N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 9-25-22	Client Initials BG	Age 31	Gender F
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Married	Allergies Bactrim: Nausea and vomiting Barium-sulfate: Nausea and vomiting Haldol: No known reaction Sulfamethoxazole: No known reaction
Code Status Full code	Height 163 centimeters	Weight 93.4 kilograms	

Medical History (5 Points)

Past Medical History: Neurodevelopmental disorder, cortical dysplasia, depression, seizures with intractable epilepsy.

Past Surgical History: Caesarean section (2019), brain (2004), wisdom teeth extraction (no known date), temporal lobectomy (no known date).

Family History:

Father: chronic obstructive pulmonary disease, renal and skin cancer.

Grandfather: leukemia and vision disorder.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): former smoker: Five pack a year smoker from 16 years old to 21 years old. Denies alcohol and drug use.

Assistive Devices: No known assistive device use.

Living Situation: lives at home with husband and two children with mother-in-law. Patient states that they are not safe at home, and they have no safe place to go after discharge. Department of Children and Family Services (DCFS) has been notified upon admission.

Education Level: Patient reports some college attended.

Admission Assessment

Chief Complaint (2 points): The client's chief complaint is breakthrough seizures.

History of Present Illness – OLD CARTS (10 points): The patient reports to the emergency department after reporting a seizure that occurred on 9-24-2022. Patient was seen in the emergency department and discharged due to no more seizure activity. Patient reports to the emergency department on 9-25-22 with a seizure that occurred at home and a staff witnessed seizure was reported in the emergency department. The seizures lasted less than one minute with no aggravating or relieving factors known at this time. Patient has a history of seizures.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): The primary diagnosis on admission is breakthrough seizures.

Secondary Diagnosis (if applicable): N/A

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

Seizures are the abnormal electrical signals in the neuron that fire uncontrollably (Mayo Foundation for Medical Education and Research, 2021). Epilepsy has two or more seizures at least twenty-four hours apart with no identifiable cause (Mayo Foundation for Medical Education and Research, 2021). This patient does have a past medical history of epilepsy. There are two main types of seizures: generalized and focal seizures (Cleveland Clinic Medical Professional, 2022). Generalized seizures are seizures that happen in both hemispheres of the brain. Focal seizures (also known as partial seizures) happen in only one brain hemisphere. A focal seizure will cause symptoms that affect only a specific part of the body or only one side of the body (Cleveland Clinic Medical Professional, 2022). Focal seizures can become generalized

if not treated (Cleveland Clinic Medical Professional, 2022). The patient did experience generalized seizures that affected the right side of the body, as evidenced by the muscle weakness of the right side of the body. Some causes of seizures include genetic mutations, epilepsy, high fever, little sleep, flashing lights, moving patterns or other visual stimulants, hyponatremia, medications, antidepressants, smoking cessation therapies, head trauma, abnormalities in the cephalic blood vessels, autoimmune disorders, stroke, brain tumor, use of recreational drugs, alcohol misuse, and the COVID-19 virus infection (Mayo Foundation for Medical Education and Research, 2021). The patient does have a history of epilepsy, cortical dysplasia (genetic mutation) and antidepressant use. Some symptoms of a tonic-clonic seizure are passing out as all the muscles tense up, causing falls and injuries to occur, uncontrolled convulsions, confusion, and muscle aches after the seizure (Cleveland Clinic Medical Professional, 2022).

