N431 Care Plan #2

Lakeview College of Nursing

Rece Doggett

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
11-15-2020	JH	57	M
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Unemployed	Married	NKA
Code Status	**Height**	**Weight**	
Full code	6' 0"	240 lb.	

Medical History (5 Points)

Past Medical History: Hypertension, degenerative disk disease, hyperlipidemia, and prediabetes are all JHs' previous diagnoses.

Past Surgical History: Gall bladder removal and ulnar nerve neuroplasty.

Family History: Brother – substance abuse, arthritis; father – cancer, psychiatry; mother – thyroid; sister & son - arthritis

Social History (tobacco/alcohol/drugs): Client no longer uses drugs or tobacco products. He quit smoking 20 years ago and smoked a pack a day for 15 years. Client stated his last use of cannabis products was 40 years ago. Now, he drinks socially or with family around the holidays.

Assistive Devices: Glasses

Living Situation: Lives with wife at home. All of the kids have moved out.

Education Level: Client graduated high school.

Admission Assessment

Chief Complaint (2 points):Dizziness

History of present Illness (10 points): JH stated he was at Aldi's grocery store walking around the fruit section. He said, "I tried to look at my wife and tell her I wasn't feeling good, but that is all I remember." According to bystander and an off-duty nurse JH's jaw clenched up and he lost

control of his bladder showing signs of a seizure. This episode lasted between 30 and 60 seconds. He was also pulseless and not breathing after the episode which resulted in the nurse performing CPR. He stated he remembers hearing the nurse say, “We got him back.” The client does not know the cause of this nor the aggravating or relieving factors for his complication.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Seizure

Secondary Diagnosis (if applicable): Hypertension, prediabetes

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

There are many different types of seizures and can occur due to many different circumstances. The different types of seizures include generalized tonic-clonic, generalized absence, generalized myoclonic, partial simple motor, partial complex seizure, and status epilepticus (SE) (Swearington & Wright, 2018). Mayo clinic (2020) describes seizures as electrical disturbances in the brain that cannot be controlled. This interruption can be anything that disrupts the normal connection between nerve cell and the brain. Seizures may be controlled with medication and avoiding triggers. It is important to monitor the length of time that a seizure lasts. If you have two or more seizures or have many episodes you have epilepsy. Seizures affect the neurological system of the body and can cause harm to extremities due to falls or involuntary jerking of limbs.

Mayo clinic (2020) tells us the signs and symptoms of a seizure are staring spells, uncontrollable jerking movements, temporary confusion, loss of consciousness or awareness, or cognitive/emotional symptoms such as fear or anxiety. To rule out metabolic causes of seizures CMP, liver and kidney functions and toxicology screens will be done. Other diagnostic tests include EEG while awake and sleeping, magnetic resonance imaging (MRI), positron emission tomography, computed tomography (CT), and skull radiographic examination (Swearington & Wright, 2018). JH did not quite understand

everything that happened. He did experience some confusion, loss of consciousness, tension/stiffening of the jaw, and anxiety as the episode was beginning. He also had many diagnostic tests performed to no conclusion as to the cause of his seizure. His blood work came back normal and all his scans came back as the doctor describes as “unremarkable”.

The types of the seizure depend on the severity of the damage it could cause. With absent seizures or petit mal seizures you are more likely to see someone just stare off into space or smack their lips which usually result in little to no danger in most circumstances. Tonic seizures stiffen muscles in your back, arms, and legs. This can result in a fall and or other physical injury. Clonic seizures occur with repeated jerking of the muscles in a rhythmic form and usually occurs around the neck, face, and arms. Tonic-Clonic seizures are known as grand mal seizures which are the most aggressive form of seizures. These seizures cause loss of consciousness, body stiffening, loss of bladder control, and biting. (Mayo Clinic, 2020).

