N311 Care Plan #1

Lakeview College of Nursing

Airelle Mitchell

Demographics (5 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
2/20/21	N.S.	87	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Widowed	Codeine
Code Status	**Height**	**Weight**	
DNR	5'3" (161.5 cm)	59.1 Kg (130.29 lb)	

Medical History (5 Points)

Past Medical History: Client has history of broken wrist, type II diabetes, and a small transient ischemic attack.

Past Surgical History: Client had her tubes tied, removal gallbladder, and appendix.

Family History: Clients' mother had a history of heart issues and diabetes. The Client's father had a history of emphysema.

Social History (tobacco/alcohol/drugs): No history of tobacco use, alcohol use, or drug use.

Admission Assessment

Chief Complaint (2 points): No feeling in lower left leg

History of present Illness (10 points): Client is an 87 year old Caucasian female and she was first admitted with a stroke mid-day on 2/16/2021 to a hospital in Danville. The client was with her niece at the time and called her daughter to come take her to the ER in Danville. Then the client was transferred over to OSF rehab floor on 2/20/2021. The Client's chief complaint was no feeling in the lower left extremity. Client stated " I lost feeling in my left lower leg and wasn't able to get up". When asked about pain, Client stated she had no pain, just loss of feeling. Client stated she had this feeling in the middle of the day. No associated characteristics with her loss of feelings. Treatment of the stroke has been through rehab to get her strength back in her leg and stroke medication. While the client was on the rehab floor at OSF, she gained most of her

strength and feeling back. The client is mobile with one assist with the use of a gait belt and walker. The client has a great support system at home with living with her daughter and when her daughter is at work, her niece will be taking care of her. The client was being discharged on 3/02/2021.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Stroke

Secondary Diagnosis (if applicable): Diabetes type II

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

Diabetes type two is the impared ability to maintain or use glucose as fuel in the body. About ninety percent of those who are affected by diabetes mellitus are type two (Capriotti, 2020). Many environmental factors play a role in one's lifestyle. For example, diet, exercise, smoking and alcohol consumption all play a role (capriotti, 2020). How Diabetes affects client's at cellular level is by glucose being absorbed through the GI tract , then it goes through the pancreas to be turned into insulin. Then insulin is rejected by the cells and the glucose is stuck in the bloodstream. This will then cause complications like hyperglycemia in the body. Further, the signs and symptoms of diabetes type two are polydipsia, polyuria, polyphagia, weight loss, weakness, stroke, fatigue, vision disturbances, and infection is possible (Capriotti, 2020). In addition, risk factors are physical inactivity, hypertension, obesity, certain ethnicities, low HDL, high LDL, insulin resistant, and family history (Goyal & Jailal, 2020).

There are 4 major types of diagnostic testing for Diabetes Mellitus. One diagnostic test that is done daily depending on the patient is Blood Glucose Levels and there are two types. The first one is an oral glucose tolerance test and glycated hemoglobin test. Another test would be urine

testing for glucosuria, islet cell autoantibodies, and C-peptide test (Capriotti, 2020). Accuchecks can be done at home as well as the hospital to check for glucose rise or fall. My Client had diagnostic imaging scans for stroke due to her having a preexisting disease known as diabetes. One risk factor of diabetes is a stroke. Over time this pre-existing disease resulted in a stroke. Treatment for Diabetes type two is through Insulin and other diabetic medication injections, and by oral antidiabetic medications (Capriotti, 2020). Therefore, my client should check her glucose levels daily and take antidiabetic medications regularly. Also, by educating my patient about diet and exercise/physical activity daily, this will further help her understand the importance of her choices.

