

N321 Care Plan # 1

Lakeview College of Nursing

Macie Wilson

Demographics (3 points)

Date of Admission 02/03/2021	Patient Initials MG	Age 85 years old	Gender Female
Race/Ethnicity Not Hispanic or Latino	Occupation Retired	Marital Status divorced	Allergies Shellfish, Aleve, Bactrim. ciprofloxacin, niacin, tetanus toxoid adsorbed.
Code Status Full	Height 5'1"	Weight 89lb	

Medical History (5 Points)

Past Medical History: Osteoporosis, oropharyngeal dysphagia, hypertensive urgency, arthritis, abdominal aneurysm, emphysema of lung, high cholesterol, hypertension, measles, nuclear sclerosis, tobacco abuse.

Past Surgical History: Cataract removal with implant, cholecystectomy, EGD colonoscopy, upper gastrointestinal endoscopy.

Family History: Patients daughter has tendencies to form blood clots.

Social History (tobacco/alcohol/drugs): Continuous dependence on cigarette smoking, 2 packs a day.

Assistive Devices: She uses a walker.

Living Situation: Home with her daughter.

Education Level: College degree in Nursing from Parkland College.

Admission Assessment

Chief Complaint (2 points): generalized weakness

History of present Illness (10 points): Mary L Gallo is an 85-year female with past medical history of CVA around 2013, essential hypertension, abdominal aortic aneurysm, lower

thoracic aortic aneurysm, is presented to the hospital with the chief complaint of right-sided weakness that started 2/3. After going through her morning routine, she noticed that her right sided upper and lower weakness. The weakness did subside after 20 minutes. The weakness did however reoccur. She states that it felt like she couldn't do anything, and her legs were numb. She also states she feels dizzy while this episode is occurring. She is on aspirin 81mg at home. Patient does continue to smoke and has done so for many years. She has history of COPD and emphysema. She is baseline independent in ADL and lives at home with her daughter. This is the first time this has happened and therefore the first time she has sought out treatment.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): TIA (transient ischemic attack)

Secondary Diagnosis (if applicable): abdominal aortic aneurysm without rupture, hypertension (chronic), dependence on cigarette smoking.

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

The client comes to the emergency room with generalized weakness. The client was later diagnosed with TIA, otherwise known as a transient ischemic attack. TIA is also known as a type of stroke. However, this stroke only lasts a few minutes and occurs when the blood supply to part of the brain is blocked for a brief period. A stroke occurs when a blood clot blocks an artery, which causes damage by the buildup of plaques or atherosclerosis. Ischemic stroke is the most common type of stroke. Symptoms of a TIA are those similar to other stroke-like symptoms however do not last as long. One of the symptoms includes numbness and weakness, troubling walking, and loss of balance, all of which the client experienced. TIA disappears within hours, although they could last up to 24 hours. To tell if these symptoms were caused by a stroke or by

a TIA, you must immediately go to the hospital. A TIA is also a warning sign that there could be a stroke in the future. To prevent a stroke from occurring, the client should take medications such as blood thinners and ask the physician about recommend surgery. The client should also try living a healthy lifestyle by not smoking, drinking, exercising, and having a good healthy diet. It is also crucial for the client to control their other health problems like hypertension (NIH 2020).

If the client were to have a stroke, her activities of daily living would be affected. The client could experience trouble speaking, seeing, weakness of the face, arms, legs, or one-sided weakness. This could cause the client to experience a loss of independence. However, the client is getting up and moving around and is no longer complaining of generalized weakness; therefore, physicians believe this was a TIA even without the MRI results coming back.

In order to diagnose a TIA, a CT of the head is done first. The CT of the head allows the care team to know if the episode was stroke related. If the CT comes back and there are signs of dead tissue due to loss of blood supply, then the physician will then need to

Pathophysiology References (2) (APA):

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

National Institute of Neurological Disorders and Stroke, NIH. (Ed.). (2020, November 17). Transient ischemic attack | tia | mini-stroke. Retrieved February 11, 2021, from https://medlineplus.gov/transientischemicattack.html#cat_92

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	4.0-4.9	5.00	4.75	Low oxygen levels (Swearing & Wright, 2019).
Hgb	12.0-16.0	13.8	13.1	Normal range
Hct	37.0-48.0%	41.8	39.9	Normal range
Platelets	150-400	193	183	Normal range
WBC	4.1-10.9	9.80	8.10	Normal range
Neutrophils	1.50-7.70	7.4	6.5	Normal range
Lymphocytes	1.00-4.90	4.5	1.7	Normal range
Monocytes	0.00-0.80	0.6	0.1	Normal range
Eosinophils	0.00-0.50	0.60	0.02	Normal range
Bands	0-5%	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 Value
Na-	136-145	133	138	Hypertension (Capriotti, 2020).
K+	3.5-5.1	4.3	3.9	Normal Range
Cl-	98-107	96	101	Normal Range
CO2	21.0-32.0	30	30	Normal Range
Glucose	70-99	109	116	Not related to diabetes (Capriotti, 2020).

