N311 Care Plan 5

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Lakeview College of Nursing

N311: Foundations of Professional Practice

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11/21/2023

Demographics (5 points)

Date of Admission	**Client Initials**	**Age**	**Gender**
10/30/2023	EM	61	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	Line Cook	Single	N/A
Code Status	**Height**	**Weight**	
Full Code	6’	271 lbs	

Medical History (5 Points)

Past Medical History: The client has a history of arthritis, diabetes mellitus, hypertension, and epilepsy.

Past Surgical History: The client had an exploratory laparotomy in 2023, a colonoscopy in 2023, and left leg surgery in 2001.

Family History: The client does not have any pertinent family history.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): The client stated that he smoked one pack of cigarettes a day for ten years before quitting five years ago. He also said that he currently smokes marijuana.

Admission Assessment

Chief Complaint (2 points): Increased seizure activity.

History of Present Illness – OLD CARTS (10 points): The client stated that he has noticed an increase in seizure activity for the past three months. The activity is typically confined to his head, but his muscles sometimes convulse. The seizures usually last for about five to ten seconds. The family of the client stated that when he has seizures, he spaces out and cannot be brought back to the here and now. The client has not noticed any aggravating factors at this time. However, he has stated that he has become fatigued, and his muscles have started aching. When asked about relieving factors, the client denied having found any. The client has been taking

medication for his epilepsy since his diagnosis. When asked to rate his pain, the client stated that he would rate his pain as a five out of ten on a zero to ten scale.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): The primary diagnosis of this client is epilepsy.

Secondary Diagnosis (if applicable): This client does not have a second diagnosis.

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

Pathophysiology References (2) (APA):

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	3.8-5.30	4.58	4.36	
Hgb	12.0-15.8	13.7	12.8	
Hct	36.0-47.0%	41.4%	39.2%	
Platelets	140-440	222	229	
WBC	4.0-12.0	7.70	19.70	
Neutrophils	47-73%	64.6%	86.3%	
Lymphocytes	18.0-42.0%	22.8%	18.6%	
Monocytes	4.0-12.0%	8.6%	7.6%	
Eosinophils	0-5.0%	3.0%	0.4%	
Bands	Not documented	Not documented	Not documented	

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	144	142	
K+	3.5-5.1	3.6	3.7	
Cl-	98-107	103	106	
CO2	22-30	30	28	
Glucose	70-99	121	206	
BUN	10-20	11	16	
Creatinine	0.6-1.0	0.91	0.87	
Albumin	3.5-5.0	3.8	Not documented	
Calcium	8.7-10.5	9.3	8.8	
Mag	1.6-2.6	Not documented	Not documented	
Phosphate	2.5-4.5	Not documented	Not documented	
Bilirubin	0.2-1.2	0.7	Not documented	
Alk Phos	40-150	121	Not documented	

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 and clear	Yellow and clear	Yellow and clear	
pH	5.5-7.5	5.9	6.1	
Specific Gravity	1.005-1.020	1.008	1.013	

Glucose	Negative	Negative	Negative	
Protein	Negative	Negative	Negative	
Ketones	Negative	Negative	Negative	
WBC	0-5	1	4	
RBC	0-2	0	1	
Leukoesterase	Negative	Negative	Negative	

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	Negative	Negative	
Blood Culture	No growth	No growth	No growth	
Sputum Culture	Negative	Negative	Negative	
Stool Culture	No growth	No growth	No growth	

Lab Correlations Reference (1) (APA):

Diagnostic Imaging

All Other Diagnostic Tests (10 points): Computed tomography scan of the brain.

Diagnostic Imaging Reference (1) (APA):

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

Medications (5 required)

Brand/Generic	enoxaparin Lovenox	HYDROmorphone Dilaudid	topiramate Topamax	ondansetron Zofran	metformin Glucophage
Dose	40 mg	0.5-1 mg	50 mg	4 mg	500 mg

Frequency	Once daily	Every 4 hours as needed	Once daily	Every six hours as needed	Twice daily
Route	Subcutaneous	Intravenous	Oral	Intravenous	Oral
Classification					
Mechanism of Action					
Reason Client Taking	Prevent deep vein thrombosis	Severe pain	Seizures	Nausea	Diabetes
Contraindications (2)					
Side Effects/Adverse Reactions (2)					

Medications Reference (1) (APA):

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The client is alert and oriented times four, appears well-groomed, and does not appear to be in acute distress.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Skin is brown, dry, warm, and intact. Skin turgor is as expected, with no signs of tenting. There are no signs of rashes, bruises, wounds, or drains. The client has a Braden score of 18.
HEENT: **Head/Neck:** **Ears:**	The head is round, symmetrical, and appropriate size and color. The neck is midline, there are no deviations, and there are no signs of wounds or

