# N301 Care Plan

Lakeview College of Nursing

Addison Pavlick

## Demographics (5 points)

| **Date of Admission** 10/14/18 | **Patient Initials** GE | **Age** 46 y/o | **Gender** male |
|---|---|---|---|
| **Race/Ethnicity** white, not hispanic/latino | **Occupation** disabled | **Marital Status** divorced | **Allergies** NKA |
| **CodeStatus** Full code | **Height** 176 cm | **Weight** 112.1 kg | |

## Medical History (5 Points)

**Past Medical History:**

- Hypertension
- GERD
- chronic cervicalgia

**Past Surgical History:**

- Balloon sinuplasty-date not noted.
- Myringotomy and insertion of tympanic ventilation-date not noted.
- Cervical spine infusion-date not noted.

**Social History (tobacco/alcohol/drugs, pertinent social factors):** Patient is currently unemployed due to being disabled. Patient lives at home outside of Charleston. Patient is a current everyday smoker who uses an electronic cigarette. Patient uses alcohol 1-2 times a month socially. Patient denies substance abuse. No family history of any conditions or diseases the patient is aware of.

## Admission Assessment

**Chief Complaint (2 points):** Right upper quadrant abdominal pain with lower back pain.

**History of present Illness (10 points):** Patient arrived to ED by ambulance with right upper quadrant pain along with lower back pain rated 10/10. Patient stated "I felt like I was getting a fever during the ambulance ride". The RUQ and lower back pain began 3 weeks ago for the first time. Pain is worsened when coughing and sneezing. Patient relayed he ate a cheeseburger and fries before he started experiencing a severe, burning pain in his right upper quadrant. Patient began sneezing and coughing after eating the cheeseburger and fries. Patient rated the pain a 10/10 in ED during assessment. Pain described as intermittent and nonradiating. Pain is aggravated by palpation, deep breathing, and movement. Patient has found no relieving factors.

## Primary Diagnosis

**Primary Diagnosis on Admission (2 points):** Rectus sheath hematoma w/ acute bleeding.

**Secondary Diagnosis (if applicable):** N/A.

**Pathophysiology of the Disease, APA format (15 points):**

Rectus sheath hematoma (RSH) is an uncommon and often clinically misdiagnosed cause of abdominal pain. It is the result of bleeding into the rectus sheath from damage to the superior or inferior epigastric arteries or their branches or from a direct tear of the rectus muscle. The rectus abdominis muscle receives its blood supply from the superior and inferior epigastric arteries. The inferior epigastric artery perforates the rectus abdominis muscle at the arcuate line, where the IEA is relatively fixed within the muscle, making its branches vulnerable to shearing forces. RSH bleeding can be spontaneous, most commonly secondary to anticoagulation therapy or the result of direct trauma (ex: recent or remote intra-abdominal procedures, motor vehicle crash, sporting activity, surgery, or acupuncture). Cases of spontaneous RSH have been reported

to occur as a result of increased intra-abdominal pressure from coughing, sneezing, or childbirth; coagulation disorders; and intra-abdominal injections; and in patients with cirrhotic liver disease, influenza, typhoid fever, or an underlying abdominal wall abscess. (Chang, 2014).

The presentation of RSH can mimic many intra-abdominal processes that can make the diagnosis challenging. Patients may complain of vomiting, nausea, and fever. Symptoms can range from slight abdominal pain to hypovolemic shock, but abdominal wall pain associated with a mass (Fothergill sign) is the most consistent finding at presentation, however, may not render the mass palpable. Patients with RSH should have a positive Carnett's sign, a clinical test to differentiate pain originating from the abdominal wall versus pain arising from an intra-abdominal source. With the patient supine, the site of maximal abdominal tenderness is identified. The patient then sits halfway up. If local palpation at the same site causes increased pain, the test is positive, meaning that the abdominal mass is fixed with contraction and located in the abdominal wall. If the pain with palpation at the identified site is alleviated when the patient sits halfway up, then the source is likely to arise from the abdominal viscera, and the contracted rectus muscle is protecting the intra-abdominal contents. Some may have flank (Grey-Turner's sign) or periumbilical ecchymosis (Cullen's sign), which does not differentiate between a retroperitoneal or abdominal wall hemorrhage. The best diagnostic modality to evaluate a suspected RSH is an abdominal computerized tomography (CT) scan, which is more specific than ultrasonography. Sonographic findings are nonspecific in some cases, and can mimic abdominal wall tumors and inflammatory diseases. Digital subtraction angiography is the most useful imaging technique to identify active bleeding. It provides information about the

