

N311 Care Plan # 2

Lakeview College of Nursing

Bao Cuong Tran

Demographics

Date of Admission 10/18/20	Patient Initials R.M.	Age 52	Gender Female
Race/Ethnicity White/Caucasian	Occupation Do it best hardware's employee	Marital Status Single	Allergies NKA (no known allergies)
Code Status Full Code	Height 5'4"	Weight 140 lbs	

Medical History

Past Medical History: None. Patient has never been to hospital before.

Past Surgical History: None

Family History: None

Social History (tobacco/alcohol/drugs): Heavy smoker (0.5 pack per day), non-drinker, no drug use.

Admission Assessment

Chief Complaint (2 points): Extreme dizziness, “the room is spinning whenever I walk”

History of present Illness (10 points): On set: On October 18, 2020, a 52 y/o white female was admitted to OSF Health Care for urinary infection with onset acute dizziness. Duration: started on Saturday, October 17, 2020 while working at night. Characteristics: the patient experienced dizziness and described that the room was spinning when standing; the symptom got worse when changing position; the patient reported left lower extremity is weaker than right. Aggravating: associated with onset headache which lasted for 10 minutes. Relieving: standing still to regain balance. Treatment: no treatment has been used since the patient has never been to a hospital before, and the symptoms are sudden.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Acute onset of severe Vertigo, Hypertension

Secondary Diagnosis (if applicable): Hypertension urgency, Bilateral impacted cerumen

Pathophysiology of the Disease, APA format (20 points): Acute Vertigo is a sensation of feeling off balance. Patients might feel like you are spinning or that the world around them is spinning (Pamela, 2019). However, this sensation is not correct. Episodes of Vertigo can last from minutes to hours and can associate with nausea, vomiting, or headache (Pamela, 2019).

Causes of vertigo is often caused by an inner ear problem (Capriotti,2016). Some of the most common causes are BPPV which stand for benign paroxysmal positional vertigo which occurs when tiny calcium particles clump up in canals of the inner ear, and confuses patient's sense of balance; Meniere's disease which is an inner ear disorder caused by a buildup of fluid and changing pressure in the ear which can lead to episodes of vertigo along with ringing in the ears and hearing loss; Vestibular neuritis or labyrinthitis which is an inner ear problem usually related to infection. The infection causes inflammation in the inner ear around nerves that are important for helping the body sense balance.

Common signs and symptoms of vertigo may include: spinning, tilting, swaying, unbalanced, pulled to one direction. In this case, the patient experience weakness in one side, spinning and, pulled to one direction when walking (Pamela, 2019). Other symptoms that may accompany vertigo include: feeling nauseated, vomiting, abnormal or jerking eye movements, headache, sweating, ringing in the ears or hearing loss.

Treatment for vertigo depends on what's causing it. In many cases, vertigo goes away without any treatment. However, in some cases, treatment is needed. Some treatment for vertigo are: vestibular rehabilitation which will help strengthen the vestibular system; Canalith

repositioning maneuvers which are done by doctors to move the calcium deposits out of the canal into an inner ear chamber so they can be absorbed by the body; and medicine. In some cases, medication may be given to relieve symptoms such as nausea or motion sickness associated with vertigo. If vertigo is caused by an infection or inflammation, antibiotics or steroids may reduce swelling and cure infection.

Pathophysiology References (2) (APA):

Capriotti, Theresa M. and Frizzell, Joan Parker, “Pathophysiology: Introductory Concepts and Clinical Perspectives” (2016). *Faculty Bookshelf* 75.

Pamela, Swearingen L. and Jacqueline, Wright D, “All-in-One Nursing Care Planning Resource” (2019). *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	4.10 – 5.7	4.9	4.71	
Hgb	12.0 – 20.0	15.0	14.5	
Hct	37% - 51%	44.5	42.9	
Platelets	140 – 400	282	268	
WBC	4.0 – 11.0	5.9	6.2	
Neutrophils				

Lymphocytes				
Monocytes				
Eosinophils				
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-	136 – 145	139	141	
K+	3.5 – 5.1	4.1	3.9	
Cl-	98 – 107	101	99	
CO2	21 – 32	25	26	
Glucose	60 – 99	282	265	Stress from the situation
BUN	7 – 18	13	17	
Creatinine	0.70 – 1.3	0.78	0.74	
Albumin	3.4 – 8.0	3.9	*	
Calcium	8.5 – 10.1	9.0	8.6	
Mag	1.6 – 2.6	1.9		
Phosphate				
Bilirubin				
Alk Phos		62		

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				
pH				
Specific Gravity				
Glucose				
Protein				
Ketones				
WBC				
RBC				
Leukoesterase				

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				
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test

reference. St. Louis, MO: Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

CT Head or Brain without contrast: No intracranial bleed; no mass lesion; no mass effect is identified. The ventricles cisterns and sulci fit the age of the patient. No abnormality in the paranasal sinues.

