N311 Care Plan 3

Student Name

Lakeview College of Nursing

N311: Foundations of Professional Practice

Clinical Instructor Name

Date

Demographics (5 points)

Date of Admission	Client Initials	Age	Gender
Race/Ethnicity	Occupation	Marital Status	Allergies
Code Status	Height	Weight	

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

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 <mark>Highlight All Abnormal Labs</mark>—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				
Hgb				
Hct				
Platelets				
WBC				
Neutrophils				
Lymphocytes				
Monocytes				
Eosinophils				
Bands				

Chemistry <mark>**Highlight All Abnormal Labs**</mark>**—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-				
K+				
Cl-				
CO2				
Glucose				
BUN				
Creatinine				
Albumin				
Calcium				
Mag				

Phosphate				
Bilirubin				
Alk Phos				

Urinalysis <mark>Highlight All Abnormal Labs</mark>—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				
pH				
Specific Gravity				
Glucose				
Protein				
Ketones				
WBC				
RBC				
Leukoesterase				

Cultures <mark>Highlight All Abnormal Labs</mark>—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				
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (1) (APA):

<center>**Diagnostic Imaging**</center>

All Other Diagnostic Tests (10 points):

Diagnostic Imaging Reference (1) (APA):

<center>**Assessment**</center>

Physical Exam (18 points) – <mark>**HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS**</mark>

General, Psychosocial/Cultural, and ONE focused assessment specific to the client is required.

The student and instructor may complete these assessments together.

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	
HEENT: **Head/Neck:** **Ears:**	.

Eyes: **Nose:** **Teeth:**	
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:**	.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	.

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) – <mark>HIGHLIGHT ALL ABNORMAL VITAL SIGNS</mark>

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. 2.	1.	
2.		1. 2.	1.	

Other References (APA):

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes

Objective Data

Client Information

Nursing Interventions