

N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 10/15/2020	Patient Initials PV	Age 69 years old	Gender Female
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Married	Allergies Codeine, Demerol, Dilantin, Keflex, Latex, Penicillin
Code Status FULL	Height 160 cm (5ft 3in)	Weight 89.7 kg (197.75 lbs)	

Medical History (5 Points)

Past Medical History: The patient has a history of anxiety, depression, diabetes type II, falls, gastroesophageal reflux disease (GERD), hyperlipidemia, hypertension (HTN), hypothyroidism, and myoclonus.

Past Surgical History:

The patient has had the following procedures:

- Left hip arthroplasty
- Cervical and Lumbar laminectomy
- Fusion implant
- Caesarean hysterectomy

Family History: The patient's mother was diagnosed with cancer (patient did not specify). Her sister was diagnosed with cardiac disorders (patient did not specify).

Social History (tobacco/alcohol/drugs): The patient stated that she only drinks alcohol on rare occasions (special occasions). She denied any smoking history, use of tobacco products, or use of illicit drugs.

Assistive Devices: The patient uses a walker and gait belt when ambulating.

Living Situation: The patient lives at home with her husband.

Education Level: The patient graduated high school from Wilmington.

Admission Assessment

Chief Complaint (2 points): The patient came in for vertigo, near syncope, and headache.

History of present Illness (10 points):

Mrs. V, a 69-year-old female, presented to the emergency department at Sarah Bush Lincoln on 10/15/2020 with vertigo, weakness in the lower extremities, and slurred speech. She stated that the onset of her symptoms started the morning of 10/15/2020 upon waking, to which she claimed she has, “never experienced these symptoms.” She said that her husband noticed that her speech was slurred. She stated that the symptoms subsided approximately 20 minutes from the start of onset. She has not implemented any interventions for relief because the symptoms resolved quickly. She denies any pain, palpitations, shortness of breath, or syncope.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Possible Transient Ischemic Attack (TIA)

Secondary Diagnosis (if applicable): Hypertension (HTN), diabetes type II, hyperlipidemia

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

Pathophysiology of TIA

A Transient Ischemic Attack (TIA) is a temporary disruption of blood flow to the brain due to an obstruction of a blood vessel (Hinkle & Cheever, 2018). Transient Ischemic Attacks are commonly known as a "mini-stroke" because individuals who experience a TIA can exhibit signs and symptoms of an actual ischemic stroke. A Transient Ischemic Attack can serve as a warning for any future possibilities of an ischemic stroke. It can also help to implement interventions for preventing a stroke (Capriotti & Frizzell, 2016). Many risk factors can lead to

the development of a Transient Ischemic Attack, which includes a familial history, age older than 55, high blood pressure, high cholesterol, cardiovascular disease, carotid artery disease, diabetes, excessive weight, and physical inactivity (Capriotti & Frizzell, 2016). Mrs. V is a 69-year-old lady with hypertension, hyperlipidemia, overweight, and type II diabetes with poorly controlled glucose levels.

Signs and symptoms

Some signs and symptoms to look out for are similar to that of an ischemic stroke. These signs and symptoms may include weakness or numbness in the face, arm, leg, slurred speech, vision disturbances, vertigo, severe headache, and balance loss (Hinkle & Cheever, 2018). Mrs. V presented to the ED with vertigo and a headache. She also stated other symptoms like slurred speech during the history of present illness assessment.

Vital signs, lab findings, and clinical data

Mrs. V's lab showed a correlation between the causes and risk factors for TIA's. Starting with her vital signs, she presented with a blood pressure of 132/82 at the assessment time on 10/19/2020. High blood pressure is one of the risk factors for developing a TIA (Capriotti & Frizzell, 2016). Mrs. V also presented with high lipid levels (hyperlipidemia) with a cholesterol level of 225, triglyceride of 164, and an LDL of 159 - these are all above normal limits. Additionally, Mrs. V has diabetes type II and a poorly controlled Hgb A1c at 8.4%.

