N321 Care Plan #1

Lakeview College of Nursing

Savannah Woods

Demographics (3 points)

Date of Admission 2/18/2020	Patient Initials O.J.H.	Age 68	Gender Female
Race/Ethnicity White	Occupation Retired	Marital Status Divorced	Allergies Environmental allergen
Code Status Full	Height 6ft	Weight 180 lbs.	

Medical History (5 Points)

Past Medical History: Cervical dysplasia, chronic liver disease, overactive bladder, colonic polyp, depression, esophageal reflux, heart disease, hyperlipidemia, hypertension, measles, mumps, palpitations, skin cancer, thyroid disease, UTI, varicella

Past Surgical History: Prosthetic implant, colposcopy, appendectomy, tonsillectomy, heart catheterization, joint replacement (bilateral), colonoscopy

Family History: Mother- cancer of bile duct, thyroid disease, father- colon cancer, hypertension, stroke, heart disease, diabetes, depression, dementia, Grandparents(mothers side)- stroke, grandpa(fathers side)- CAD, grandma(fathers side)- CAD, Alzheimer's

Social History (tobacco/alcohol/drugs): former smoker, alcohol

Assistive Devices: none

Living Situation: lives alone

Education Level: Was a nurse practitioner before retirement

Admission Assessment

Chief Complaint (2 points): dizziness, difficulty walking

History of present Illness (10 points): Client went to Mexico; dizziness began after climbing a pyramid in the heat. Dizziness has been intermittent since then, woke up at 6am more severe dizziness with associated walking difficulty.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Vertigo

Secondary Diagnosis (if applicable):N/A

Pathophysiology of the Disease, APA format (20 points): Vertigo is the sensation of feeling off balance. It is often caused by an inner ear problem, some causes include: BPPV, Meniere's disease, vestibular neuritis or labyrinthitis. Other causes though less common could be head or neck injury, brain problems like a stoke or tumor, medication that damage the ear, and migraine headaches.

Symptoms:

-spinning

-tilting

-swaying

-unbalanced

-pulled in one direction

-feeling nauseated

-abnormal jerking eye movements

-Vomiting

-headache

-sweating

-ringing in the ears or hearing loss

Treatment for vertigo usually depends on its cause, often it does away without treatment. If not, some treatments include:

-vestibular rehabilitation

-canalith repositioning maneuvers

-medication

-surgery

The client had prior gone on a vacation to Mexico, there she climbed a pyramid where the first onset of what she thought was dizziness set in. Client says that since then it has happened intermittently. She had woken up at around 6am the morning of her admission with much more severe dizziness, as well as difficulty walking. Vertigo can have many causes, though pt. cause is not yet determined. Possibility of having developed vestibular neuritis while in Mexico or having BPPV.

Pathophysiology References (2) (APA): Ambardekar, N. (2018, December 22). Vertigo: Causes, Symptoms, and Treatment. Retrieved from https://www.webmd.com/brain/vertigo-symptoms-causes-treatment#1

Benign paroxysmal positional vertigo (BPPV). (2018, June 30). Retrieved from https://www.mayoclinic.org/diseases-conditions/vertigo/symptoms-causes/syc-20370055

Laboratory Data (15 points)

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	**3.80-5.30 10 (6)/moL**			
Hgb	**12.0-15.8 g/dL**			
Hct	**36.0-47.0%**			
Platelets	**140-440 10**			

	(3)/moL			
WBC	**4.00-12.00 10 (3)/moL**		**13.20**	**Inflammation, infection**
Neutrophils	**47.0-73.0%**		**90.8%**	**Inflammation, infection**
Lymphocytes	**18.0-42.0%**		**6.3%**	**infection**
Monocytes	**4.0-12.0%**		**2.4%**	**infection**
Eosinophils	**0.0-5.0%**			
Bands	**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-	**135-144 mmol/L**			
K+	**3.5-5.1 mmol/L**			
Cl-	**98-107 mmol/L**			
CO2	**21-31 mmol/L**			
Glucose	**70-99 mg/dL**	**142**	**166**	**Possible development of diabetes from age**
BUN	**7-25 mg/dL**			
Creatinine	**0.50-1.00 mg/dL**			
Albumin	**3.5-5.7 g/dL**			
Calcium	**8.8-10.2 mg/dL**			
Mag	**N/A**			
Phosphate	**N/A**			
Bilirubin	**0.0-0.2 mg/ dL**			

