

N311 Care Plan 1

Lakeview College of Nursing

Angel Roby

Demographics (5 points)

Date of Admission 10/04/2021	Patient Initials L.A.	Age 57	Gender Female
Race/Ethnicity White/Non-Hispanic	Occupation Employed	Marital Status Divorced	Allergies Latex (Rash)
Code Status Full code	Height 5'5" (165 cm)	Weight 223 lbs. (101.3 kg)	

Medical History (5 Points)**Past Medical History:**

Screening mammogram (06/08/2021)

Past Surgical History:

Esophagogastroduodenoscopy Biopsy (08/30/2021)

Laparoscopic cholecystectomy (Unknown date)

Family History:

Lung cancer – Grandfather (M)

Lung cancer – Uncle (D)

Social History (tobacco/alcohol/drugs):

No use of tobacco, alcohol, or drugs

Admission Assessment

Chief Complaint (2 points): Back pain (All over back)

History of present Illness (10 points): Arthritis on the spine and kidney problems

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Spinal arthritis

Secondary Diagnosis (if applicable): N/A

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

A joint disorder is termed an arthropathy; when the disorder involves inflammation of one or more joints, the disorder is called arthritis. (Capriotti, 2020) The causes of arthritis in the back or neck vary depending on the type of arthritis you have. Besides normal wear and tear and autoimmune triggers, in many cases the exact cause remains unknown. Genetic components have been identified in connection with some forms of spinal arthritis, meaning that it may be hereditary. (Capriotti, 2020)

Capriotti, T.C. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

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	4.57	4.26	N/A
Hgb	12.0 – 15.5	13.2	12.5	Low hemoglobin level due to bleeding internally (Bladh, Leeuwen, 2015)
Hct	35 – 45	39.2	37.2	N/A
Platelets	140 – 400	283	253	N/A
WBC	4.0 – 9.0	11	6.9	High WBC count due to an infection (Bladh, Leeuwen, 2015)
Neutrophils	2.4 – 8.4	8.3	4.6	N/A
Lymphocytes	0.8 – 3.7	1.8	1.7	N/A
Monocytes	4.4 – 12	6	7.3	N/A
Eosinophils	0 – 6.3	1.1	2.8	N/A
Bands	10 – 16 (%)	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	139	N/A	N/A
K+	3.5 – 5.1	4.5	N/A	N/A
Cl-	98 – 107	106	N/A	N/A
CO2	22 – 29	27	N/A	N/A
Glucose	70 – 99	94	N/A	N/A
BUN	6 – 20	15	N/A	N/A
Creatinine	0.50 – 1.00	0.96	N/A	N/A

Albumin	3.5 – 5.2	N/A	N/A	N/A
Calcium	8.4 – 10.5	8.8	N/A	N/A
Mag	1.7 – 2.2	N/A	N/A	N/A
Phosphate	2.4 – 4.5	N/A	N/A	N/A
Bilirubin	0.0 – 1.2	N/A	N/A	N/A
Alk Phos	35 – 105	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	Yellow, clear	N/A	N/A
pH	5.0 – 9.0	7.5	N/A	N/A
Specific Gravity	1.005 – 1.025	1.012	N/A	N/A
Glucose	Negative	Negative	N/A	N/A
Protein	Negative	Negative	N/A	N/A
Ketones	Negative (None)	Negative	N/A	N/A
WBC	0 – 0.5	Negative	N/A	N/A
RBC	0 – 3.0	Negative	N/A	N/A
Leukocyte Esterase	Negative	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	10,000 colonies/ml	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):

Bladh, M.B., & Leeuwen, A.L. (2015). *Comprehensive handbook of laboratory & diagnostic tests with nursing implications* (6th ed.). FA. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Computerized tomography (CT) – 03/06/2015

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

Medications (5 required)

Brand/Generic	tofacitinib	Cortisone acetate	Ibuprofen	Methotrexate	Cyclosporine
Dose	5 mg	300 mg	400 mg	7.5 mg	2.5 mg
Frequency	Twice, daily	Once, daily	Every 6 hrs., as needed	Weekly	Twice, daily
Route	Orally	Orally	I.V. Infusion	Orally	Orally
Classification	Pharmacologic: Janus kinase inhibitor Therapeutic: Antirheumatic	Pharmacologic: Glucocorticoid Therapeutic: Anti-inflammatory	Pharmacologic: NSAID Therapeutic: Analgesic, anti-inflammatory	Pharmacologic: Folate antagonist Therapeutic: Antineoplastic	Pharmacologic: Polypeptide Therapeutic: Antirheumatic
Mechanism of Action	Modulates the signaling pathway by inhibiting the enzyme, Janus kinase.	Binds to intracellular glucocorticoid receptors and suppressors inflammatory and immune responses	Blocks activity of cyclooxygenase , the enzyme needed to synthesize prostaglandins, which mediate inflammatory response.	May exert immunosuppressive effects by inhibiting replication and function of T and possible B lymphocytes.	Causes immunosuppression by inhibiting the proliferation of T lymphocytes
Reason Client Taking	Spinal arthritis	Spinal arthritis	Back and neck pain	Spinal arthritis	Spinal arthritis
Contraindications (2)	Hypersensitivity to medication or its	Hypersensitivity to cortisone or its components	Angioedema, asthma caused by	Breastfeeding, pregnancy	Abnormal renal function, uncontrolled

	components	Systemic fungal infection	hypersensitivity to aspirin or other NSAIDs Bleeding		hypertension
Side Effects/Adverse Reactions (2)	Fatigue, fever, headache, insomnia	Behavior changes, depression, dizziness, euphoria, fatigue, headache	Dizziness, headache, nervousness, seizures	Aphasia, dizziness, chills, drowsiness, fatigue, fever	Confusion, headache, lethargy

Medications Reference (APA):

Jones & Bartlett Learning. (2021). *Nurse’s drug handbook* (20th ed.). Ascend Learning Company.

