patient verbalized accurate understanding the disease process** **Goals; patient showed no evidence of shoulder subluxation**

2. Fatigue with decreased exercise tolerance, due to generalized weakness	**Patient complained at the ED about generalized body weakness**	**1. Assist with exercise depending on tolerance.** **2. Assist with vital signs at frequent interval and be alert to any changes**	**Patient verbalized accurate understanding the disease process** **Goals; patient shows absence of chest pain and dysrhythmias**
1. Need for health teaching due to unfamiliarity with the disease process as evidence by patient inability to recognise the signs for CVA	**increasing the patient's knowledge about their condition to promote their treatment regimen.**	**1. Discuss symptoms that necessitate medical attention** **2. Caution patient to avoid grapefruit when taking statin medications**	**Patient verbalized accurate understanding the disease process** **Goal;Patient verbalizes accurate knowledge about CVA, and lifestyle modifications needed**

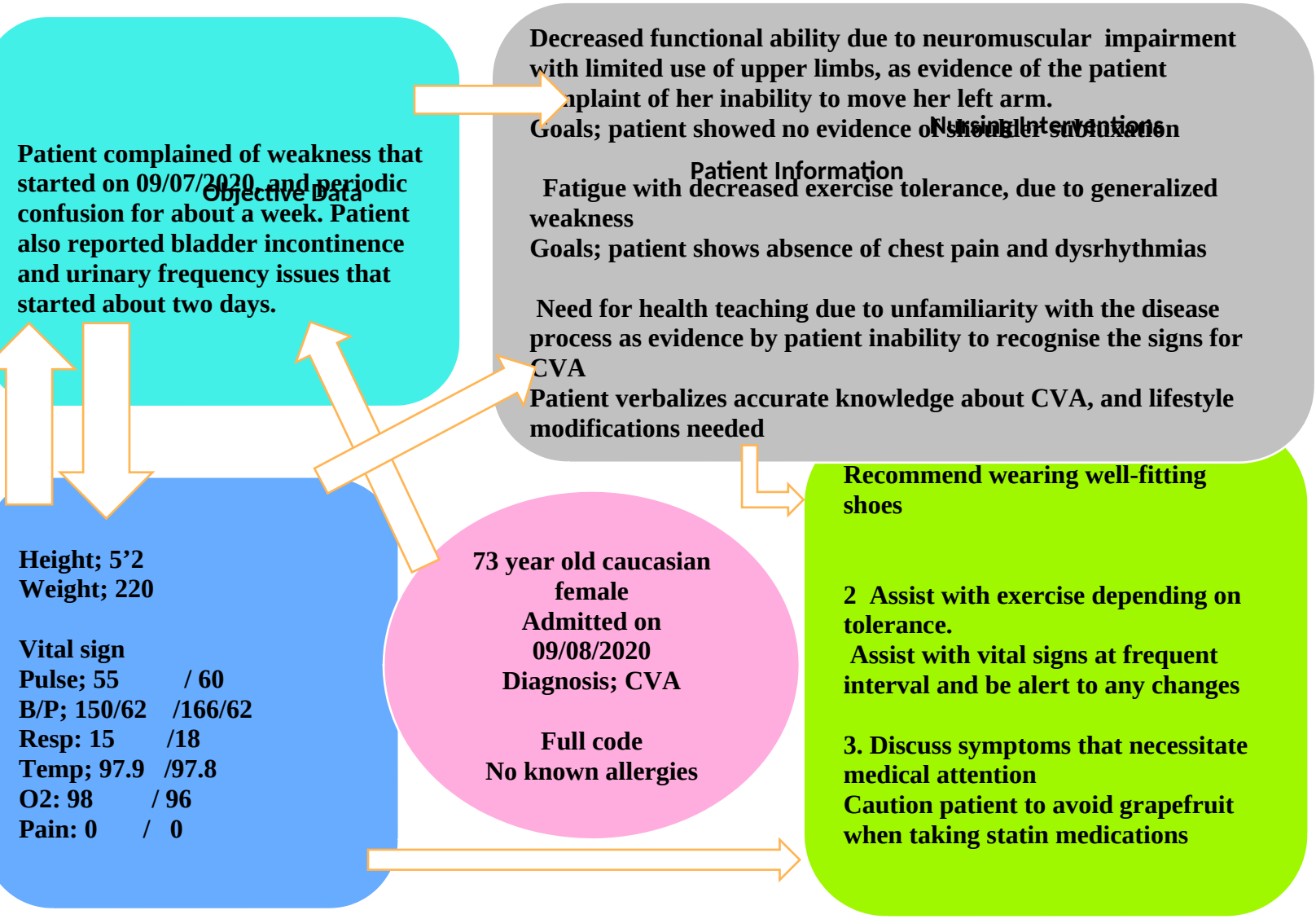
Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and psychiatric-mental health*. Elsevier.

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes



N321 Care Plan

N321 Care Plan