

N311 Care Plan # 2

Lakeview College of Nursing

Kaniqua Barnes-McMillian

Demographics (5 points)

Date of Admission 03/06/2021	Patient Initials CS	Age 70	Gender Female
Race/Ethnicity Caucasian	Occupation Director of public library	Marital Status Single	Allergies Morphine, sulfa antibiotic, hydrocodone
Code Status Full Code	Height 5'6 (66in)	Weight 172 lb. (78.9 kg)	

Medical History (5 Points)

Past Medical History: History of systolic and diastolic HF, Paroxysmal Afib ,Hyperlipidemia, type 2 diabetes(2016) and Scleroderma (2015).

Past Surgical History: N/A

Family History: Mother (Deceased) – Had a heart attack-, Brother (Deceased)- heart attack

Social History (tobacco/alcohol/drugs): Patient stated: “I never smoked or drink before.”

Assistive Devices: Patient stated: “ I use to use a walker and sometimes a cane at home

Living Situation: Patient lives at home with his sister

Education Level: Patient has an associates degree.

Admission Assessment

Chief Complaint (2 points): The sister of the patient said “ My sister stated having blurry vision and her speech started to slur and she passed out”

History of present Illness (10 points):. On March 6th, the patient sister stated, “ my sister started to have blurry vision and her speech began to slur and she passed out. She was immediately rushed to the hospital” (onset). The patient was admitted to OSF on March 6th at 1630. The Patient stated that she started to have blurry vision and slurred speech (location). The

patient sister stated, “She had no prior symptoms besides blurry vision and my sister fainting happened so suddenly” (duration). The patient said she was not in pain at all but started to feel weak (characteristics). The patient do not recall having anything symptoms besides the blurry vision and slurred speech (associated). The stroke was all of a sudden so the patient didn’t have time for any relieving factors (relieving). The patient didn’t take any medication because of the suddenness of the stroke (treatment). Patient has history of Heart failure and Scleroderma, which could have, contribute to the stroke but there was no direct cause of the stroke. Once the CT was done, they found a bleed on left part of brain.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Stroke of the left side of the brain

Secondary Diagnosis (if applicable):

Pathophysiology of the Disease, APA format (20 points): Scleroderma is an autoimmune disease that has no known cause and there is an abnormal build up of fibrous tissue on the skin and organs (Capriotti, 2020). Scleroderma can be classified as disease affecting on the skin or systemic disease of the whole body (Capriotti, 2020). The patient was diagnosed with systematic sclerosis because it affected her skin and other organs like kidney and muscles. The clinical presentation of the disease can be chronic pain, fatigue, muscle aches, and swelling with limited range of motion (Capriotti, 2020). The patient stated “ I started to see changes in the appearance of my skin and I started to become extremely tired all of the time”. The patient also mentioned that she eventually experienced difficulty swallowing than switch over to only consuming liquid food and non-solid. When you have Scleroderma, there is an inflammatory

reaction when there is injury to the endothelial lining (Capriotti, 2020). The reaction activates cell infiltrate of the vascular, skin, and some organs (Capriotti, 2020). This whole process leads to extensive deposition of collagen, which causes fibrosis in the skin, subcutaneous tissues, and deep tissues (Capriotti, 2020). Since Scleroderma is still considered rare, there is no exact test to diagnosis it. The diagnosis is just based on patient symptoms and physically finding abnormal skin on the body (Capriotti, 2020). There is no specific treatment for the disease; the doctors just treat the symptoms (Capriotti, 2020). The patient is treated with immunosuppressive therapy because the disease affects her skin severely. The nurse priorities are to monitor any changes of the patient symptoms to help treat them.

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	3.90-4.98x10 ⁶ /mcL	4.2	4.36	n/a
Hgb	12.0-15.5g/dL	8.5	9.7	The patient has heart disease and difficulty breathing which why the Hgb levels are increases (Capriott, 2020).
Hct	35-45%	26.4	30.9	High levels of Hct is caused by dehydration, the patient made need more fluid intake (Capriott, 2020).
Platelets	140-400K/mcL	124	127	The patient has an open wound below the abdomen, which is infected. The

				platelets are high because of the infection (Capriott, 2020).
WBC	4.0-9.0K/mcL	7.0	8.90	n/a
Neutrophils	40-70%	65	63	n/a
Lymphocytes	10-20%	10.1	n/a	n/a
Monocytes	3.0-13.0%	5.8	7.1	n/a
Eosinophils	0-8.0%	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-	135-145mmol/L	141	145	n/a
K+	3.5-5.1mmol/L	3.5	3.6	n/a
Cl-	98-107mmol/L	105	107	n/a
CO2	22-29mmol/L	27	25	n/a
Glucose	70-99mg/dL	206	241	The patient has diabetes, which is why the blood glucose is high. The body using or isn't making enough hormone insulin (Capriott, 2020).
BUN	7-18mg/dL	10	16	
Creatinine	0.50-1.00mg/dL	1.92	1.67	When the creatinine is high, it indicates possible malfunction or failure of the kidneys (Capriott, 2020).
Albumin	3.5-5.2g/dL	3.5	4.0	
Calcium	8.4-10.5mg/dL	8.7	8.9	
Mag	1.6-2.6mg/dL	2.4	n/a	