Assessment

Physical Exam (18 points)

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Patient was alert and oriented to person, place, time, and situation (x4) Patient showed no signs of distress Overall appearance: In a gown, hair seemed brushed, clear skin
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises:	Skin color is within expected range for ethnicity. Smooth, warm, pink and intact. Turgor presented as elastic with no rashes, bruises, or wounds. Braden score: 20 (low risk of pressure ulcer)

Wounds: . Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	Head/Neck: Symmetrical, lymph nodes are not palpable, and head appears to be normocephalic. Symmetrical trachea, no deviation presented. Ears: Symmetrical, no cerumen seen outside of ear canal, no trouble with her hearing. Eyes: Extraocular movements are within expected range. Patient does not wear glasses or contacts. Symmetrical, pupils dilated bilaterally Nose: No deviated septum, symmetrical Teeth: All teeth present, gums are pink and moist
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 <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema: N/A	S1 and S2 were audible, no murmurs heard, S3 and S4 were not heard Cardiac rhythm: Within expected range Peripheral pulses: Radial (3+), Brachial (2+), carotid (2+) bilaterally Capillary refill: Capillary refill within 2 seconds
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	No abnormal lung sounds were heard upon auscultation. Respiratory rate was 16 while seated on bed. Tracheal – Loud, within expected range Bronchovesicular – Loud, high-pitched Vesicular – Soft, blowing sound
GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention:	Patient states that her diet at home is a low sodium diet due to her kidney problems. Her current diet is still a low sodium diet due to the same reason. Height: 5'5" Weight: 223 lbs. Auscultation bowel sounds: N/A Last BM: Last night (10/03/2021) Palpation: N/A Inspection:

<p>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"/> Type:</p>	<p>Distention, incisions, scars, drains, and wounds were not present on the patient.</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: 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: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Urine was yellow and clear and shows no abnormal odor. The quantity of her output of urine was around 800 mL a day.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" 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>Neurovascular status is within expected range. Range of motion is also within expected range. Has some weakness in her arms (numbing, tingling). Patient has no assistive devices. Most of her strength is intact beside the numbness in her arms. Fall score: 24 Patient's activity/mobility status shows a limp on left leg due to her pain in her back Patient is independent and needs no assistance with equipment and needs no support when walking and standing.</p>
<p>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input checked="" type="checkbox"/> Arms <input checked="" type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Patient moves most of her extremities well. Patient has a limp in her left leg and feels numbness and tingling in both arms. Orientation is 4x. Patient's mental status is within expected range. Speech is within expected range and patient is able to articulate and speak clearly. Senses are all intact followed with her level of consciousness.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level:</p>	<p>Coping method(s): N/A Patient's developmental level is a bachelor's degree that she achieved in 2003. Religion:</p>

Religion & what it means to pt: Personal/Family Data (Think about home environment, family structure, and available family support):	Christianity (Very important). She prays every night. Personal/Family data: Lives home alone with pet dog. Family support (Yes)
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Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1200	86 (Radial)	135/86 (LA)	16	37.4 C (Tympanic)	98% (RA)

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1200	4/10	Lower back and upper neck	Bearable pain	Dull pain	Extra pillows for neck and back

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1,500 mL (water/sprite) 100% (food)	800 mL (urine)

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.
<p>1. Patient is experiencing back pain related to her arthritis in her back as evidenced by “My back hurts when I move and turn around.”</p>	<p>This was the patient’s chief complaint. The patient is experiencing moderate back pain.</p>	<p>1. Pain medication</p> <p>2. Pillows to support back</p>	<p>Patient stated that the pain medication brought her pain down from a 4 to a 2.</p> <p>Patient believes that the interventions and goals implemented worked. Goal met.</p>
<p>2. Patient is a fall risk related to her back pain as evidenced by, “My back pain makes it hard for me to walk.”</p>	<p>This was the patient’s chief complaint. The patient is limping due to her back pain.</p>	<p>1. Pain medication</p> <p>2. Assistance in getting in and out of bed.</p> <p>Bed in low position and call light within reach</p>	<p>Patient believes that the interventions and goals implemented worked. Goal met.</p> <p>Patient stated that the pain medication brought her pain down from a 4 to a 2.</p>

Overall APA format (5 points):

Bartlett, J.B., Lynn, P.L., & Taylor, C.T. (2019). *Fundamentals of nursing: The art and science of person-centered care* (9th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Patient states her pain as a 4 on a scale of 10
Patient states, "My back hurts when I move and turn around."
Patient states, "My back pain makes it hard to walk."

Nursing Diagnosis/Outcomes

Patient is experiencing back pain related to her arthritis in her back as evidenced by, "My back hurts when I move and turn around."

Outcomes: The patient's pain went down from a 4 to a 2 on the pain scale

Patient is a fall risk related to her back pain as evidenced by, "My back pain makes it hard to for me to walk."

Outcomes: Made sure that goal was met by putting the bed in a low position and putting the call within reach.

Objective Data

Patient's blood pressure was high due to pain felt in neck and back
Pulse rate was high before interventions were implemented

Patient Information

Spinal arthritis which causes back and neck pain when the patient moves around.

Nursing Interventions

Pain medication and pillows to support back and neck.
Bed in low position and call light within reach