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

Goyal. R., & Ishwarlal. Jailal. (2020, November 20). Diabetes. NCBI. https://www.ncbi.nlm.nih.gov/books/NBK513253/

Laboratory Data (20 points)

If laboratory data is unavailable, values will be assigned by the clinical instructor

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.90-4.98 (mill/cumm)**	**3.32**	**3.32**	**Clients decreased values are due to a loss of cells during stroke (Saunders, 2021)**
Hgb	**12.0-15.5 (gm/dL)**	**8.2**	**8.2**	**Clients low levels could be due to anemia (Saunders, 2012)**

Hct	**35-45 %**	**28.6**	**25.7**	**Clients low levels due to clients age (Saunders, 2012)**
Platelets	**140-400 (1000/mm3)**	**556**	**488**	**Clients high levels related to iron deficiency anemia. (Saunders, 2012)**
WBC	**4.0-9.0 (10 x 3/uL)**	**9.0**	**8.4**	**N/A**
Neutrophils	**40-70 %**	**N/A**	**N/A**	**N/A**
Lymphocytes	**10-20%**	**N/A**	**N/A**	**N/A**
Monocytes	**5 %**	**N/A**	**N/A**	**N/A**
Eosinophils	**1-4%**	**N/A**	**N/A**	**N/A**
Bands	**0.0-10.0%**	**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 (mEq/L)**	**139**	**140**	**N/A**
K+	**3.5-5.1 (mEq/L)**	**4.4**	**4.9**	**N/A**
Cl-	**98-107 (mEq/L)**	**104**	**105**	**N/A**
CO2	**22-29 (mEq/L)**	**26**	**26**	**N/A**
Glucose	**60-110 (mg/dL)**	**201**	**109**	**High levels upon admission due to stress and client has Diabetes Mellitus type II. (Saunders, 2012)**
BUN	**8-23 (mg/dL)**	**25**	**30**	**High levels are due to clients recent stroke (Saunders, 2012)**
Creatinine	**0.05-1.00 (mg/dL)**	**1.00**	**1.05**	**N/A**
Albumin	**3.5-5.2 (gm/dL)**	**N/A**	**N/A**	**N/A**
Calcium	**8.4-10.0 (mg/dL)**	**9.0**	**9.1**	**N/A**

Mag	**1.6-2.4 (mg/dL)**	**N/A**	**N/A**	**N/A**
Phosphate	**2.5-5 (mg/dL)**	**N/A**	**N/A**	**N/A**
Bilirubin	**0.0-1.2 (mg/dL)**	**N/A**	**N/A**	**N/A**
Alk Phos	**35-105 (U/L)**	**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**	**N/A**	**Yellow clear**	**N/A**
pH	**5.0-8.0**	**N/A**	**N/A**	**N/A**
Specific Gravity	**1.005-1.034**	**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	**0-0.5**	**N/A**	**N/A**	**N/A**
RBC	**0-3**	**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	**Negative**	**N/A**	**N/A**	**N/A**
Blood Culture	**Negative**	**N/A**	**N/A**	**N/A**
Sputum Culture	**Negative**	**N/A**	**N/A**	**N/A**
Stool Culture	**Negative**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (APA):

Lakeview college of Nursing Diagnostic Lab Value Sheet

Sarah Bush Lincoln Center Hospital System. Medical Values

Malarkey, M. Louise., & McMorrow, M. E. (2012). *Saunders Nursing guide to laboratory and diagnostic tests.* St. Louis, MO: Elvisier/Saunders.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

CT Stroke Protocol done on 2/16/2021 - Mild cerebral atrophy. Chronic ischemic degeneration.

MRI Brain scan without contrast done on 2/17/2021- N/A

CT Angio head and neck without contrast with PP done on 2/17/2021 - Impression showed narrowing of the R/L carotid arteries.

X-Ray of chest single view Portable done on 2/19/2021 - Impression showed cardiomegaly with mild pulmonary congestion, which could be due to CHF.

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

Medications (5 required)