BUN	5-20	21	19	Dehydration (Swearing & Wright, 2019).
Creatinine	0.5-1.5	0.77	0.78	Dehydration (Swearing & Wright, 2019).
Albumin	3.4-5.0	N/A	N/A	N/A
Calcium	8.5-10.1	10.0	9.8	N/A
Mag	1.7-2.2	N/A	N/A	N/A
Phosphate	2.5-4.8	N/A	N/A	N/A
Bilirubin	0.2-0.8	N/A	N/A	N/A
Alk Phos	34-104	N/A	N/A	N/A
AST	12-31	N/A	N/A	N/A
ALT	7-40	N/A	N/A	N/A
Amylase	23-85	N/A	N/A	N/A
Lipase	0-160	N/A	N/A	N/A
Lactic Acid	0.5-1.6	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	0.9-1.2	1.0	N/A	N/A
PT	11-12.5	11.1	N/A	N/A
PTT	24-45	37	N/A	Normal range

D-Dimer	0-0.5	N/A	N/A	N/A
BNP	0-100	N/A	N/A	N/A
HDL	0-50	N/A	N/A	N/A
LDL	0-130	N/A	N/A	N/A
Cholesterol	0-200	N/A	N/A	N/A
Triglycerides	0-150	N/A	N/A	N/A
Hgb A1c	4.0-5.6	5.4	N/A	N/A
TSH	0.35-5.0	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	Colorless-Yellow, clear	N/A	N/A	N/A
pH	5.0-7.0	N/A	N/A	N/A
Specific Gravity	1.003-1.005	N/A	N/A	N/A
Glucose	negative	N/A	N/A	N/A
Protein	negative	N/A	N/A	N/A
Ketones	negative	N/A	N/A	N/A
WBC	0-25	N/A	N/A	N/A
RBC	0-20	N/A	N/A	N/A
Leukoesterase	negative	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	Normal	N/A	N/A	N/A
Blood Culture	Normal	N/A	N/A	N/A
Sputum Culture	Normal	N/A	N/A	N/A
Stool Culture	Normal	N/A	N/A	N/A

Lab Correlations Reference (APA):

Pietrangelo, A. (2020, May 15). Understanding Multiple Sclerosis (MS). Retrieved from <https://www.healthline.com/health/multiple-sclerosis>

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): MRI Head. CT Angio Head and neck WWO contrast W PP.

Diagnostic Test Correlation (5 points): Suspected stroke.

Diagnostic Test Reference (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis.

Current Medications (10 points, 1 point per completed med)

***10 different medications must be complete Home Medications (5 required)**

Brand/Generic	Aspirin	Protonix/ pantoprazo le	Tylenol/ acetaminophen	Flexeril/ cyclobenzaprine	Symbicort/ budesonide-formoterol fumarate
Dose	324 mg	40 mg	650 mg	5 mg	2 puff
Frequency	daily	daily	Every 4 Hr. PRN	Daily	2 times daily
Route	Oral	Oral	Oral	Oral	Inhalation
Classification	Salicylate NSAID	Proton pump inhibitor, Antiulcer.	Nonsalicylate, para- aminophenol derivative, antipyretic, nonopioid analgesic.	Tricyclic antidepressant- like agent, skeletal muscle relaxant.	Corticosteroid, antiasthmatic anti-inflammatory.
Mechanism of Action	Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis.	Interferes with gastric acid secretion by inhibiting the hydrogen- potassium- adenosine triphosphatase enzyme system, or proton pump, in gastric parietal cells.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Acts in the brain stem to reduce or abolish tonic muscle hyperactivity.	Inhibits inflammatory cells and mediators possibly by decreasing influx into nasal passages, bronchial walls, or the intestines. As a result, nasal or airway inflammation decreases.
Reason Client Taking	arthritis	esophagitis	To relieve mild to moderate pain	Osteoporosis	To provide Maintenance therapy in asthma
Contraindications (2)	Active bleeding and current or recent ulcers.	Hypersensitivity to pantoprazole and concurrent therapy with rilpivirine	Sever hepatic impairment and severe active liver disease.	Acute recovery phase of MI and arrhythmias	Status asthmaticus and recent septal ulcers.