Diagnostic testing

The provider may order an MRI angiogram of the brain and neck with or without contrast. The provider might order a head CT and an echocardiogram also (Hinkle & Cheever, 2018). Mrs. V had an MRI angiogram of the brain and neck without contrast. Her brain MRI was clear, but her MRI angiogram of the neck showed that her right carotid artery had a 70%

stenosis. The provider sent Mrs. V for an echocardiogram and a head CT, which showed no abnormal findings.

Treatments

TIA treatments include pharmacologic interventions like antiplatelet and anticoagulant drugs, surgery to remove atherosclerotic plaques, and angioplasty (Hinkle & Cheever, 2018). Mrs. V is on 40mg of Lovenox during her inpatient stay. She is also on 81mg of aspirin, an antiplatelet drug, for her pain.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

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	3.9-5.0	5.43	4.83	Normal lab value
Hgb	12.0-15.5	12.8	11.4	Normal lab value
Hct	35-45%	40.1	35.7	Normal lab value
Platelets	150-500 K	306	255	Normal lab value
WBC	4.5-11 K	8	5.8	Normal lab value

Neutrophils	45.3-79%	58.5	60.8	Normal lab value
Lymphocytes	11.8-45.9%	27.3	23.5	Normal lab value
Monocytes	4.4-12.0%	6.4	6.4	Normal lab value
Eosinophils	0.0-6.3%	N/A	N/A	N/A
Bands	0.0-5.0%	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-	135-145	136	135	Normal lab value
K+	3.5-5.0	4.1	4.3	Normal lab value
Cl-	98-108	103	101	Normal lab value
CO2	22-29	26	27	Normal lab value
Glucose	70-100	233	260	Glucose can be increased in diabetic patients (Hinkle & Cheever, 2018). The patient has type II diabetes.
BUN	8-25	16	16	Normal lab value
Creatinine	0.6-1.2	1.51	1.46	CCB and ACE inhibitors can cause an increased risk for renal dysfunction in patients with type II diabetes (Jones & Bartlett Learning, 2019). The patient is a type II diabetic on amlodipine and lisinopril for management of hypertension. Increased levels can also be caused by PPI therapy (Jones & Bartlett Learning, 2019). The patient is on pantoprazole.
Albumin	3.5-5.0	4	N/A	Normal lab value
Calcium	8.6-10.4	9.2	8.6	Normal lab value

Mag	1.6-2.4	N/A	N/A	N/A
Phosphate	2.5-4.5	N/A	N/A	N/A
Bilirubin	0.0-1.2	0.7	N/A	Normal lab value
Alk Phos	35-105	N/A	N/A	N/A
AST	0-35	19	N/A	Normal lab value
ALT	24-36	N/A	N/A	N/A
Amylase	30-110	N/A	N/A	N/A
Lipase	12-70	N/A	N/A	N/A
Lactic Acid	0.5-2.2	N/A	N/A	N/A
Troponin	0-0.4	<0.010	N/A	Normal lab value
CK-MB	0-4.9	N/A	N/A	N/A
Total CK	22-198	N/A	N/A	N/A

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	0.86-1.14	0.95	N/A	Normal lab value
PT	11.9-15	12.9	N/A	N/A
PTT	25-40	29.8	N/A	N/A
D-Dimer	<500	N/A	N/A	N/A
BNP	0-99	N/A	N/A	N/A
HDL	40-80	33	N/A	N/A
LDL	85-125	159	N/A	LDL can be increased in patients

				with hyperlipidemia (Capriotti & Frizzell, 2016). The patient has hyperlipidemia.
Cholesterol	<170	255	N/A	Cholesterol can be increased in patients with hyperlipidemia (Capriotti & Frizzell, 2016). The patient has hyperlipidemia.
Triglycerides	50-150	164	N/A	Triglycerides can be increased in patients with hyperlipidemia (Capriotti & Frizzell, 2016). The patient has hyperlipidemia.
Hgb A1c	<6%	8.4	N/A	7% and above is considered uncontrolled diabetes (Hinkle & Cheever, 2018). The patient has diabetes type II.
TSH	0.5-5	N/A	N/A	N/A