Alk Phos	**34-104 u/L**	**133**		**Chronic liver disease**
AST	**13-39 u/L**			
ALT	**7-25 u/L**			
Amylase	**N/A**			
Lipase	**N/A**			
Lactic Acid	**N/A**			

Other Tests 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
INR	**0.8-1.1**			
PT	**10.1-13.1 sec**			
PTT	**25-36 sec**			
D-Dimer	**N/A**			
BNP	**N/A**			
HDL	**>40 mg/dL**			
LDL	**<130 mg/dL**			
Cholesterol	**<200 mg/dL**			
Triglycerides	**<150 mg/dL**			
Hgb A1c	**4.0-6.0%**			
TSH	**0.270-4.200 miu/L**		**0.076**	**Thyroid disease**

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	**N/A**			**No urinalysis was done**
pH	**N/A**			
Specific Gravity	**N/A**			
Glucose	**N/A**			
Protein	**N/A**			
Ketones	**N/A**			
WBC	**N/A**			
RBC	**N/A**			
Leukoesterase	**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	**N/A**			**No cultures were done**
Blood Culture	**N/A**			
Sputum Culture	**N/A**			
Stool Culture	**N/A**			

Lab Correlations Reference (APA): Tests Index. (n.d.). Retrieved from https://labtestsonline.org/tests-index

Diagnostic Imaging

All Other Diagnostic Tests (5 points): BUN/Creatinine ratio- Normal: 6-20, admission-25, today-26

Chest Xray

-no acute cardiopulmonary findings. Mild hyperinflation

MRI brain/wo contrast

-Mild cerebral and cerebellar atrophy with the right matter ischemic changes to small vessel disease. No space occupying lesions. No abnormal areas of contrast enhancement. No diffusion abnormalties.

Diagnostic Test Correlation (5 points): Dizziness can be caused by several issues. To check if the reasoning had to do with somewhere in the brain, or chest. Such as the patients blood flow or air ways could have been a cause as well.

Diagnostic Test Reference (APA): Harvard Health Publishing. (n.d.). Diagnostic Tests and Medical Procedures. Retrieved from https://www.health.harvard.edu/diagnostic-tests-and-medical-procedures

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**Cannabidiol**	**levothyroxine**	**Toprol-XL**	**Multivitamin**	**N/A**
Dose	**50mg**	**150mcg**	**100 mg**	**N/A**	
Frequency	**daily**	**1-tab daily**	**1-tab daily**	**N/A**	
Route	**oral**	**oral**	**oral**	**oral**	
Classification	**cannabinoid**	**Chemical: synthetic thyroxine Therapeutic: thyroid hormone replacement**	**Chemical: beta-adrenergic antagonist Therapeutic: antianginal, antihypertensive, MI prophylaxis and treatment**	**N/A**	
Mechanism of Action	**N/A**	**Replaces endogenous thyroid hormone, which may exert its physiologic effects by controlling DNA transcription and protein synthesis**	**Inhibits stimulation of beta-receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand.**	**N/A**	
Reason Client Taking	**N/A**	**Thyroid disease**	**hypertension**	**N/A**	
Contraindications (2)	**N/A**	**Acute MI, hypersensitivity to**	**Acute heart failure, cardiogenic**	**N/A**	

		levothyroxine or its components, uncorrected adrenal insufficiency	**shock**		
Side Effects/Adverse Reactions (2)	**N/A**	**Angina, headache**	**Fatigue, dry eyes or mouth**	**N/A**	
Nursing Considerations (2)	**N/A**	**Be aware that it is not to be used for treatment of obesity or for weight loss. Monitor PT of patient who is receiving anticoagulants; she may require a dosage adjustment.**	**Assess EKG of patients who take, because they may be at risk for AV block. Be aware that the dosage for heart failure is highly individualized.**	**N/A**	

Hospital Medications (5 required)

Brand/ Generic	**Dexamethasone**	**enoxaparin**	**Lopressor**	**Synthroid**	**Toprol-XL**
Dose	**10mg**	**80 mg**	**5mg**	**112 mcgd**	**100mg**
Frequency	**Every 12 hrs.**	**Every 12 hrs.**	**Every 6 hrs.**	**daily**	**daily**