		containing products.			
Side Effects/Adverse Reactions (2)	Confusion and diarrhea	Anxiety and Chest pain	Fever and muscle spasm	Dizziness And facial flushing	Bad taste and back pain
Nursing Considerations (2)	<ol style="list-style-type: none"> 1. Ask about tinnitus. 2. Don't crush timed-release or controlled release aspirin tablets. 	<ol style="list-style-type: none"> 1. Administer delayed release oral suspension 30 minutes before a meal. 2. Flush I.V. line with normal saline after giving medication. 	<ol style="list-style-type: none"> 1. Use with caution in client with hepatic impairment or active hepatic disease. 2. Monitor renal function in client on long-term therapy. 	<ol style="list-style-type: none"> 1. Avoid giving drug to elderly patients because of anticholinergic effects. 2. Use with caution in patients with history of low seizure threshold. 	<ol style="list-style-type: none"> 1. Administer respules by jet nebulizer connected to an air compressor. 2. Monitor patient for evidence of hypersensitivity.

Brand/Generic	Lipitor/atorvastatin	HEParin/porcine	Nicotine/NicoDerm	Nutrisource fiber packet	Labetlol/ Normodyne;trandate
Dose	20mg	5,000 Units	21MG/24HR	1 Packet	10mg
Frequency	Nightly	3 times per day	Daily	Daily	PRN
Route	Oral	Sub Q	Transdermal	Oral	Intravenous
Classification	HMG-CoA reductase inhibitor antihyperlipidemic	Anticoagulant	Nicotinic agonist	Nutritional replacement	antihypertensive

Mechanism of Action	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown.	Binds with antithrombin III, enhancing antithrombin III's inactivation of the coagulation enzymes thrombin and factors Xa and XIa. Prevents conversion of prothrombin to thrombin.	Binds selectively to nicotinic-cholinergic receptors at autonomic ganglia, in the adrenal medulla, at neuromuscular junctions, and in the brain.	Used to put fiber into the body to aid in digestion	Selectively blocks Alpha one and beta two receptors in vascular smooth muscle in beta one receptors in heart to reduce blood pressure and peripheral vascular resistance.
Reason Client Taking	To reduce risk of acute cardiovascular events.	To prevent peripheral arterial embolism.	To relieve nicotine withdrawal symptoms.	nutritional replacement.	To manage hypertension.
Contraindications (2)	Active hepatic disease and hypersensitivity to atorvastatin.	Pork or its components and uncontrolled bleeding.	Arrhythmias and skin disorders.	Allergies and breast feeding.	Asthma and heart failure.
Side Effects/Adverse Reactions (2)	Depression and hypotension.	Thrombosis and asthma.	Arrhythmias and bronchospasm.	Diarrhea and dehydration.	Bradycardia and ventricular arrhythmias
Nursing Considerations (2)	1. Use atorvastatin cautiously in patients who consume substantial quantities of alcohol. 2. expect liver function tests to be performed before therapy starts.	1. use heparin cautiously in alcoholics. 2. alternate injection sites.	1. know that transdermal system should not be used in patients who have history of seizures. 2. take off before MRI	1. monitor patients bowel movements. 2. make sure patient is aware of what they are taking.	1 keep patient in supine position for three hours after IV administration. 2.monitor

			to avoid burns.		blood glucose level in diabetic patient because medication may conceal symptoms of hypoglycemia.
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Hospital Medications (5 required)

Medications Reference (APA):

2020 nurses drug handbook. (2020). Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): Alertness: X4 Orientation: X4 Distress: anxious Overall appearance: WDL	Well-kept, clean, and dressed appropriate
INTEGUMENTARY (2 points): Skin color: WDL Character: ruddy Temperature:	Warm, dry, intact, elastic, without discoloration Warm to touch.

<p>Turgor: Rashes: None Bruises: None Wounds: None Braden Score: 17 Drains present: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Type:</p>	<p>Good skin Turgor.</p>
<p>HEENT (1 point): Head/Neck:WDL Ears: hearing aids in place Eyes: glasses on Nose: WDL Teeth: WDL</p>	<p>Head/neck symmetrical at rest and with movement.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: strong bilaterally Capillary refill: less than 3seconds 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:</p>	<p>Regular rhythm, S1, S2, no reported chest pain.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Depth regular, pattern regular, unlabored</p>
<p>GASTROINTESTINAL (2 points): Diet at home: regular Current Diet: cardiac Height: 5'1" Weight: 89 lb Auscultation Bowel sounds: WDL Last BM: N/A 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"/></p>	<p>Abdomen soft, nondistended, bowel sounds audible, no scars incisions, drains or wounds present.</p>

