N441 Care Plan

Lakeview College of Nursing

Twila Douglas

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
09/28/2020	J.T.	71	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Married	Trazadone
Code Status	**Height**	**Weight**	
Full	6’	67.3 kg	

Medical History (5 Points)

Past Medical History: Past medical history includes anxiety, benign prostate hyperplasia, colon polyps, and kidney stones.

Past Surgical History: Past surgical history includes knee arthroscopy, inguinal hernia repair, orchiectomy, cervical disc repair, and colonoscopy.

Family History: Family history includes paternal grandfather having dementia. Brother had heart problems, arthritis, and diabetes. Patient’s daughter, mother, and son all have arthritis. Patient’s father, brother, maternal grandfather, and maternal grandmother all had cancer.

Social History (tobacco/alcohol/drugs): Patient smoked 20 packs per year, but is currently smoke-free. Patient denies use of alcohol or drug use.

Assistive Devices: Patient used walker to ambulate.

Living Situation:Patient is currently living at home with wife. Patient has support from wife and family with care.

Education Level: Patient was a college graduate and there were no learning barriers presented.

Admission Assessment

Chief Complaint (2 points): Back pain, not relieved with medications

History of present Illness (10 points):

The patient complains of back pain that radiates to bilateral lower extremities and muscle pain that has worsened over the past six months. Pain characteristics include hours of spasms, throbbing, and aching. Aggravating factors include strenuous activities, walking, and prolonged sitting. In the past, narcotics and medical treatment helped manage, but have been unsuccessful in the past six months. The patient has continued to take narcotics to try to manage pain. The patient rated back pain 6 out of 10 and stated pain is constant with periods of excruciating pain. Patient treatment plans include surgical intervention with pain management.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Primary diagnosis was lumbar stenosis with neurogenic claudication.

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points):.

The pathophysiology is related to the dysfunction of the cord due to degenerative instability and mechanical cord compression. Narrowing that is progressive of the spine's spaces causes pressure on the nerves that travel through the spine. Spinal stenosis causes pain and cramps to the musculoskeletal system. Legs numbness or pins and needles are common symptoms affecting the sensory system.

Signs and symptoms of lumbar stenosis are pain, numbness, and weakness in the legs, calves, or buttocks. Symptoms can increase with a long period of standing or when walking. Pain can radiate into legs or thighs. Pain may improve with bending forward, lying down, or sitting.

Diagnosis is consists of a neurosurgeon using information obtained from medical history, physical examination, test results, and symptoms. Imaging for diagnosis include CT scan, MRI, X-Ray, and myelogram. Labs drawn for diagnostic reasonings are comprehensive metabolic panel and complete blood count. The patient was screened for Staphylococcus aureus. The patient was typed and crossed, in case a blood transfusion was needed. The patient has a COVID

swab to test for the virus. This patient had a comprehensive metabolic panel and arterial blood gases drawn.

Treatment for lumbar stenosis can be surgical or non-surgical. Non-surgical interventions include anti-inflammatory medication, analgesics, epidural injections, and physical therapy. When non-surgical interventions are not managing symptoms, surgical interventions are available. Surgical intervention for lumbar stenosis includes laminotomy, foraminotomy, and fusions. This patient was using non-surgical intervention with medication and physical therapy, but no longer were managing pain. The patient received bilateral L3/L4, L4/L5 laminectomy and foraminotomy, and right L5/S1 laminectomy and foraminotomy with microdissection. Clinical findings showed lumbar stenosis with neurogenic claudication.