Current Medications (10 points, 2 points per completed med) *5 different medications must be completed*

Medications (5 required)

Brand/ Generic	Amlodipine /Norvasc	Enoxaparin /Lovenox	Glipizide	Hydrochlorazine	Acetaminophen/ Tylenol
Dose	5mg	40mg	15g	5mg	650mg
Frequency	daily	Every 24 hours	Every morning before breakfast	Every 6 hours	PRN
Route	oral	subcutaneous	oral	oral	oral
Classification	antihypertensive	anticoagulant	antidiabetic	Anti-inflammatory	antipyretic
Mechanism of Action	Decreased peripheral vascular resistance.	Potentiate the action of antithrombin III	Stimulate insulin release in pancreas	Block the activity of cyclooxygenase	Inhibit cyclooxygenase enzyme.
Reason Client Taking	To treat hypertension	To treat hypertension	Control blood sugar	Relieve pain and fever	Reduce pain
Contraindications	Hypersensitivity	Active	Hypersensitivity	Active	Severe hepatic

ions (2)	tive to amlodipine or its components	major bleeding	tive to glipizide	bleeding	impairment
Side Effects/ Adverse Reactions (2)	Anxiety, dizziness	Confusion , bloody stool	Anxiety, chills, depression	confusion	Fatigue, fever

Medications Reference (APA):

Institute for Safe Medication Practice: ISMP Medication Safety Alert. <http://www.ismp.org/>.

Jones & Barlett Learning. (2020). 2020 Nurse’s Drug Handbook. Burlington, MA

Assessment

Physical Exam (18 points)

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Alerted and oriented to person, place, time No acute physical distress
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Skin is pink, warm, and dry, no rashes, bruise, or lesions on exposed skin No palpable cervical or supraclavicular adenopathy bilaterally Cap refill is less than 3 seconds
HEENT: Head/Neck: Ears:	Head atraumatic and normocephalic Neck supple Pupils equal bilaterally, no icterus,

Eyes: Nose: Teeth:	conjunctival exudate bilaterally No ear discharge, no facial swelling, no external otitis/rhinitis/pharyngitis/oral thrush No pain or visual disturbance
CARDIOVASCULAR: 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 checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:	Clear S1&S2 sound, regular rhythm, no murmurs, gallops, or rubs No chest pain Pulses are palpable No edema No cyanosis
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	Equal air entry bilaterally, clear to auscultation bilaterally No shortness of breath No chest tightness No cough, choking
GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: 10/12/2020 Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Abdomen is soft, nontender, normal bowel sounds, no hepatosplenomegaly No nausea, diarrhea
GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals:	Urine is light yellow, no odor Small amount of urine

<p>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" 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>Negative for myalgias, joint swelling, and arthralgias High fall risk Need assistance for walking</p>
<p>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Alert, oriented Move 4 extremities spontaneously and symmetrically Dizziness, weakness Weaker on one side</p>
<p>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):</p>	<p>Religious English only Dysphonic mood, sleep disturbance No family</p>

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:35 a.m.	61	131/73	18	97.9 (oral)	95%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8 a.m.	2	Shoulder	mild	Dull, mild	Raising the head of the bed

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
360	50

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<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 		<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.
1. Cerumen impaction	Related to vertigo as evidence by “the room is spinning”, “extreme dizziness”	1. Manual removal cerumen with the cooperation of the patient 2. Topical preparations since the patient has no known allergies	Goal partial met as the patient feels better, but still need assistance for walking
2. Risk of fall	Related to vertigo	1. Ambulating	Goal met as the patient

	<p>as evidence by “lean to one side when walking”, “run into things then fall”</p>	<p>with cane, and assistance from the nurse</p> <p>2.Set bed, floor, and chair alarm so the nurse can be in the room to assist when the patient try to walk alone</p>	<p>has not experienced any falls during the stay in the hospital</p>
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Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient complain of “the room is spinning”, “extreme dizziness”, “lean to one side when walking”, “run into things then fall”

Nursing Diagnosis/Outcomes

Cerumen impaction related to vertigo as evidence by “the room is spinning”, “extreme dizziness”

* Risk of fall related to vertigo as evidence by “lean to one side when walking”, “run into things then fall”

Objective Data

Chief Complaint: Extreme dizziness
Primary Diagnosis: Acute onset of severe Vertigo, Hypertension
Pulse: 61
BP: 131/73
Respiratory: 18
Temperature: 97.9
O2: 95%

Patient Information

A 52 y/o white female presented with onset acute dizziness started on Saturday, October 17, 2020 while working at night. The patient experienced dizziness and described that the room was spinning when standing, associated with onset headache which lasted for 10 minutes..

Nursing Interventions

1. Manual removal cerumen with the cooperation of the patient
2. Topical preparations since the patient has no known allergies
3. Ambulating with cane, and assistance from the nurse
4. Set bed, floor, and chair alarm so the nurse can be in the room to assist when the patient try to walk alone