number of bleeding sites and their exact location. A complete blood count, coagulation studies, type, and crossmatch should be considered for all patients. (Wiler, 2007).

Patient presented with right upper quadrant abdominal pain stating he felt febrile. Patient's pain worsened when coughing, sneezing, and with movement. Pain was aggravated by palpation, deep breathing, and movement. Physician ordered a CT, ultrasound, and bloodwork confirming the diagnosis of a rectus sheath hematoma w/ acute bleeding.

**References:**

Wiler, J. L. (2007, November). Diagnosis: Rectus Sheath Hematoma : Emergency Medicine News. Retrieved from https://journals.lww.com/em-news/fulltext/2007/11000/Diagnosis__Rectus_Sheath_Hematoma.21.aspx

Chang, W. (2014, November 02). Rectus Sheath Hematoma. Retrieved from https://reference.medscape.com/article/776871-overview

**Laboratory Data (15 points)**

**CBC: Highlight All Abnormal Labs, Explanations must contain in-text citations in APA format.**

| Lab | Normal Range | Admission Value | Today's Value | Reason for Abnormal Value |
|---|---|---|---|---|
| **RBC** | 4.28-5.56 | 4.76 | N/A | N/A |
| **Hgb** | 13-17 | 14.7 | 13.6 | N/A |
| **Hct** | 38.1-48.9 | 43.5 | 39.9 | N/A |
| **Platelets** | 149-393 | 369 | N/A | N/A |
| **WBC** | 4.0-11.7 | 12.1 | N/A | A high white blood cell count isn't a specific disease, but it can indicate |

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|---|---|---|---|---|
| | | | | another problem, such as infection, stress, inflammation, trauma, allergy, or certain diseases. (Braun, 2013). |
| **Neutrophils** | 45.3%-79% | 76.8% | N/A | N/A |
| **Lymphocytes** | 11.8%-45.9% | 12.3% | N/A | N/A |
| **Monocytes** | 4.4%-12.0% | 9.9% | N/A | N/A |
| **Eosinophils** | 0.0%-6.3% | 0.2% | N/A | N/A |
| **Bands** | 0.0%-1.0% | N/A | N/A | N/A |

**Chemistry: Highlight Abnormal**

| **Lab** | **Normal Range** | **Admission Value** | **Today's Value** | **Reason For Abnormal** |
|---|---|---|---|---|
| **Na+** | 136-145 | 136 | N/A | N/A |
| **K+** | 3.5-5.1 | 3.8 | N/A | N/A |
| **Cl-** | 98-107 | 101 | N/A | N/A |
| **CO2** | 22-29 | 24 | N/A | N/A |
| **Glucose** | 70-99 | 115 | N/A | Eating too much of the wrong kinds of carbohydrates may cause your blood sugar to rise. You get glucose from the foods you eat. Patient's blood glucose was not fasting, he had just ate a cheeseburger and french fries. (Hess-Fischl, 2018) |
| **BUN** | 6-20 | 14 | N/A | N/A |
| **Creatinine** | 0.70-1.20 | 0.87 | N/A | N/A |
| **Albumin** | 3.5-5.2 | 4.2 | N/A | N/A |
| **Calcium** | 8.6-10.4 | 9.5 | N/A | N/A |