Some people have auras before the seizure occurs. Other symptoms of seizures may be starring and unable to get the person's attention (Cleveland Clinic Medical Professional, 2022). The patient does experience the symptoms of a tonic-clonic seizure. Diagnostic testing that can occur are neurological exams, blood tests (for blood sugar levels, white blood cells, genetic conditions, electrolyte imbalances), lumbar puncture, electroencephalogram (EEG) to measure the electrical activity of the brain, magnetic resonance imaging (MRI) for abnormalities of the brain, computerized tomography (CT) for abnormalities of the brain, positron emission tomography (PET) for abnormalities of the brain. Single-photon emission computerized tomography (SPECT) for visualizing blood flow in the brain (Mayo Foundation for Medical Education and Research, 2021). The patient had a blood test and neurological exams because of the patient's previous history of seizures. Treatment options include antiseizure medications,

epilepsy surgery, diet changes, brain stimulation, and vagal nerve stimulation (Cleveland Clinic Medical Professional, 2022). The patient has a past surgical history of a temporal lobectomy and is currently on antiseizure medications with a new prescription.

Pathophysiology References (2) (APA):

Cleveland Clinic Medical Professional. (2022, April 13). Seizure: What it is, causes, symptoms & types. Cleveland Clinic. Retrieved October 1, 2022, from https://my.clevelandclinic.org/health/diseases/22789-seizure

Mayo Foundation for Medical Education and Research. (2021, February 24). Seizures. Mayo Clinic. Retrieved October 1, 2022, from https://www.mayoclinic.org/diseases-conditions/seizure/symptoms-causes/syc-20365711

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	4.0-5.8 x10^6/mcL	4.79 x10^6/mcL	4.24 x10^6/mcL	
Hgb	12.0-15.8g/dL	13.2 g/dL	12.1 g/dL	
Hct	36-47%	40.5%	36%	
Platelets	140-440 K/mcL	303 K/mcL	244 K/mcL	
WBC	4.0-12.0 K/mcL	6.9 K/mcL	5.6 K/mcL	
Neutrophils	40-60%	60%	45.9%	
Lymphocytes	19-49%	29.1%	43%	
Monocytes	3.0-13.0%	7.6%	7.1%	
Eosinophils	0.0-8.0%	2.4%	3%	The patient may be experiencing an increase of eosinophiles due to an

				allergic disease such as hay fever (Mount Sinai Staff, n.d.)
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-	135-145 mmol/L	138 mmol/L	139 mmol/L	
K+	3.5-5 mmol/L	4.1 mmol/L	4.3 mmol/L	
Cl-	98-107 mmol/L	106 mmol/L	108 mmol/L	Dehydration can cause an increase in chloride (Luo, 2017)
CO2	21-31 mmol/L	26 mmol/L	28 mmol/L	
Glucose	70-99 mg/dL	90 mg/dL	86 mg/dL	
BUN	7-25 mg/dL	8 mg/dL	13 mg/dL	
Creatinine	0.50-1.20 mg/dL	0.65 mg/dL	0.62 mg/dL	
Albumin	3.5-5.7 g/dL	3.9 g/dL	3.3 g/dL	Malnutrition can cause low levels of albumin (Luo, 2018)
Calcium	8.6-10.3 mg/dL	8.7 mg/dL	7.9 mg/dL	Malnutrition can cause low levels of calcium (Biggers, 2020)
Mag	1.6-2.6 mg/dL	N/A	1.8 mg/dL	
Phosphate	2.4-4.5 units/L	N/A	3.2 units/L	
Bilirubin	0.3-1.0 mg/dL	0.3mg/dL	N/A	
Alk Phos	44–147 units/L	126units/L	N/A	
AST	5-30 U/L	14 U/L	N/A	
ALT	5-30 U/L	11 U/L	N/A	
Amylase	30-125 U/L	N/A	N/A	

Lipase	10-150 U/L	N/A	N/A	
Lactic Acid	4.5-19.8 mg/ dL	N/A	N/A	
Troponin	0-0.4 ng/mL	N/A	N/A	
CK-MB	0-4 ng/mL	N/A	N/A	
Total CK	25-200 units/ L	N/A	N/A	