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 Clear	Yellow Turbid	N/A	Turbid color of urine can indicate dehydration (Hinkle & Cheever, 2018). Mrs. V stated that she does not drink fluids consistently.
pH	5.0-8.0	5.0	N/A	Normal lab value
Specific Gravity	1.005-1.034	1.016	N/A	Normal lab value
Glucose	Normal	>1,000	N/A	Positive glucose in urine can be seen in patients with poorly uncontrolled glucose levels (Hinkle & Cheever, 2018). Mrs. V has a poorly uncontrolled Hgb A1c at 8.4%.
Protein	Negative	Trace	N/A	Trace protein in urine can indicate dehydration (Hinkle & Cheever, 2018). Mrs. V stated that she does not drink fluids consistently.
Ketones	Negative	Negative	N/A	Normal lab value
WBC	<5	>100	N/A	The patient was positive for E. coli in her UA. WBC above 5 in urine is indicative of a UTI (Hinkle &

				Cheever, 2018).
RBC	0-4	4	N/A	Normal lab value
Leukoesterase	Negative	500	N/A	Positive leukoesterase in urine indicates there is an elevated number of WBC (Hinkle & Cheever, 2018). Mrs. V had a presence of E. coli in her urine culture which can indicate a UTI.

Arterial Blood Gas **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
pH	7.35-7.45	N/A	N/A	N/A
PaO2	80-100	N/A	N/A	N/A
PaCO2	35-45	N/A	N/A	N/A
HCO3	22-26	N/A	N/A	N/A
SaO2	95-100	N/A	N/A	N/A

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	Positive	N/A	Mrs. V had E. coli in urine culture
Blood Culture	Negative	Negative	N/A	Normal lab value
Sputum Culture	Negative	Negative	N/A	Normal lab value
Stool Culture	Negative	Negative	N/A	Normal lab value

Lab Correlations Reference (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

Jones & Bartlett Learning. (2019). *Nurses drug handbook*.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- 1.) MRI of the brain without contrast
- 2.) MRI angiogram of the brain without contrast
- 3.) MRI angiogram of the neck without contrast
- 4.) Echocardiogram
- 5.) Head CT

Diagnostic Test Correlation (5 points):

- 1.) An MRI/MRI angiogram allows for visualization of blood vessel activity that can detect blocked blood vessels (Hinkle & Cheever, 2018). The MRI angiogram of the neck showed a 70% stenosis of the right carotid artery.
- 2.) A head CT determines if the event is ischemic or hemorrhagic and this helps the provider decide on the treatment needed (Hinkle & Cheever, 2018). The head CT of the patient showed no abnormalities.
- 3.) An echocardiogram shows an outline of the heart's movements (Hinkle & Cheever, 2018). The patient's heart showed no abnormalities.

Diagnostic Test Reference (APA):

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

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

Home Medications (5 required)