As a nurse when a client has a seizure the number one priority is to keep the client safe and ensuring a safe environment. Adjust medication appropriately as some have more severe adverse effects. Medication is the best method of treatment for seizures, but when you start medications for seizure chances are you will need to take them the rest of your life. The nurse should also assess the financial capabilities and assess adherence to plan of care. Some medication can be given through IV to stop and prevent seizures such as Ativan. If the client is not understanding as to the cause of the disease after diagnostic testing the best thing to do is find and avoid triggers. Seizure pads were provided for the patient to prevent injury if another seizure were to occur.

Pathophysiology References (2) (APA):

Hinkle, J. L., & Cheever, K. H. (2017). *Brunner & Suddarth's textbook of medical-surgical nursing*. LWW.

Seizures - Symptoms and causes. (2020, June 3). Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/seizure/symptoms-causes/syc-20365711

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	4.4 – 5.8	**4.11**		
Hgb	13 – 16.5	**13.2**		
Hct	38 – 50	**37.8**		
Platelets	140 – 446	**158**		
WBC	4 – 12	**8.4**		
Neutrophils	40 – 60	**64.1**		**Neutrophils are the bodies most abundance WBC. Elevated levels may show beginning signs of a bacterial infection. (American Association for Clinical Chemistry, 2020).**
Lymphocytes	18-42	**27.1**		
Monocytes	4-12	**7.2**		
Eosinophils	0.0 - 5.0	**0.7**		
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-	133 – 144	**139**		
K+	3.5 – 5.1	**3.5**		
Cl-	98 – 107	**106**		
CO2	21 – 31	**24**		
Glucose	70 – 99	**112**		**Diabetes can cause glucose levels to be high. Prediabetes is the beginning stage of diabetes (Hinkle & Cheever, 2017).**
BUN	7 – 25	**16**		
Creatinine	0.5 – 1.2	**0.96**		
Albumin	3.5 – 5.7	**4.1**		
Calcium	8.6 – 10.3	**8.6**		
Mag				
Phosphate				
Bilirubin	0.2 – 0.8	**0.3**		
Alk Phos	34 - 104	**61**		
AST	13 - 39	**39**		
ALT	7 – 52	**39**		
Amylase				
Lipase				
Lactic Acid				
Troponin				

CK-MB				
Total CK				

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	**No labs available**			
PT				
PTT				
D-Dimer				
BNP				
HDL				
LDL				
Cholesterol				
Triglycerides				
Hgb A1c				
TSH				

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	**No UA in chart**		
pH	4.5 – 8.0			
Specific Gravity	1.003 – 1.030			

Glucose	Neg			
Protein	Neg			
Ketones	Neg			
WBC	Neg,0 – 2			
RBC	Neg, 0 – 2			
Leukoesterase	Neg			

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	**No ABGs performed**			
PaO2				
PaCO2				
HCO3				
SaO2				

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	**No cultures performed**			
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Complete blood count (CBC) - Understand the test & your results. (2020, April 12). Patient Education on Blood, Urine, and Other Lab Tests| Lab Tests Online. https://labtestsonline.org/tests/complete-blood-count-cbc

Hinkle, J. L., & Cheever, K. H. (2017). *Brunner & Suddarth's textbook of medical-surgical nursing*. LWW.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Other diagnostics JH underwent include an MRI w/o contrast – the results show no evidence of acute infarction. CT of the head and neck with contrast – unremarkable. CT of head and brain w/o contrast – no significant findings. EKG 12 lead that reads normal sinus, normal rhythm. EEG which also shows no abnormal findings. All tests were taken due to the loss of consciousness and to check for injury to the head or brain.

Diagnostic Test Correlation (5 points): Computed tomography (CT) checks for lesions hematomas or tumors in the brain, head, neck, or abdomen (Swearingen & Wright, 2018). These problems can be triggered by trauma or naturally by the body. MRI or magnetic resonance imaging shows a more in depth picture that the CT does, but looks for similar complications. Skull radiographic examination – reveals tumors, fractures, and calcifications (Swearingen & Wright, 2018). The tests the patient had done are listed above with the results. CT scans may be ordered if a patient experiences syncope, head trauma, or headaches that do not go away.