| | | | | |
|---|---|---|---|---|
| **Mag** | 1.6-2.4 | N/A | N/A | N/A |
| **Phosphate** | 2.5-4.5 | N/A | N/A | N/A |
| **Bilirubin** | 0.0-1.2 | <0.2 | N/A | N/A |
| **Alk Phos** | 40-130 | 79 | N/A | N/A |
| **AST** | 0-40 | 29 | N/A | N/A |
| **ALT** | 0-41 | 25 | N/A | N/A |
| **Amylase** | 23-85 | N/A | N/A | N/A |
| **Lipase** | 13-60 | N/A | N/A | N/A |
| **Cholesterol** | <200 | N/A | N/A | N/A |
| **Triglycerides** | <150 | N/A | N/A | N/A |
| **Lactic Acid** | 0.5-2.0 | N/A | N/A | N/A |

**Other Tests Highlight Abnormal**

| **Lab Test** | **Normal Range** | **Value on Admission** | **Today's Value** | **Reason For Abnormal** |
|---|---|---|---|---|
| **INR** | 0.86-1.14 | 0.95 | N/A | N/A |
| **PT** | 11.9-15.0 | 12.9 | N/A | N/A |
| **PTT** | 22.6-35.3 | N/A | 27.3 | N/A |
| D-Dimer | >500 | N/A | N/A | N/A |
| **BNP** | >100 | N/A | N/A | N/A |

**Urinalysis Highlight Abnormal**

| Lab Test | Normal Range | Value on Admission | Today's Value | Reason For Abnormal |
|---|---|---|---|---|
| **Color & Clarity** | yellow, clear | yellow, clear | N/A | N/A |
| **pH** | 5.0-8.0 | 5.0 | N/A | N/A |
| **Specific Gravity** | 1.005-1.034 | 1.031 | N/A | N/A |
| **Glucose** | normal | normal | N/A | N/A |
| **Protein** | negative | negative | N/A | N/A |
| **Ketones** | negative | negative | N/A | N/A |
| **WBC** | 0-5.0 | N/A | N/A | N/A |
| **RBC** | 0-3.0 | N/A | N/A | N/A |
| **Leukoesterase** | negative | negative | N/A | N/A |

**Cultures**

| Test | Normal Range | Value on Admission | Today's Value | Explanation of Findings |
|---|---|---|---|---|
| **Urine Culture** | negative | N/A | N/A | N/A |
| **Blood Culture** | negative | N/A | N/A | N/A |
| **Sputum Culture** | N/A | N/A | N/A | N/A |

**Lab Correlations Reference (APA):**

Braun, P. (2013, March 13). A blog to help you optimize your full-body and life performance. Retrieved from http://blog.insidetracker.com/45247913486-high-white-blood-cell-count-what-you-should

Hess-Fischl, A. (2018, September 07). Hyperglycemia: When Your Blood Glucose Level Goes Too High. Retrieved from https://www.endocrineweb.com/conditions/hyperglycemia/hyperglycemia-when-your-blood-glucose-level-goes-too-high

**Other Diagnostic Tests (EKG, Echocardiogram, X-Rays, CT scan, etc) (5 points):**

**Diagnostic Test Correlation, APA Format & References (5 points):**

Ultrasound of upper abdomen (10/14)- Ultrasound imaging of the abdomen uses sound waves to produce pictures of the structures within the upper abdomen. It is used to help diagnose pain or distention (enlargement) and evaluate the kidneys, liver, gallbladder, bile ducts, pancreas, spleen and abdominal aorta. Ultrasound is safe, noninvasive and does not use ionizing radiation. (Radiological Society of North America, RSNA, & American College of Radiology, 2018). An ultrasound of the upper abdomen was done to rule out cholecystitis/cholelithitis due to complaint of right upper quadrant pain. Ultrasound came back negative.

