

N311 Care Plan # 2
Lakeview College of Nursing
Alyssa Brooks

Demographics (5 points)

Date of Admission 7-27-21	Patient Initials J.L.	Age 85	Gender Male
Race/Ethnicity Caucasian	Occupation Retired	Marital Status N/A	Allergies None
Code Status Full	Height 183 centimeters	Weight 68.8 kilograms	

Medical History (5 Points)

Past Medical History: Fall risk, lumbar pain, lumbar radiculopathy, lumbar spinal stenosis, myofascial pain.

Past Surgical History: Bilateral transforaminal epidural steroid injection with fluoroscopy (6-14-21), trigger point injections (1-2 muscle groups) (6-14-21), transforaminal lumbar epidural steroid injection with fluoroscopy (left) (2-3-21), trigger point injections (1-2 muscle groups) (2-3-21), bilateral transforaminal epidural steroid injection with fluoroscopy (6-1-20), trigger point injections (1-2 muscle groups) (6-1-20), bilateral transforaminal epidural steroid injection with fluoroscopy (9-20-19), trigger point injections (1-2 muscle groups) (9-20-19), hip replacement (1-1-18), epidural injection of lumbar spine using fluoroscopic guidance (5-21-15), nephrectomy (1-1-1952)

Family History: no qualifying data available

Social History (tobacco/alcohol/drugs): Denies any history of use.

Admission Assessment

Chief Complaint (2 points): Patient complains of neck pain related to a fall.

History of present Illness (10 points): Patient is an 85 year old male who presents to the emergency department on 7-18-21 with past medical history of

falling, lumbar radiculopathy, lumbar spinal stenosis, and myofascial pain. He comes in on 7-18-21 with syncopial complaints without loss of consciousness times two on 7-18-21. He also complains of low back and neck pain. He states he hit a magazine rack with his neck when he fell, but denies any trauma to his head. He states over the past year he has constantly been falling multiple times a week. He feels this is from weakness. He is not on any home medications. He was recently seen on 7-6-21 by the emergency department for a fall that caused him to hit his low back on carpeted stairs. They completed a computed tomography (CT) of his lumbar spine at that visit that did not reveal any acute findings. They placed him on indomethacin and hydrocodone as needed for breakthrough pain. He denies any chest pain, dizziness, loss of consciousness, dyspnea, wheezing, fevers, chills, edema, vomiting, diarrhea, or nausea. No past history of myocardial infarction, Deep vein thrombosis, pulmonary embolism, congestive heart failure, or arrhythmias. The emergency department completed a CT scan of the cervical spine that revealed no cervical spine fracture of acute intracranial abnormalities. Patient had positive orthostatic. Comprehensive metabolic panel revealed elevated glucose. Blood urea nitrogen elevated from his previous visit, alkaline phosphate, and total bilirubin complete blood count reveals normal white blood cell count with a left shift. Hospitalist service was consulted for

diagnoses of falling, dehydration, orthostasis, lumbar pain, and fall risk. The medical surgical, family, and social histories were reviewed.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Spinal stenosis in lumbar region without neurogenic claudication.

Secondary Diagnosis (if applicable):N/A

- **Pathophysiology of the Disease, APA format (20 points):** Spinal stenosis is a narrowing of the spaces within your spine, which can put pressure on the nerves that travel through the spine. Spinal stenosis in the lumbar region without neurological claudication is a narrowing of space in the spine within the lower back and is the most common spinal stenosis (Mayo Clinic Staff, 2020). Some causes of spinal stenosis in the lumbar region are congenital. In most causes of spinal stenosis of the lumbar region without neurological claudication is due to an overgrowth of bone from osteoarthritis or Paget's disease (Mayo Clinic Staff, 2020). Another cause of spinal stenosis of the lumbar region without neurological claudication could include herniated disks, thickened ligaments, tumors, or spinal injuries (Mayo Clinic Staff, 2020). Signs and symptoms of spinal stenosis of the lumbar region without neurological claudication include numbness or tingling in a foot or leg, weakness in a foot or leg. (Mayo Clinic Staff, 2020). Risk factors for spinal

