NRS 201

201

Care Plan Rubric and Instructions for NRS 201

Assessment (15%)

Pathophysiology (15%)

Explanation/rationale for pertinent Lab values. (10%)
Include actual values, range of normal values, and what the value means in relationship to your client's response to illness.

Medications (15%) Include the medication name, classification, action, reason for administration, potential side effects (common & dangerous), nursing implications, and evaluation of medication effectiveness.

Client Variable Stressors (per Neuman) (5%)

Nursing Diagnosis (5%)(At least two dx, one should be other than physiological)

Plan (10%)Goals and nursing interventions with rationale and references. Include at least three interventions for each Nursing Diagnosis.

Interventions (10%) This section is what nursing care that you actually provided.

Evaluation of nursing interventions and goals (5%)

What you learned while caring for this patient. (5o/o)

APA Format, Grammar, Spelling and Writing Quality (5%)
Clinical documentation must be included (Lab and Medication sheets)

Care Plan Guide: Choose a patient that you have cared for this semester. Using your weekly clinical paperwork, you will write a care plan paper in APA format. Start with a brief introduction of the patient's admission date, admitting diagnosis, recent history, age, and gender. The introduction should be one or two paragraphs in length.

The next section of your paper is a write up of your assessment. You may want to use sub-headings to organize your assessment findings. Use your Jarvis book and your assessment sheets to write your assessment findings in paragraph form with appropriate terminology. You will want to be thorough, but concise. This portion of your paper is worth 15% of the total grade.

After the assessment, you should discuss the Pathophysiology of your patient's primary medical diagnosis or diagnoses. If there are many, you should focus on the one (or two maximum) that are the most pertinent to the current admission. You should cite the sources that you use for your information. It would be appropriate to use your Pathophysiology book or another Pathophysiology book. Journal articles about the disorder are also appropriate (Wikipedia is not an appropriate resource). This section is also worth 15o/o, so you should discuss the pathophysiology in some depth.

The next section is a discussion of lab values. Pick three lab values that are significant for this patient's pathophysiologic condition or their overall condition and discuss the normal values, your patient's values, and the implications to this patient. Do not list all the lab values here. You will attach the lab sheets to the end of the paper. This part should be a discussion of the significant values. It is worth 10% of the grade. You should make use of a lab reference book or other text for your citations in this section.

After the lab values, you should discuss the most pertinent medications. Many patients are taking a large number of medications. You should choose to discuss the medications that are most pertinent to the pathophysiology or the assessment fmdings. You will include the complete medication forms at the end of the paper as well. This section is also worth 15% of the total points, so you should discuss the medications in some depth. You will probably want to cite a drug guide or pharmacology book here.

Using the Neuman System's Model, identify stressors for this patient. Your list of stressors should include physiological, psychological, sociocultural, developmental, and spiritual stressors. You may not be able to identify stressors in all these areas, but you should assess more than just the physiological aspect of your patient. This is worth 5% of the grade.

The next part is your actual care plan. You should have at least two nursing diagnoses and one should be other than a physiological problem. You need to include the actual NANDA diagnosis with the etiology (related to) and the defining characteristics (as evidenced by) for each of your diagnoses. The diagnoses are worth 5o/o of the grade.

For each of your diagnoses, you need to identify appropriate expected outcomes or goals. Remember that they should be client-focused, specific, measurable, achievable, realistic, and time-limited. You should include short-term and long-term goals. Under the goals, list the nursing interventions that you planned to help the patient achieve the goals. Include rationale and references with your interventions. Good references could be your Intro to Nursing textbook, your Skills textbook, a journal article, or a nursing Care Plan book. This section is worth 1Oo/o.

The section on interventions should include what interventions were performed during your care. Avoid the use of first person

pronouns in the discussion of the patient's care. This section is also worth 10%. You do not need any references here.

The purpose of the evaluation section is to discuss whether the goals were met, if there is progress toward the goals, whether the interventions are still appropriate, what changes you would suggest. This is worth 5%.

The last section is a paragraph or two about what you learned. You may use first person pronouns in this section. This is worth 5% of the grade.

Your paper will be graded for the use of APA style. Be sure to include a cover page and references. Proper grammar, spelling, and punctuation are expected. Refer to APA references for guidance or use APA software. Please attach your lab and medication sheets at the end of the paper.

Clinical Care Plan 2

CSU Channel Islands

Clinical Care Plan 2

Medical Diagnosis

1. R. is an 82-year-old man diagnosed with functional decline secondary to scalp melanoma and dementia. He had a multifocal resection on his left scalp with a skin graft closure. J. R. now has a wound VAC for the skin graft, and shows some wound separation that may be due to scratching.