			PRN		
Route	**intravenous**	**SubQ**	**intravenous**	**oral**	**oral**
Classification	**Chemical: synthetic adrenocortical steroid Therapeutic: anti-inflammatory, diagnostic aid, immunosuppressant**	**Chemical: low-molecular-weight heparin Therapeutic-antithrombotic**	**Chemical: beta-adrenergic antagonist Therapeutic: antianginal, antihypertensive, MI prophylaxis and treatment**	**Chemical: synthetic thyroxine Therapeutic: thyroid hormone replacement**	**Chemical: beta-adrenergic antagonist Therapeutic: antianginal, antihypertensive, MI prophylaxis and treatment**
Mechanism of Action	**Binds to intracellular glucocorticoid receptors and suppresses inflammatory immune responses**	**Potentiates the action of antithrombin III, a coagulation inhibitor**	**Inhibits stimulation of beta-receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand**	**Replaces endogenous thyroid hormone, which may exert its physiologic effects by controlling DNA transcription and protein synthesis**	**Inhibits stimulation of beta-receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand**
Reason Client Taking	**To treat possible inflammation in ear that could be causing vertigo**	**To prevent blood clots**	**hypertension**	**Thyroid disease**	**hypertension**
Contraindications (2)	**Administration of live-virus vaccine to patient or family member, hypersensitivit**	**Active major bleeding, history of heparin-induced thrombocytopenia**	**Acute heart failure, cardiogenic shock**	**Acute MI, hypersensitivity to levothyroxine or its components,**	**Acute heart failure, cardiogenic shock**

	y to dexamethasone or its components			**uncorrected adrenal insufficiency**	
Side Effects/ Adverse Reactions (2)	**Depression, bradycardia**	**Confusion, bloody stools**	**Fatigue, dry eyes or mouth**	**Angina, headache**	**Fatigue, dry eyes or mouth**
Nursing Considerations (2)	**Give oral drug with food to decrease GI distress, shake IM solution before injecting deep into large muscle mass**	**Don't give drug by IM injection, Keep protamine sulfate nearby in case of accidental overdose**	**Assess EKG of patients who take, because they may be at risk for AV block. Be aware that the dosage for heart failure is highly individualized.**	**Be aware that it is not to be used for treatment of obesity or for weight loss. Monitor PT of patient who is receiving anticoagulants; she may require a dosage adjustment.**	**Assess EKG of patients who take, because they may be at risk for AV block. Be aware that the dosage for heart failure is highly individualized.**

Medications Reference (APA): Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Appears alert and oriented** **No acute distress** **Well kept, no apparent odor**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 19** **Drains present: Y☐ N ☒** **Type:**	**Client slightly pale, skin warm and dry, turgor <3 sec, nor rashes, small bruises on stomach from injections while in hospital, no wounds, Braden score 19, no drains**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head and neck are symmetrical, auricle is moist and pink without lesions noted, canal is clear with very little ear wax, sclera is white, cornea clear, conjunctiva pink, no visible drainage, lids are moist and pink without lesions noted, PERRLA good**
CARDIOVASCULAR (2 points): **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:**	**Clear S1 and S2 sounds though slightly irregular, no murmurs, gallops or rubs, PMI at 5th intercostal space at MCL, pulses 2+ throughout, capillary refill <3 sec**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Respirations are regular even and nonlabored, symmetrical, no wheezes or crackles noted**
GASTROINTESTINAL (2 points):	**Normal diet at home, normal diet while**

Diet at home: **Current Diet** **Height: 6ft** **Weight:180 lbs.** **Auscultation Bowel sounds:** **Last BM: N/A** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**admitted, bowel sounds normoactive, soft nontender, no organomegaly or masses, no scars, no incisions or wounds**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 10** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Full ROM, no supportive devices, strength 5/5, fall risk of score at 10**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -**	**Client is alert and oriented, speaks well and understands everything that is going on**

Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Client is a Christian at First church of Christ**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	**76**	**119/54**	**16**	**98.6**	**96**
N/A	**Did not have time**	**Did assessment with Gina**	**Gina knows**		

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0720	**0-10**	**N/A**	**0**	**N/A**	**N/A**
1530	**0-10**	**N/A**	**0**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22g **Location of IV: right top of hand** **Date on IV:2/20/2020** **Patency of IV: Good flow** **Signs of erythema, drainage, etc.: N0**	Saline Lock

