N311 Care Plan 2

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Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Henry

October 3, 2024

Demographics (5 points)

Date of Admission 9/29/2024	**Client Initials** RMA	**Age** 58 y.o	**Gender** Female
Race/Ethnicity Hispanic or Latino	**Occupation** Disability	**Marital Status** Married	**Allergies** Latex – Rash Levonorgestrel-ethinyl Estrad – Itching
Code Status Full (No ACP docs)	**Height** 4’ 11”	**Weight** 115 lbs 1.6 oz	

Medical History (5 Points)

Past Medical History: Anemia in chronic kidney disease, anxiety, asthma, congestive heart failure, chronic kidney disease, age-related cataract of left eye, combined systolic and diastolic congestive heart failure, diabetes, dialysis patient, degenerative joint disease, edema, gastroparesis, hypercholesterolemia, hyperlipidemia, hypertension, intraabdominal hematoma, lung nodule, pneumonia, sleep apnea, thyroid disease, transient ischemic attack, pulmonary vascular congestion, port-a-cath in place, pulmonary hypertension.

Past Surgical History: AV fistula **or** graft venous (left), shoulder surgery (left), cesarean section, cataract removal, finger surgery (left), central venous catheter, toe amputation (right), finger fracture surgery, cholecystectomy, laparoscopy, gallbladder surgery, colonoscopy, esophagogastroduodenoscopy, cataract removal with implant, vascular surgery, exploratory of abdomen, cardiac catheterization, upper gastrointestinal endoscopy.

Family History: Father (deceased) – asthma, congestive heart failure, renal failure

Mother (deceased) – diabetes, hypertension

Sister – diabetes, hypertension

Brother – leukemia/lymphoma

Brother – unknown cancer

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient denies history of smoking tobacco, being exposed to tobacco smoke, or using smokeless tobacco. Patient denies the use of alcohol or recreational drugs.

Admission Assessment

Chief Complaint (2 points): Seizure

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

Patient arrived at the emergency department via emergency medical services with complaints of a seizure that took place at home. The seizure occurred on Sunday, September 29th and lasted for approximately 5 minutes. Patient states that she attended church, went out to eat, and went home prior to the seizure taking place. Occurring to the patient's husband, she was sitting when the incident took place. The seizure consisted of body stiffness, abnormal body movements, and tongue biting. The patient claims she does not remember the seizure taking place and had confusion upon the emergency responder's arrival to her home. The patient did not attempt to treat the seizure prior to emergency services arriving. Patient denies any prior history of seizures but states that she has had a couple of small strokes. Patient was FAST negative upon arrival to the emergency department. Patient claims she recently discontinued use of prescription Klonopin. She stated that she tapered off the drug and hasn't used it in two weeks.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Seizure Disorder

Secondary Diagnosis (if applicable): End Stage Renal Disease

Pathophysiology

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

Disease Pathophysiology

A seizure occurs when there is a sudden charge of electrical activity occurring between neurons that causes short term effects in the movement of muscles, behaviors, or levels of consciousness (John Hopkins, 2021). The occurrence of a sudden onset seizure may be related to issues occurring in the central nervous system, cardiac events, or psychiatric episodes (Huff, 2023). Seizures often have a duration of 30 seconds to 5 minutes and are considered a medical emergency if the episode lasts longer. The occurrence of two seizures occurring over 24 hours apart that have no known underlying cause is considered epilepsy (Mayo, 2023). Epileptic episodes are often the primary association with seizure diagnoses, but epileptic seizures only account for one type of attack (Huff, 2023). Many factors contribute to the pathophysiology of seizure disorders due to the broadness of the diagnosis. Currently seizures are categorized by two classifications, partial and generalized (Huff, 2023).

Partial

Partial seizures, also referred to as focal seizures, begin in one area of the brain and travel to other areas. As the brain becomes more involved the symptoms become more apparent or more severe. There are several more specific sects of partial seizures including focal unaware seizures**,** complex partial seizures, focal aware seizures**,** and tonic-clonic seizures (John Hopkins, 2021).

Generalized

Generalized seizures differ from partial seizures due to the surges of uncontrolled electrical pulses occurring in two areas of the brain concurrently. Generalized seizures can be classified as absence seizures, myoclonic seizures, tonic seizures, atonic seizures, and tonic-

clonic seizures. Seizures may begin as partial and progress into generalized (John Hopkins, 2021).

Etiology

The diagnosis of a seizure disorder is broad and can encompass numerous etiologies and symptoms. Seizures may be singular events or part of recurring episodes. In any sense, seizures may be caused by genetic disorders, medications, electrolyte disturbances, infections, sleep deprivation, traumatic brain injuries, or other systematic disturbances (Huff, 2023).

