N311 Care Plan # 1

Lakeview College of Nursing

Name

Andrea Stiff

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
10-10-20	B.R.	53	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	No occupation	Divorced	Ceclor, Erythromycin, Sulfa drugs
Code Status	**Height**	**Weight**	
Full Code	160 cm	75.6 kg	

Medical History (5 Points)

Past Medical History: Migraines, Fibromyalgia, depression, and anxiety

Past Surgical History: Hysterectomy, gall bladder removal, and ovaries removed

Family History: Father: severe diabetic, high blood pressure, mother: diabetic, heart disease; aortic valve disorder, Hyperlipidemia, Hypertension

Social History (tobacco/alcohol/drugs): pt reports consuming alcohol 3 to 4 days per week and 4 to 5 drinks at a time the past year. Pt states that she is going to quit. No tobacco or drug use.

Admission Assessment

Chief Complaint (2 points): Stomach pain and severe headache

History of present Illness (10 points): On October 10th a 53 y/o, Caucasian, divorced female was admitted to Sarah Bush Lincoln Hospital for complaints of abdominal pain and a severe headache. The patient had a severe headache 3 to 4 days prior to admission and the stomach pain has lasted a couple of weeks, the patient gets migraines often, but the pain in her head is currently not a regular one of her migraines. She described the pain as a sharp pain in her abdominal area and a sharp pain in her head as well. No other associated factors with the abdominal and head pain. The patient uses cool compress and migraine masks to relieve the pain as well as lying down in a quiet and dark room. Patient also takes Ibuprofen 2-4 times a day.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Pain management

Secondary Diagnosis (if applicable): n/a

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

There are two categories of headaches. The first category is known as Primary which arise independent of any other medical illness or trauma cause (Capriotti, 2015). The second category is called Secondary, these are caused by another primary condition, such as head injury or concussion; vascular problems, such as aneurysms or arteriovenous malformations; medication side effects; sinus disease; and tumors (Capriotti, 2015).

Tension-Type Headaches (TTH) are found to be the most common type of the primary category (Capriotti, 2015). TTH can be primarily a central neurological disturbance which is very similar to a migraine (Capriotti, 2015). TTH can also be a result of increased cervical and pericranial muscle activity muscle activity (Capriotti, 2015). To diagnose someone with a TTH there are no tests run, just clinical findings. To treat TTH patients commonly use analgesics such as aspirin (Capriotti, 2015).

Another type of primary headaches is a migraine. A migraine is a periodic, throbbing headache (Capriotti, 2015). While having a migraine the patient may have other associated symptoms such as altered perception, nausea, and severe pain. Knowledge regarding pathophysiology is incomplete (Capriotti, 2015). Diagnosing a patient with a migraine is based on clinical findings and symptoms (Capriotti, 2015). Some physicians may order a MRI or CT to rule out any other causes of the headaches.

A sinus headache is an example of a secondary headache. According to The International Headache Society, acute sinus headaches are occurring in conjunction with acute sinusitis (Capriotti, 2015). The pain is caused by sinus pressure and this pain can worsen when a patient leans over because all of the pressure in the head (Capriotti, 2015). When doing a physical assessment, we palpate the facial area over the sinuses, the maxillary sinus and the frontal sinus. If a patient is experiencing a sinus headache those two area will be tender and painful while palpating. A sinus x-ray may be used to confirm a diagnosis (Capriotti, 2015). The treatment for a sinus headache is typically a nasal decongestant or antibiotics (Capriotti, 2015).

Pathophysiology References (2) (APA):

Capriotti, Theresa M. and Frizzell, Joan Parker,. (2015). "Pathophysiology: Introductory Concepts and Clinical Perspectives (2015). *Faculty Bookshelf*. 75.