Diagnostic Test Reference (APA):

Swearingen, P. L., & Wright, J. (2018). *All-in-One nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. Mosby.

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

Home Medications (5 required)

Brand/Generic	Tylenol Acetaminophen	Hydrocodone-acetaminophen				
Dose	650 mg	5 – 325 mg				
Frequency	PRN Q4	PRN Q4				
Route	PO	PO				
Classification	Non opioid analgesic	Opioid analgesic				
Mechanism of Action	Binds to pain receptors	Binds to pain receptors				
Reason Client Taking	Fever, pain	Acute pain				
Contraindications (2)	Hypersensitivity to components or drug, hepatic impairment	Taking with acetaminophen (OD), use caution in those who have abused drugs in the past				
Side Effects/Adverse Reactions (2)	Agitation, anxiety, stridor	N/V/D, abdominal pain				
Nursing Considerations (2)	Use cautiously in those with hepatic impairment, monitor renal function, give as prescribed to prevent overdose	Ensure proper dosage and administration, Check drug-drug interactions				
Key Nursing Assessment(s)/Lab(s)	Liver enzymes should be	Liver enzymes,				

Prior to Administration	checked, assess clients pain before giving, don't give with the Norco	clients neuro and pain should be assessed before administration				
Client Teaching needs (2)	It can be easy to overdose on Tylenol when taking with Norco because it also has the drug in it, take as recommended (Jones & Bartlett, 2018)	This substance can be addictive, take as prescribed to avoid dependency. (Jones & Bartlett, 2018)				

Hospital Medications (5 required)

Brand/Generic	Zestril Lisinopril	Hydrochlorothiazide	Porcine HEParin		
Dose	10mg	12.5mg	5000 units		
Frequency	Daily	Daily	Q8 hours		
Route	PO	PO	SubQ		
Classification	Antihypertensive	Antihypertensive	Anticoagulant		
Mechanism of Action	Inhibits conversion of angiotensin I	Decreases cardiac output, extracellular fluid volume, or plasma volume.	Binds with antithrombin III preventing blood from clotting		
Reason Client Taking	HTN	HTN	Prevent DVT		
Contraindications (2)	Concurrent aliskiren use, patients with renal	Anuria, hypersensitivity to drug or other thiazides	Active bleeding, breastfeeding, history of HIP (heparin-induced		

	impairments		thrombocytopenia)		
Side Effects/Adverse Reactions (2)	Confusion depression chest pain, syncope	Dizziness, weakness, chills, fever	Chills, dizziness, chest pain, easy bruising		
Nursing Considerations (2)	Should not be given to those hemodynamically unstable after an MI, use cautiously with clients who have fuild volume deficit, heart failure, or impaired renal function.	Check blood pressure, monitor weight daily, give with food to increase bioavailability	Should not be given to neonates, infants, or pregnant women due to the benzyl alcohol, alternate injection sites to prevent skin breakdown.		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Kidney function labs, Assess blood pressure before giving.	Blood pressure, electrolytes labs,	Check clotting factors, and look for bruising or other signs of internal bleeding. Check for bleeding at injection site		
Client Teaching needs (2)	Helps control and does not cure HTN, Tell patient to report dizziness especially in the first few days of starting this medication. (Jones & Bartlett, 2018).	Take with food, change positions slowly, especially in the mornings. (Jones & Bartlett, 2018).	Makes you more prone to bleeding, can not be taken orally, use a soft-bristled toothbrush. (Jones & Bartlett, 2018).		