CT of abdomen and pelvis w/ IV contrast (10/15)- This procedure is typically used to help diagnose the cause of abdominal or pelvic pain and diseases of the internal organs, small bowel and colon, such as: infections such as appendicitis, pyelonephritis or infected fluid collections, also known as abscesses, inflammatory bowel disease such as ulcerative colitis or Crohn's disease, pancreatitis or liver cirrhosis, cancers of the liver, kidneys, pancreas, ovaries and bladder as well as lymphoma, kidney and bladder stones, abdominal aortic aneurysms (AAA), injuries to abdominal organs such as the spleen, liver, kidneys or other internal organs in cases of trauma. CT scanning of the abdomen/pelvis is also performed to guide biopsies and other procedures

such as abscess drainages and minimally invasive tumor treatments, plan for and assess the results of surgery, such as organ transplants, stage, plan and properly administer radiation treatments for tumors as well as monitor response to chemotherapy. (Radiological Society of North America, RSNA, & American College of Radiology, 2018). Physician ordered a CT of the abdomen and pelvis w/ IV contrast due to right upper quadrant pain and lower back pain. CT confirmed a rectus sheath hematoma w/ acute bleeding.

Radiological Society of North America, RSNA, & American College of Radiology. (2018, April 10). Ultrasound - Abdomen. Retrieved from https://www.radiologyinfo.org/en/info.cfm?pg=abdominus

Radiological Society of North America, RSNA, & American College of Radiology. (2018, June 18). Computed Tomography (CT) - Abdomen and Pelvis. Retrieved from https://www.radiologyinfo.org/en/info.cfm?pg=abdominct

**Current Medications (10 points, 1 per completed med))**

**Home Medications (5 required)**

| **Brand/Generic** | Carvedilol (Jones & Bartlett, 2018, pg 169) | Fluticasone nasal (Flonase) (Jones & Bartlett, 2018, pg 472) | Meloxicam (Healthline, 2018) | Protonix (n.d., 2017) | Ondansetron hydrochloride (Zofran) (Jones & Bartlett, 2018, pg 814) |
|---|---|---|---|---|---|

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|---|---|---|---|---|---|
| **Dose** | 3.125 mg, BID. | 0.05%, 2 sprays daily (50 mcg/spray=100 mcg daily) | 7.5 mg (1 tab), daily | 40 mg (1 tab) delayed release, BID, daily | 8 mg (1 tab), Q6h |
| **Route** | oral | inhalation, nasal spray | oral | oral | oral |
| **Classification** | anti-hypertensive, beta blocker | antiasthmatic, anti-inflammatory. | nonsteroidal antiinflammatory | PPI | antiemetic |
| **Action** | reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload. | inhibits cells involved in the inflammatory response of asthma, such as basophils, eosinophils, lymphocytes, macrophages, mast cells, and neutrophils. also inhibits production or secretion of chemical mediators, such as cytokines eicosanoids, histamine, and leukotrienes. | Anti-inflammatory effects of meloxicam are believed to be due to inhibition of prostaglandin synthetase (cylooxygenase), leading to the inhibition of prostaglandin synthesis. As prostaglandins sensitize pain receptors, inhibition of their synthesis may be associated with the analgesic and antipyretic effects of | Gastric acid secretion is decreased by inhibiting the H+, K+-ATPase enzyme system responsible for acid production. | blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally st vagal nerve terminals in the intestine. Reduces nausea and vomiting by preventing serotonin release in the small intestine and by blocking signals to the CNS. |

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| | | | meloxicam. | | |
| **Reason Client Taking** | decrease HR and BP. | allergy relief. | control pain. | short term tx for GERD. | prevent nausea and vomiting. |
| **Contraindications (2)** | pulmonary edema, bradycardia. | hypersensitivity to fluticasone or its components, untreated nasal mucosal infection. | hypersensitivity, urticaria. | hypersensitivity, angioedema. | concomitant use of apomorphine, congenital long QT syndrome. |
| **Side Effects/Adverse Reactions (2)** | dizziness, fatigue. | dizziness, dry mouth and throat. | nausea, diarrhea. | hypomagnesemia, C diff. | arrhythmias, agitation. |
| **Nursing Considerations (2)** | 1. use cautiously in pts w/ peripheral vascular disease<br>2. monitor pts blood glucose level during therapy. | 1. monitor pt closely at start of therapy, especially if pt has severe allergy to milk. if hypersensitivity reaction occurs, notify prescriber, expect drug to be discontinued, and provide supportive care, as prescribed.<br>2. know that if pt takes a systemic corticosteroid, expect to | 1. blood pressure liver function kidney function red blood cell count to check for anemia.<br>2. store at room temperature. | 1. Monitor for and immediately report S&S of angioedema or a severe skin reaction.<br>2. Lab tests: Urea breath test 4–6 wk after completion of therapy. | 1. use calibrated container or oral syringe to measure dose of oral solution.<br>2. monitor pt closely for signs and symptoms of hypersensitivity. |

