Back pain
husband brought to emergency
Emergency on thursday
husband daughter son
house (Brooklyn)
*IV color

Admission Diagnosis: Spinal Stenosis lumber region without neurogenic claudication

NEW YORK UNIVERSITY
COLLEGE OF NURSING
NURSE-UN.1245 Leadership and Management in Nursing

NURSING CARE PLAN

STUDENT'S NAME: Yaq CLINICAL INSTRUCTOR: _____

DATE OF PATIENT CARE: 9/23/2021

DEMOGRAPHIC DATA:

Patient Assignment #: 55 Rm 29 Age: F Gender: _____ Date of Admission 9/20/2021 Advance Directives CPR
(Indicate if DNR/DNI or Full Code)

HISTORY OF PRESENT ILLNESS: Patient was admitted & taken to ē OR ē Same day for Procedure

REASON FOR SEEKING HEALTHCARE ("What brought you to the hospital?" – must include "What happened, where, when, how long PTA"): chief complain Spinal stenosis, Lumbar region neurogenic claudication. lower back & bilateral leg pain left leg worsening, right leg started 4 months ago. Bilateral buttock & lateral thigh & Lateral leg Thigh & dorsum of foot, left worse than right, with numbness & tingling

ADMITTING MEDICAL DIAGNOSIS (DIAGNOSES): Acute midline low back pain without Sciatica
SP: Transforaminal Lumbar interbody fusion Spine Single level. L4-L5

Standard precaution

ALLERGIES: No known REACTION: N/A

I. PAST MEDICAL HISTORY (Include date condition was diagnosed, if known):
hyperlipidemia, hypertension, Lower back pain (with left sided sciatica

II. PAST PSYCHIATRIC HISTORY: NO
Describe & include history of treatment:

Current Mood: [ ] Depressed [ ] Anxious [ ] Withdrawn No
Communication: [✓] Verbal [ ] Non-verbal [ ] Cues/behaviors (specify) _____
Other: _____

Gen Surgery / Neuro or Tho Spine
A&O x 4
JP drain

III. PAST SURGICAL HISTORY (Include dates of surgery, if known):
Colonoscopy 2018
Tubal ligation
Lumbar Fusion Bilateral 09/20/2021 Transforaminal lumbar interbody fusion Spine single level open. L4-5

IV. PSYCHOSOCIAL HISTORY:
Spiritual/ Cultural Assessment: Religion Catholic Cultural/ethnic background Spanish Marital status married
Smoking: [ ] Yes (Specify # cigarettes/ packs per day ___) [✓] No Smoking Cessation Teaching: [ ] Yes [✓] No
Substance Abuse: [ ] Yes (Specify Substance _____ Treatment _____) [✓] No history

V. VACCINE HISTORY:
Influenza Vaccination – [ ] Yes (Date: _____) [✓] No Pneumovax [ ] Yes (Date: _____) [✓] No 65↑
If No, Specify Reason _____
Other: _____

VI. LAB VALUES (Include Date of Results, Specific Value with Unit of Measure, & if High or Low) 9/21/2021 3:10 pm

1 radiology result

Hemoglobin – 10.2 ↓ 11.2-15.7
Hematocrit – 29.9 ↓ 34-45%
WBC – 11.4 ↑ 4.0-10.0
Platelets – 258 N 150-400
RBC – 3.46 ↓ 3.90-5.20
Na – 138 N
K – 4.1 N
CO_2 – 23 N
CL – 104 N
BUN – 19 N
Creatinine – 0.73 N
Glucose – 133 H
Fingerstick –
~~Calcium 10.5~~
Albumin – N/A 9/15/2021 4.3
PT –
INR –
PTT –
Calcium 8.8
AST 24
ALT 30

VII. VITAL SIGNS and PAIN ASSESSMENT No pain

BP 122/80 Apical HR (rate/ rhythm) _____ Radial (rate/rhythm) _____ RR 18 Temp. 98.6 Pulse Oximetry _____ Pain 0/10
Height 5'1" Weight 166 BMI 31.49 Indicate if: [✓] Normal [ ] Overweight [ ] Obese [ ] Underweight
O_2 96 room air