Brand/Generic	Norvasc amlodipine	Aspirin aspirin	Lipitor atorvastatin	Levemir insulin detemir	Prinivil lisinopril
Dose	10mg (2 tabs)	81mg (1 tab)	80mg (1 tab)	45 units	40mg (2 tabs)
Frequency	Daily	Daily	Daily; HS	HS	Daily
Route	PO	PO	PO	SQ	PO
Classification	CCB; Antihypertensive	Nonopioid analgesic	Antihyperlipidem ic	Antidiabetic	ACE Inhibitor; Antihypertensive
Mechanism of Action	Inhibits influx of extracellular calcium ions across slow calcium channels.	Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis. Pain is relieved due to prostaglandins being blocked form being able to transmit pain from the periphery to the spinal cord.	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver by increasing the number of LDL receptors on liver cells to increase LDL uptake and breakdown.	Lowers blood glucose by stimulating peripheral glucose uptake by fat, skeletal muscle, and by inhibiting hepatic glucose production.	The medication prevents the actions of the angiotensin converting enzyme that converts angiotensin I to angiotensin II.
Reason Client Taking	Hypertension (HTN)	Pain	Hyperlipidemia	Diabetes Type II	Hypertension
Contraindications (2)	Renal impairment; hypersensitivity	Hemophilia; PUD	Active hepatic disease; unexplained rise in serum transaminase level	Hypersensitivity ; acute episode of hypoglycemia	Renal impairment; hypersensitivity to lisinopril
Side Effects/Adverse	Syncope;	Heartburn;	Syncope;	Hypoglycemia;	Ataxia;

Reactions (2)	arrhythmias	tinnitus	hepatitis	UTI	Hyperglycemia
Nursing Considerations (2)	Use amlodipine cautiously in patients with severe aortic stenosis; Assess pt frequently for chest pain	Ask about tinnitus; monitor bleeding time	Should not be used with colestipol or cholestyramine for additive antihyperlipidemic effects; Use cautiously in patients who consume a lot of alcohol or has a history of liver disease	Monitor patient's blood glucose levels closely and detect the need for dosage adjustments; monitor patient for hypersensitivity reactions	Should not be given to patients who are hemodynamically unstable after an acute MI; Use cautiously in patients with fluid volume deficit, heart failure, impaired renal function, or sodium depletion
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor blood pressure; Monitor liver function because amlodipine is extensively metabolized by the liver	Monitor PT, PTT, and INR; Monitor patients who are at risk for falls	Monitor liver functions; monitor renal functions	Monitor glucose levels before administration; monitor the patient's potassium levels – may cause hypokalemia	Monitor blood pressure before and after administration; Monitor for dehydration which can lead to hypotension
Client Teaching needs (2)	Take with food to reduce GI upset; Immediately notify your provider of dizziness, arm or leg swelling, difficulty breathing, hives, or rash	Take with food to reduce GI upset; stop taking aspirin and notify the provider for symptoms of internal bleeding like coughing up blood or tarry stools	Educate that atorvastatin is not a replacement for a healthy diet; Advise patient with diabetes to monitor glucose levels closely	Monitor your glucose levels; monitor for signs and symptoms of hypoglycemia	Take lisinopril at the same time everyday; caution to avoid hazardous activities such as driving until dizziness or other nervous system symptoms abates

Hospital Medications (5 required)

Brand/Generic	Lovenox enoxaparin	Phenergan promethazine	Synthroid levothyroxine	Zofran ondansetron	Protonix pantoprazole
Dose	40mg	12.5mg	88mcg (1 tab)	4mg (2mL)	40mg (1 tab)
Frequency	Daily	Q4H; PRN	Daily (morning)	Q6H; PRN	Daily
Route	SQ	IM	PO	IV push	PO
Classification	Antithrombotic	Antiemetic	Thyroid hormone	Antiemetic	Antiulcer; PPI