stenosis of the lumbar region without neurological claudication are over the age of 50, trauma, congenital spinal deformity such as scoliosis, and a genetic disease affecting bone and muscle development throughout the body (Mayo Clinic Staff, 2020). Diagnosis of spinal stenosis of the lumbar region without neurological claudication would include an X-radiation (X-ray) to look for abnormal shape of the spine (*Neurogenic Claudication*, 2021). Magnetic resonance (MR) imaging would be another way to diagnose spinal stenosis of the lumbar region without neurological claudication by revealing whether the stenosis is due to a bulging or herniated disc (*Neurogenic Claudication*, 2021). Computed tomography (CT) scan can diagnose spinal stenosis of the lumbar region without neurological claudication by looking for abnormalities of the bones and soft tissues (*Neurogenic Claudication*, 2021). Treatments of spinal stenosis of the lumbar region without neurological claudication can include medication such as pain relievers, antidepressants for chronic pain, opioids for pain (Mayo Clinic Staff, 2020). Other forms of treatments for spinal stenosis of the lumbar region without neurological claudication can include physical therapy, steroid injections, decompression procedures for patients with thickened ligaments, surgery, and alternative medicine (Mayo Clinic Staff, 2020). My patient is at a high risk of having spinal stenosis of the lumbar region without neurological

claudication due to his age over 50 and a history of multiple falls and trauma to his lumbar region. Treatment for this patient includes pain management, physical therapy, and steroid injections.

Reference:

Mayo Clinic Staff. (2020, October 24). *Spinal Stenosis*. Mayo Clinic. Retrieved October 15, 2021, from <https://www.mayoclinic.org/diseases-conditions/spinal-stenosis/symptoms-causes/syc-20352961>.

Neurogenic Claudication. Columbia Neurosurgery in New York City. (2021, July 21). Retrieved October 15, 2021, from <https://www.neurosurgery.columbia.edu/patient-care/conditions/neurogenic-claudication>.

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	4.0-5.8x10 ⁶ /mcl	4.4 x10 ⁶ /mcl	N/A	
Hgb	12.0-15.8g/dL	14.3 g/dL	N/A	
Hct	36.0-47.0%	41.9%	N/A	
Platelets	140-440K/mcl	239 k/moL	N/A	
WBC	4.0-12.0K/mcl	11.6 k/moL	N/A	
Neutrophils	40-60%	85.9%	N/A	An increase of neutrophils may be a result from a traumatic injury due to inflammation. (Writers, 2021)
Lymphocytes	19-49%	8.1%	N/A	Low lymphocytes may result from severe stress like a traumatic injury. (Writers, 2021)
Monocytes	3.0-13.0%	5.5%	N/A	
Eosinophils	0.0-8.0%	0.2%	N/A	
Bands	0.0-10.0%	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-	134-144mmol/L	139mmol/L	N/A	
K+	3.5-5.1mmol/L	4.5mmol/L	N/A	
Cl-	98-107mmol/L	103mmol/L	N/A	

CO2	21-31mmol/L	25mmol/L	N/A	
Glucose	70-99mg/dL	176mg/dL	N/A	Trauma, such as a fall, can cause high glucose levels in the blood (Writers, 2021).
BUN	7-25 mg/dL	31mg/dL	N/A	Elevated BUN levels can indicate dehydration (Writers, 2021).
Creatinine	0.50-1.20mg/dL	1.03mg/dL	N/A	
Albumin	3.5-5.7 g/dL	4.1g/dL	N/A	
Calcium	8.6-10.3 mg/dL	9.7mg/dL	N/A	
Mag	1.6-2.6 mg/dL	N/A	N/A	
Phosphate	2.4-4.5 units/L	N/A	N/A	
Bilirubin	0.3-1.0 mg/dL	1.3mg/dL	N/A	Slightly elevated bilirubin may indicate liver damage or liver injury from a fall (Writers, 2021).
Alk Phos	34-104 units/L	111units/L	N/A	Slightly elevated alkaline phosphate may indicate liver damage or liver injury from a fall (Writers, 2021).