<p>Type:</p>	
<p>GENITOURINARY (2 Points): Color: yellow Character: Clear Quantity of urine: N/A 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: N/A Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	
<p>MUSCULOSKELETAL (2 points): Neurovascular status: generalized weakness ROM: preformed Supportive devices: Gait belt Strength: weak ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 17 Activity/Mobility Status: 1 assist Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input checked="" type="checkbox"/></p>	
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: X4 Mental Status: anxious Speech: clear Sensory: care clustered LOC: No</p>	
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): N/A Developmental level: older adult Religion & what it means to pt.: N/A Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>Patient has a good support system and spends a lot of time with her family.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	92	175/85 in right arm	16	98.3 F oral	96% on room air
1140	85	164/97 in left arm	16	97.8 F oral	95% on room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	0	N/A	N/A	N/A	N/A
1140	0	N/A	N/A	N/A	N/A

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:	22 gag Right arm 2/3/21 N/A WDL, dressing maintained

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240	Unmeasured

Nursing Care

Summary of Care (2 points)

Overview of care: The client states she has enjoyed the nurses and people who have taken care of her. She also states she feels better already.

Procedures/testing done MRI and CT of head

Complaints/Issues: client states “I just want to go home”.

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: The client complained that the food what hard to swallow and would like something a little softer. The client is moving around well and ambulates with just a gait belt.

Physician notifications: The physician claims the client will be able to go home after test results come back.

Future plans for patient: There are no future plans at this time.

Discharge Planning (2 points)

Discharge location: Home with daughter.

Home health needs (if applicable): N/A

Equipment needs (if applicable): Walker.

Follow up plan: meet with primary care doctor.

Education needs: Unsteady gait, diet, smoking cessation.

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none"> • Include full nursing 	<ul style="list-style-type: none"> • Explain why the nursing 		<ul style="list-style-type: none"> • How did the patient/family

diagnosis with “related to” and “as evidenced by” components	diagnosis was chosen		<p>respond to the nurse’s actions?</p> <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
1. Impaired mobility related to weakness as evidenced by the client stating, “I fell down because my legs just gave out.”	This diagnosis was chosen because the patient’s safety is important. The patient was independent prior therefore we want to work on her mobility.	<ol style="list-style-type: none"> preform ROM. ambulate client in hallway. 	The patient enjoyed getting up and walking even if it was to and from the bathroom. The goal is not completely completed however the client was getting better at walking to and from the bathroom while I was there.
2. Risk for aspiration related to dysphagia evidence by client stating, “it’s hard to swallow.”	The airway is essential to living therefore this is why this nursing diagnosis was chosen.	<ol style="list-style-type: none"> order softer food for the client. Sit the client up in high fowlers while eating or drinking. 	The patient agreed to the interventions and allowed the team to order a softer lunch. The outcome was successful, and we followed through with our interventions for lunch.
3. Respiratory infection related to tobacco use evidence by client stating, “I smoke two packs a day.”	The client has been smoking for a long time and does seem to be out of breath when going to the bathroom. It is important part of the client’s health.	<ol style="list-style-type: none"> Give the client recourses to cease smoking. practice breathing exercises. 	The client disagreed with this nursing diagnosis as well as the interventions. The goal of this intervention might be to limit the amount the client smokes instead of cessation.

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*. St. Louis, MO: Elsevier.

Concept Map (20 Point

Subjective Data

Patient states she isn't in any pain and rates her pain as a zero. Patient also states she lives with her daughter however is independent at home. Patient tells provider that her legs gave out and became very weak.

Nursing Diagnosis/Outcomes

Nursing diagnosis: Impaired mobility related to weakness as evidenced by the client stating, "I fell down because my legs just gave out."
Outcome: The patient enjoyed getting up and walking even if it was to and from the bathroom. The goal is not completely completed however the client was getting better at walking to and from the bathroom while I was there.

Nursing diagnosis: Risk for aspiration related to dysphagia evidence by client stating, "it's hard to swallow."
Outcome: The patient agreed to the interventions and allowed the team to order a softer lunch. The outcome was successful, and the client followed through with our interventions for lunch.

Nursing diagnosis: Respiratory infection related to tobacco use evidence by client stating, "I smoke two packs a day."
Outcomes: The client disagreed with this nursing diagnosis as well as the interventions. The goal of this intervention might be to limit the amount the client smokes instead of cessation.

Objective Data

Patient was admitted 2/3 with generalized weakness. Patient has steady gait to and from the bathroom. Patient has hypertension and is dehydrated upon arrival.

Patient Information

Patients initials MG
85 years old
female

Nursing Interventions