			replacement		
Mechanism of Action	Binds with antithrombin III and inactivates clotting factors (thrombin and factor Xa)	Acts centrally on medullary chemoreceptive trigger zone and by decreasing vestibular stimulation and labyrinthine function in the inner ear	Replaces thyroid hormone	Blocks serotonin receptors centrally – this reduces nausea and vomiting by preventing serotonin release in the small intestine	Interferes with gastric acid secretion by inhibiting the proton pump in gastric parietal cells
Reason Client Taking	VTE prophylaxis for inpatient stay	Nausea	Hypothyroidism	Nausea	GERD
Contraindications (2)	Major bleeding; thrombocytopenia	Hypertensive crisis; angle-closure glaucoma	Acute MI; untreated thyrotoxicosis	Long QT syndrome; hypersensitivity	Concurrent therapy with rilpivirine containing products; hypersensitivity
Side Effects/Adverse Reactions (2)	Headaches; thrombocytopenia	Hyperglycemia; hypertension	Headache; worsening of diabetic control	Elevated liver enzymes; syncope	Elevated triglycerides; hyperglycemia
Nursing Considerations (2)	Use with extreme caution in patients with a history of heparin-induced thrombocytopenia; Use extreme caution in patients with an increased risk of hemorrhage	Inject IM form deep into large muscle mass and rotate sites; patient should not have intradermal allergen test within 72 hours of receiving promethazine	Levothyroxin therapy is not to be used for treatment of obesity or for weight loss; Monitor blood glucose level of diabetic patient because drug may worsen glycemic control	Monitor patient closely for signs and symptoms of hypersensitivity; monitor patient's electrocardiogram as ordered	Administer delayed release 30 minutes before a meal; monitor urine output – the drug can cause acute interstitial nephritis
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor clotting factors (aPTT)	Monitor hematologic status as ordered – may cause bone marrow suppression	Monitor glucose levels before administration	Monitor telemetry for long QT interval	Monitor PR or INR during therapy. The patient is on anticoagulants.
Client Teaching needs (2)	Notify provider about reactions like bleeding; Instruct the patient	Notify provider if the patient has involuntary movements and	This drug is a life long therapy; Take with a full glass	Advise patient to use calibrated container or oral syringe to	Swallow pantoprazole tablets whole, do not chew;

	that taking aspirin or other NSAIDS can increase risk for bleeding	restlessness; Advise patient to avoid hazardous activities until the CNS effects of the drug has worn off	of water to avoid choking	measure oral solution; immediately report signs and symptoms of hypersensitivity, such as rash	Take medication 30 minutes before a meal
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Medications Reference (APA):

Jones & Bartlett Learning. (2019). *Nurses drug handbook*.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>The patient was awake and oriented to person, place, time, and situation (x4). The patient responded to the questions asked appropriately. She looked well nourished and in a good mood.</p> <p>There were no visible signs of distress noted or discomfort reported by the patient.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Braden Score: 20 (not a skin risk)</p> <p>The skin was pink in color, intact, warm, and dry to touch with good skin turgor.</p> <p>There were no rashes, bruises, or wounds noted or reported by the patient.</p> <p>No drains are present.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>The patient’s head is normocephalic and midline with no deviations. Trachea is midline. The patient exhibited PERRLA and the six cardinal fields of gaze. The tympanic membrane is pearly, grey in color, and intact bilaterally. There was no drainage in the patient’s ears. Her nose showed no deviated septum. Her nose showed equal turbinates, bilaterally. The oral mucosa is pink, moist, and intact with teeth present. Tongue was</p>

	<p>pink in color.</p> <p>No abnormalities noted.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	<p>S1 and S2 were heard. The patient was on telemetry, which showed sinus regular rate and rhythm. Peripheral pulses were palpated in pedal sites; graded at 2+ bilateral. Her capillary refill was less than 3 seconds.</p> <p>The patient's MRI angiogram of the neck, showed 70% stenosis of the right carotid artery. No bruit was heard on two separate assessments.</p> <p>There was no edema or JVD noted.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>The patient's respirations were even and unlabored at 20 breaths/min at the time of assessment. Her lungs were clear to auscultation in all lobes bilaterally with no accessory muscle use. The patient's chest moved with each respiration with no chest wall deformities noted. Her O2 sat was noted at 94% at the time of assessment.</p> <p>The patient had no productive cough.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Ht: 160 cm (5ft 3in) Wt: 89.7 kg (197.75 lbs)</p> <p>Last BM: Patient stated 10/18/2020</p> <p>The patient was not on any special diet at home; she was on regular diet in the hospital. Her abdomen was soft and non-distended with active bowel sounds in the LLQ. Re-auscultation of all quadrants was done for 3-5 minutes each after the patient ate breakfast; active bowel sounds were heard in all quadrants. The abdomen was round and moved with respirations.</p> <p>There was no organomegaly noted. No distention, incision, scar, drain, or wound noted. No feeding tubes in use.</p> <p>The patient did not report any discomfort.</p>
<p>GENITOURINARY (2 Points):</p>	<p>Upon assessment, the patient's urine was clear</p>

