N311 Care Plan #5

Lakeview College of Nursing

Davis Coffey

Demographics (5 points)

Date of Admission 09/13/2022	**Client Initials** J.M.	**Age** 48	**Gender** Female
Race/Ethnicity White	**Occupation** Disabled	**Marital Status** Single	**Allergies** Hydromorphone and Tramadol
Code Status Full Code	**Height** 162.6 cm	**Weight** 110.7 kg	

Medical History (5 Points)

Past Medical History:

Past Surgical History:

Family History:

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

Admission Assessment

Chief Complaint (2 points):

History of Present Illness – OLD CARTS (10 points):

Primary Diagnosis

Primary Diagnosis on Admission (3 points):

Secondary Diagnosis (if applicable):

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

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives (2nd ed.). F. A. Davis Company. https://fadavisreader.vitalsource.com/books/9781719641470

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	4.28-5.56x10^6/mcL	N/A		
Hgb	13-17 g/dL	N/A		
Hct	38.1-48.9%	N/A		
Platelets	149-393K/mcL	N/A		
WBC	4-11.7K/mcL	N/A		
Neutrophils	45.3-79%	N/A		
Lymphocytes	11.8-45.9%	N/A		
Monocytes	4.4-12.0%	N/A		
Eosinophils	0-6.3%	N/A		
Bands	0.0-10.0%	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-	136-145mmol/L	N/A		
K+	3.5-5.1mmol/L	N/A		
Cl-	98-107mmol/L	N/A		
CO2	21-31mmol/L	N/A		
Glucose	74-109mg/dL	N/A		

BUN	**7-25mg/dL**	**N/A**		
Creatinine	**0.7-1.3mg/dL**	**N/A**		
Albumin	**3.5-5.2g/dL**	**N/A**		
Calcium	**8.6-10.3mg/dL**	**N/A**		
Mag	**1.6-2.6 mg/dL**	**N/A**		
Phosphate	**2.4-4.5 units/L**	**N/A**		
Bilirubin	**0.3-1.0mg/dL**	**N/A**		
Alk Phos	**34-104units/L**	**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**		
pH	**6.0-8.0**	**N/A**		
Specific Gravity	**1.001-1.030**	**N/A**		
Glucose	**Negative**	**N/A**		
Protein	**Negative**	**N/A**		
Ketones	**Negative**	**N/A**		
WBC	**0.0-0.5**	**N/A**		
RBC	**0.0-3.0**	**N/A**		
Leukoesterase	**Negative**	**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		
Blood Culture	Negative	N/A		
Sputum Culture	Negative	N/A		
Stool Culture	Negative	N/A		

Lab Correlations Reference (1) (APA):

Diagnostic Imaging

All Other Diagnostic Tests (10 points): N/A

Diagnostic Imaging Reference (1) (APA): N/A

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

Medications (5 required)

Brand/Generic	Atorvastatin Calcium/ Lipitor	Clonazepam/ Rivotril	Gabapentin/ Gralise	Levothyroxine sodium/ Eltroxin (CAN)	Tizanidine HCl/ Zanaflex
Dose					
Frequency					
Route					
Classification	Pharmacologic: Therapeutic:	Pharmacologic: Therapeutic:	Pharmacologic: Therapeutic:	Pharmacologic: Therapeutic:	Pharmacologic: Therapeutic:
Mechanism of Action					
Reason Client Taking					

Contraindications (2)					
Side Effects/Adverse Reactions (2)					

Medications Reference (1) (APA):

Jones, D.W. (2022). *Nurse's drug handbook*. (21th ed). Jones & Bartlett Learning

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient was alert and oriented to self, time, place, and situation. Patient was in no acute distress and was well groomed.	
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Skin color:** Peach and appropriate for ethnicity. **Character:** Intact and dry **Temperature:** Cold and dry during palpation **Turgor:** Normal mobility, elastic **Rashes:** No rashes observed **Bruises:** No bruises observed **Wounds:** Slight scar on head (from fall) **Braden Score: 16**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head/Neck:** Head and neck symmetrical, trachea midline, carotid pulse normal (2+) bilaterally, lymph nodes not palpable **Ears:** No lumps, lesions, or deformities observed (tympanic membrane not observed) **Eyes:** PERRLA intact, EOM intact, (red eye reflex and vision test not performed) **Nose:** Septum midline, (turbinates not overserved) **Teeth:** Good dentation with oral mucosa pink	.