References:

Pathophysiology References (2) (APA):

Lumbar Spinal Stenosis. (2020). Retrieved 3 October 2020, from https://www.hopkinsmedicine.org/health/conditions-and-diseases/lumbar-spinal-stenosis

Lumbar Spinal Stenosis – Symptoms, Diagnosis and Treatments (2020). Retrieved 2 October 2020, from https://www.aans.org/en/Patients/Neurosurgical-Conditions-and-Treatments/Lumbar-Spinal-Stenosis

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	Lab not drawn			
Hgb	Lab not drawn			
Hct	Lab not drawn			
Platelets	Lab not drawn			
WBC	Lab not drawn			
Neutrophils	Lab not drawn			
Lymphocytes	Lab not drawn			
Monocytes	Lab not drawn			
Eosinophils	Lab not drawn			
Bands	Lab not drawn			

Patient did not have any CBC labs drawn

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145	134	N/A	Lab was normal
K+	3.5-5.1	3.8	N/A	Lab was normal
Cl-	98-107	102	N/A	Lab was normal
CO2	21-32	30.9	N/A	Lab was normal

Glucose	**60-99**	**85**	**N/A**	**Lab was normal**
BUN	**7-18**	**16**	**N/A**	**Lab was normal**
Creatinine	**0.70-1.30**	**1.01**	**N/A**	**Lab was normal**
Albumin	**Not drawn**			
Calcium	**Not drawn**			
Mag	**1.6-2.6**	**1.8**	**N/A**	**Lab was normal**
Phosphate	**Not drawn**			
Bilirubin	**Not drawn**			
Alk Phos	**Not drawn**			
AST	**Not drawn**			
ALT	**Not drawn**			
Amylase	**Not drawn**			
Lipase	**Not drawn**			
Lactic Acid	**Not drawn**			
Troponin	**Not drawn**			
CK-MB	**Not drawn**			
Total CK	**Not drawn**			

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	Lab not drawn			
PT	Lab not drawn			
PTT	Lab not drawn			
D-Dimer	Lab not drawn			
BNP	Lab not drawn			
HDL	Lab not drawn			
LDL	Lab not drawn			
Cholesterol	Lab not drawn			
Triglycerides	Lab not drawn			
Hgb A1c	Lab not drawn			
TSH	Lab not drawn			

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Urinalysis not performed			
pH				

Specific Gravity				
Glucose				
Protein				
Ketones				
WBC				
RBC				
Leukoesterase				

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35-7.45**	**7.35**	**7.35**	
PaO2	**80-100**	**425.7**	**233.0**	**Increased oxygen levels in inhaled air**
PaCO2	**35-45**	**43.3**	**43.4**	

HCO3	**22-26**	**23.2**	**23.4**	
SaO2	**95-100**	**99.1**	**98.7**	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**Lab not drawn**			
Blood Culture	**Lab not drawn**			
Sputum Culture	**Lab not drawn**			
Stool Culture	**Lab not drawn**			

Lab Correlations Reference (APA):

Complete blood count (CBC) - Mayo Clinic. (2020). Retrieved 2 October 2020, from https://www.mayoclinic.org/tests-procedures/complete-blood-count/about/pac-20384919

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Patient did not have any diagnostic testing performed during hospital visit. Patient had diagnostic imaging performed prior to surgery hospital visit.

Diagnostic Test Correlation (5 points): No diagnostic test performed

Diagnostic Test Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins

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

10 different medications must be completed

Home Medications (5 required)

Brand/Generic	Prilosec/ Omeprazole	Benadryl/ Diphenhydramine	**lexapro/ Escitalopram**	**Lunesta/ Eszopiclone**	Hydroxyzine/ Atarax
Dose	**20 mg**	**325 mg**	**20 mg**	**2 mg**	**25 mg**
Frequency	**Before meals**	**PRN**	**Daily**	**Bedtime**	**PRN X3**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Skeletal muscle relaxant**	**Antihistamine**	**Antidepressant**	**Sedative**	**Antihistamine**