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| | | taper dosage by no more than 2.5 mg daily at weekly intervals, starting 1 week after fluticasone therapy begins. | | | |
| **Client Teaching needs (2)** | 1. instruct pts to swallow extended release capsules whole.<br>2. warn pt drug may cause dizziness, lightheadedness, & orthostatic hypotension. | 1. urge pt to use regularly, as prescribed, and stress that drug is not for acute bronchospasm.<br>2. tell patient prescribed two inhalations to wait at least 1 minute between them. | 1. You can take meloxicam with or without food. If it upsets your stomach, take it with food or milk.<br><br>2. You can cut or crush the oral tablet. | 1. Contact physician promptly if any of the following occur: Peeling, blistering, or loosening of skin; skin rash, hives, or itching; swelling of the face, tongue, or lips; difficulty breathing or swallowing.<br>2. Do not breast feed while taking this drug without consulting physician**.** | 1. reassure pt with transient blindness that it will resolve within a few minutes to 48 hours.<br>2. advise pt to immediately report signs of hypersensitivity, such as rash. |

**Hospital Medications (5 required)**

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|---|---|---|---|---|---|
| **Brand/Generic** | Carvedilol<br><br>(Jones & Bartlett, | Famotidine<br><br>(Jones & Bartlett, | Losartan hydrochlorothiazide | Protonix<br><br>(n.d., 2017) | N/A |

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|---|---|---|---|---|---|
| | 2018, pg 453) | 2018, pg 453) | (Jones & Bartlett, 2018, pg 653) | | |
| **Dose** | 3.125 mg, BID | 40 mg (2 tabs), BID. | 50 mg, 12.5 mg, daily | 40 mg (1 tab), delayed release, daily | N/A |
| **Route** | oral | oral | oral | oral | N/A |
| **Classification** | antihypertensive, beta blocker. | antiulcer agent, gastric acid secretion inhibitor. | ARB, antihypertensive. | PPI | N/A |
| **Action** | reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload. | H2 blocker. | blocks binding of angiotensin II to receptor sites in many tissues, including adrenal glands and vascular smooth muscle. | Gastric acid secretion is decreased by inhibiting the H+, K+-ATPase enzyme system responsible for acid production. | N/A |
| **Reason Client Taking** | decrease HR and BP. | treat GERD. | management of HTN. | short term tx of GERD. | N/A |
| **Contraindications (2)** | pulmonary edema, bradycardia. | hypersensitivity to famotidine, other H2 receptor antagonists, or their | concurrent aliskiren therapy (in pts w/ diabetes or renal impairment), hypersensitiv | hypersensitivity, angioedema. | N/A |