<p>Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size:</p>	<p>and yellow in the toilet hat measured at 500 mL.</p> <p>No distention of the bladder noted. The patient did not report any changes in voiding or dysuria. The patient did not have a catheter or on dialysis.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Fall Score: 60 (high fall risk)</p> <p>The patient has a history of falls.</p> <p>The patient was able to perform active range of motion in both upper and lower extremities, bilaterally. She exhibited equal bilaterally strength in all four extremities. The patient is a 1 assist for getting out of bed. The patient requires a walker and a gait belt with stand-by ambulation.</p> <p>There was no joint swelling noted. No discomforts reported.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>The patient moved all extremities well (MAEW). PERRLA was noted. Her strength is equal bilaterally in all extremities. Her mental status is appropriate for her age. She is alert and oriented x4. The patient speaks English as her primary language; she fluently and clearly responded to questions. Sensory is intact.</p> <p>No change in LOC noted.</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>The patient lives at home with her husband. She has six (6) children living out of state. She has six (6) siblings residing in Illinois. Mrs. V is a Baptist and has very strong beliefs.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
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0800	68	132/82	20	36.1	94%
1100	66	126/78	18	36.3	96%

Vital Sign Trends: The patient's vital signs showed a slight decrease in blood pressure and heart rate between the initial assessment and second assessment. Amlodipine (10mg) and lisinopril (40mg) were included in her 0900 medications. These medications aim to help reach and maintain the therapeutic ranges of blood pressure.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric	None	0/10	None	None
1100	Numeric	None	0/10	None	None

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	18 gauge, saline lock Right Antecubital (AC) Started on 10/15/2020 Patent with dry and intact dressing. No signs of erythema or drainage noted.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
4 ounces of water (120 mL)	500 mL

4 ounces of coffee (120 mL)	
Total from 0800-1100: <u>240 mL</u>	

Nursing Care

Summary of Care (2 points)

Overview of care: The first set of vital signs were taken at approximately 0800. The patient has ongoing hypertension and her blood pressure at the time of assessment was at 132/82. Mrs. V was given her morning medications at approximately 0930. After medication administration, I did a head-to-toe assessment on Mrs. V. There was nothing unusual noted or reported by the patient. Her medical diagnostic results show that she has a 70% stenosis of the right carotid artery. The artery was assessed and no bruit was heard. The last set of vital signs were taken at 1100; Mrs. V's blood pressure showed a slight decrease from the morning's vital signs.

Procedures/testing done: Mrs. V did not have any procedures ordered or done during my time on the floor. However, she had five (5) diagnostic tests done after being admitted to the hospital. These are – MRI of the brain without contrast, MRI angiogram of the brain without contrast, MRI angiogram of the neck without contrast, a head CT, and an echocardiogram.

Complaints/Issues: Mrs. V was very comfortable and had no complaints during my time on the floor.

Vital signs (stable/unstable): Mrs. V's vital signs were stable throughout my time on the floor. Her heart rate, respirations, oxygen, and temperature were all within normal limits between 0800 and 1100. She does have hypertension so her elevated blood pressure at 132/82 and 126/78 were within expected findings.

Tolerating diet, activity, etc.: Mrs. V was on no special diet and she was tolerating the diet well.

Physician notifications: The patient's physician did not have any notifications or did not see the patient during my time on the floor.

Future plans for patient: The goal for Mrs. V is to get her home safe, but at the time of providing my care, she had no discharge orders.