Patltophysiology

Melanocytes, or melanin producing cells, are located in the basal layer of the skin (Porth & Matf1n, 2009). Melanoma is the result of genetic mutations that alter the cell proliferation of melanocytes and transform them into cancerous melanoma cells (Porth & Matfin, 2009). Melanoma may develop from either previously occurring lesions such as moles, or from healthy skin (Porth & Matf1n, 2009). Risk factors for melanoma include ultraviolet radiation, sun exposure, family history, and patient history of melanoma (Porth & Matfin, 2009). Melanoma can be assessed using the ABCDE scale, which stands for asymmetry, borders, color, diameter and evolution (Porth & Matfin, 2009). If a mole becomes asymmetrical, irregular in its borders, appears to be more than one color, larger than 6mm and changes appearance, than it should be evaluated for potential melanoma. Melanoma develops in stages. The first stage melanoma is the unhindered proliferation of melanocytes (Porth & Matfin, 2009). Next, the radial growth stage is when melanoma cells begin to grow outward in a circular fashion (Porth & Matfin, 2009). The vertical growth stage is when melanoma cells begin to grow outwardly in 3 dimensions, forming a nodule (Porth & Matfin, 2009).

Assessment findings

Upon assessment, J. R. was very pleasant and oriented to person and place. He was often confused about time. For example, he had difficulty recalling when his last bowel movement was (may be due to constipation), and was not able to tell me when he had surgery for his stomach ulcer. He is able to verbalize, but prefers to mouth answers or just smile when asked questions. His pupils were equal, round and accommodative, but reacted very subtly to light changes.

The muscle strength in his lower limbs was significantly decreased in comparison to his upper limbs. He is able to raise his arms up and pull himself up in bed, but exhibits rigidity in his legs and has difficulty lifting his legs to put on socks. I was informed by the physical therapist that his family had arranged home care for him that helped him to the bathroom (presumably with a wheel chair), although he was able to walk. This may explain his some of functional decline with respect to his mobility, because his family was not aware that he was able to walk and therefore enabled him to stay in bed.

J. R. had a normal respiratory rate, did not exhibit any extra effort during breathing and was able to take deep breaths. However, I did notice that his chest would flutter intermittently. asked him if he was having difficulty or pain with breathing and the patient reported no pain or difficulty. The cardiovascular assessment for this patient was within normal limits, except for his pedal pulses. The pedal pulses were present, but faint, rated at a 1 or 2. J. R.'s feet showed no signs of clubbing, and were not cyanotic.

J. R. had normal urination, sometimes incontinent due to impaired mobility. Patient reported no pain with regular urination. J. R. reports constipation, which is congruent with his previous assessments in his chart. He had a large bowel movement towards the end of my shift at 1300 that was of nonnal color and consistency. I observed that he had a scar on his abdomen

from a previous surgery that he was unable to recall. I found from his medical records that it was for a repaired stomach ulcer. His abdomen was distended, but soft with no pain or rebound tenderness. The shape of his stomach has been documented before in his medical records and appears to be normal for this patient.

The patient's skin is intact, although a little dry with some redness from scratching. He has a bruise on his left for arm from a blood draw. There is a recently healed scar on his left shoulder from his donor site, and an older scar on his abdomen from a previous surgery. J. R. has a wound VAC on his scalp for his left scalp resection with some wound separation due to the patient scratching the site.

Diagnostic tests

For melanoma, the diagnostic tests that I would expect to see done are a physical exam to examine the affected area, and if melanoma is suspected, a subsequent biopsy of the skin tissue (Porth & Matfin, 2009). Evaluation and biopsy of the lymph nodes should also be done to see if metastasis has occurred (Porth & Matfin, 2009). I did not find any documentation of a biopsy in his medical records, but it was reported that J. R.'s melanoma was full thickness and had to have 2 surgeries to excise all the cancerous skin.

Labs

Upon evaluation of my patient's CBC results, I saw trends of low RBC count that read 3.5 (4/1112), 3.46 (4/4/12), and 3.21 (4/9112). This pattern was consistent with his HCT, which was 33.9 (4/1112), 33.2 (4/4112) and 30.8 (4/9/12). In addition to these values, his hemoglobin was also low 11.6 (411/12), 11.4 (4/4/12) and 10.4 (4/9112). The way that these values are decreasing, I suspect that the patient may be bleeding. However, my patient was recently in surgery, which could also explain these low levels.