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| | | components. | ity to losartan or its components. | | |
| **Side Effects/Adverse Reactions (2)** | dizziness, fatigue. | AV block, anxiety. | dizziness, hypotension. | hypomagnesemia, C diff. | N/A |
| **Nursing Considerations (2)** | 1. use cautiously in pts w/ peripheral vascular disease.<br><br>2. monitor pts blood glucose level during therapy. | 1. shake oral suspension for 5-10 seconds.<br><br>2. dilute injection form w/ normal saline solution 5-10 ml. | 1. monitor blood pressure and renal function studies as ordered to evaluate drug effectiveness.<br><br>2. periodically monitor pts serum potassium level, as ordered, to detect hyperkalemia. | 1. Monitor for and immediately report S&S of angioedema or a severe skin reaction.<br><br>2. Lab tests: Urea breath test 4–6 wk after completion of therapy. | N/A |
| **Client Teaching needs (2)** | 1. instruct pts to swallow extended release capsules whole.<br><br>2. warn pt drug may cause dizziness, lightheadedness, & orthostatic | 1. store oral suspension at room temperature.<br><br>2. caution pt to avoid alcohol and smoking during famotidine therapy. | 1. instruct pt to avoid potassium containing salt substitutes because they may increase risk of hyperkalemia.<br>2. warn pt to tell all prescribers of losartan | 1. Contact physician promptly if any of the following occur: Peeling, blistering, or loosening of skin; skin rash, hives, or itching; swelling of the face, tongue, or | N/A |

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| | hypotension. | | therapy. | lips; difficulty breathing or swallowing.<br><br>2. Do not breast feed while taking this drug without consulting physician. | |

**Lab Reference (APA Format):**

Protonix (Pantoprazole): Side Effects, Interactions, Warning, Dosage & Uses. (2017, December 22). Retrieved from https://www.rxlist.com/protonix-drug.htm

*2018 Nurses drug handbook (17th ed.).* (2018). Burlington, MA: Jones & Bartlett Learning.

Healthline. (2018, June 10). Meloxicam, Oral Tablet. Retrieved from https://www.healthline.com/health/meloxicam-oral-tablet#important-considerations

## Assessment

**Vital Signs, 2 sets (5 points)**

| **Time** | **Pulse** | **B/P** | **Resp Rate** | **Temp** | **Oxygen** |
|---|---|---|---|---|---|
| 1231 | 82 | 140/89 | 18 | 36.5℃ | 97%, room air |
| | | | | | |

**Physical Exam (18 points)**

| | |
|---|---|
| **NEUROLOGICAL (2 points):**<br>**MAEW: Y ☐ N☐**<br>**PERLA: Y ☐ N☐**<br>**Strength Equal: Y ☐ N ☐ if no -**<br>**Legs ☐ Arms ☐ Both ☐**<br>**Orientation, Mental Status, Speech, Sensory, LOC:** | Patient awake sitting up in his chair, A&O x4. Patient appears to not be in any pain nor fatigued. Patient speaks English at a normal pace. Patient MAEW for his current age and condition. Patient's strength is bilaterally equal. Patient shows no signs of neurological damage or deficit. |
| **MUSCULOSKELETAL (2 points):**<br>**Neurovascular status, ROM, Supportive devices/strength**<br><br>**ADL Assistance Y☐ N ☐**<br>**Fall Risk: Y ☐ N☐**<br>**Activity/Mobility Status:**<br>**Independent (up ad lib) ☐**<br>**Needs assistance with equipment ☐**<br>**Needs support to stand and walk☐** | Fall risk: 35.<br>Patient exhibits active range of motion bilaterally. Patient shows no sign of neurovascular deficit. Patient is a fall risk. Patient is up with 1 standby assist and to the bathroom for bowel movements (patient uses a urinal for urinary continence). Patient is able to sit on the side of bed without assistance but requires a gait belt and standby assist due to being a fall risk. Patient benefits from the assistance of glasses for vision. Patient does not use assistive devices at hospital and denies use of assistive devices at home. |
| **CARDIOVASCULAR (2 points):**<br>**Heart sounds:**<br>**S1, S2, S3, S4, murmur etc.**<br>**Cardiac rhythm (if applicable)**<br>**Peripheral Pulses:** radial, pedial.<br>**Capillary refill:** <2 seconds<br>**Neck Vein Distention: Y ☐ N ☐**<br>**Edema Y ☐ N ☐**<br>**Location of Edema:** N/A | Patient is currently being monitored on telemetry. Patient was noted to be in normal sinus rhythm on admission. Heart sound auscultated x5. S1, S2 heart sounds noted. Radial and pedal pulses assessed. Pulses graded 2+ and present bilaterally. Capillary refill average at <2 seconds. Patient shows no signs of edema. Negative for neck vein distention. Patient has an IV in his right arm. |
| **RESPIRATORY (2 points):**<br>**Accessory muscle use: Y☐ N ☐**<br>**Breath Sounds: Location, character** | No accessory muscle use when breathing. Trachea midline, no deviations. Patient denies current shortness of breath. Patient does not present with a cough. Anterior and posterior lung sounds auscultated. Lung sounds were clear bilaterally. Patient currently breathing room air. Patient denies the use of oxygen at home. |