Other Tests 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
INR	0.9-1.2	N/A	N/A	
PT	11-14 sec	N/A	N/A	
PTT	20-40 sec	N/A	N/A	
D-Dimer	< 500 ng/mL	N/A	N/A	
BNP	< 100 mg/mL	N/A	N/A	
HDL	40-80 mg/dL	N/A	N/A	
LDL	85-125 mg/dL	N/A	N/A	
Cholesterol	3-5.5 mmol/ L	N/A	N/A	
Triglycerides	50-150 mg/dL	N/A	N/A	
Hgb A1c	4%-6%	N/A	N/A	
TSH	0.5-5 mIU/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	

Arterial Blood Gas 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
pH	7.35-7.45	N/A	N/A	
PaO2	80-100 mmHg	N/A	N/A	
PaCO2	35-45 mmHg	N/A	N/A	
HCO3	22-26 mEq/L	N/A	N/A	
SaO2	92-100%	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 (1) (APA):

Biggers, A. (2020). Calcium deficiency disease (hypocalcemia): 7 symptoms and causes. Medical News Today. Retrieved October 1, 2022, from https://www.medicalnewstoday.com/articles/321865#summary

Luo. (2018). Hypoalbuminemia: Causes, treatment, and symptoms. Medical News Today. Retrieved October 1, 2022, from https://www.medicalnewstoday.com/articles/321149#causes

Luo. (2017). Hyperchloremia (high chloride): Symptoms, causes, and treatments. Medical News Today. Retrieved October 1, 2022, from https://www.medicalnewstoday.com/articles/319801

Mount Sinai Staff. (n.d.). Eosinophil count - absolute. Mount Sinai Health System. Retrieved October 1, 2022, from https://www.mountsinai.org/health-library/tests/eosinophil-count-absolute

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 (5 points): Electrocardiogram (9-25-22): Results revealed normal sinus rhythm with no abnormalities.

Diagnostic Test Correlation (5 points): An electrocardiogram records the hearts electrical signals (Mayo Foundation for Medical Education and Research, 2022). The reason the test is ordered is to rule out any cardiac changed related to the seizures. The results reveal no abnormalities and a normal sinus rhythm.

Diagnostic Test Reference (1) (APA):

Mayo Foundation for Medical Education and Research. (2022, March 19). Electrocardiogram (ECG or EKG). Mayo Clinic. Retrieved October 1, 2022, from https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983

Current Medications (10 points, 1 point per completed med)

10 different medications must be completed

Home Medications (5 required)

Brand/ Generic	Briviact/ brivaracetam	Clonapam/ clonazepam	Lamictal/ lamotrigine	Nayzilam/ midazolam hydrochloride	Trileptal/ oxcarbazepine
Dose	100 mg	300mg	200mg	5mg	1200mg
Frequency	BID	Daily	BID	PRN	At night
Route	Oral	Oral	Oral	Nasal	Oral
Classification	Pharmacologic: anticonvulsant (Jones & Bartlett, 2020). Therapeutic: anticonvulsant (Jones & Bartlett, 2020).	Pharmacologic: benzodiazepine (Jones & Bartlett, 2020). therapeutic: anticonvulsant (Jones & Bartlett, 2020).	Pharmacological: phenyltriazine (Jones & Bartlett, 2020). Therapeutic: anticonvulsant (Jones & Bartlett, 2020).	Pharmacological: benzodiazepine (Jones & Bartlett, 2020). Therapeutic: sedative-hypnotic (Jones & Bartlett, 2020).	Pharmacological: carboxamide derivative (Jones & Bartlett, 2020). Therapeutic: anticonvulsant (Jones & Bartlett, 2020).
Mechanism of Action	High selectivity affinity for the synaptic vesicle protein 2A in the brain (Jones & Bartlett, 2020).	Potentiating the gamma-aminobutyric acid (Jones & Bartlett, 2020).	Blocks sodium channels inhibiting excitatory neurons (Jones & Bartlett, 2020).	Increasing gamma-aminobutyric acid activity (Jones & Bartlett, 2020).	Blocking sodium channels preventing seizures (Jones & Bartlett, 2020).
Reason Client Taking	seizures	seizures	seizures	seizures	seizures
Contraindications (2)	Hypersensitivity and the use of rifampin (Jones &	Acute-narrow-angle	Use of rifampin and oral	Acute-angle-closure	Hormonal contraceptive use and alcohol