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):

Writers, R. N. S. (2021, July 28). *Laboratory values: NCLEX-RN*. RegisteredNursing.org. Retrieved October 18, 2021, from <https://www.registerednursing.org/nclex/laboratory-values/>.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Computed tomography (CT) of the brain and head without contrast on 7-18-21 related to a syncope episode. Impressions revealed no acute intracranial

abnormalities. Computed tomography (CT) of the cervical spine without contrast on 7-18-21 related to pain after a fall. Impression revealed no cervical spine fracture or acute malalignment. X- radiation (X-ray) of the chest in 1 view on 7-18-21 related to a syncope episode. Impressions revealed no acute cardiopulmonary process.

Reference:

Fayad, L. (n.d.). *CT scan versus MRI versus X-ray: What type of imaging do I need?* Johns Hopkins Medicine. Retrieved October 15, 2021, from <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/ct-vs-mri-vs-xray>.

Current Medications (10 points, 2 points per completed med)

5 different medications must be completed

Medications (5 required)

Brand/Generic	Tivorbex/ Indomethacin	Pacerone/Amiodarone hydrochloride	Zanaflex/ Tizanidine hydrochloride	Topro; XL extended release/ Metoprolol succinate ER	Combivent /Ipratropium- Albuterol solution
Dose	25mg	200mg	2mg	25mg	0.5-2.5 (3)mg 3mL
Frequency	1 capsule q.8.h.	1 tab in the morning	1 capsule q.8.h.	1 tab in the morning	1 vial inhale q.4.h. PRN
Route	Oral	Oral	Oral	Oral	Oral
Classification	Analgesic (Jones & Bartlett, 2020)	Class III antiarrhythmic (Jones & Bartlett, 2020).	Antispasmodic (Jones & Bartlett, 2020).	Antihypertensive (Jones & Bartlett, 2020).	Bronchodilator (Jones & Bartlett, 2020).
Mechanism of Action	Blocks activity of cyclooxygenase which mediate inflammatory response and cause local vasodilation, pain, and swelling (Jones & Bartlett, 2020).	Acts on cardiac cell membranes, prolonging repolarization and the refractory period and raising ventricular fibrillation threshold (Jones & Bartlett, 2020).	Reduces spasticity by decreasing the release of excitatory amino acids (Jones & Bartlett, 2020).	It reduces blood pressure by decreasing renal release of renin. (Jones, Bartlett, 2020)	Blocking acetylcholine’s effects in bronchi and bronchioles and causing bronchodilation (Jones & Bartlett, 2020).
Reason Client Taking	To treat mild to moderate pain.	To maintain heart arrhythmia.	To manage acute and intermittent increases of muscle tone with spasticity (Jones & Bartlett, 2020).	To manage hypertension	To make breathing easier.
Contraindications (2)	History of asthma and urticaria (Jones & Bartlett, 2020).	Bradycardia that causes syncope and cardiogenic shock (Jones & Bartlett, 2020).	Hypersensitivity to tizanidine and use with ciprofloxacin (Jones & Bartlett, 2020).	Cardiogenic shock and a heart blockage greater than first degree. (Jones, Bartlett, 2020).	Hypersensitivity to atropine and interacts with anticholinergics by increasing anticholinergic effects (Jones & Bartlett, 2020).
Side Effects/Adverse Reactions (2)	Arrhythmias and heart failure (Jones & Bartlett, 2020).	Acute renal failure and Stevens-Johnson syndrome (Jones & Bartlett, 2020).	Hepatic failure and hepatomegaly (Jones & Bartlett, 2020).	Hepatitis and leukopenia (Jones, Bartlett, 2020)	Atrial fibrillation and bronchospasm (Jones & Bartlett, 2020).

Medications Reference (APA):

Jones & Bartlett. (2020). *Nurse's Drug Handbook* (12th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Alert A&Ox4 Not distressed Well groomed
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:	Appropriate for ethnicity Dry, intact Warm Loose N/A Left arm between elbow and hand N/A 19 No N/A
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	Normocephalic, neck supple, no masses noted Symmetrical, hard of hearing, no signs of drainage Pupils are equal and reactive to light, PERLA with EOM intact Patent with no signs of a deviated septum Wears dentures fit well, gums are pink and moist, no sores
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 type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:	Auscultated, no murmurs present S1, S2 Sinus brady Popliteal 3+ Less than 3 seconds No No N/A
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character	No Anterior, posterior auscultated bilaterally clear
GASTROINTESTINAL:	