Mechanism of Action	**Prilosec suppresses acid secretions made in the stomach.**	**Benaryl reverses elects of histamine on capillaries, which reduces allergic reaction symptoms.**	**Lexapro inhibits the reuptake of the neurotransmitter serotonin and enhances the actions of serotonin.**	**Lunesta binds to the brains GABA receptor and calms the brain allowing sleep to occur.**	**A selective and potent histamine receptor invert agonist**
Reason Client Taking	**Acid reflux**	**Allergies**	**Depression**	**Insomnia**	**Allergies and itching**
Contraindications (2)	**1. Patients with liver problems 2. Patients with diarrhea from Clostridium diccicili bacteria.**	**1. Patients with high blood pressure 2. Patient with closed angle glaucoma**	**1. Patients at risk for QT prolongation 2. Patients at risk for serotonin syndrome**	**1. Patients with suicidal thoughts 2. Patients with decrease lung function**	**1. Early pregnancy 2. Patients with prolonged QT interval**
Side Effects/Adverse Reactions (2)	**1. Headache 2. Nausea**	**1. Blurred vision 2. Drowsiness**	**1. Headache 2. Nausea**	**1. Unpleasant taste in mouth 2. Headache**	**1. Drowsiness 2. Constipation**
Nursing Considerations (2)	**1. Monitor for onset of black, tarry stools 2. Monitor for abdominal pain**	**1. Administer with food if GI upset occurs 2. Monitor patient response to medication**	**1. Monitior for suicudal thoughts 2. Contraindicated with MAOI.**	**1. Assess patient while sleeping. 2. Monitor for signs and symptoms of CNS depression**	**1. Monitor for side effect s 2. Administer with food if GI upset occurs**

Key Nursing Assessment(s) Prior to Administration	**1. Monitor for side effects 2. Monitor urinalysis for hematuria**	**1. Check allergies 2. Check vital signs**	**1. Assess for suicidal tendencies 2. Assess for serotonin syndrome**	**1. Assess sleeping patterns 2. Should not be taken with or immediately after a meal**	**1. Check allergies to hydroxyzine or cetirizine 2. Assess skin color**
Client Teaching needs (2)	**1. Prilosed is usual taken at least 1 hour prior to meal. 2. Common side effects teaching**	**1. Side effect eduction 2. Do not operate machinery or drive while taking this medication after discharge.**	**1. Teach patient about side effects. 2. It may take up to 4 weeks for symptoms to improve**	**1. Supervision is needed when getting up to bathroom over night 2. Monitor for side effects**	**1. Educate on side effects 2. Assess skin color**

Hospital Medications (5 required)

Brand/Generic	**Flexeril/ Cyclobenzaprine**	**Lexapro/ Escitalopram**	**Flomax/ Tamsulosin**	**Norco/ hydrocodone/acetaminophen**	**Colace/ Docusate sodium**
Dose	**10 mg**	**20 mg**	**0.4 mg**	**10-325 mg X2**	**200 mg**

Frequency	**TID**	**Daily**	**Daily**	**PRN Q6**	**BID**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Skeletal muscle relaxant**	**Antidepressant**	**Alpha-1 blocker**	**Narcotic**	**Anionic surfactant**
Mechanism of Action	**Flexeril acts on the brainstem which reduces somatic motor activity that leads to reduction in muscle spasm.**	**Lexapro inhibits the reuptake of the neurotransmitter serotonin and enhances the actions of serotonin.**	**Causes smooth muscles in the bladder neck and prostate to relax, which results in urine flow rate improvement and reduces symptoms of BPH**	**Norco relates to opiate receptors in the central nervous system.**	**Lowers surface tension allowing lipids and water to penetrate the stool**
Reason Client Taking	**Muscle stiffness and pain**	**Depression**	**BPH**	**Pain**	**Helps promote a bowel movement**
Contraindications (2)	**1. Patient with hyperthyroidism 2. Within 14 days of taking a MAOI**	**1. Patients at risk for QT prolongation 2. Patients at risk for serotonin syndrome**	**1. Patients with hypersensitivity to flomax. 2. Patient with hypersensitivity to any component of flomax capsules**	**1. Patient with significant respiratory depression. 2. Patient with known or suspected gastrointestinal obstruction**	**1. Allergies to docusate 2. Patient with blockage of the stomach or intestines.**