Phosphate	2.4-4.5 units/L	n/a	n/a	
Bilirubin	.3-1.0 mg/dL	n/a	n/a	
Alk Phos	34-104 units/L	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	n/a	
pH	5.0-9.0	n/a	n/a	
Specific Gravity	1.003-1.013	n/a	n/a	
Glucose	Negative	n/a	n/a	
Protein	Negative	n/a	n/a	
Ketones	Negative	n/a	n/a	
WBC	0.0-0.5	n/a	n/a	
RBC	0.0-3.0	n/a	n/a	
Leukoesterase	Negative	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	
Blood Culture	Negative	n/a	n/a	
Sputum Culture	Negative	n/a	n/a	
Stool Culture	Negative	n/a	n/a	

Lab Correlations Reference (APA):

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

Malarkey, L. M., & McMorrow, M. E. (2012). *Saunders nursing guide to laboratory and diagnostic tests*. St. Louis, MO: Elsevier/Saunders.

Malenica, M., Prnjavorac, B., Bego, T., Dujic, T., Semiz, S., Skrbo, S., . . . Causevic, A. (2017, April). Effect of Cigarette smoking on HAEMATOLOGICAL parameters in healthy population. Retrieved March 09, 2021, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5511531/>

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

XR Chest Views 08/18/2019- moderately extensive infiltrates in the lower lobe bilaterally.

There are increased intestinal markings in the remainder of both lungs.

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

Brand/ Generic	Baclofen Lioresea	Insulin lispro	Nystatin Imycastan	Pantoprazol e protonix	Escitalopram Lexapro
Dose	5 mg	3 units	500,000 units	40units	10mg
Frequency	TID	TID	4x	Daily	Once daily
Route	PO	Sub-Q	Sub-Q	PO	PO
Classification	Skeletal muscle relaxants (Jones, 2020).	Human insulin and antidiabetic (Jones, 2020).	Polyene macrolide and antifungal (Jones, 2020).	Proton pump inhibitor and antiulcer(Jo nes, 2020).	Selective serotonin reuptake and antidepressa nt (Jones, 2020).
Mechanism of Action	“It reduces the release of excitatory	“Lowers blood glucose levels by stimulating	“Binds to sterols in fungal cell	“Interferes with gastric acid	“Inhibits reuptake of the

	neurotransmitters and substance P by binding to the BABA-B receptor” (Jones, 2020).	peripheral glucose uptake by fat and skeletal muscle“(Jones,2020).	membranes, impairing membrane integrity” (Jones,2020)	secretion by inhibiting the hydrogen-potassium-adenosin triphosphate enzyme system” (Jones,2020).	neurotransmitter serotonin by CNS neurons, thereby increasing serotonin ” (Jones,2020).
Reason Client Taking	To relax muscles	To lower blood glucose	To treat fungal infection	To treat erosive esophagitis associated with GERD	To treat generalized anxiety disorder
Contraindications (2)	Active bleeding and coagulation disorders (Jones, 2020).	Chronic lung disease and chronic obstructive pulmonary disease (Jones, 2020).	Hypersensitivity to nystatin or its components (Jones, 2020).	Hypersensitive to pantoprazole and benzimidazoles (Jones, 2020).	Therapy with pimozide and hypersensitive to escitalopram (Jones, 2020).
Side Effects/Adverse Reactions (2)	Confusion and stroke (Jones, 2020).	Confusion and UTI. (Jones, 2020).	Leukopenia and lymphopenia (Jones, 2020).	C-diff and hepatic failure (Jones, 2020).	Seizures and suicidal ideation (Jones, 2020).

Medications Reference (APA):

Jones, D.W. (2020). Nurse’s drug handbook. (A. Bartlett, Ed.) (19th ed.). Jones & Bartlett

Learning.

Assessment

Physical Exam (18 points)

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient was alert and oriented to person, place, time, and situation. (x3) Patient was showing no signs of distress or any pain. Overall physical appearance was clean and well taking care of.</p>
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<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> x Type:</p>	<p>Patient skin was warm, pink, but had a pressure ulcer. Also had a lot of bruising. The patient. The skin turgor is less than 3. The patient had red dots all over face. The Braden score is 9 which is high risk of getting pressure sore due immobility from the stroke.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>The patient head appear to be normocephalic. The neck seems to be symmetrical. The patient was able to hear me very clearly. There were no signs of hearing loss. The patient eyes show PERLLA and shows good ROM. The patient had very dry eyes and takes medicated eye drops There was no drainage from the nose.</p>
<p>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 <input type="checkbox"/></p>	<p>S1 and S2 were heard. I was not able to hear S3 or S4. The heartbeat seemed to be regular. I did not hear any murmur or anything unusual. I was able to palpate carotid, radial, and brachial pulses in the left arm but not the right due to cast over arm. Capillary refill was than 3.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N x <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>The patient had no abnormal lung sounds. There was no wheezing or crackle in the lungs. The respiration rate was 17, which is normal. The patient oxygen level was 94%, which is also normal. The patient had a nasal cannula to help her get enough oxygen. Her oxygen level was 94%, which means it is effective.</p>
<p>GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains:</p>	<p>The patient states that at home they usually eat liquids and gelatin due to Dysphagia. The patient height is 5'6 (66in). The patient weight is 172lb (78.9kg). I was able to see bowel sounds in all 4 quadrants. The patient last bowel movement was yesterday night (03/09/2021). The patient denies any diarrhea or nausea. There are open wounds in the abdominal area. The patient does have any drainage or and multiple wounds. The patient does not have an Ostomy or any feeding tubes or PEG tube.</p>