IV dressing assessment: clean, no bleeding, no redness or swelling	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
N/A	**N/A**

Nursing Care

Summary of Care (2 points)

Overview of care given medication for heart rate

Procedures/testing done: cbc, cmp, Xray, MRI

Complaints/Issues: fast heart rate

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: pt. on normal diet

Physician notifications:

Future plans for patient: keep heart rate in normal range

Discharge Planning (2 points)

Discharge location: home

Home health needs (if applicable):

Equipment needs (if applicable):

Follow up plan:

Education needs:

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Risk for falls related to dizziness as evidenced by difficulty walking	**Client can become unsteady and lose balance due to dizziness**	**1.provide fall risk wrist band** **2.keep patient's bedside clean and clear from objects he/ she mat hit their head on**	**Clients room was well kept and kept the fall risk bracelet on**
2. Impaired transfer ability related to dizziness as evidenced by unsteadiness	**Client will not be able to move around as easy due to the feeling of everything moving**	**1. encourage slow movements** **2.ask that a family member stay with patient**	**Patient said her daughter will be coming to see her soon and plans to come by everyday when she gets off work.**
3. Risk for clots related to staying in bed as evidenced by needing to minimize movement	**Client will be on fall risk and not moving much as to not worsen feeling of dizziness, low movement can cause clots.**	**1. Make sure patient receives medication to prevent clots** **2 do some minor exercises in bed to help move the blood throughout the body**	**Client has full ROM and was receiving her medications, was not there to see exercises done in bed**

Other References (APA):

Concept Map (20 Points):

Past Medical History: Cervical dysplasia, chronic liver disease, overactive bladder, colonic polyp, depression, esophageal reflux, heart disease, hyperlipidemia, hypertension, measles, mumps, palpitations, skin cancer, thyroid disease, UTI, varicella
Past Surgical History: Prosthetic implant, colposcopy, appendectomy, tonsillectomy, heart catheterization, joint replacement (bilateral), colonoscopy
Family History: Mother- cancer of bile duct, thyroid disease, father- colon cancer, hypertension, stroke, heart disease, diabetes, depression, dementia, Grandparents(mothers side)- stroke, grandpa(fathers side)- CAD, grandma(fathers side)- CAD, alzheimers
Social History (tobacco/alcohol/drugs): former smoker, alcohol
Client went to Mexico, dizziness began after climbing a pyramid in the heat. Dizziness has been intermittent since then, woke up at 6am more severe dizziness with associated walking difficulty.

Nursing Diagnosis/Outcomes

1.Risk for falls related to dizziness as evidenced by difficulty walking

2.Impaired transfer ability related to dizziness as evidenced by unsteadiness

3.Risk for clots related to staying in bed as evidenced by needing to minimize movement

Objective Data

Appears alert and oriented
No acute distress
Well kept, no apparent odor
Client slightly pale, skin warm and dry, turgor <3 sec, nor rashes, small bruises on stomach from injections while in hospital, no wounds, braden score 19, no drains
Head and neck are symmetrical, auricle is moist and pink without lesions noted, canal is clear with very little ear wax, sclera is white, cornea clear, conjunctiva pink, no visible drainage, lids are moist and pink without lesions noted, PERRLA good
Clear S1 and S2 sounds though slightlty irregular, no murmurs, gallops or rubs, PMI at 5th intercostal space at MCL, pulses 2+ throughout, capillary refill <3 sec
Respirations are regular even and nonlabored, symmetrical, no wheezes or crackles noted
Normal diet at home, normal diet while admitted, bowel sounds normoactive, soft nontender, no organomegaly or masses, no scars,no incisions or wounds
Full ROM, no supportive devices, strength 5/5, fall risk of score at 10
Client is alert and oriented, speaks well and understands everything that is going on
Client is a Christian at First church of Christ

Patient Information

J.H 68 yrs old
Female
White Retired
Divorced
Full Code Allergies: environmental
Height: 6ft weight: 180 lbs
Date of admission: 2/18/2020

Nursing Interventions

1.provide fall risk wrist band

2.keep patients bedside clean and clear from objects he/she mat hit their head on

1. encourage slow movements

2.ask that a family member stay with patient

1.Make sure patient receives medication to prevent clots

2 do some minor excerizes in bed to help move the blood throughout the body

Subjective Data

N321 Care Plan