Side Effects/Adverse Reactions (2)	**1. Drowsiness 2. Headache**	**1. Headache 2. Nausea**	**1. Dizziness 2. Diarrhea**	**1. Drowsiness 2. Nausea**	**1. Diarrhea 2. Abdominal cramping**
Nursing Considerations (2)	**1. Monitor vital signs 2. Monitor for drowsiness and reduced psychomotor skills.**	**1. Monitior for suicudal thoughts 2. Contraindicated with MAOI.**	**1. Monitor for side effects 2. Monitor urine output**	**1. Monitor vital signs 2. Monitor for reactions**	**1. Monitor stool 2. Monitor for any skin break down**
Key Nursing Assessment(s) Prior to Administration	**1. Assess vital signs 2. Assess expectant outcomes from medication**	**1. Assess for suicidal tendencies 2. Assess for serotonin syndrome**	**1. Monitor urninaylisis 2. Administered approximately one-half hour following meal.**	**1. Assess vitals prior to medication administration 2. Assess pain and goals of pain management therapy**	1. Check CBC 2. Monitor bowel movement prior to administration
Client Teaching needs (2)	**1. Side effect education 2. Do not take more than prescribed**	**1. Teach patient about side effects. 2. It may take up to 4 weeks for symptoms to improve**	**1. Do not crush, chew or open capsules. 2. Do not take medication with similar medicines.**	**1. Do not exceed prescribed dosage 2. Do not attempt to do strenuous activities while taking medication**	**1. Signs of diarrhea 2. Signs of skin irritation**

Medications Reference (APA):

Drugs.com | Prescription Drug Information, Interactions & Side Effects. (2020). Retrieved 2 October 2020, from https://www.drugs.com/

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:oriented , open eyes spontaneous, obeys commands** **Orientation: X4** **Distress: Patient did not appear to be in any distress** **Overall appearance: Patient appeared to be in pain, but was pleasant.**	

INTEGUMENTARY (2 points): **Skin color: no discoloration** **Character: warm, skin intact** **Temperature:warm on all extremities** **Turgor: <3 seconds** **Rashes: no rashes** **Bruises: no bruises** **Wounds: no wounds** **Braden Score:20** **Drains present: Y☐ N ☐ YES** **Type:Jackson pratt**	
HEENT (1 point): **Head/Neck:atraumatic, normocephalic, no JVD** **Ears: NO hearing devices, no drainage, appears to be equal** **Eyes: PERRLA, glasses at bedside, eyelids equal** **Nose: no septal deviation or drainage** **Teeth: Dental appliance present, teeth missing**	.
CARDIOVASCULAR (2 points): **Heart sounds: S1,S2 present, no murmurs** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):normal sinus rhythm** **Peripheral Pulses:present, 2+** **Capillary refill: <3 seconds** **Neck Vein Distention: Y ☐ N ☐NO** **Edema Y ☐ N ☐Yes**	.

Location of Edema: laminectomy incision on back	
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐NO** **Breath Sounds: Location, character** **Anterior, equal bilaterally, clear in all lobes** **ET Tube:NONE** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	.
GASTROINTESTINAL (2 points): **Diet at home: regular** **Current Diet: regular** **Height: 6'** **Weight:67.3 kg** **Auscultation Bowel sounds: normative in all 4 quadrants** **Last BM: 09/27/2020** **Palpation: Pain, Mass etc.: soft non-tender, no distended** **Inspection: No massess** **Distention: non distended** **Incisions: laminectomy incision** **Scars: none**	.

Drains: JP X2 **Wounds: none** **Ostomy: Y ☐ N ☐ NO** **Nasogastric: Y ☐ N ☐NO** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐NO** **Type:**	
GENITOURINARY (2 Points): **Color: Yellow** **Character: no sediments, no foul odor** **Quantity of urine: 300 mL** **Pain with urination: Y ☐ N ☐NO** **Dialysis: Y ☐ N ☐NO** **Inspection of genitals: N/A, NO** **Catheter: Y ☐ N ☐NO** **Type:** **Size:** **CAUTI prevention measures:N/A**	
MUSCULOSKELETAL (2 points): **Neurovascular status: warm, pulses present, no numbness or tingleness** **ROM: Active ROM with all extremities** **Supportive devices: Walker** **Strength: Strong** **ADL Assistance: Y☐ N ☐ YES** **Fall Risk: Y ☐ N☐YES** **Fall Score: 10.** **Activity/Mobility Status: 1 assist, gait**	.