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.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.90-4.98 mill/cumm	4.20	3.73	
Hgb	12.0-15.5 gl/dL	13.6	12.1	
Hct	35%-45%	39.2	35.1	
Platelets	140-400 1000/mm3	161	147	
WBC	4.0-9.0 10*3/uL	4.6	4.5	
Neutrophils	40%-70%	69.0	39.4	
Lymphocytes	10%-20%	24.3	49.9	High lymphocytes can indicate an infection or other inflammatory conditions. Inflammation could be in the abdominal area causing pain. (Capriotti, 2015).
Monocytes	2%-8%	3.9	5.3	
Eosinophils	1%-4%	2.1	4.5	Eosinophils can indicate an allergic reaction or cancer. Patient was possibly going to get a liver biopsy, possible cancer in the liver? (Capriotti, 2015).
Bands	0-10%	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-	135-145 mEq/L	141	140	
K+	3.5-5.1 mEq/L	3.9	3.8	
Cl-	98-107 mEq/L	106	105	
CO2	22-29 mEq/L	29	28	
Glucose	70-99 mg/dL	99	109	High glucose can indicate diabetes or eating foods that cause the blood sugar to increase. (Capriotti, 2015).
BUN	6-20 Mg/dL	12	16	
Creatinine	0.50-1.00 Mg/dL	0.93	0.82	
Albumin	3.5-5.2 gm/dL	3.5	3.8	
Calcium	8.4-10.5 mg/dL	9.0	9.1	
Mag	1.7-2.2 mg/dL	n/a	n/a	
Phosphate	2.5-4.5 mg/dL	n/a	n/a	
Bilirubin	0.0-1.2 mg/dL	0.4	0.3	
Alk Phos	35-100 U/L	104	114	High Alk Phos. can indicate lymphoma, heart failure, or a bacterial infection. (Capriotti, 2015). Pt had a UTI prior to admission so that could indicate a bacterial infection.

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	straw	straw	Unable to obtain*	
pH	5-9	6.0	*	
Specific Gravity	1.003-1.030	1.005	*	
Glucose	normal	normal	*	
Protein	negative	negative	*	
Ketones	negative	negative	*	
WBC	0-5/hpf	n/a	*	
RBC	0-4/hpf	n/a	*	
Leukoesterase	negative	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	n/a	n/a	***No cultures completed for this patient**
Blood Culture	negative	n/a	n/a	
Sputum Culture	negative	n/a	n/a	
Stool Culture	negative	n/a	n/a	

Lab Correlations Reference (APA):

Lakeview College of Nursing reference sheet.

Capriotti, Theresa M. and Frizzell, Joan Parker,. (2015). "Pathophysiology: Introductory Concepts and Clinical Perspectives (2015). *Faculty Bookshelf*. 75.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

CT abdomen and pelvis w/o contrast

Bilateral nephrolithiasis

Diffuse hepatic steatosis

No inflammation, obstructions or significant acute abnormalities

EKG

Normal sinus rhythm

Pos. left arterial enlargement

Nonspecific T wave

Abnormality now evident in anterior leads

XR chest 1 view

Heart size normal

Lungs clear

There are healed granulomatous changes no visualized pneumothorax or pleural effusion

Osseous intact

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

Medications (5 required)

See next page

Brand/Generic	Heparin/ Heparin	Lamictal/ Lamotrigine	ConZip/ Tramadol hydrochloride	Benadryl/ Diphenhydramine hydrochloride	Microzide/ Hydrochlorothiazide
Dose	5000 units = 1 mL	50 mg	50 mg	50 mg	25 mg
Frequency	2x day	1x day	1x day	1x day	1x day
Route	SubQ	PO	PO	PO	PO
Classification	Anticoagulant	Anticonvulsant	Opioid agonist	Antihistamine	Diuretic
Mechanism of Action	Binds with antithrombin III enhancing antithrombins III's inactivation of the coagulation enzymes thrombin and factors Xa and Xla. Thrombin is needed for conversions of	Blocking the release of neurotransmitters, lamotrigine inhibits the spread of seizure activity in the brain, reduces seizure frequency and diminishes mood swings.	Binds with mu receptors and inhibits the reuptake of norepinephrine and serotonin, which may account for tramadol's analgesic effect	Diphenhydramine acts as an inverse agonist at the H1 receptor, thereby reversing effects of histamines on capillaries, reducing allergic reaction symptoms.	Inhibits sodium chloride transport in the distal convoluted tubule. More sodium is then excreted in the kidney with accompanying fluid.

Brand/Generic	Heparin/ Heparin	Lamictal/ Lamotrigine	ConZip/ Tramadol hydrochloride	Benadryl/ Diphenhydramine hydrochloride	Microzide/ Hydrochlorothiazide
	fibrinogen to fibrin; without fibrin, clots can't form.				
Reason Client Taking	Blood thinner	Prevent/control seizures	For pain	Allergies	Manage hypertension
Contraindications (2)	Sever thrombocytopenia; uncontrolled active bleeding except in DIC	Hypersensitivity to lamotrigine or its components	Acute or severe bronchial asthma in the absence of resuscitative equipment or unmonitored setting, alcohol intoxication; children underage of 12; excessive use of central-acting analgesics, hypnotics, opioids, or other psychotropic drugs; hypersensitivity to tramadol or its components.	Breastfeeding; hypersensitivity to diphenhydramine, similar antihistamines, or their components; use in newborns or premature infants.	Anuria; hypersensitivity to hydrochlorothiazide, other thiazides, sulfonamide derivatives, or their components.
Side Effects/Adverse Reactions (2)	Chills, dizziness, fever, headache, neuropathy	Amnesia, anxiety, aseptic meningitis,	Agitation, anxiety, asthenia,	Confusion, dizziness, drowsiness	Asthenia, dizziness, fever, headache,