	and moist, uvula midline, posterior pharynx had no exudate or bleeding while tonsils were 1+ in size, hard palate intact, soft palate rises and falls symmetrically	
CARDIOVASCULAR: **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 rhythm and rate. S1 and S2 sounds heard normally. No murmurs, gallops, or bruits. All peripheral pulses palpable, 2+. Capillary refill less than 3 seconds. No edema noted.	.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Normal breath sounds in all landmarks. Normal respiratory rate and rhythm with no wheezes, rhonchi, or stridor.	.
GASTROINTESTINAL: **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:**	**Diet at home:** Regular **Current Diet:** Regular **Height:** 182.8 cm **Weight:** 91 kg **Auscultation Bowel sounds:** Not assessed **Last BM:** 10/30/2022 **Palpation: Pain, Mass etc.:** Not assessed **Inspection:** Not assessed **Distention:** N/A **Incisions:** N/A **Scars:** N/A **Drains:** N/A **Wounds:** N/A **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:**	**Color:** Urine not observed **Character:** Urine not observed **Quantity of urine:** Urine not observed **Pain with urination: Y ☐ N ☐** Not accessed **Dialysis: Y ☐ N ☒** **Inspection of genitals:** Not assessed	

Catheter: Y ☐ N ☐ **Type:** **Size:**	**Catheter: Y ☐ N ☒** **Type:** **Size:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 50** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	**Neurovascular status:** **ROM:** Partial ROM **Supportive devices:** Wheelchair, gaitbelt, walker **Strength:** Not accessed **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 65** **Activity/Mobility Status:** Up with assistance **Independent (up ad lib)** ☐ **Needs assistance with equipment X** **Needs support to stand and walk X**	
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** A&O x4 **Mental Status:** A&O x4 **Speech:** Clear **Sensory:** Intact **LOC:** A&O x4	
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):**	**Coping method(s):** Not completed **Developmental level:** Appropriate for age **Religion & what it means to pt.:** Christian **Personal/Family Data (Think about home environment, family structure, and available family support):** Wife- visits very frequently and lives at home with her	

Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1100	96 bpm	102/72	16 rpm	98 F	98%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1100					

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Breakfast- 50-75% **Lunch- 50-75%**	**No output observed** **(Patient Incontinent)**

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

Nursing Diagnosis • 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	Rationale • Explain why the nursing diagnosis was chosen	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for impaired skin integrity related to pressure over bony prominence as evidenced by impaired movement.	Patient has impaired movement which increases risk for pressure ulcers.	1.Inspect patients' skin Q8. 2.Reposition patient appropriately.	1. Patient does not experience further skin breakdown.	Client cooperative in intervention and outcome goal. Family and staff not informed of goal or interventions.
2. Risk for self-	Patient has	1. Encourage	1. Patient will	Client

care deficit related to neuromuscular impairment as evidenced by poor personal hygiene.	poor hygiene and inability to perform ADL's from neuromuscular impairment.	patient to perform self-care to the maximum of ability as defined by the patient 2.Provide assistive devices and aids as indicated: shower chair, elevated toilet seat with arm supports	perform self-care activities within the level of own ability	cooperative in intervention and outcome goal. Family and staff not informed of goal or interventions.

Other References (APA):

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

Vera, M. (2022, March 18). *9 multiple sclerosis nursing care plans*. Nurseslabs. Retrieved November 3, 2022, from https://nurseslabs.com/9-multiple-sclerosis-nursing-care-plans/

Concept Map (20 Points

Subjective Data

Patient states has severe back pain at around 11:00 on 10/27/2022. Severity is 6/10. Pain started after working with physical therapy at 10:30 and has not let up since. She claims it is a sharp stabbing pain and nothing has been done to relieve it. Repositioning in wheelchair was offered in order to help relieve pain.

Nursing Diagnosis/Outcomes

Risk for impaired skin integrity related to pressure over bony prominence as evidenced by impaired movement.
Patient does not experience further skin breakdown.
Risk for self-care deficit related to neuromuscular impairment as evidenced by poor personal hygiene.
Patient will perform self-care activities within the level of own ability

Objective Data

VS: Within Normal Ranges
Platelet- 578K/mcL
Glucose- 191m g/dL
WBC- 14.7K/mcL

Client Information

A 48-year-old female who presented to ER with respiratory distress. At Rehab facility now for assistance with ADL's due to MS and multiple other disorders.

Nursing Interventions

1.Inspect patients' skin Q8.

2.Reposition patient appropriately.

3. Encourage patient to perform self-care to the maximum of ability as defined by the patient

4. Provide assistive devices and aids as indicated: shower chair, elevated toilet seat with arm supports