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|---|---|
| **GASTROINTESTINAL (2 points):**<br>**Diet at home:** regular.<br>**Current Diet:** heart healthy, 1,800-2,000 calories/day.<br>**Height:** 176 cm.<br>**Weight:** 112.1 kg.<br>**Auscultation Bowel sounds:** active bowel sounds.<br>**Last BM:** 10/14.<br>**Palpation: Pain, Mass etc.**<br>**Inspection: distention, incisions, scars, drains, wounds**<br>**Ostomy: Y ☐ N ☐**<br>**Nasogastric: Y ☐ N ☐**<br>**Feeding tubes/PEG tube Y ☐ N ☐**<br>**Type:** N/A. | Patients current diet is heart healthy, 1,800-2,000 calories/day. Patients home diet is regular. Patient is an everyday smoker, uses an electronic cigarette, uses alcohol 1-2x a month, and denies substance abuse. Patient is here for observation. No ostomy or PEG tubes. Patient does not have an NG tube. Patient has an abdominal binder. Patients last bowel movement was the 14th, patient states he has had flatus. Patient and daily weights deny any weight gain or loss. |
| **INTEGUMENTARY (2 points):**<br>**Skin color**<br>**character, turgor, rashes, bruises:**<br>**wounds:**<br>**Braden scale :** 21.<br>**Drains present: Y☐ N ☐ Type:** N/A. | Patient states he is Caucasian and presents with a fair skin tone. Skin has normal elasticity, warm to touch. No abnormal texture. Patient has light brown hair and brown eyes. Brown chest and facial hair. No notable skin turgor. No rashes or bruises. Patient has an abdominal binder. |
| **HEENT (2 points):**<br>**Head:**<br>**Ears:**<br>**Eyes:**<br>**Nose:**<br>**Teeth** | Head is midline with no deviations. Hair is brown in color. Ears show no abnormal drainage, tympanic membrane visible, pearly grey. Hair barely present on chin and upper lip. PEERLA. Patient uses glasses regularly. Nose shows no deviated septum, turbinates equal bilaterally. Oral mucosa is pink, moist, no notable abnormalities. Patient's teeth present in yellow to white in color. |
| **GENITOURINARY (2 Points):**<br>**Color, character, quantity of urine, pain,**<br>**Dialysis Y ☐ N ☐**<br>**Inspection of genitals**<br>**Catheter: Y ☐ N ☐ Type:** N/A. | Patient is able to ambulate to the bathroom x1 standby assist. No dialysis or genital abnormalities noted. Patient does not have a foley catheter. Urine is clear, yellow. Patient has had 1,150 ml of input and has urinated 3x today. Patient denies pain, hesitancy or urgency on urination. No abnormal odor. Patient is on I&O's. |

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| **PSYCHOSOCIAL/CULTURAL (2 points):**<br>**Coping methods,**<br>**Educational level**<br>**Developmental level,**<br>**Ethnicity,**<br>**Religion & what it means to pt.**<br>**Occupation (previous if retired)**<br>**Personal/Family Data (Think about home environment, family structure, and available family support)** | Patient presents neutral in his chair. Patient relaxes in bed/his chair and passes time on his phone or watching television. Patient lives at home with family. Patient is a current everyday smoker, uses an electronic cigarette, and denies substance abuse. Patient uses alcohol 1-2x/month. Patient states he completed high school. Patient appears to have good family support. Patient has no religious preferences. Patient is unemployed/disabled. |