Discharge Planning (2 points)

Discharge location: Mrs. V will be discharged home with her husband.

Home health needs (if applicable): Mrs. V does not need any home health needs other than adherence to medication treatment.

Equipment needs (if applicable): Mrs. V will need to use her walker during ambulation. She will need to use her gait belt as well when walking.

Follow up plan: Mrs. V will need to follow up with her primary care provider for any further episodes of vertigo or slurred speech. She will also need to follow up to make sure that she is adhering to her prescribed medications.

Education needs: Mrs. V and her husband will need education on recognizing the signs and symptoms of TIA or stroke. They will need to know what to do, who to call, and where to go. Mrs. V will need education on safety precautions related to falls. Her fall score is 60 making her a high risk for falls. Lastly Mrs. V will need education with managing her diabetes Hgb A1c and hypertension.

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Intervention (2 per	Evaluation
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<ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>dx)</p>	<ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for falls related to vertigo as evidenced by history of falls</p>	<p>The patient has a history of falls.</p>	<p>1. Identify the patient’s risk for falls.</p> <p>2. Reduce or eliminate contributing factors for falls.</p>	<p>The individual will demonstrate selective prevention measures.</p>
<p>2. Ineffective health management related to hypertension, hyperlipidemia, and diabetes as evidence by elevated serum lab values.</p>	<p>The patient’s lab values are risk factors for developing a TIA or possible stroke.</p>	<p>1. Engage in a collaborative negotiation.</p> <p>2. Initiate health teachings and referrals as needed.</p>	<p>The individual will describe the relationship of present lifestyle and her health problems.</p>
<p>3. Risk for unstable blood glucose level related to diabetes type II as evidenced by poorly controlled Hgb A1c.</p>	<p>The patient has a poorly controlled Hgb A1c.</p>	<p>1. Educate patient about diet for glucose control.</p> <p>2. Educate patient about physical activities for glucose control.</p>	<p>The individual will demonstrate adequate knowledge with better approach to controlling her glucose levels.</p>
<p>4. Social isolation related to absence of support system as evidenced by depression.</p>	<p>All of the patient’s children live outside of Illinois and rarely visits.</p>	<p>1. Promote hopefulness.</p> <p>2. Explore activities that can improve coping on a day-to-day basis.</p>	<p>The individual will identify coping mechanisms.</p>

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

The patient did not report any pain during the shift
She stated that she is tolerating her diet well
She did not report any discomfort

Nursing Diagnosis/Outcomes

Risk for falls related to vertigo as evidenced by history of falls
Outcome: The individual will demonstrate selective prevention measures.
Ineffective health management hypertension, hyperlipidemia, and diabetes as evidenced by elevated serum lab values.
Outcome: The individual will describe the relationship of present lifestyle and her health problems.
Risk for unstable blood glucose level related to diabetes type II as evidenced by poorly controlled Hgb A1c
Outcome: The individual will demonstrate adequate knowledge with better approach to controlling her glucose levels.
Social isolation related to no family close by as evidenced by depression
Outcome: The individual will identify coping mechanisms.

Objective Data

Mrs. V had a blood pressure of 132/82 mm Hg
Her serum glucose was at 260
Her LDL was at 159
Her Cholesterol was at 225
Her triglycerides was at 164
Her Hgb A1c was at 8.4
Her MRI angiogram of the neck confirmed a 70% stenosis of the right carotid artery.

Patient Information

Mrs. V is a 69-year-old female who presented into the ED at SBL for vertigo, near syncope, and headache.

Nursing Interventions

- 1. Identify the patient's risk for falls.
- 2. Reduce or eliminate contributing factors for falls.
 - 1. Engage in a collaborative negotiation.
- 2. Initiate health teachings and referrals as needed.
 - 1. Educate patient about diet for glucose control.
- 2. Educate patient about physical activities for glucose control.
 - 1. Promote hopefulness.
- 2. Explore activities that can improve coping on a day-to-day basis.