Medications

J. R. is taking Clindamycin HCl in doses of 150 mg twice daily at 0900 and 2100. This medication is an antibiotic, which is relevant to his current condition because he is a post-op patient with an open wound on his head that is at high risk for infection. Clindamycin is normally given alone or in combination with metformin (Lehne, Moore, Crosby, & Hamilton, 2010). A normal adult dose of clindamycin is 120 mg orally given every 8 hours, and should be given 30 minutes before a meal (Lehne et al., 2010). Adverse reactions of clindamycin include increased uric acid, dizziness, and arthropathy (Lehne et al., 2010). These would be important to note because my patient already has cognitive impairment and stiffness, and this drug may put him at an increased risk for falls.

J. R. is receiving Memantine HCl at 10 mg PO daily. This drug is an NMDA antagonist and is used to treat the symptoms of dementia (Lehne, Moore, Crosby, & Hamilton, 2010). This is relevant to my patient because his confusion, which is related to his dementia, is impairing his ability for self-care. A normal dose given to adults that take this drug regularly is 10 mg PO, twice a day (Lehne et al., 2010). Adverse reactions of this drug are dizziness, headache, constipation and increased confusion (Lehne et al., 2010). I would monitor use of this drug closely to make sure it is not aggravating my patient's already confused state.

Lastly, my patient is on Oxycodone/acetaminophen for pain at 5 mg/325 mg in one tablet PO every 4 hours PRN. This is important because my patient may be experiencing pain from his melanoma removal and it is important to manage this pain properly to increase his quality of life and functionality. He reports no pain, so the pain management regimen seems to be effective. Normal adult dosage of this medication is usually 1 tablet PO every 6 hours with a maximum of 60 mg of oxycodone and 4 g acetaminophen a day (Lehne, Moore, Crosby, & Hamilton, 2010).

Because of the potential for hepatotoxicity, I would make sure not to exceed the 4 g of acetaminophen. My patient should also be evaluated for decreased liver function to make sure that the dosage is not too high for him to metabolize (Lehne et al., 2010).

Nursing Diagnoses, Interventions and Rationale

J.R. is experiencing chronic confusion related to his dementia (Ackley & Ladwig, 2011). Although not debilitating, his confusion affects his ability to orient to time. This diagnosis is evidenced by his responses when I asked him questions such as "when did your nurse give you your medication?" or "when was the last time you went to the bathroom?" and the patient was unable to answer. I expect that this will put him at risk of not taking his medication on time if he is discharged. He also has trouble processing long commands with many steps. This was apparent during physical therapy where he was unresponsive when the PT spoke to him at length, but responded well with short, simple commands. The interventions I would implement for his confusion would be frequent reorientations to time, as well as beginning each interaction by identifying myself and calling the client by name. Golby et. al (2005) states that dementia causes memory loss and inhibits the ability for remembering people and places, so the patient will need frequent reminding which will help them orient themselves. The outcomes that I would expect for this patient is that he would continue to be oriented throughout the day, with assistance from the hospital staff.

J. R. is also experiencing ineffective health maintenance (Ackley & Ladwig, 2011) related to his scratching and confusion about his self-care. This is evidenced by his disregard for repeated warnings about scratching his surgical area, and the subsequent wound separation that has occurred. The nursing intervention I would implement would be to contact the family and

include them in supporting the patient in his self-care. Individuals that have a support system show improved disease management and higher quality of life. (Schulz et al, 2008).

References

Ackley, B. J., & Ladwig, G. B. (2011). *Nursing Diagnosis Handbook* (9th ed.). St. Louis, Missouri: Elsevier.

Golby, A., Silverberg, G., Race E. et al: Memory encoding in Alzheimer's disease: an tMRI study of explicit and implicit memory, *Brian J Neural* 128(Part 4);733-787, 2005.

Lehne, R. A., Moore, L.A., Crosby, L. J., & Hamilton, D. B. (2010). *Pharmacology for Nursing Care* (7th ed.). St. Louis, Missouri: Elsevier.

Porth, C. M., & Matfin, G. (2009). Disorders of hearing and vestibular function. In II. Surrcna (Ed.), *Pathophysiology: Concepts of altered health states* (8th ed.). Philadelphia, PA: Lippincott-Raven Publishers.

Schulz, U., Pischke, C. R., Weidner, G. et al: Social support group attendance is related to blood pressure, health behaviours, and quality of life in the Multicenter Lifestyle demonstration Project, *Psycho! Health Med* 3(4):423-473, 2008.