Eyes: **Nose:** **Teeth:**	lesions. Carotid artery is present and palpable +2. The ears are of normal skin color and are free of any wounds, rashes, lesions, deformities, or drainage. Hearing is intact based on conversations with the client. Eyes are symmetrical bilaterally with no signs of lesions or drainage. The sclera is white and cornea is clear bilaterally. The nasal mucosa is moist and pink; there is no signs of drainage in the nose. The client has all of his teeth and they appear to be in good condition. .
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:**	Heart sounds are clear in all areas with S1 and S2 present. There were no signs of S3, S4, or murmurs in the client's heart. Peripheral pulses were present and palpable bilaterally and capillary refill was under two seconds. There were no signs of neck vein distention or edema.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Breath sounds were clear anteriorly, posteriorly, and bilaterally. There was not any accessory muscle use.
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:**	

GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	
MUSCULOSKELETAL: **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: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	.
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):**	.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

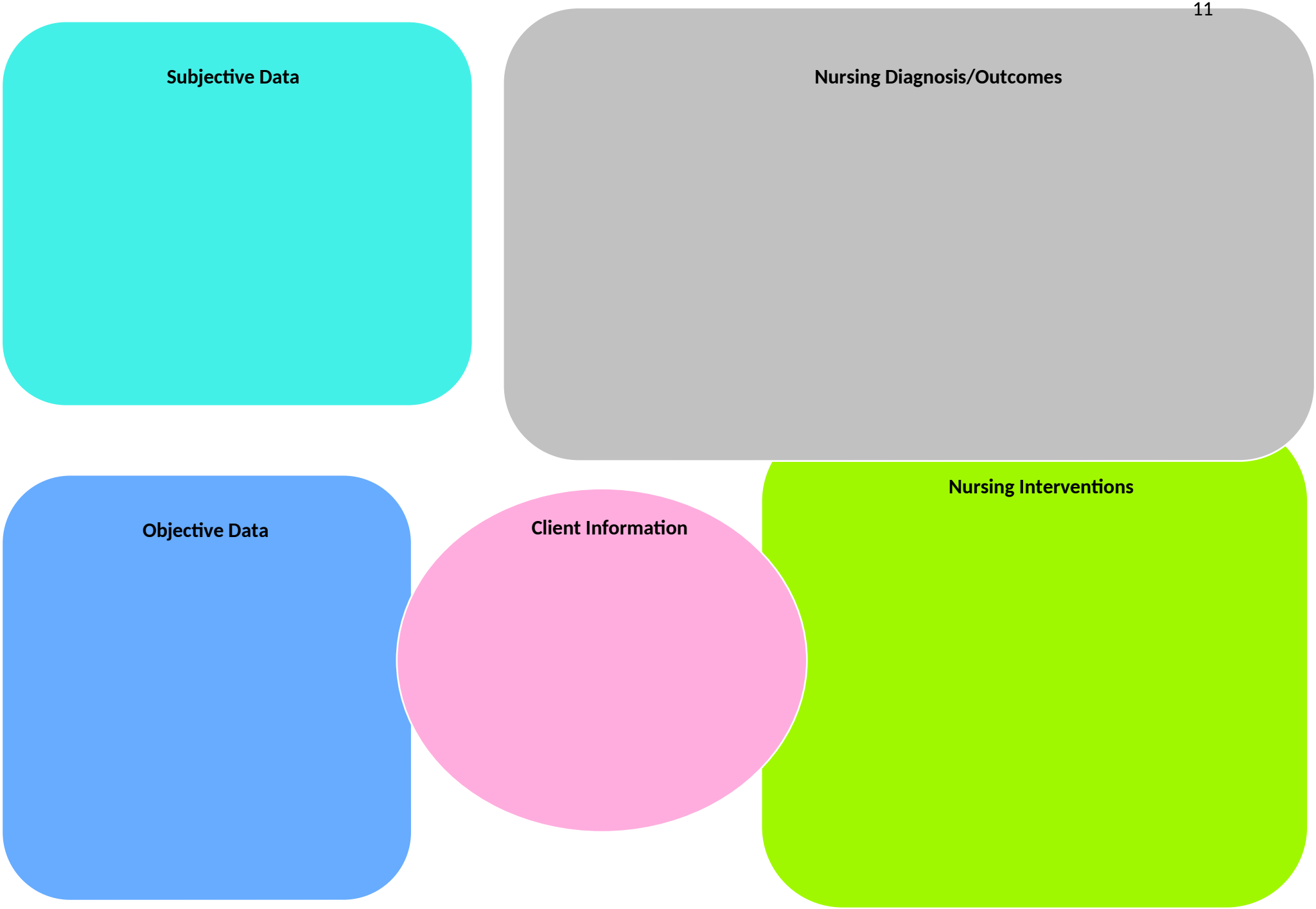
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

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.		**1.**	**1.**	

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

Other References (APA):

Concept Map (23 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Nursing Interventions
Objective Data
Client Information