Brand/Generic	Heparin/ Heparin	Lamictal/ Lamotrigine	ConZip/ Tramadol hydrochloride	Benadryl/ Diphenhydramine hydrochloride	Microzide/ Hydrochlorothiazide
		ataxia, confusion, depression, dizziness, drowsiness, emotional lability, exacerbation of parkinsonian symptoms, fever, headache, increase seizure activity, lack of coordination, suicidal ideation	depression, depression, dizziness, emotional lability, euphoria, fatigue, fever, hallucinations, headache, hypertonia, hypoesthesia, insomnia, lethargy, nervousness, paresthesia, restlessness, rigors, seizures, serotonin syndrome, somnolence, suicidal ideation, tremor, vertigo, weakness.		insomnia, paresthesia, restlessness, vertigo, weakness.

Medications Reference (APA):

Institute for Safe Medication Practices: ISMP Medication Safety Alert. (2020). *2020 Nurse's Drug Handbook.* (Nineteenth ed.). Burlington, MA: Jones & Bartlett learning

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented to time, place and person x4 No distress Well-groomed and dressed with make up on
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Pink Dry/normal Warm Turgor x2 No rashes present Bruises on lower abdomen due to heparin injections No wounds present 22
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head and neck symmetrical, normal range of motion in head, neck and mandible. No tracheal deviation. Ears free of discharge Nose symmetrical, no drainage, no septum deviation Teeth are white, good oral hygiene, no uvula deviation, mucosa is pink and moist, no swollen tonsils .
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:**	 Normal S1 and S2, no murmurs, gallops, or rubs were heard in the S3 and S4. Capillary refill is less than 3 seconds Peripheral pulses present and symmetric.
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	 Respirations are clear, regular, nonlabored, no wheezes or crackles.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:**	 Regular diet at home Hospital diet low sodium 160 cm 75.6 kg Bowel sounds are active

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:**	Last bm 10-9-20 No pain, no mass
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☒ N ☐** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Straw/yellow Clear Voided 800 Burning pain, Pt. had a UTI prior to admission.
MUSCULOSKELETAL: **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☐**	Normal ROM Patient up ad lib No weakness
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is aware of name, DOB, location, date Articulative speech Mature and cognitive Alert No neuro 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):**	 Friends and family Mature Christian Pt has sisters

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0755	**66**	**146/81**	**16**	**36.2**	**96**

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0755	**Numeric 0-10**	**Head and Abdomen**	**Abdomen- 8 Head- 2**	**Harsh and sharp**	**Cool washcloth for head and walk for abdominal pain**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600 mL	**800 mL**

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as	• Explain why the nursing diagnosis was		• How did the patient/family respond to the nurse's actions?

evidenced by" components	chosen		• Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to.. and evidenced by…	Patient was holding her abdominal area and stated her pain was an 8/10 pt also stated "I just want this pain to go away".	**1.**Gave the patient a cool washcloth for her headache **2.**Took the patient for a walk to help move her bowels	Patient had no family members present. Patient was no longer sleeping, instead she was sitting up in the bed. Patients head was relieved from the cool washcloth. Goal was met.
2. n/a		**1.** **2.**	

Other References (APA):

Concept Map (20 Points):

Subjective Data

Pt stated her pain was a 8/10 and requested medication to relieve the pain and she stated "I just want the pain to go away"

Nursing Diagnosis/Outcomes

Acute pain as evidenced by the patient holding her abdominal area and stating she had a headache. Patient also stated "I just want this pain to go away". Goal partially met when I checked back with her and she was up and moving around in stead of laying down and sleeping.

Objective Data

Pt holding abdominal area
Vitals
HR: 66
O2: 96
BP: 146/81
R: 16
T: 36.2

Patient Information

Pt has a history of migraines
Patient also takes medications for migraines

Nursing Interventions

1. Let the patient lay down in her room where it was dark and quiet to relieve her head with a cool washcloth.
2. Let the patient walk around to get her bowels moving so she would have a better chance of having a bowel movement to relieve her abdominal pain.
3. Check on the pt every hour to check her pain.