Signs and Symptoms

The manifestations of seizures may be based on the type of seizure, severity of the event, and the individual. Signs and symptoms may include but are not limited to temporary confusion, jerking body movements, shaking, loss of consciousness, lockjaw, and emotional or behavioral changes (Mayo, 2023).

Diagnostic Testing

There are testing options to determine if an individual is experiencing a seizure. Diagnostic tests may include electroencephalogram, computerized tomography, or magnetic resonance imaging. An electroencephalogram is the most common diagnostic test and may help determine the type, severity, and location of the seizure (Mayo, 2023).

References

Huff, J. S. (2023). *Seizure*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK430765/

Johns Hopkins Medicine. (2021). *Types of seizures*. https://www.hopkinsmedicine.org/health/conditions-and-diseases/epilepsy/types-of-seizures

Mayo Foundation for Medical Education and Research. (2023). *Seizures*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/seizure/symptoms-causes/syc-20365711

Pathophysiology References (2) (APA):

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1529	55 bpm	138/62	18	96.7 F	96%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1529	NRS	N/A	0	No pain during assessment.	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1400 – 480 mL IV fluid intake	0 mL

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

Nursing Diagnosis	Rationale	Interventio	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	**ns (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. Increased risk for fall related to ambulation as evidenced by fall risk score of 85, diabetic ulcer on right foot, missing digit on right foot, and patient claiming to feel weak.	**Patient is at increased risk for fall which may result in serious injury during ambulation.**	**1.Clear all obstacles between the patient's bed and the bathroom. This includes the bedside table, chairs, and patient's belongings.** **2.Keep patient's bed in the lowest position with brakes locked at all times that transport is not taking place.**	**1. Patient will experience no fall related injury as evidenced by zero falls taking place during ambulation prior to discharge from the hospital.**	**Patient would be able to ambulate to the bathroom with less risk of fall. This would make the patient more comfortable and decrease any anxiety associated with ambulation for the patient and family.**
2. Risk for infection related to inadequate primary defense as evidenced	**The patient's first line of defense against infections is compromis**	**1. Perform proper bathing and disinfection protocol for patient and patient's**	**1. The patient will remain free of infection as evidenced by no signs and symptoms of infection**	**Patient will not obtain any healthcare associated infections. This will improve the experience of the patient and the**

by diabetic ulcer on anterior right foot.	**ed making her at an increased risk for developing an infection.**	**environmen t.** **2.Monitor ulcer on right foot and report early signs or symptoms of infection**	**including redness, swelling, or abnormal vital signs during the remainder of the hospital stay.**	**family. This will also ensure that focus remains on the patient's primary health concerns.**

Other References (APA):

Concept Map (23 Points):

Subjective Data

Patient states "I am feeling a little weak."

Complaints of right shoulder pain and generalized achiness

Nursing Diagnosis/Outcomes

1. Increased risk for fall related to ambulation as evidenced by fall risk score of 85, diabetic ulcer on right foot, missing digit on right foot, and patient claiming to feel weak.
Outcome: Patient will experience no fall related injury as evidenced by zero falls taking place during ambulation prior to discharge from the hospital.

2. Risk for infection related to inadequate primary defense as evidenced by diabetic ulcer on anterior right foot.
Outcome: The patient will remain free of infection as evidenced by no signs and symptoms of infection including redness, swelling, or abnormal vital signs during the remainder of the hospital stay.

Objective Data

Fall risk score of 85.

Has undergone a toe amputation on right foot

Blood pressure: 138/62

Pulse: 55 BPM

Patient is using supplemental oxygen via nasal cannula

Diabetic ulcer on anterior right foot

Calcium: 8.5 mg/DL
RBC: 3.46 L
Hemoglobin: 10.5 L
Hematocrit: 31.6 L
Platelet count: 62L

Client Information

Presents with seizure.
DOA: 9/29/2024
Initials: RMA
Gender: Female
58 Year-Old
Marital Status: Married
DOB: 5/18/1966
Height: 4'11"
Weight: 115 lbs 1.6 oz
Code Status: Full

Nursing Interventions

Clear all obstacles between the patient's bed and the bathroom. This includes the bedside table, chairs, and patient's belongings.

Keep patient's bed in the lowest position with brakes locked at all times that transport is not taking place.

Perform proper bathing and disinfection protocol for patient and patient's environment.

Monitor ulcer on right foot and report early signs or symptoms of infection