belt, and walker **Independent (up ad lib) NO** **Needs assistance with equipment NO** **Needs support to stand and walk NO**	
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐ YES** **PERLA: Y ☐ N☐ YES** **Strength Equal: Y ☐YES N ☐ if no - Legs ☐ Arms ☐ Both ☐BOTH** **Orientation:Oriented to person, place, time, and situation** **Mental Status: Stable and alert** **Speech: Clear, spontaneous, logical** **Sensory: intact, no deficits** **LOC: alert and oriented X4**	.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): spirituality, family, acceptance, smartphone, and television** **Developmental level:Patient is well educated on diagnosis and shows an understanding.** **Religion & what it means to pt.: Patient is Catholic and it is important to then** **Personal/Family Data (Think about home environment, family structure, and available family support): Patient lives at home with wife. Patient's children live near by and will be available with wife to assist in care.**	.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
715	68	113/63	18	97.2F oral	97%
1059	63	110/63	19	97.3F oral	93%

Vital Sign Trends/Correlation: Vital signs remained stabled

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
715	Number	Back	6	Constant spams	Flexeril, and Norco given. Care clustered, quiet environment, relaxation, and necessary movements minimized

1140	**Number**	**Back**	**6**	**Aching**	**Flexeril, and Norco given. Care clustered, quiet environment, relaxation, and necessary movements minimized**

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV:16 gauge **Location of IV: left forearm** **Date on IV: 09/38/2020** **Patency of IV: flushed without difficulty** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: Clean, dry, intact**	Hep locked, no medication running
Other Lines (PICC, Port, central line, etc.)	
Type: None **Size: N/A** **Location: N/A** **Date of insertion: N/A** **Patency: N/A** **Signs of erythema, drainage, etc.: N/A** **Dressing assessment: N/A** **Date on dressing: N/A** **CUROS caps in place: Y ☐ N ☐ N/A** **CLABSI prevention measures: N/A**	

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
240 mL	**300 mL**

Nursing Care

Summary of Care (2 points)

Overview of care:

The patient's vital signs and neurological status were monitored every four hours and remained stable. Patient had complaints of back pain, muscle cramping, and pain from the incisional site, which was managed with medication. The patient had an abnormal increase in PaO2. The patient is on a regular diet and is tolerating the diet. Patient will continue to work on pain management and regaining strength. The patient needs to have a bowel movement before discharge home. The patient will have a follow-up appointment after discharge.

Procedures/testing done: Patient had a Staphylococcus aureus screening, type and screen, COVID swab, comprehensive metabolism panel, and arterial blood gases performed.

Complaints/Issues: Patient complained of back pain and soreness.

Vital signs (stable/unstable): Patient vital signs remained stabled

Tolerating diet, activity, etc.: Patient is tolerating a regular diet, and activity includes ambulating with 1 assist, walker, and a gait belt.

Physician notifications: NONE

Future plans for patient:

The patient will be discharged with a walker to home after a bowel movement.

Discharge Planning (2 points)

Discharge location: Patient will be discharged to home

Home health needs (if applicable): No health needs are needed for patient

Equipment needs (if applicable): Patient will need a walker for home, which was delivered today

Follow up plan: Patient has a post op visit on 10/13/2020 in the brain and spine department

Education needs: The patient was educated on weight restriction after surgery. The patient is not to drive 2-3 weeks after surgery. Never drive while taking opioid pain medication. Arrange for frequently used home items to be nearby. Medication should be taken as prescribed by a physician. The incision site should be monitored daily for redness, drainage, or tenderness. Wait three days after surgery to start showering, and be sure to pat the incision dry and do not run r apply cream or lotions to the incision.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