<p>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 <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>Regular Regular 183 centimeters 68.8 kilograms Active in all four quadrants 10-10-21 Soft, nontender, no masses noted N/A N/A N/A N/A N/A No No N/A No N/A</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>N/A N/A N/A No No N/A No N/A N/A</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>Intact Active and passive intact Walker, wheelchair, glasses Equal in arms and legs 3+ Yes Yes 60 With assistance No Yes yes</p>
<p>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/></p>	<p>Yes Yes</p>

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:	Yes Both Times 4 Alert Clear Glasses, hard of hearing N/A
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):	Television, movies Appropriate for age Presbyterian, not regularly attending church Home alone

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	54 b/m radial	100/57 mmHg right arm	16 breaths/ minute R.A.	97.1 °F temporal	97% R.A.

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1129	Numeric	None	0/10	None	none

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
N/A	N/A

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis <ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” components 	Rational <ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 	Intervention (2 per dx)	Evaluation <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. Risk for loneliness related to social isolation as evidenced by family status (Phelps, 2020).	Client is living in a rehabilitation facility and states” my family does not visit” (Phelps, 2020).	Spend sufficient time with patient to allow self-expression of feelings and loneliness (Phelps, 2020). Help patient identify social activities that patient can initiate (Phelps, 2020).	Goal met. Patient enjoyed talking to nurse for 30 minutes about feelings and loneliness. Goal met. Nurse gave patient information about activities that the patient can attend in the facility.
2. Risk for falls related to difficulty with gait as evidenced by impaired balance (Phelps, 2020).	Client needs assistance when transferring because he has impaired balance when standing (Phelps, 2020).	1. teach patients with unstable gait to properly use assistive devices (Phelps, 2020). 2.improve environmental safety factors as needed (Phelps, 2020).	Goal met. Client understands how to use walker when walking. Goal met. Client keeps room free of clutter.

Resource:

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual* (11th ed.).

Wolters Kluwer.

Overall APA format (5 points):

Concept Map (20 Points):

He complains of low back and neck pain. He states he hit a magazine rack with his neck when he fell, but denies any trauma to his head. He states over the past year he has constantly been falling multiple times a week. He feels this is from weakness. He denies any chest pain, dizziness, loss of consciousness, dyspnea, wheezing, fevers, chills, edema, vomiting, diarrhea, or nausea.

Subjective Data

Patient is 54 years old.
 Blood pressure: 100/57 mmHg
 Preparations: 16 breaths/ minute R.A.
 Temperature: 97.1°F temporal
 Oxygen: 97% R.A.

Objective Data

Computed tomography (CT) of the brain and head without contrast on 7-18-21 related to a syncope episode. Impressions revealed no acute intracranial abnormalities. Computed tomography (CT) of the cervical spine without contrast on 7-18-21 related to pain after a fall. Impression revealed no cervical spine fracture or acute malalignment. X-radiation (X-ray) of the chest in 1 view on 7-18-21 related to a syncope episode. Impressions revealed no acute cardiopulmonary process.

Patient is an 85 year old male who presents to the emergency department on 7-18-21 with past medical history of falling, lumbar radiculopathy, lumbar spinal stenosis, and myofascial pain. He comes in on 7-18-21 with syncopal complaints without loss of consciousness times two on 7-18-21. He also complains of low back and neck pain. He states he hit a magazine rack with his neck when he fell, but denies any trauma to his head. He states over the past year he has constantly been falling multiple times a week. He feels this is from weakness. He is not on any home medications.

Patient Information

Nursing Diagnosis/Outcomes

Risk for loneliness related to social isolation as evidenced by family status (Phelps, 2020).
 Risk for falls related to difficulty with gait as evidenced by impaired (Phelps, 2020)

Spend sufficient time with patient to allow self-expression of feelings and loneliness (Phelps, 2020).

Help patient identify social activities that patient can initiate (Phelps, 2020).

1. teach patients with unstable gait to properly use assistive devices (Phelps, 2020).

2.improve environmental safety factors as needed (Phelps, 2020).