	Bartlett, 2020).	glaucoma and hepatic disease (Jones & Bartlett, 2020).	contraceptive use (Jones & Bartlett, 2020).	glaucoma and chronic obstructive pulmonary disease (Jones & Bartlett, 2020).	use (Jones & Bartlett, 2020).
Side Effects/ Adverse Reactions (2)	Suicidal ideation and angioedema (Jones & Bartlett, 2020).	Suicidal ideation and respiratory depression (Jones & Bartlett, 2020).	Suicidal ideation and increased seizure activity (Jones & Bartlett, 2020).	Bradypnea and hypotension (Jones & Bartlett, 2020).	Suicidal ideation and hypotension (Jones & Bartlett, 2020).
Nursing Considerations (2)	Monitor for thoughts of suicidal ideation and monitor for bronchial spasms/ angioedema (Jones & Bartlett, 2020).	Monitor for suicidal ideation and respiratory depression (Jones & Bartlett, 2020).	Monitor for suicidal ideation and a rash (Jones & Bartlett, 2020).	Assess for alcohol use and recover time may be up to six hours (Jones & Bartlett, 2020).	Monitor patient's skin closely and liver function (Jones & Bartlett, 2020).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Do a thorough respiratory assessment prior to administration (Jones & Bartlett, 2020). Initiate fall precautions (Jones & Bartlett, 2020).	Respiratory assessment/ rate and monitor liver enzymes (Jones & Bartlett, 2020).	Skin assessment and monitor for fever (Jones & Bartlett, 2020).	Blood pressure and respiratory assessment/rate (Jones & Bartlett, 2020).	Liver function tests and skin assessment (Jones & Bartlett, 2020).
Client Teaching Needs (2)	Report any symptoms of suicidal ideation and come to the	Do not stop suddenly (Jones & Bartlett,	Report a rash immediately and report	How to administer nasal spray	Report a rash immediately and report any symptoms of

	emergency room or call 911 (Jones & Bartlett, 2020). Do not operate machinery until the effects of the medication are known (Jones & Bartlett, 2020).	2020). Do not drink alcohol (Jones & Bartlett, 2020).	changes in vision (Jones & Bartlett, 2020).	and avoid alcohol use (Jones & Bartlett, 2020).	suicidal ideation and come to the emergency room or call 911 (Jones & Bartlett, 2020).

Hospital Medications (5 required)

Brand/Generic	Toradol/ ketorolac	Vistaril/ hydroxyzine	Ativan/ lorazepam	Reglan/ metoclopramide	Zofran/ ondansetron
Dose	15mg	25mg	1mg	10mg	4mg
Frequency	Q6H	QID	Q1H	Q6H	Q6H
Route	IV Push	Oral	IV Push	IV Push	IV Push
Classification	Pharmacological: NSAID (Jones & Bartlett, 2020). Therapeutic: analgesic (Jones & Bartlett, 2020).	Pharmacologic: piperazine derivative (Jones & Bartlett, 2020). Therapeutic: anxiolytic (Jones & Bartlett, 2020).	Pharmacologic: benzodiazepine (Jones & Bartlett, 2020). Therapeutic: anxiolytic (Jones & Bartlett, 2020).	Pharmacologic: dopamine 2 receptor antagonist (Jones & Bartlett, 2020). Therapeutic: antiemetic (Jones & Bartlett, 2020).	Pharmacologic: selective serotonin receptor antagonist (Jones & Bartlett, 2020). Therapeutic: antiemetic (Jones & Bartlett, 2020).
Mechanism of Action	Blocks cyclooxygenase (Jones	Competes for histamine receptor sites	Inhibits gamma-aminobutyri	Antagonizes the inhibitory effect of dopamine on	Blocks serotonin receptors

