

N311 Care Plan #2

Lakeview College of Nursing

Airelle Mitchell

Demographics (5 points)

Date of Admission 3/03/21	Patient Initials S.S.	Age 69	Gender Female
Race/Ethnicity Caucasian	Occupation Retired teacher of 35 years	Marital Status Married	Allergies Augmentin (Amoxicillin Clavulanate) - reaction to this medication is severe vomiting. Neosporin (topical) - reaction to this is a mild rash.
Code Status Full	Height 5'3" (160 cm)	Weight 88.5 Kg (195 lb)	

Medical History (5 Points)

Past Medical History: Obesity, Coronary Artery Disease, Hypertension, Basilar Artery Aneurysm (09/12/2019), Chronic Lymphocytic Leukemia (diagnosed on 12/22/2017), Osteoarthritis of the Knees - Bilateral, Nodule of parotid gland, Transient Ischemic Attack, Rosacea, and Myocardial infarction.

Past Surgical History: Pituitary surgery, Total Knee Arthroplasty, and Coronary Angioplasty with Stent Placement.

Family History: Mother - cancer

Social History (tobacco/alcohol/drugs): Client denies any use of tobacco or drugs. Client states "I drink a glass of wine one time a month at a wine club".

Admission Assessment

Chief Complaint (2 points): Left side impaired

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History of present Illness (10 points): Client is a 69 year old caucasian female and she was admitted to Carle hospital for a stroke. Client states she fell that morning and didn't think anything of it. Later when the client was having the stroke, she didn't notice till her family realized her facial expressions were not moving properly and they couldn't understand her. Once her husband and family realized she was having a stroke, they called 911 and an ambulance took her to Carle around noon. Then she was transferred to a rehabilitation center at OSF on 3/03/2021. She has major bruising on her left side of lower and upper extremities. When asked about her pain on a numeric pain scale, the client denied any pain and has no aggravating factors. If the client is in pain, she is treating it with tylenol. Client is working to be discharged by the end of that week.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Hemorrhagic stroke

Secondary Diagnosis (if applicable): Hemiparesis of left nondominant side

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

Hemorrhagic Stroke is a medical emergency and is caused by weakened blood vessels that rupture in the brain and bleeds around the outside of the brain's lining. When it accumulates too much, it will compress the tissue lining of the brain, which can cause two types of problems: aneurysms and arteriovenous malformations (ASA). These are also called intracerebral hemorrhage and subarachnoid hemorrhage. A hemorrhagic stroke can account for “13% of stroke cases” and stroke is the number five leading cause of disability (ASA). The **signs and symptoms** of a stroke is a severe headache, hemiparesis, facial paralysis (facial droop),

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weakness, nausea and vomiting, confusion, disorientation, hypertension, seizures, and stiff neck (Capriotti, 2020). **Risk factors** for a Hemorrhagic stroke are hypertension, heart disorders, uncontrolled diabetes, tobacco use, a diet high in salt, excess alcohol use, cholesterol, obesity, and previous stroke or TIA (Capriotti, 2020). **Diagnostic imaging** for a stroke would be by taking images of the brain through a CT scan, transcranial doppler, and an MRA of the brain (Capriotti, 2020). My client had no diagnostic imaging in her chart, but these would have been the best tests to diagnose her stroke. **Treatment** for a stroke would be to keep stable and have supportive care by maintaining airway and blood pressure, decrease cerebral edema with IV mannitol or hypertonic saline, and rehabilitation for hemiparesis.

My client was at risk for a stroke due to previous heart conditions which lead to the heart attack to be expected. She has had a myocardial infarction, coronary artery disease, a transient ischemic attack, and hypertension. Some of the imaging that she might have gone through is having a CT scan or MRI. My client has been taking a few medications like Plavix and Norvasc for her heart. As well as, medication for her high blood pressure (hypertension). Further, my client **should be educated** on F.A.S.T. This is an acronym that could save someone's life and it stands for Face drooping, Arm weakness, Speech difficulties, and Time to call 911 (ASA). Also, I would educate the client on what to do at home to prevent another stroke. Some ways would be by taking her blood pressure, checking blood glucose, not smoking, controlling cholesterol by eating better, and getting active.

