N311 Care Plan # 1

Lakeview College of Nursing

Sarah Brown

Not finished many parts.

42/150

Demographics (5/5 points)

Date of Admission	Patient Initials	Age	Gender
09/19/2019	R.W>	95	M
Race/Ethnicity WH	**Occupation**	**Marital Status** married	**Allergies** Hismanal Cipro [CIPROFLOXACIN] Darvocet-n 100 [PROPOXYPHENE N-ACETAMINOPHEN] Ibuprofen Indocin [INDOMETHACIN SODIUM] Iodinated contrast media Zocor [SIMVASTATIN]
Code Status DNR	**Height** 66 inches	**Weight** 184 lbs	

Medical History (5/5 Points)

Past Medical History: History of blepharitis, BRVO (Branch retinal vein occlusion) (left eye), CAD (Coronary artery disease), Cancer (thyroid), Cataract, CKD (Chronic kidney disease), Stage III, Diabetes mellitus, Dyslipidemia, Gout, Hypertension, Hypothyroidism, Obstructive sleep apnea, Renal disease, Sleep apnea (uses CPAP), Stroke-like symptoms (09/15/2019), Thyroid cancer, TIA (Transient ischemic attack), Type II or unspecified type diabetes mellitus without mention of complication, not stated as uncontrolled, V-tach and ventricular tachycardia.

Past Surgical History: Stent vessel bilateral (x5A); appendectomy; cholecystectomy; hip fracture surgery (left hip with pins); hernia repair; thyroidectomy; gallbladder removal; pt

ca/stent; pacemaker insertion; egd/colonoscopy and endoscopy upper and lower; gastroscopy.

Family History:

Social History (tobacco/alcohol/drugs):

Admission Assessment

Chief Complaint (1/2 points):. (was not able to assess or interview the patient)

History of present Illness (10/10 points):. 95 year old male with history of CVAS (ischemic) admitted for conditioning and therapy post hospitalization 09/15-09/19 after developing dizziness; headache; increased weakness of Left upper extremity and lower extremity; difficulty getting out of bed.

Discharge summary=upon arriving at the emergency department, there was concern for acute ischemic stroke with/NIH 11, therefore, patient was given tPA and admitted to Intensive Care Unit. CT of the brain showed no acute hemorrhage or large acute infarct. Neurological evaluation concluded present atypical for stroke and more likely stroke mimic. A follow up CT of the brain is without evidence of new ischemic infarct or hemorrhage and recommended to switch home aspirin to Plavix and continue a statin. Code stroke was called on 09/17/2019 for new left sided facial droop, STAT CT of the brain was negative for acute intracranial hemorrhage, discussed with Neuro Dr. advised that this was part of his old right sided hemispheric stroke, continue current management and continue Plavix. Patient was noted to have UCx50,000 cfu/mL Proteus mirabillis that could be contaminant as patient does have an indwelling foley and has been clinically stable vs stable, afebrile, no leukocytosis, no abdominal or suprapubic pain. Patient was also noted

to have aki on CKD stage III that resolved with IV fluids. Patient now (09/20/2019) stable and discharged to ECF for rehab.

Primary Diagnosis

Primary Diagnosis on Admission (3/3 points): Type II Diabetes Mellitus without complications

Secondary Diagnosis (if applicable): Chronic Kidney Disease, Stage III (moderate)

Pathophysiology of the Disease, APA format (5/20 points): Obesity and increased abdominal fat distribution patterns are associated with insulin resistance, which characterizes the disorder. There is also a strong family history of Type II Diabetes in affected individuals. Both these factors contribute to the development of Type II Diabetes mellitus. Please read the rubric for care plan

Pathophysiology References (2) (APA):

Laboratory Data (5/20 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				
Hgb				
Hct				
Platelets				
WBC				
Neutrophils				
Lymphocytes				
Monocytes				
Eosinophils				
Bands				

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-				
K+				
Cl-				
CO2				
Glucose				
BUN				
Creatinine				
Albumin				
Calcium				
Mag				

Phosphate				
Bilirubin				
Alk Phos				

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				**Straw and clear**
pH		**8.0**		
Specific Gravity	**1.005**			
Glucose				**negative**
Protein				
Ketones	**negative**			
WBC		**250^**		
RBC		**594^**		
Leukoesterase		**moderate**		

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				
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (0/10 points):

Current Medications (3/10 points, 2 points per completed med)
5 <u>different</u> medications must be completed

Medications (5 required)

Brand/Generic	**Clopidogrel/Plavix**	**Dextrose 40%/glucose**	**Amlodipine/Norvasc**		
Dose	**75 mg tablet**	**Oral gel 15g of dextrose**	**Tablet 5 mg**		
Frequency	**Daily**	**PRN**	**Daily**		
Route	**PO**	**PO**	**PO**		
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					