	& Bartlett, 2020).	reducing histamine reactions (Jones & Bartlett, 2020).	c acid (Jones & Bartlett, 2020).	GI smooth muscle (Jones & Bartlett, 2020).	in the GI (Jones & Bartlett, 2020).
Reason Client Taking	Headaches	Anxiety	Seizures	Nausea, vomiting, and headache	Nausea
Contraindications (2)	Active peptic ulcer disease and bleeding (Jones & Bartlett, 2020).	Early pregnancy and prolonged QT interval (Jones & Bartlett, 2020).	Respiratory insufficiency and sleep apnea syndrome (Jones & Bartlett, 2020).	Epilepsy and catecholamine-releasing paragangliomas (Jones & Bartlett, 2020).	Apomorphine use and other serotonin receptor antagonist use (Jones & Bartlett, 2020).
Side Effects/Adverse Reactions (2)	Bleeding and respiratory depression (Jones & Bartlett, 2020).	Seizures and prolonged QT interval (Jones & Bartlett, 2020).	Respiratory depression and suicidal ideation (Jones & Bartlett, 2020).	Seizures and suicidal ideations (Jones & Bartlett, 2020).	Hypotension and arrythmia (Jones & Bartlett, 2020).
Nursing Considerations (2)	Monitor liver enzymes and monitor for respiratory depression (Jones & Bartlett, 2020).	Do not give IV or subcutaneously and observe for oversedation (Jones & Bartlett, 2020).	Monitor respiratory depression and do not IV lorazepam with the same syringe as buprenorphine (Jones & Bartlett, 2020).	Report any signs of toxicity and monitor for traditive dyskinesia (Jones & Bartlett, 2020).	Avoid in patients with phenylketonuria and monitor for serotonin syndrome (Jones & Bartlett, 2020).
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Respiratory assessment and liver enzymes (Jones & Bartlett, 2020).	Respiratory assessment and cardiac assessment (Jones & Bartlett, 2020).	Respiratory assessment and liver enzymes (Jones & Bartlett, 2020).	Neurological assessment and musculoskeletal assessment (Jones & Bartlett, 2020).	Musculoskeletal assessment and monitor for low potassium and

					magnesium (Jones & Bartlett, 2020).
Client Teaching Needs (2)	Report any bleeding and do not drink alcohol (Jones & Bartlett, 2020).	Avoid alcohol and report to provider if pregnancy is possible (Jones & Bartlett, 2020).	Avoid alcohol and report excessive drowsiness (Jones & Bartlett, 2020).	Monitor for symptoms of suicidal ideation and report that to provider or call 911 (Jones & Bartlett, 2020). Report any involuntary movements (Jones & Bartlett, 2020).	Reassure blindness may occur and resolve within 48 hours and seek medical attention if symptoms persist or worsen (Jones & Bartlett, 2020).

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: Alertness: Alert	The client is alert and oriented times four and does not show any signs of distressed. The client