**Pain Assessment, 2 sets (2 points)**

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| 1231 | 2/10 | abdominal,RUQ, umbilical region. | patient denies pain being severe. | aching. | No interventions implemented. |
| 1430 | 2/10 | abdominal, RUQ, umbilical region. | patient denies pain being severe. | aching/pressure. | No interventions implemented. |

**IV Assesssment (2 Points)**

| Site Location, Patency/Condition & Date | Fluid Type/Rate or Saline Lock |
|---|---|
| Peripheral IV 20g right antecubital. | 10/14, no phlebitis, infiltration present, catheter patent. NS running at 75ml. |

**Intake and Output during Your Shift (2 points)**

| Intake | Output |
|---|---|
| 1,150 ml. | Urinated 3x. |

**Nursing Care**

**Summary of care- Narrative of Nursing care provided, patient status throughout the day, any major concerns, etc (2 points):**

Patient was sitting upright in his chair with his glasses and telephone. Patient's vitals were taken along with a rating of his pain from 0-10. Patient passed time by watching television and using his telephone. Patient called to use the bathroom with 1 person standby assist. Physician visited with patient and explained he wanted to get his Hct and Hgb to a more normal level before discharge. Nurse waited for lab results to question provider on what to implement for patient.

**Discharge Planning- Identify discharge needs, education, home health services/equipment, family involved, etc (2 points):**

Patient will return home after observation due to a rectus sheath hematoma w/ acute bleeding. Patient will return home with family. Patient does not require assistive devices nor oxygen at home. Patient should be educated regarding the expected duration of symptoms related to the type of rectus sheath hematoma (RSH) present. This will provide reasonable expectations related to need for pain control and work limitations. Patient can follow up with their primary care physician or surgeon for pain control as the hematoma resolves.

***The following must be listed in order of priority and must be NANDA approved Diagnosis (18 points Total, 3 points for each complete diagnosis with 2 interventions & Rationale, 3 points for correct prioritization)**

| Nursing Diagnosis | Rational | Intervention (2 per dx) |
|---|---|---|
| 1. Ineffective breathing pattern<br><br>(Swearingen, 2016, p. 397) | r/t pain in abdomen and healing rectus sheath hematoma. | **1.** Instruct the patient to splint the abdomen to reduce pain on movement, coughing, and deep breathing. |

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| | | **2.** Monitor oximetry readings q2-4h. |
| 2. Risk for bleeding<br><br>(Swearingen, 2016, p. 398) | r/t actual decrease in blood volume secondary to rectus sheath hematoma. | **1.** Assess extremities for temperature, color, capillary refill, and strength of distal pulses. Report significant findings.<br><br>**2.** Monitor heart rate and cardiovascular status continually until the pts condition is stable. Report dramatic changes to the health care provider. |
| 3. Imbalanced nutrition<br>(Swearingen, 2016, p. 402) | d/t decreased intake occuring w/ disruption of GI tract integrity (trauma). | **1.** Monitor laboratory values, including prealbumin, albumin, total protein, and blood glucose.<br><br>**2.** Collaborate with the health care provider, dietician, and pharmacist to assess the pts metabolic needs based on type of injury, activity level, and nutritional status before surgery. |
| 4. Fall risk<br>(Swearingen, 2016, p. 252) | r/t weakness secondary to pain medications. | **1.** Make sure bed is in low position at all times when leaving the room.<br>**2.** Manage pain prior to ambulating to reduce pain or discomfort. |
| 5. Acute pain<br>(Swearingen, 2016, p. 39) | r/t healing of rectus sheath hematoma. | **1.** Use at least identifiers (pts name, medical record number, etc) before administering medication.<br><br>**2.** Use a preventative approach, administer prn pain medications before pain becomes severe as well as before painful procedures, ambulation, and bedtime. |

**Overall APA Format/Neatness/Grammar (5 point):**

**Concept Map Attached (20 points):**