Time	Location of Pain	Scale (Pre)	Interventions	Scale (Post)	Comments
10:00am	lower Back	No pain (4	meclocaban. oxycodone	No Pain	

Surgical Pain

Diagnosis: Spinal Stenosis lumbar region without neurogenic claudication

VIII. INTAKE & OUTPUT (During your shift – indicate amount in ml.):

INTAKE		OUTPUT	
Type	Amount	Type	Amount
P.O. (water, juice, soup, meds)		URINE	
INTRAVENOUS (IV)		OSTOMY	
FEEDING		DRAINAGE	10 cc Serosanguineous.
OTHER (specify)		OTHER (specify)	
TOTAL		TOTAL	

IX. PERIPHERAL & CENTRAL INTRAVENOUS LINES

Type _____ Date Inserted _____ Site _____ Describe Site Appearance Dry No drainage

X. PHYSICAL ASSESSMENT / SYSTEMS REVIEW Drainage site 09/20/21 (Right lower back collapsible closed device Incision 09/20/21 midline 08:58 back vertical

1. Neurological System:

Subjective Data: _____

LOC: [✓] Alert [ ] Confused [ ] Lethargic [ ] Restless [ ] Aphasic Orientation: [ ] Time [ ] Place [ ] Person

Pupils: [✓] Equal [ ] Unequal [ ] Brisk [ ] Sluggish [ ] Nonreactive [ ] Irregular [ ] Opaque Aids: [ ] Glasses [ ] Hearing Aid

Other: _____

Describe abnormal findings: _____

2. Neuromuscular System:

Subjective Data _____

Motor & Sensory Function: [✓] Intact Weakness: [ ] Right [ ] Left Paralysis: [ ] Right [ ] Left

Gait: [✓] Steady [ ] Unsteady Use of Assistive device: [ ] Cane [✓] Walker [ ] Wheelchair

Other: _____

Describe abnormal findings: _____

3. Cardiovascular:

Subjective Data: _____

[ ] Chest Pain (Describe) No Pain [ ] Palpitations (Describe) _____

Peripheral Pulses (Specify 0 – 3+): Radial: [ ] Right [ ] Left Brachial: [ ] Right [ ] Left Femoral: [ ] Right [ ] Left

Dorsalis Pedis: [ ] Right [ ] Left Posterior Tibialis [ ] Right [ ] Left

Dargostic Result: CT Scan
CT Lumbar Spine without IV contrast (9/9/2021)
Alignment: Preserved Lumbar Lordosis. ~~Red~~ 9:32
redemarstraked grade 1 anterolisthesis @ L4-5
minimal Lumbar dextrocurvature.
Disc: Mild L4-5 disc space narrowing. Small multilevel endplate osteophytes.
L4-5: Grade 1 anterolisthesis with uncovering of small circumferential disc bulge, Severe bilateral facet arthrosis. Mild central Canal Stenosis. Mild bilateral neuroforaminal Stenosis
L5-S1: Small circumferential disc bulge with minimal osteophytic ridging. Severe bilateral facet arthrosis. No central canal Stenosis. Mild/moderate left & mild right neuroforaminal Stenosis

Pt took antibiotics.

Consult to Pain mgt consultation 9/21/2021

1. Atorvastatin tablet 40mg oral daily (Lipitor) Antilipemic
Used to lower bad cholestrol Y

2. Cyclobenzaprine tab 5mg, oral TID 3 times Daily Y
Skeletal Muscle relaxant / Muscle Spasm.

3. enoxaparin (Lovenox): Anticoagulant
Injection 40mg Subcutaneous every 24hrs

4. hydrochlorothiazide tablet 25mg oral daily
Antihypertensive; Diuretic, thiazide. Y
Used for Edema's etc

5. pregabalin (lyrica) capsule 50mg
Anticonvulsant, GABA Analog / anxiety
general pain,

6. oxyCodone (Roxicodone) Y
Analgesic / opriod Pain mgt.

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Obama2021!

ONS