Orientation: Oriented times four Distress: Not distressed Overall appearance: Well groomed	is well groomed.
INTEGUMENTARY: Skin color: appropriate for ethnicity Character: dry, intact Temperature: warm Turgor: elastic Rashes: N/A Bruises: N/A Wounds: N/A Braden Score: 21 Drains present: Y☐ N ☒ Type: N/A	The client's skin appropriate for ethnicity and is dry and intact. The client's temperature is warm. The clients skin turgor is elastic with no rashes, bruises, or wounds noted. The Braden score is twenty-one. No drains are present.
HEENT: Head/Neck: normocephalic, neck supple, no masses noted Ears: symmetrical, no signs of drainage Eyes: pupils are equal and reactive to light, PERLA, and EOM intact Nose: nares patent with no signs of deviated septum Teeth: gums are pink and moist, teeth show no signs of carries, no masses or lesions noted.	The client's head is normocephalic, the neck is supple, and no masses noted. The ears are symmetrical with no signs of drainage present. The pupils are equal and reactive to light. PERLA and EOM intact. The nares are patent with no signs of deviated septum. The gums are pink, moist, and intact. The teeth show no signs of dental carries. No masses or lesions noted.
CARDIOVASCULAR: Heart sounds: auscultated, no murmurs present S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): S1 and S2 Peripheral Pulses: radial +2 Capillary refill: less than 3 seconds Neck Vein Distention: Y ☐ N ☒ Edema Y ☐ N ☒ Location of Edema: N/A	The heart sounds auscultated with no murmurs present. S1 and S2 with normal sinus rhythm. +2 radial pulses noted bilaterally. The capillary refill less than three seconds noted in all extremities. No signs of neck vein distention or edema.
RESPIRATORY: Accessory muscle use: Y☐ N ☒ Breath Sounds: Location, character Anterior and posterior auscultated clear and equal bilaterally	The client showed no signs of accessory muscle being used. Anterior and posterior breath sounds auscultated clear and equal bilaterally.
GASTROINTESTINAL: Diet at home: regular Current Diet: regular	The client's diet at home and the current diet is regular. The client is one hundred and sixty-three centimeters and weighs ninety-three point four

Height: 163 cm Weight: 93.4 kg Auscultation Bowel sounds: active in all four quadrants Last BM: 9-24-22 Palpation: Pain, Mass etc.: Soft, nontender, no masses noted Inspection: Distention: N/A Incisions: N/A Scars: on abdomen Drains: N/A Wounds: N/A Ostomy: Y ☐ N ☒ Nasogastric: Y ☐ N ☒ Size: N/A Feeding tubes/PEG tube Y ☐ N ☒ Type: N/A	kilograms. The client has active bowel sounds in all four quadrants and the last bowel movement was on September twenty-fourth of this year. The client's abdomen is soft and nontender with no masses noted. There are no signs of distention, incisions, or wounds in the abdominal area. A scar on the lower abdomen is noted from previous cesarean section. No ostomy is present. Nasogastric tube is not present. No feeding or PEG tubes are present.
GENITOURINARY: Color: pale yellow Character: clear Quantity of urine: one void Pain with urination: Y ☐ N ☒ Dialysis: Y ☐ N ☒ Inspection of genitals: clean, dry, intact Catheter: Y ☐ N ☒ Type: N/A Size: N/A	The client's urine is pale yellow and clear. The quantity of urine is voiding once with flushing before measurable. The client reports no pain with urination. The client is not receiving dialysis. The genitalia are clean, dry, and intact. No catheter is present.
MUSCULOSKELETAL: Neurovascular status: intact ROM: Active and passive intact Supportive devices: N/A Strength: 5/5 on left side, 3/5 on right side ADL Assistance: Y☐ N ☒ Fall Risk: Y ☒ N☒ Fall Score: 60 Activity/Mobility Status: Independent (up ad lib) Needs assistance with equipment ☐ Needs support to stand and walk☒	The neurovascular status is intact. The range of motion is intact active and passively. The client does not use supportive devices and has strength 5/5 on left side. The strength is a 3/5 on the right side of the body. The client does not need activities of daily living assistance and is a fall risk. The fall score is sixty and the client needs support to stand and walk.
NEUROLOGICAL: MAEW: Y ☐ N☒ PERLA: Y ☒ N☐ Strength Equal: Y ☐ N ☒ if no - Legs	The client can move left side well and right side has a deficit noted. PERLA is intact. The strength is not equal in arms and legs as the right side has a deficit noted. The client is oriented times four.

☐ Arms ☐ Both ☒ Orientation: times four Mental Status: developmental delay Speech: Clear, studder Sensory: N/A LOC: N/A	The client has a developmental delay. The client's speech is clear with a studder noted. No sensory or LOC.
PSYCHOSOCIAL/CULTURAL: Coping method(s): music Developmental level: some college Religion & what it means to pt.: N/A Personal/Family Data (Think about home environment, family structure, and available family support): client lives at home with husband, children, mother-in-law	The client listens to music as a coping method. The client has some college attended. The client is Christian with no deviation in medical care. The client lives at home with husband, children, and mother-in-law.

