N321 Care Plan #2

Lakeview College of Nursing

Aleisa Gutierrez

Demographics (3 points)

Date of Admission 3/28/21	Patient Initials J.D.A	Age 28 y/o	Gender M
Race/Ethnicity Caucasian/white	Occupation Unemployed	Marital Status Relationship	Allergies N.K.A
Code Status Full Code	Height 183.52 cm	Weight 96.70 kg	

Medical History (5 Points)

Past Medical History: Anxiety, Depression

Past Surgical History: reports no past surgical history

Family History: reports no past family medical history

Social History (tobacco/alcohol/drugs): drinks alcohol (beer) 1-2 times a week, smokes marijuana daily, former tobacco smoker (quit 5 years ago).

Assistive Devices: reports no use of assistive devices

Living Situation: lives at home with girlfriend Chelsea

Education Level: high school and some college

Admission Assessment

Chief Complaint (2 points): Abdominal Pain

History of present Illness (10 points): Patient reports to the emergency department complaining of abdominal pain (3/18). Pt. claims that the pain in his lower abdomen started last night (3/27) and has been worsening ever since. Pt. feels "cramping pain". Pt. feels nauseas but reports no vomiting. Pt. also reported having dark tarry stools. Pt. is experiencing no relief and has not taken anything to help alleviate the pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Colitis

Secondary Diagnosis (if applicable):n/a

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

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J.P, "Pathophysiology: Introductory Concepts and Clinical

 Perspectives" (2nd ed.). F.A. Davis Company.

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	3.90-4.98	5.12	4.49	
Hgb	12.0-15.5	15.1	13.1	
Hct	35-45	43.4	38.6	
Platelets	140-400	274	208	
WBC	4.0-9.0	19.3	13.4	
Neutrophils	40-70	90.4	71.9	
Lymphocytes	10-20	15.6	18.0	
Monocytes	4.4-12.0	3.5	9.3	
Eosinophils	0-6.3	0.1	0.5	
Bands	0-5.1	0.1	0.3	

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**	**139**	**140**
K+	**3.5-5.1**	**4.0**	**3.7**
Cl-	**98-107**	**105**	**106**
CO2	**22-29**	**26**	**29**
Glucose	**70-99**	<mark>**125**</mark>	**91**
BUN	**6-20**	**12**	**14**
Creatinine	**.50-1.00**	**0.95**	<mark>**1.15**</mark>
Albumin	**3.5-5.2**	**4.9**	**4.0**
Calcium	**8.4-10**	**9.4**	**8.4**
Mag	**1.6-2.5**	**n/a**	**1.8**
Phosphate	**35-105**	**n/a**	**n/a**
Bilirubin	**.3-1.0**	**1.0**	<mark>**1.4**</mark>
Alk Phos	**30-120**	**99**	**82**
AST	**10-30**	**18**	**12**
ALT	**10-40**	**21**	**15**
Amylase	**30-110**	**n/a**	**n/a**
Lipase	**0-160**	**n/a**	**n/a**
Lactic Acid	**0.5-1**	**n/a**	**n/a**

Other Tests <mark>Highlight All Abnormal Labs</mark>—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	0.8-1.1	n/a	n/a	n/a
PT	11-13.5	n/a	n/a	n/a
PTT	30-40 sec	n/a	n/a	n/a
D-Dimer	<250	n/a	n/a	n/a
BNP	<100	n/a	n/a	n/a
HDL	>60	n/a	n/a	n/a
LDL	<130	n/a	n/a	n/a
Cholesterol	<200	n/a	n/a	n/a
Triglycerides	<150	n/a	n/a	n/a
Hgb A1c	<5.7%	n/a	n/a	n/a
TSH	0.5-5.0	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	Pale yellow-deep amber	Light yellow/clear	Light yellow/clear	
pH	5-8	7.5	n/a	
Specific Gravity	1.005-1.034	1.050	n/a	
Glucose	negative	n/a	n/a	
Protein	negative	n/a	n/a	
Ketones	negative	n/a	n/a	
WBC	negative	n/a	n/a	
RBC	negative	n/a	n/a	
Leukoesterase	negative	n/a	n/a	

Cultures <mark>Highlight All Abnormal Labs</mark>—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 (1) (APA):

Lakeview College of Nursing, "Tab: Diagnostics: Lab"

Capriotti, T., & Frizzell, J.P, "Pathophysiology: Introductory Concepts and Clinical

    Perspectives" (2nd ed.). F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Diagnostic Test Correlation (5 points):

Diagnostic Test Reference (1) (APA):

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

Home Medications (5 required) ***<mark>*** NO HOME MEDICATION REPORTED</mark>***

Brand/Generic					
	*	*	*	*	*
Dose					
	*	*	*	*	*
Frequency					
	*	*	*	*	*
Route					
	*	*	*	*	*
Classification					
	*	*	*	*	*
Mechanism of Action	*	*	*	*	*
Reason Client Taking	*	*	*	*	*
Contraindications (2)	*	*	*	*	*

Side Effects/Adverse Reactions (2)	*	*	*	*	*
Nursing Considerations (2)	*	*	*	*	*

Hospital Medications (5 required)

Brand/Generic					
Dose					
Frequency					
Route					
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations					

(2)					

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). 2019 Nurse's Drug Handbook. Burlington, MA

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Responsive to stimuli** **ANO X1** **No visible signs of distress** **Overall appearance was appropriate**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 **Skin color is usual for ethnicity** **Supple** **Warm** **Elastic turgor** **No rashes** **No bruises** **No wounds** **18** **n/a**

HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Normocephalic, no deviation of trachea** **No drainage, grey-pink tympanic membrane** **No drainage, symmetrical, pink conjunctiva** **No septum deviation, polyps, turbinate** **Teeth intact, no visible dental caries**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	**Normal S1/S2 heart sounds heard** **No murmur or gallops heard** **Normal steady rate and rhythm** **Peripheral pulses 3+** **Capillary refill 2 sec** **n/a**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**No use of accessory muscles** **Respiration pattern is bila** **Bronchovesicular breath sounds** **Equal lung aeration**

GASTROINTESTINAL (2 points):
Diet at home:
Current Diet
Height:
Weight:
Auscultation Bowel sounds:
Last BM:
Palpation: Pain, Mass etc.:
Inspection:
   Distention:
   Incisions:
   Scars:
   Drains:
   Wounds:
Ostomy: Y ☐   N ☐
Nasogastric: Y ☐   N ☐
   Size:
Feeding tubes/PEG tube   Y ☐   N ☐
   Type:
	.

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐**	

Dialysis: Y ☐   N ☐
Inspection of genitals:
Catheter: Y ☐   N ☐
    Type:
    Size:	

MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **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:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
.					

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

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:**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

Nursing Care

Summary of Care (2 points)

Overview of care:

Procedures/testing done:

Complaints/Issues:

Vital signs (stable/unstable):

Tolerating diet, activity, etc.:

Physician notifications:

Future plans for patient:

Discharge Planning (2 points)

Discharge location:

Home health needs (if applicable):

Equipment needs (if applicable):
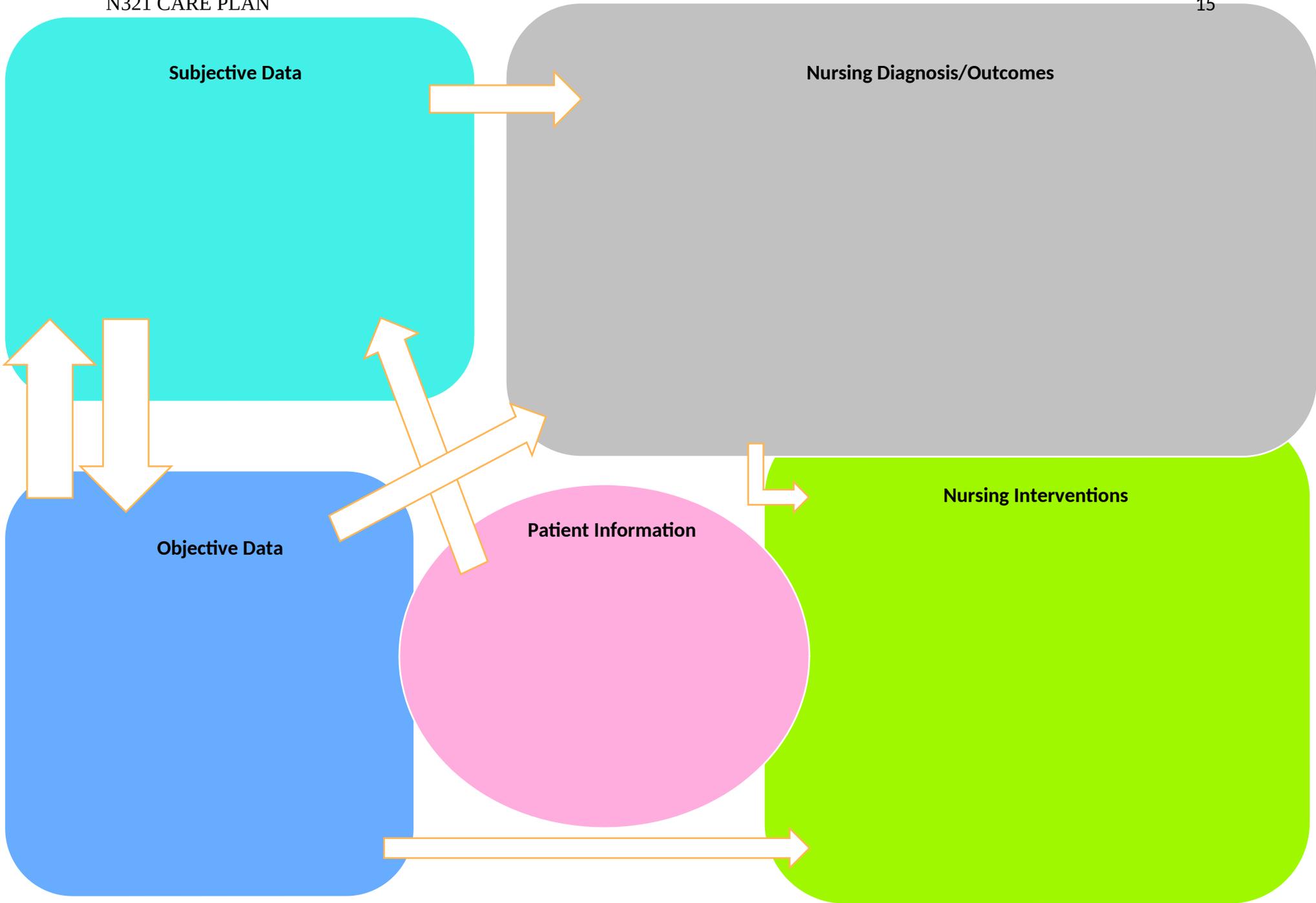
Follow up plan:

Education needs:

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.		**1.** **2.**	
2.		**1.** **2.**	
3.		**1.** **2.**	

Other References (APA):

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes

Objective Data

Patient Information

Nursing Interventions