American Stroke Association. *About stroke*. (n.d.). Retrieved March 21, 2021, from <https://www.stroke.org/en/about-stroke>

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

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)	3.9	3.7	Client's recent stroke caused a loss of cells. (Saunders, 2012)
Hgb	12.0-15.5 (gm/dL)	10.1	9.8	Client bruises easily, so these low levels could be due to anemia. (Saunders, 2012)
Hct	35-45 %	34.1	31.0	Low levels due to clients age. (Saunders, 2012)
Platelets	140-400 (1000/mm ³)	210	190	N/A
WBC	4.0-9.0 (10 x 3/uL)	8.64	8.82	N/A
Neutrophils	40-70 %	N/A	N/A	N/A
Lymphocytes	10-20%	11	N/A	N/A
Monocytes	5 %	4.9	N/A	N/A
Eosinophils	1-4%	1.3	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
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Na-	135-145 (mEq/L)	142	N/A	N/A
K+	3.5-5.1 (mEq/L)	3.9	N/A	N/A
Cl-	98-107 (mEq/L)	105	N/A	N/A
CO2	22-29 (mEq/L)	32	N/A	Cardiac disorders related to a lack of blood circulation. This could be related to client's recent and past cardiac issues. (Saunders, 2012)
Glucose	60-110 (mg/dL)	115	N/A	due to shock or trauma from a recent stroke. (Saunders, 2012)
BUN	8-23 (mg/dL)	23	N/A	N/A
Creatinine	0.05-1.00 (mg/dL)	0.75	N/A	N/A
Albumin	3.5-5.2 (gm/dL)	3.4	N/A	This level is on the border and could be related to malabsorption of amino acids in protein synthesis. (Saunders, 2012)
Calcium	8.4-10.0 (mg/dL)	8.9	N/A	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)	1.3	N/A	N/A
Alk Phos	35-105 (U/L)	69	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	Pale yellow, clear	N/A
pH	5.0-8.0	N/A	N/A	N/A

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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):

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N/A - Client did not have any diagnostic imaging done at OSF, nor were they transferred from Carle.

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

Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol)	amlodipine (Norvasc)	atorvastatin (Lipitor)	clopidogrel (Plavix)	lisinopril (Prinivil, Zestril)
Dose	Tablet 650 mg	Tablet 10 mg	Tablet 40 mg	Tablet 75 mg	Tablet 30 mg
Frequency	Daily	Daily	Nightly	Daily	Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Nonsalicylate, para-aminophenol derivative (Jones, 2021)	Calcium channel blocker (Jones, 2021)	HMG-CoA reductase inhibitor (Jones, 2021)	P2Y12 platelet inhibitor	Angiotensin-converting enzyme (ACE) inhibitor. (Jones, 2021)
Mechanism of Action	Blocks prostaglandin production and interferes with pain impulse in the PNS. (Jones, 2021)	slow channel blocker that inhibits smooth cardiac muscles contractions and restoring blood flow. (Jones, 2021)	Reduces plasma cholesterol and lipoprotein by inhibiting HMG-CoA (Jones, 2021)	To prevent aggravating platelets from forming a thrombi (Jones, 2021)	May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II. (Jones, 2021)
Reason Client Taking	Mild to moderate pain. (Jones, 2021)	To control Hypertension (Jones, 2021)	to reduce risk of CVA (Jones, 2021)	To reduce thrombotic events such as a stroke. (Jones, 2021)	To treat heart failure or hypertension. (Jones, 2021)

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Contraindications (2)	Severe hepatic impairment and severe active liver disease. (Jones, 2021)	Hypersensitivity to amlodipine or its components. (Jones, 2021)	active hepatic disease and unexplained persistent rise in serum transaminase level. (Jones, 2021)	active pathological bleeding, including intracranial hemorrhage (Jones, 2021)	hereditary or idiopathic angioedema or history of angioedema related to previous treatment with an ACE inhibitor and hypersensitivity to lisinopril. (Jones, 2021)
Side Effects/Adverse Reactions (2)	Hypertension and dyspnea (Jones, 2021)	Dyspnea, peripheral edema (Jones, 2021)	cognitive impairment and facial paralysis. (Jones, 2021)	fatigue and vasculitis. (Jones, 2021)	

Medications Reference (APA):

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

Assessment**Physical Exam (18 points)**

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Client was oriented to person, place, and situation (x3). No distress noted. She appeared to have good hygiene and was well groomed.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N X Type:	Client's skin was warm, pale, smooth, and intact. Skin turgor was less than 4 seconds. Skin was abest of rashes, lesions, and wounds. She has major bruising on her left buttock, left arm, left side hip, and a small bruise on her right side of face. Small amount of acne was present on her face. No drains were present. Braden score of 18 represents mild to moderate risk of a pressure sore.

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HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	Client's HEENT were symmetrical. Trachea without deviation. No signs of lymphadenopathy inspected or palpated. No hearing deficit. Sclera was white. Conjunctiva was pink. EOMs symmetrical. No dentures. Mild distention in top teeth.
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 X Edema Y X N <input type="checkbox"/> Location of Edema: Ankles Lower extremities.	Clear S1 and S2 sounds. No signs of gallop, rubs, or murmurs auscultated. Capillary refill was less than 3 seconds. Pulses were 2+. Slight edema in ankles of the lower left extremities. No JVD was seen.
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N N Breath Sounds: Location, character	Breath sounds auscultated and were regular, even, and unlabored bilaterally. No use of accessory muscles. No sign of crackles, wheezing, or rhonchi notes.
GASTROINTESTINAL: 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 X Nasogastric: Y <input type="checkbox"/> N X Size: N/A Feeding tubes/PEG tube Y <input type="checkbox"/> N X Type: N/A	Client states she eats and drinks "Skim milk. sandwiches with wheat bread, tuna, and chicken salad at home. Current diet is Cardiac. 5'3" (160cm) 88.5 Kg (195 lb) Bowel sounds were normoactive. Last Bowel movement 3/08/21 afternoon (pm). No sign of masses or pain while palpating abdomen. No sign of incisions or distention. Client had scars on chest and knees (Bilateral). No drains, wounds, ostomy, NG, or feeding tubes present.