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1100	93 beats/minute	116/73mmHg on the left arm	16 breaths/minut e	36.9 ℃ tympanic	95% room air
1510	76 beats/minute	116/73mmHg on the left arm	18 breaths/minut e	37℃ tympanic	96% room air

Vital Sign Trends: The patient's pulse lowered, and the oxygen saturation went up, the vital signs remained stable throughout the shift.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1115	Numeric	Head	6/10	Dull	Pain medication administered.

1515	Numeric	Head	5/10	Pounding	Patient refused 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: Fluid type/Rate or Saline lock:	20 gage Right antecubital 9-25-22 Patent No signs of drainage, redness, or swelling. The dressing is clean, dry, and intact. 75ml/hr of normal saline

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
300ml of milk 450ml of normal saline Total: 750ml	One urine void that was flushed before it could be measured.

Nursing Care

Summary of Care (2 points)

Overview of care: The patient reports a dull/ bounding head pain. Pain medication was administered, and the client reports an improvement in pain. No seizure activity noted during this shift. The patient is eager to discharge but reports hesitation with starting a new medication at home. Education on the at home medication was performed and patients' question were answered. Patient's concerns are alleviated, and the teach-back method was utilized. Patient plans to discharge within the day.

Procedures/testing done: No procedure/testing was performed during the shift.

Complaints/Issues: The patient complains of head pain throughout the day but reports that pain medication does alleviate the pain. The patient has issues of the new medication to start at home. Education of the new medication is noted, and the patient responds well to the education by reporting back the information.

Vital signs (stable/unstable): The vital signs remained stable through the shift.

Tolerating diet, activity, etc.: The patient is tolerating the regular diet well and remains in bed for most of the shift. Patient does walk with standby assistance to the bathroom.

Physician notifications: Physician plans on discharging today with discharge orders placed by the end of shift. Physician orders a new medication for the patient to start at home and to call with any concerns.

Future plans for client: The patient plans to discharge on 9-26-22. The patient will start a new medication at home.

Discharge Planning (2 points)

Discharge location: The patient will discharge from inpatient to home.

Home health needs (if applicable): no home health needs are required.

Equipment needs (if applicable): No equipment needs are required.

Follow up plan: The patient should follow up with their primary care provider in one week following discharge.

Education needs: The patient needs to be educated on the signs and symptoms of seizures, new medication, pain management, no operating heavy machinery because of seizure activity, and when to come back to the emergency department.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rationale	Interventions	Outcome Goal	Evaluation

• Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	• Explain why the nursing diagnosis was chosen	(2 per dx)	(1 per dx)	• How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Ineffective airway clearance related to retained secretions as evidenced by seizure disorder (Phelps, 2020).	The client has a history of seizures and that is the client's chief complaint.	1. Assess respiratory status every four hours (Phelps, 2020). 2. Encourage sputum expectoration (Phelps, 2020).	1. Airway will remain patent (Phelps, 2020).	Goal met. Respiratory assessment was maintained every four hours with airway patent. Goal met. Client is able to expectorate sputum when needed.
2. Risk for aspiration related to barrier to elevating upper body as evidenced by decrease in level of consciousness (Phelps, 2020).	The client has history of seizures with loos of consciousness.	1. Monitor neurological status (Phelps, 2020). 2. Keep suction available at all times (Phelps, 2020).	1. Prevention of aspiration (Phelps, 2020).	Goal met. Neurological status was assessed. Goal met. Suction is available at bedside if needed.
3. Ineffective breathing pattern related to decreases consciousne	The client has a history of seizures and losing consciousnes s	1. Suction airway as needed (Phelps, 2020).	1. Clients respiratory rate will remain stable (Phelps, 2020).	Goal met. Suction is provided at bedside if needed. Goal met.