Medications Reference (APA):

Learning, J. &. (2018). *2019 nurse's drug handbook*. Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	JH is AO x4 Appears in hospital gown Shows no acute distress
INTEGUMENTARY (2 points): **Skin color: Pink** **Character: Dry** **Temperature: Warm** **Turgor: Rapid** **Rashes: See right** **Bruises: " "** **Wounds: None** **Braden Score: 27 – low risk** **Drains present: Y☐ N ☒** **Type:**	Client fell from a standing to sitting position and then ended in a supine position this resulted in some bruising to the clients left shoulder and scarring where he had a previous surgery on his elbow.
HEENT (1 point): **Head/Neck: See right for whole section** **Ears:** **Eyes:** **Nose:** **Teeth:**	Normocephalic, no abnormalities involving the ears, eyes, nose, or teeth. Smile is even bilaterally
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): Regular** **Peripheral Pulses: 2+** **Capillary refill:<3 seconds** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: None**	S1 and S2 sounds present with no S3 or S4 noted. EKG shows normal sinus and normal rhythm

RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No use of accessory muscles Clear lung sounds bilaterally
GASTROINTESTINAL (2 points): **Diet at home: Normal** **Current Diet Normal** **Height: 6'** **Weight: 240 lb.** **Auscultation Bowel sounds: hyperactive** **Last BM: Previous day** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Client does not show any abnormalities upon inspection of the abdomen. There is a scar in the upper right quadrant from a gall bladder removal. No distention incision, drains or wounds noted.
GENITOURINARY (2 Points): **Color: Yellow** **Character: Clear** **Quantity of urine: unknown** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Chart states the clients output is 700.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM: Full ROM** **Supportive devices: glasses** **Strength: strong/full strength** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 45** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐**	Client stood up and squatted even with the bed experiencing no issues or loss of balance. Due to fall and IV the fall score is 45 placing him under a fall risk.

Needs support to stand and walk☐	
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: Follows commands** **Mental Status: understands and comprehends** **Speech: Clear** **Sensory: Normal** **LOC: Loss of consciousness at the store.**	
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Christian** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Client enjoys spending time outdoors and fishing with his kids and grandkids. Lives at home with a very supportive wife.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1100	**71**	**142/78**	**18**	**98.3 oral**	**98% RA**
1500	**63**	**133/71**	**16**	**98.6 Oral**	**100% RA**

Vital Sign Trends: Vitals signs stable throughout stay.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1430	Numerical	N/A	0/10	None	None
1655	Numerical	N/A	0/10	None	None

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g **Location of IV: R median vein** **Date on IV:11/15/2020** **Patency of IV: Functions properly** **Signs of erythema, drainage, etc.:** **IV dressing assessment: Clean, dry, intact**	Saline lock currently has no fluids running, but functions well

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1480	**700**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient diagnostic tests do not show any cause of syncope or seizure. Client seems to feel better with minimal intervention**.**

Procedures/testing done: Multiple CTs, an MRI, and labs were drawn on this patient. An EKG was also performed to check for cardiac related syncope.

Complaints/Issues: The only complaint the client has is the inability to find the cause of the problem.

Vital signs (stable/unstable): Vitals were stable during shift**.**

Tolerating diet, activity, etc.: Client seems to be tolerating activities as normal with no difficulties or challenges.

Physician notifications: None were listed.

Future plans for patient: Possible cardiology consult to check if the clients syncope was caused by a cardiac related issue.

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): None

Equipment needs (if applicable): None

Follow up plan: Possibly neurology visit if the doctor recommends it before discharge.

Education needs: General seizure education in care something happens again.