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<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N X Dialysis: Y <input type="checkbox"/> N X Inspection of genitals: Catheter: Y <input type="checkbox"/> N X Type: Size:</p>	<p>Client ambulated to the bathroom twice on my shift. Both times the color of void was pale yellow and clear. Client denied any pain while urinating. The client stated she had a normal amount of urine.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y X N <input type="checkbox"/> Fall Risk: Y X 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>Neurovascular status is oriented and active. Client's ROM is passive. Client uses 1 assist with a gait belt and walker. Wheelchair for safety when walking. Strength was equal in both lower and upper extremities. Fall score of 55 from Morse Fall Scale. Client is a high fall risk due to history of falling, secondary diagnosis, and uses ambulatory aids.</p>
<p>NEUROLOGICAL: MAEW: Y X N <input type="checkbox"/> PERLA: Y X N <input type="checkbox"/> Strength Equal: Y X N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both X Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Strength is equal in upper and lower extremities bilaterally. Client is alert and oriented to person, place, and situation. Mental status is normal for her age. Cognitive speech was a bit hard to understand at times during my time with her. Fingers and toes had normal responsiveness to stimulation. Client had no signs of LOC.</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>Client did not have any coping methods. Client's developmental level is normal and has a masters degree in teaching. Her religion is Lutherin. She lives with her husband and has many family members that live near her and her husband. Good support system at home.</p>

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	88 bpm RA	148/78 mmHG RA (Hypertension)	16 rpm	98.2 F 36.7 C Temporal	98% LA

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0935	Numeric	N/A	0	N/A	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
120 mL by P.O. of Ice water.	Client voided x2. No BM on my shift.

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. Impaired Mobility	Related to recent stroke as evidenced by hemiparesis	1. Cardiac vital vital signs and	Goal met: Auscultated clients heart sounds and took clients vital signs.

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	affected on the left side and is one assist with gait belt.	monitoring heart rate rhythm 2. Ambulate client with gait belt and walker. Wheelchair for safety.	Goal Met: Client was able to ambulate down the hall. Client showed signs of SOB, so the client took a break on the wheel chair. After a short break the client ambulated back to the room.
1. Impaired Verbal Communication	Related to stroke as evidence by hemiparesis of the left non dominant side.	1. Giving the client more time to respond when communicating. 2. Listening carefully and attentive to the client when she is speaking.	Goal Met: When communicating with the client, I gave her more time to respond to my question. Goal Met: During my time with the client, I listened carefully and attentively when she was communicating with me.

Overall APA format (5 points):

Concept Map (20 Points):

Subjective Data:

1. Client Denies any pain.
2. Pain 0/10
3. Client states she eats "skim milk, sandwiches with wheat bread, tuna, and chicken salad".

Objective data:

1. Blood pressure of 148/78
2. Client has good hygiene.
3. Temporal temperature of
4. Client needed assistance with gait belt and was able to go to ambulate to bathroom with a walker for support.

Nursing Diagnosis & outcomes:

1. Impaired mobility related to recent stroke as evidence by hemiparesis of the left side and is 1 assist with gait belt.
 - Goal met by auscultating client's heart sounds and taking client's vital signs. Goal met when client was able to ambulate down the hall and when client showed SOB, we used a wheelchair to let her rest. After a few minutes of resting she walked back to her room.
2. Impaired verbal communication related to stroke as evidence by hemiparesis of the left non dominant side.
 - Both Goals were met by letting the client communicate at her pace. And when communicating with the client, I was able to listen carefully and attentively to understand what she was communicating.

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Patient Information:

Client is an 69 year old female.
History of TIA, CLL,
Osteoarthritis of the knees
bilateral, Myocardial infarction,
Obesity, Coronary Artery
Disease, Hypertension, &
Basilar Artery Aneurysm. She
was admitted to OSF on 3/03/21
for rehabilitation of a chief
complaint of hemiparesis of the
left side.

Nursing Interventions:

1. Cardiac vital signs and monitoring heart rate rhythm.
2. Ambulate client with a gait belt and walker. Wheelchair for safety.
3. Giving the client more time to respond when communicating.
4. Listening carefully and attentive to the client when she is speaking.