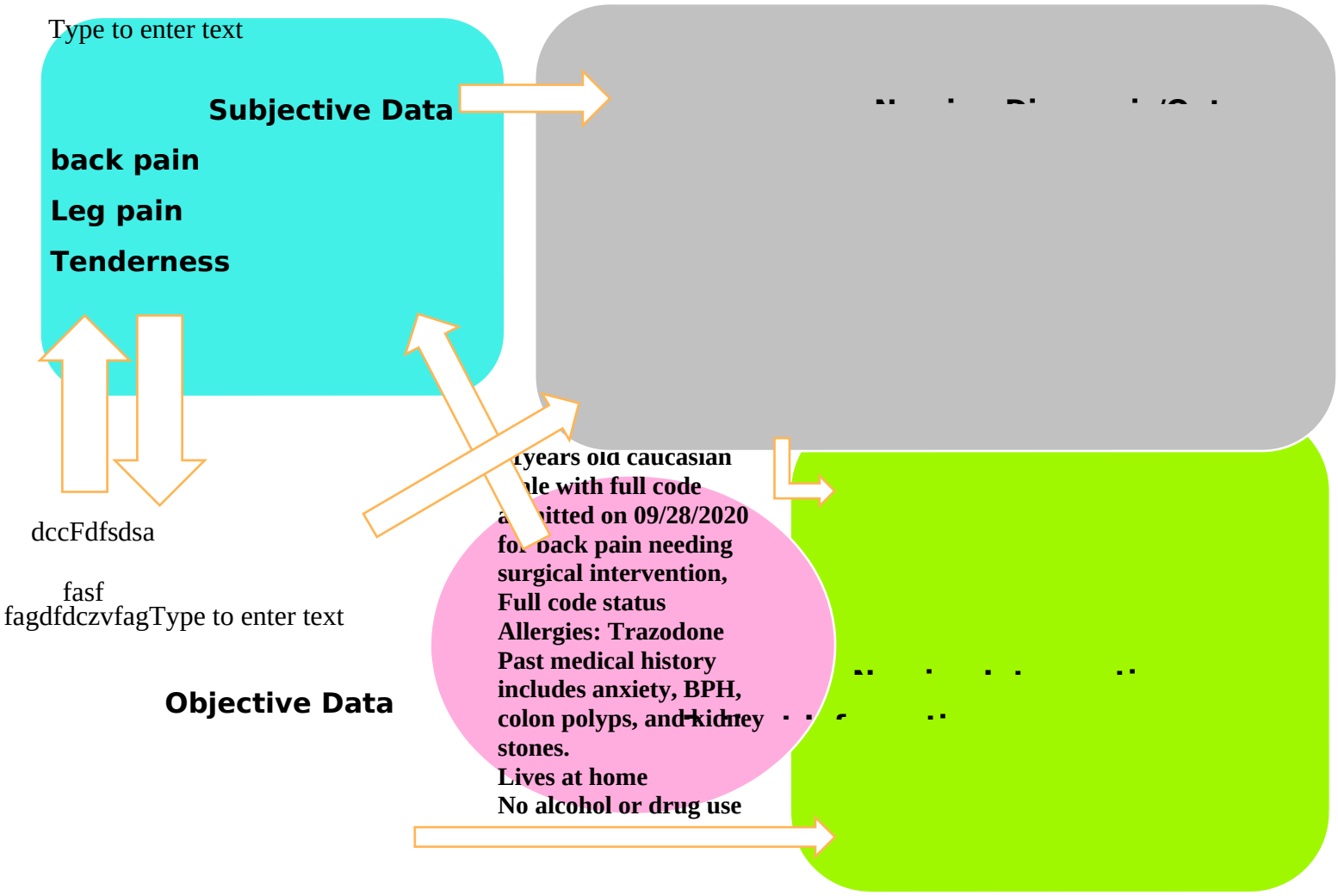
Nursing Diagnosis	**Rational**	**Intervention (2 per dx)**	**Evaluation**
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