<p>Wounds: Ostomy: Y <input type="checkbox"/> N <input type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size:</p>	<p>The patient did not have to use the bathroom while I was there. I ask the patient did they notice and unusual color or smell of their urine. The patient mention there was nothing unusual about their urine and they were able to go regularly. The patient is not on dialysis or does not have a catheter. The patients wears a diaper due to immobility.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input 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>The patient neurovascular status seems to be intact. The patient has control of all their senses. The client was able to display ROM in left arm without help but couldn't move left are due to stroke. The patient was able to display opposition with left hands The patient is also using a gait belt to help get in wheelchair. The patient is maximum assist with ambulating and ADLs besides eating. Patient needs assistance with bathing and toileting but are able to eat all by herself. The patient current fall risk score is 90, which he is at high risk for falling. The patient upper extremities are not strong. The left arm can move but cannot move the right arm at all. The patient needs max support when standing up and walking</p>
<p>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>The patient is able to move upper extremities but is not able to move lower extremities due to double amputation. Eyes show PERLA signs. The patient has equal strength and both arms but no strength and legs due to double amputation. The patient is A&O x3 and is alert but seem to be in extreme pain. Patient speech seems to be normal and no signs slurs.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s):</p>	<p>Patient states "She is very frustrated because she can not express herself due to stroke".</p>

Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	Patients seem to be extremely unhappy with her life because she usually loves to travel with her sister. The patient is a Christian, which helps her get through her illness. The patient has a sister she lives and take good care of her.
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Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0802	73	163/68	17	97.9	94%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9:21	0/10	Body	0	n/a	n/a

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
660ml	Changed one diaper

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. Immobility: Immobility was related to	The nursing diagnosis was chosen because	1.I can safely transfer patient from the bed to	<ul style="list-style-type: none"> The patient seemed to be very unhappy about the stroke

<p>the recent stroke the patient had evidenced by right side of body paralyzed.</p>	<p>being immobile can cause complications with ADLS and really affect the quality of the patient's life.</p>	<p>the chair with assistance to avoid immobility complications.</p> <p>2. I can perform range of motion to all extremities.</p>	<p>due to usually traveling a lot.</p> <ul style="list-style-type: none"> • The sister was very supportive of the patient and assisted her in every way possible. • The long term goal of the patient is to be able to walk on her own with a assistive device such as a walker.
<p>2. Fall risk is related to the stroke the patient had and its evidenced by recent falls due to immobility and paralyzed on the right side of the body.</p>	<p>The patient had some recent falls, which can be deadly. The patient fall risk is a 90, which is very high risk.</p>	<p>1. Keep the bed in lowest position and also keeping the bed rails up with call light in reach</p> <p>2. Make sure patient is wearing fall risk armband and make sure the bed alarm is on. Patient can also wear non-skid socks. Use gait belt and someone else for support when ambulating.</p>	<ul style="list-style-type: none"> • The patient stated, " I don't think I will ever walk again". The patient was very unhappy and frustrated with the after affects of the stroke.

Overall APA format (5 points):

Concept Map (20 Points):

Subjective Data

The patient stated: " I don't think I would ever be able to walk again."
The patient stated: "I am very frustrated with not be able to walk."

Nursing Diagnosis/Outcomes

Immobility: Immobility was related to the recent stroke the patient had evidenced by right side of body paralyzed.
The patient seemed to be very unhappy about the stroke due to usually traveling a lot. The sister was very supportive of the patient and assisted her in every way possible. The long-term goal of the patient is to be able to walk on her own with a assistive device such as a walker.
Fall risk is related to the stroke the patient had and its evidenced by recent falls due to immobility and paralyzed on the right side of the body.
The patient stated, " I don't think I will ever walk again". The patient was very unhappy and frustrated with the after affects of the stroke

Objective Data

The patient had elevated HgB and HCT because she has an heart disease. CT that the patient had a bled on her left side of her brain which is where the stroke was located.

Patient Information

The patient is an 70 year old female with Diabetes, heart disease, Heart failure and scleroderma. The patient was admitted on 03/06/2021 due to having a stroke affecting her right side of the body.

Nursing Interventions

- I can safely transfer patient from the bed to the chair with assistance to avoid immobility complications.**
- I can perform range of motion to all extremities**
- Keep the bed in lowest position and also keeping the bed rails up with call light in reach**
- 2. Make sure patient is wearing fall risk armband and make sure the bed alarm is on. Patient can also wear non-skid socks. Use gait belt and someone else for support when ambulating.**

