Nursing Notes

Initials/Signature: Alexis Porohnavi Rm No: 328B

Actual Patient Problem: Impaired skin integrity

Clinical Reasoning: Diabetic L foot ulcer, toe amputation, erythematous

Goal: MD dressing will be clean, dry, and intact post/op I&D on L foot Met: ☐ Unmet:☐

Goal: JS will not have any signs of developing additional diabetic ulcers during my care Met: ☐ Unmet:☐

Actual Patient Problem: Acute pain: L foot

Clinical Reasoning: Diabetic ulcer, post op I&D to L foot

Goal: JS will report a pain decrease of less than 5/10 on a numerical scale after analgesic administration Met: ☐ Unmet:☐

Goal: JS will not need any more analgesics during my shift Met: ☐ Unmet:☐

		warm and cool sensation but can feel sharp and dull pain; states "with my anxiety a lot of times I'm not hungry"; stated L foot in pain and grimaced when taking off sock; states his feet always feel numb and tingly; has Dexcom on L upper arm; BG 129				
2	1020	Stated pain 5/10 post op I&D	0940	RN administered 25mcg fentanyl	1030	stated pain was 7/10
1, 2	1030	Stated L foot pain after surgery 7/10 when resting and 9/10 when walking	1033	Administered 0.5mg hydromorphone, changed linens	1120	Stated pain decreased to 5/10
1, 2, 3,	1100	asking for anxiety medication	1110	Administered gabapentin 300 mg, sertraline 100mg, meropenem 1000mg, alprazolam 0.5mg	1130	Lying in bed, wife, and daughter at bedside
1, 4	1115	BG 117	1115	Educated on importance of controlling BS with diet and how proper diet will also help with wound healing	1115	Verbalized understanding
2	1230	Reporting pain 8/10	1245	Administered 0.5mg hydromorphone	1250	Stated he's already feeling better, lying in bed comfortably with family at bedside

Additional Patient Problems: 3) anxiety 4) r/f unstable blood glucose

Patient Problem	**Time**	**Relevant Assessments** Indicate pertinent assessment findings.	**Time**	**Multidisciplinary Team Intervention** What interventions were done in response to your abnormal assessments?	**Time**	**Reassessment/Evaluation** What was your patient's response to the intervention?

Significant Event Documentation: Use the area below to document any significant events that happened during your time of care.