Medications Reference (APA):

Assessment

Physical Exam (5/18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**(No physical assessment or interview was completed with this patient-filling in the "basics that could be observed from a distance as instructed") ???** **No fever, chills, oriented x2**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	. Chart states hard of hearing; hearing device is noted on patient
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**	**No noted shortness of breath or cough**

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:**	**Noted that the patient has a long term cath present, no N/V/D observed**
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 ☐**	**Not observed to be in physical pain, no wincing, yelling or crying noted.**
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 (0/5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

Pain Assessment, 1 set (0/5 points)

Time	Scale	Location	Severity	Characteristics	Interventions

Intake and Output (0/2 points)

Intake (in mL)	Output (in mL)

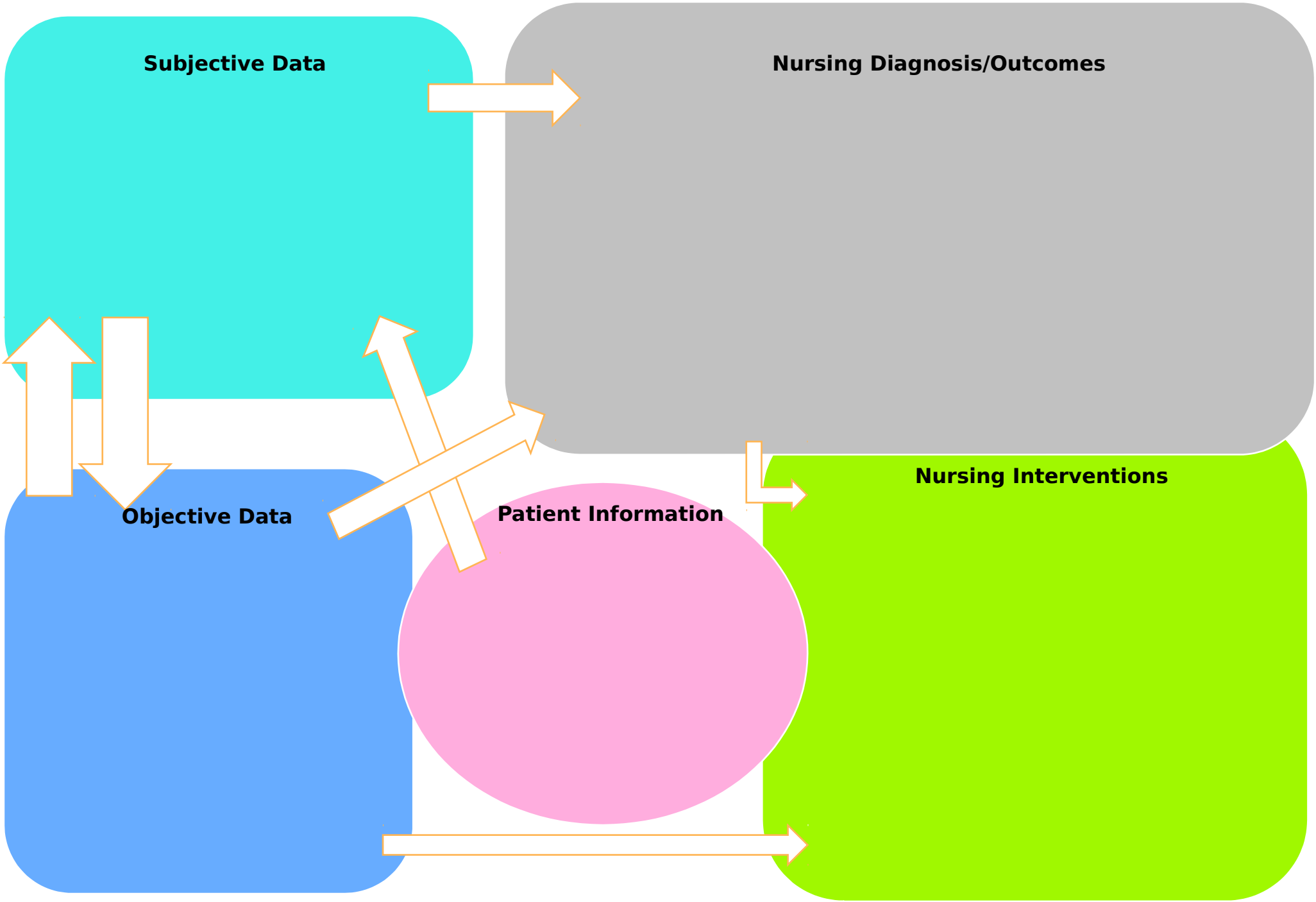
Nursing Diagnosis (0/15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1.		**1.** **2.**	
2.		**1.** **2.**	

Other References (APA):

Concept Map (0/20 Points):


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