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. Acute pain related to the fall as evidence by bruising and verbal expression.	Managing pain is important for providing the best possible patient care.	1.Assess client pain and determine OLDCARTS of the pain 2.Determine clients perception of pain and take vitals before administering any medications (Nurseslabs, 2020)	Client is currently not experiencing pain at this time. Earlier, the client experienced so chest soreness from the chest compressions the day before. The client was given Tylenol and has not had pain since.
2. Risk for fall related to inability to	Falls contribute to many injuries among people of	1. Assess client for fall risk upon admission and	The client is a risk for falls due to the recent fall and saline lock. The

control body as evidenced by the previous fall the patient experienced concurrent to his seizure.	all ages. Preventing injury from falls should be a priority for anyone who is at risk.	throughout stay and history of falls. 2.Look for changes in mental status or any other physical changes to the client (Nurseslabs, 2017).	client shows no changes of physical or mental status. This is a positive outcome because the patient has a steady gait and can walk without issue.
3. Powerlessness related to inability to control body as evidenced by client stating that it was embarrassing and the desire to be with his grandkids even though he is unable to at the current moment.	Powerlessness can lead to negative emotions such as fear, anxiety, and hopelessness. Identifying and helping someone feel empowered can be therapeutic to mental and physical health.	1.Assess for feelings of depression, hopelessness, or extreme grief. 2Evaluate client's ability to identify and interact in different situations of stress or hardship (Nurseslabs, 2018).	Client understands that the event that happened was not something that he could have prevented and is able to start moving forward. He is currently of a sound mind and understanding of the emotions he had and has implemented his own coping mechanisms.
4. Need for health teaching due to unfamiliarity of disease as evidenced by the client stating this has never happened before and clients	The client verbally expressed the fact he has never had a seizure before and never really thought about or investigated this subject.	1.Assess what the client knows about seizures and how they effect the body. 2. Teach client and family basic interventions as to what to do when someone has a seizure. (Nurseslabs, 2019).	Client verbalized understanding to knowing there are different kinds of seizures. Client now knows when a person is having an episode to maintain a safe environment, turn person on their side, and to keep the individual safe by protecting the head.

Other References (APA):

Swearingen, P. L., & Wright, J. (2018). *All-in-One nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. Mosby.

Acute pain – Nursing diagnosis & care plan. (2020, April 30). Nurseslabs. https://nurseslabs.com/acute-pain/

Risk for falls – Nursing diagnosis & care plan. (2017, September 23). Nurseslabs. https://nurseslabs.com/risk-for-falls/

Powerlessness – Nursing diagnosis & care plan. (2018, May 4). Nurseslabs. https://nurseslabs.com/powerlessness/

Deficient knowledge – Nursing diagnosis & care plan. (2019, March 14). Nurseslabs. https://nurseslabs.com/deficient-knowledge/

Concept Map (20 Points):

Subjective Data

JH expressed that he was experiencing dizziness and wanted to tell his wife he was not feeling well. He does not remember anything after this because he lost consciousness.

Nursing Diagnosis/Outcomes

Acute pain – JH experienced minimal pain during his stay. He received medication at the beginning of the day during our clinical stay and he did not require any further interventions. Altogether the client has had a positive outcome for acute pain.

Risk for falls – Client shows steady gait with no physical or mental impairments. The client is at risk for falls but presents well on his feet and is able to squat even with the hospital bed.

Powerlessness – Client understands that this was a life event that was unable to be prevented. Client expressed the desire to find what the problem was even though there is no evidence as to why this seizure occurred.

Knowledge deficit/need for health teaching – Client now knows more about what to do if a person experiences a seizure. He also knows it is important to help someone to the ground if they feel that a seizure is about to start again.

Objective Data

Clients lab work and imaging came back with little evidence for what caused this episode. Client is not currently displaying any symptoms of syncope or feelings that are abnormal. Vitals were stable throughout JH's stay.

Patient Information

Client is a 57 YO male who was admitted for a syncopal episode. Patient is compliant with current medications.

Nursing Interventions

Acute pain – Assess pain, HPI, and clients perception of pain

Risk for falls – Assess clients physical and mental status, assess client fall risk score and plan accordingly

Powerlessness – encourage client to express feeling of sadness or grief and help the client move past those feelings, assess verbal and nonverbal cues for client emotional or physical stability.

Knowledge deficit – Assess what the client knows about seizures and what to do if one occurs.