1. **Ineffective breathing pattern R/T decreased lunch expansion due to pain AEB patient discomfort with deep breathing**	**Patient stated feeling discomfort when breathing.**	**1. Auscultate breathe sounds** **2. Administer supplemental oxygen**	**The patient responded well with deep breathing exercises, and no oxygen was needed.** **The goal was completed to help with decreasing comfort when breathing, and no modifications were needed.**
2. **Ineffective tissue perfusion R/T diminshed/interupted blood flow AEB decreased in muscle strength**	**Patient was experiencing swelling at the operative site and decreases in muscle strength.**	**1. Monitor vital signs** **2. Watch for deterioration in neurological status. Check neurological signs periodically and compare to patient baseline**	**The patient was understanding of the need for neurological checks and assessment of vital signs.** **The goal to have stable vital signs and neurological checks were achieved.**
3. **Acute pain R/ T surgical manipulation AEB reports pain 6 out 10, and alterations muscle tone**	**Patient had surgery and was reporting pain 6 out of 10**	**1.** **Administer narcotics and muscle relaxants** **2. Assess pain intensity, location, radiation of pain, changes in sensation, and description.**	**The patient responded well to pain management therapy. The patient showed no signs and symptoms of adverse effects of medication.** **The goal of managing pain was achieved with modification to increase the narcotic dosage.**

4. Constipation R/T pain and swelling in the surgical site, narcotic use, and immobilization AEB Change in frequency, consistency, and amount of stool	Patient hasn't had a bowel movement and complains of discomfort.	1.Document and observe abdominal distention and ascultatae bowel sounds 2. Administer laxatives, stool softners, as indicated.	The patient was unable to produce a bowel movement before the end of the clinical shift. The patient was given Fleet enema to produce bowel cement. The goal was completed with modifications, including adding fleet enema.
5. Impaired physical mobility R/T laminectomy and foraminectomy AEB having surgery on 09/28/2020	Patient physical mobility is limited from surgery and pain.	1. Provide a safe environment with 3 bed rails up, important items nearby, and bed in lowest position. 2. Use anti embolic stockings or sequential compression devices	The patient understood the use of a walker and gait belt to promote safety. The goal was met to keep the patient safe while having impaired physical mobility.

Other References (APA):

Concept Map (20 Points):


Type to enter text
Subjective Data
back pain
Leg pain
Tenderness
dccFdfsdsa
fasf
fagdfdczvfagType to enter text
Objective Data
years old caucasian
le with full code
itted on 09/28/2020
for back pain needing
surgical intervention,
Full code status
Allergies: Trazodone
Past medical history
includes anxiety, BPH,
colon polyps, and kidney
stones.
Lives at home
No alcohol or drug use

Objective data:

BP 113/63

Pulse 68

Temperature 97.2F

Oxygen 97%

Respirations 18

Incision bandage

Elevated PaO2 425.7 and 233.0

Sodium levels low 135

Nursing diagnosis and outcomes

1. **Ineffective breathing pattern R/T decreased lunch expansion due to pain AEB patient discomfort with deep breathing**
    a. **Maintain oxygen saturation >95 prior to discharge**
2. **Ineffective tissue perfusion R/T diminshed/interrupted blood flow AEB decreased in muscle strength**
    a. **Perform range of motion actives daily prior to discharge to increase muscle strength**

3. **Acute pain R/T surgical manipulation AEB reports pain 6 out 10, and alterations muscle tone**
    a. **Follow pain management and have pain down to 3 out of 10 prior to end of day.**

4. **Constipation R/T pain and swelling in the surgical site, narcotic use, and immobilization AEB Change in frequency, consistency, and amount of stool**
    a. **Patient will have bowel movement prior to discharge**

5. **Impaired physical mobility R/T laminectomy and foraminectomy AEB having surgery on 09/28/2020**
    a. **Patient will work with therapy and be able to perform ADLs prior to discharge.**

Nursing interventions

1. Auscultate breathe sounds

2. Administer supplemental oxygen

3. Monitor vital sign

4. Watch for deterioration in neurological status. Check neurological signs periodically and compare to patient baseline

5. Administer narcotics and muscle relaxants

6. Assess pain intensity, location, radiation of pain, changes in sensation, and description.

7.Document and observe abdominal dissension and ascultate bowel sounds

8. Administer laxatives, stool softeners, as indicated.

9. Provide a safe environment with 3 bed rails up, important items nearby, and bed in lowest position.

10.Use anti embolic stockings or sequential compression devices