ss as evidenced by neurological impairment (Phelps, 2020).		2. Assess and record respiratory rate every four hours (Phelps, 2020).		Respiratory assessment was preformed every four hours.
4. Risk for falls related to decrease in lower extremity strength as evidenced by impaired balance (Phelps, 2020).	The client has a three-fifths muscle strength on the right side of body.	1. Teach client about proper use of assistive devices (Phelps, 2020). 2. Assess ability to use call bell (Phelps, 2020).	1. Apply safety measure to reduce the risk of falls (Phelps, 2020).	Goal partially met. The client will not have assistive devices but the clint does use assistance to stand via another person. Goal met. The client demonstrates the use of call bell.

Other References (APA):

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

Concept Map (20 Points):

Patient reports a pain of 6/10 and 5/10 in the head area throughout shift. The client complains of breakthrough seizures. The client is a former smoker for the age of 16- 21 years old. 5 pack a year smoker. The client denies alcohol or drug use.

Subjective Data

1.Ineffective airway clearance related to retained secretions as evidenced by seizure disorder (Phelps, 2020).
Outcome: Airway will remain patent (Phelps, 2020).
2.Risk for aspiration related to barrier to elevating upper body as evidenced by decrease in level of consciousness (Phelps, 2020).
Outcome: Prevention of aspiration (Phelps, 2020).
3.Ineffective breathing pattern related to decreases consciousness as evidenced by neurological impairment (Phelps, 2020).
Outcome: Clients respiratory rate will remain stable (Phelps, 2020).
4.Risk for falls related to decrease in lower extremity strength as evidenced by impaired balance (Phelps, 2020).
Outcome: Apply safety measure to reduce the risk of falls (Phelps, 2020).

Nursing Diagnosis/Outcomes

Albumin: 3.3 g/dL, Calcium:7.9 mg/dL, Eosinophils:2.4%,3%, Cl-: 108 mmol/L, Electrocardiogram (9-25-22): Results revealed normal sinus rhythm with no abnormalities. 1100: 93 beats/minute, 116/73mmHg on the left arm, 16 breaths/minute, 36.9 °C tympanic, 95% room air. 1510: 76 beats/minute, 116/73mmHg on the left arm, 18 breaths/minute, 37°C tympanic, 96% room air

Objective Data

The patient reports to the emergency department after reporting a seizure that occurred on 9-24-2022. patient was seen in the emergency department and discharged due to no more seizure activity. Patient reports to the emergency department on 9-25-22 with a seizure that occurred at home and a staff witnessed seizure was reported in the emergency department. The seizures lasted less than one minute with no aggravating or relieving factors known at this time. Patient has a history of seizures. Past Medical History: Neurodevelopmental disorder, cortical dysplasia, depression, seizures with intractable epilepsy.
Past Surgical History: Caesarean section (2019), brain (2004), wisdom teeth extraction (no known date), temporal lobectomy (no known date).
Family History:
Father: chronic obstructive pulmonary disease, renal and skin cancer.
Grandfather: leukemia and vision disorder.
Social History): former smoker: Five pack a year smoker from 16 years old to 21 years old. Denies alcohol and drug use.
Assistive Devices: No known assistive device use.
Living Situation: lives at home with husband and two children with mother-in-law. Patient states that they are not safe at home, and they have no safe place to go after discharge. Department of Children and Family Services (DCFS) has been notified upon admission.
Education Level: Patient reports some college attended.

Client Information

Nursing Interventions

1.Assess respiratory status every four hours (Phelps, 2020).
2.Encourage sputum expectoration (Phelps, 2020).
.Monitor neurological status (Phelps, 2020).
.Keep suction available at all times (Phelps, 2020).
.Suction airway as needed (Phelps, 2020).
.Assess and record respiratory rate every four hours (Phelps, 2020).
.Teach client about proper use of assistive devices (Phelps, 2020).
.Assess ability to use call bell (Phelps, 2020).