Brand/Generic	**amLODIPine (NORVASC) Tablet**	**ascorbic acid Tablet**	**(COREG) carvedilol Tablet**	**Aspirin EC Tablet**	**Clopidogrel bisulfate (PLAVIX) Tablet**
Dose	5 mg	500 mg	3.125 mg	81 mg	75 mg
Frequency	Daily	Daily	twice daily	Daily	Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Calcium channel blocker (Jones, 2021)	Vitamins; Water soluble (RxList, 2021)	Nonselective beta blocker & alpha-1 blocker (Jones, 2021)	Salicylate (Jones, 2021)	P2Y12 platelet inhibitor (Jones, 2021)
Mechanism of Action	slow channel blocker that inhibits smooth cardiac muscles contractions and restoring blood flow. (Jones, 2021)	is for tissue repair and collagen formation (RxList, 2021)	reduces cardiac output and tachycardia, causes vasodilation and reduces blood pressure and cardiac workload. (Jones, 20121)	a non-steroidal anti-inflammatory drug (NSAIDS) (RxList, 2021)	To prevent aggravating platelets from forming a thrombi (Jones, 2021)
Reason Client Taking	To treat hypertension. (Jones, 2021)	For vitamin C supplement (RxList, 2021)	to treat mild to severe chronic heart failure of ischemic (Jones, 2021)	To reduce risk of death and recurrent stroke. (Jones, 2021)	To reduce thrombotic events such as a stroke. (Jones, 2021)
Contraindications (2)	Hypersensitivity to amlodipine or its components. (Jones, 2021)	Contraindicated to those who show hypersensitivity to any component of this prescription	Bronchial asthma, cardiac shock. (Jones, 2021)	Active bleeding or coagulation disorders;hypersensitivity to aspirin (Jones, 2021)	active pathological bleeding, including intracranial hemorrhage (Jones, 2021)

Side Effects/Adverse Reactions (2)	chest pain, palpitations, peripheral edema. (Jones, 2021)	Nausea, vomiting (RxList, 2021)	Hypertension, malaise (Jones, 2021)	confusion, diaphoresis (Jones, 2021)	CNS: dizziness, fatal intracranial bleeding. (Jones, 2021)

Medications Reference 1 (APA):

Jones, D. W. (2021). *Nurse's drug handbook.* (A. Barlett, Ed.) (20th ed.). Jones & Bartlett Learning.

RxList. (2021). RxList. WebMD. Retrieved 5 March 2021 from https://www.rxlist.com/script/main/hp.asp

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Client was alert and oriented to person, place, time, and situation (x4). No acute distress noted. She appeared to have good hygiene and her appearance was good.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N X** **Type:**	Client's skin was warm, pink, smooth, and intact. Skin turgor was less than 4 seconds. Skin was absent of rashes, leasoins, bruises, and wounds. No drains were present. Client had a Braden score of 22 (not at risk). I deducted one for mobility because the client uses a walker and is one assist. Client was able to walk to the bathroom and do activities.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Clients head and neck appeared to be symmetrical. Trachea without deviation. No sign of lymphadenopathy inspected or palpated. No hearing deficit. EOMs symmetrical. Sclera White. No drains, or lesions present, and conjunctiva was pink. Client has Dentures. Dentures have good hygiene.

CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N X** **Edema Y ☐ N X** **Location of Edema:** **N/A**	Could hear S1 and S2. client noted a murmur. When auscultated, murmur was faint and unclear. no sign of gallops or rubs. Capillary refill was less than 3 seconds. Pulses were 2+. No edema inspected. No JVD was seen.
RESPIRATORY: **Accessory muscle use: Y☐ N X** **Breath Sounds: Location, character**	Breath sounds auscultated and were regular, even, and unlabored bilaterally. No Sign of wheezing, crackles, or rhonchi noted.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains: N/A** **Wounds: N/A** **Ostomy: Y ☐ N X** **Nasogastric: Y ☐ N X** **Size:** **Feeding tubes/PEG tube Y ☐ N X** **Type:**	Client states “she eats anything and everything even though she shouldn't”. Current Diet is daibetic. Carb count. 5’3” 130.29 lb Bowel sounds were normoactive, the client had just eaten breakfast. Last BM 3/2/21 Morning (am). No sign of pain or masses when palpating Abdomen. No sign of distention or incisions. Client has scars on upper chest, RLQ, LLQ from hysterectomy, appendectomy, and gallbladderectomy. No drains, wounds, ostomy, NG, or feeding tubes present.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N X** **Dialysis: Y ☐ N X** **Inspection of genitals:** **Catheter: Y ☐ N X** **Type:** **Size:**	Client stated “my urine was yellow and clear.” Not able to see client void during my time in the hospital. Client denied any pain while voiding. Client stated she had a normal amount of urine.

MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: YX N ☐** **Fall Risk: Y X N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Neurovascular status is Normal. Client was able to perform ROM. Client is one assist with a gait belt and uses a walker to ambulate. Strength is equal in upper extremities bilaterally. Lower right leg is stronger than the left leg due to diabetic stroke. strength in lower left leg ⅘. Needs assistants when getting in shower. Fall risk is an 18. Low fall risk. Client needs a walker and gait belt when doing activities.
NEUROLOGICAL: **MAEW: Y X N** **PERLA: Y X N☐** **Strength Equal: Y ☐ N X if no -** **Legs ☐ Arms X Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Strength is equal in upper extremities bilaterally. Lower right leg is stronger than the left leg. Client is alert and oriented to time, place, person, and situation. Mental status is normal for her age. Normal cognitive speech. Fingers and toes had normal responsiveness. Client had no sign of LOC.
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):**	Client lives at home with her daughter. niece stays with the client while daughter is at work. These are her support systems. Client states her coping methods "cleaning, doing puzzles, and bingo to relieve stress". Clients religion is protistent. Client stated that it means the whole world to her. Her developmental level is normal and has a high school diploma.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0915	**82 bpm** **LRA**	**131/65** **mmHg** **(RA)**	**14 rpm**	**36.6 C** **(98.0 F)** **Oral**	**95%** **(RA)**

		(prehyperte nsion)			

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0929	**Numeric Pain Scale**	**N/A**	**0**	**N/A**	**N/A**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
960 mL oral Intake - 960 mL	**N/A**

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

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. Risk for unstable blood glucose related to diabetic stroke evidenced by the client states "she eats	Client has diabetes type two and has not changed lifestyle habits. Clients diet is not compliant with doctors advice for a diabetic and carb count diet.	**1.** Continue to emphasize diabetic management education and diet modifications despite clients non-compliance. **2.** Educate clients about performing	1. Goal Met. Client was able to understand the differences between healthy and bad foods. 2. Goal Met. Client was able to ambulate with her

anything and everything".		physical activity ranging from short distance walks to chores around the house that requires more energy.	walker with rehabilitation services.
1. Risk for falls related to impaired mobility as evidenced by the loss of sensation in client's lower left extremity due to diabetic stroke. .	The client is experiencing loss of sensation in the lower left extremity. She states that "sometimes the feeling is lost and then will come back". client is 1 assist with a gait belt and uses a walker to ambulate.	**1.** Providing a walker and assistance with gait belt during ambulation. **2.** Making the hospital room clutter free and having the client's belongings in close proximity.	1. Goal Met. Client was able to ambulate to the bathroom using a walker and no assistance. 2. Goal met. when in the room, the client used the dressers and closet for all her things to ensure environmental safety.

Overall APA format (5 points):

Concept Map (20 Points)

Subjective Data:

1. Client stated she will need help getting to the shower with walker.
2. Clients last bowel movement and Void was the morning of 3/02/21.
3. Client sated "I have no 0 pain".

Nursing Diagnosis/Outcomes

1. Risk for unstable blood glucose related to diabetic stroke
   - Client has diabetes type two and has not changed lifestyle habits. Client's diet is not complaint with doctors advice for a diabetic and carb count diet.
   - Outcome both goals were met.
2. Risk for falls related to impaired mobility as evidence by the loss of sensation in clients lower left extremity due to diabetic stroke.
   - The client is experiencing loss of sensation in the lower left extremity. She states that "sometimes the feeling is lost and then will come back". Client is 1 assit with a gait belt and uses a walker to ambulate.
   - Outcome both goals were met for the understanding and safety of the client.

Obje tive Data

Objective Data

1. Blood pressure reading was 131/65 (RA)
2. Pulses on R/LA were 82 bpm.
3. Client had good hygiene
4. Clients temperature orally was 98.0 F.
5. Client was able to dress herself and go to the bathroom with walker.

P nt Information

Patient is an 87 year old cuacasion female with a history of Small tIA, Diabetes type two, and broken wrist. She was admitted to the ER for loss of feeling in her left lower extrimity and chief complain is the same. No pain.

Nursing Interventions

1. Continue to emphasize diabetes management education and diet modifications
2. Educate the client about performing physical activity ranging from short to longer intervals.
3. Providing walker and assistance with the gait belt during ambulation.
4. Making the hospital room clutter free and having the clients belongings in close proximity.