

Student Name: Crystal Fabila

Unit: SA

Pt. Initials: N/A

Date: Click here to enter a date.

3/24/2021

1. Disease Process & Brief Pathophysiology

Hypertension is in a normal

circulation, pressure is transferred from the heart muscle to the blood each time the heart contracts and then pressure is exerted by the blood as it flows through the blood vessels.

2. Factors for the Development of the Disease/Acute Illness

- Increased sympathetic nervous system activity.
- Increased renal reabsorption.
- Increased RAAS activity.
- Overweight/obesity
- Increased intake of sodium
- Smoking/alcohol

3. Signs and Symptoms

- dizziness
- fatigue
- Irregular heart beat
- vision problems

4. Diagnostic Tests pertinent or confirming of diagnosis

- 12-lead ECG
- Chest x-ray
- Kidney & Nephrography scan

5. Lab Values that may be affected

- blood chemistry
- H/H
- Creatine levels
- Urinalysis
- Uric acid

6. Current Treatment

- Thiazide diuretic
- beta blocker
- ACE inhibitors

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7. Focused Nursing Diagnosis:

Constipation: When bowel movements become less frequent than normal. It is accompanied by a difficult or incomplete passage of stool

8. Related to (r/t):

- Acute abdominal pain
- distention
- Straining of stools

9. As evidenced by (aeb):

- Hemorrhoids
- Perforation of colon

11. Nursing Interventions related to the Nursing Diagnosis in #7:

1. I will teach patient to take at least 20g of dietary fiber.

Evidenced Based Practice:

2. I will teach patient to include physical activity and exercise.

Evidenced Based Practice:

3. I will teach patient to try to eliminate at a regular time period.

Evidenced Based Practice:

I will teach patient to sit in a warm bath to minimize rectal discomfort.

10. Desired patient outcome:

- Patient maintains passage of soft formed stool at a frequency perceived as "normal" by patient.
- Patient states relief from discomfort of constipation.
- Patient identifies measures that prevent or treat constipation.

12. Patient Teaching:

1. Patient encouraged to intake sufficient fluid intake.
2. Patient is to talk with dietician about dietary sources of fiber.
3. Patient needs to monitor frequency and consistency of stool.

13. Discharge Planning/Community Resources:

1. Patient will use laxatives or enemas for short-term management of constipation.
2. Patient is to include regular physical activity or exercise.
3. Patient is to follow a balanced diet that comprises adequate fiber, fresh fruit, vegetables, and grains.

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Patient Physical Assessment Narrative

PHYSICAL ASSESSMENT NARRATIVE BY SYSTEMS: (Complete using assessment check list and reminders below).

GENERAL INFORMATION (Time of assessment, admit diagnosis, general appearance)

08:30AM, melena and constipation, pt. awake and alert, answered my questions

Neurological-sensory (LOC, sensation, strength, coordination, speech, pupil assessment)

awake and alert, orientated to person, place, & time, III, IV VI: EOM - intact, V: light touch face - normal in all 3 divisions of V

Comfort level: Pain rates at Not assessed (0-10 scale) **Location:** _____

Psychological/Social (affect, interaction with family, friends, staff)

talkative, pleasant, no family or friends present in the room

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing)

Sclera - clear & white, ears symmetrical, auditory canals without drainage, nasal septum midline

Respiratory (chest configuration, breath sounds, rate, rhythm, depth, pattern)

Chest symmetrical, trachea midline, breath sounds clear to auscultation (CTA) bilaterally, breathing room air

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)

S₁ and S₂ heard in all 4 locations, no extra sounds or murmurs auscultated, radial pulses: 2+ bilaterally and equal, pedal pulses: 2+ bilaterally & equal

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IM1 Patient Physical Assessment Narrative
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Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) abdomen distended, pt complained of abdominal pain, no masses or guarding, normal bowel sounds auscultated

Last BM 3/22/2021

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) not observed

Urine output (last 24 hrs) N/A LMP (if applicable) N/A

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities) normal flexion extension, lateral rotation and tilting, muscles: normal size, joints: normal ROM

Skin (skin color, temp, texture, turgor, integrity) skin warm, dry, & intact, no cyanosis, clubbing, upper or lower extremities

Wounds/Dressings
IV dressing to (R) forearm, 20g, no drainage or pain

Other
vitals: T - 98.4, B/P - 137/85, heart rate 100, R-16, O₂ - 98, room air.