N441 Care Plan

Lakeview College of Nursing

Delaney Lockard

Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
10/06/2020	J.B.	48 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian/white	Unemployed	Divorced	NKA
Code Status	**Height**	**Weight**	
Full code	182 cm	53.5 kg	

Medical History (5 Points)

Past Medical History: Stage IV renal cell carcinoma with metastasis to lungs, diabetes mellitus type 1, fluid volume deficit

Past Surgical History: Right nephrectomy in 2014

Family History: No known family history

Social History (tobacco/alcohol/drugs): Tobacco smoker - 1.5 packs/day, alcohol use - one to two times a year, current substance abuser

Assistive Devices: No assistive devices present

Living Situation: Patient lives with his elderly parents in a house.

Education Level: GED or equivalence to a high-school diploma

Admission Assessment

Chief Complaint (2 points): "Vomiting and high blood sugar"

History of present Illness (10 points): J.B. is a 48-year-old male who presented to the ED via ambulance on 10/06/2020. He reports that his chief complaint is "vomiting for one day and high blood sugar." He stated that his blood glucose level had been above 600 since 10/05/2020. He complains of generalized weakness that restricts him from getting around his home. He denies any presence of hematemesis, diarrhea, shortness of breath, pain, or fever.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Diabetic ketoacidosis

Secondary Diagnosis (if applicable): Lactic acidosis

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

Diabetic ketoacidosis is a life-threatening condition created from having no insulin reserve, most commonly present in patients with uncontrolled diabetes mellitus type I (Capriotti & Frizzell, 2018). Without insulin, the intracellular environment does not receive the glucose it needs for oxidation and energy metabolism and glucose can no longer be transported from the bloodstream into the cell membrane (Swearingen, 2016). Impairment of this glucose reuptake results in high glucose levels, or hyperglycemia. The body tries to compensate to make up for these abnormalities. The liver gets put into overdrive and releases ketones into the bloodstream, altering blood pH and leading to ketoacidosis (Capriotti & Frizzell, 2018).

Signs and symptoms of diabetic ketoacidosis include polydipsia, polyphagia, severe nausea, vomiting, Kussmaul's respirations, and dehydration (Capriotti & Frizzell, 2018). Furthermore, neurological symptoms can present themselves with an altered level of consciousness, lethargy, generalized weakness, and even coma (Swearingen, 2016). Vital signs during DKA can show to be tachycardic and hypotensive (Swearingen, 2016). In this patient's case, he states to have generalized weakness in addition to his chief complaint of "nausea and vomiting."

Diagnostic testing for the disease process of diabetic ketoacidosis include blood glucose testing with levels above 250 mg/dL, serum pH testing with an arterial blood pH of less than 7.3, and a serum bicarbonate level lower than 15 mEq/L. In addition, a urinalysis is performed to identify the presence of ketonuria (Capriotti & Frizzell, 2018). A urinalysis is usually the first

test that is ordered (Capriotti & Frizzell, 2018). A complete metabolic panel should be performed to assess electrolyte imbalances and liver function tests (Capriotti & Frizzell, 2018).

Treatment for this patient's new diagnosis includes correcting the elevated glucose levels with insulin via intravenous therapy. Blood glucose levels should be assessed every hour until stabilized (Capriotti & Frizzell, 2018). IV fluids such as 0.45% normal saline followed by dextrose-containing solutions can be used to treat the imbalanced electrolytes that are apparent (Swearingen, 2016). Cardiac monitoring can be necessary when there are significant electrolyte imbalances (Capriotti & Frizzell, 2018). Potassium may be required to treat the presence of hypokalemia as well. Finally, it is vital to monitor for changes in vital signs that indicate hypovolemic shock and changes in mental status, which can indicate cerebral edema (Capriotti & Frizzell, 2018).

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. (2016). *Pathophysiology: Introductory concepts and clinical perspectives.* Davis Company.

Swearingen, P.L. (2016). *All-in-one care planning resource: medical-surgical, pediatric, maternity & psychiatric nursing care plans.* Elsevier/Mosby.

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 (10/06/20)	Today's Value (10/06/20)	Reason for Abnormal Value
RBC	3.80-5.41 mcl	4.96 mcl	N/A	N/A
Hgb	11.3-16 g/L	15 g/L	N/A	N/A
Hct	37-47%	47%	N/A	N/A

Platelets	140-400 k/mcl	509 k/mcl	N/A	The patient's platelet level is increased due to his stage IV renal carcinoma with metastasis to his lungs (Van Leeuwen and Bladh, 2017).
WBC	4.0-11.4 k/mcl	22.4 k/mcl	N/A	The patient's white blood cell level is increased due to his body fighting off sepsis (Van Leeuwen and Bladh, 2017).
Neutrophils	45.3-79%	89.5%	N/A	The patient's neutrophils are increased due to the presence of malignancies (Van Leeuwen and Bladh, 2017).
Lymphocytes	11.8-45.9%	5.3%	N/A	The patient's lymphocyte levels are decreased due to using chemotherapy to treat his malignancies (Van Leeuwen and Bladh, 2017).
Monocytes	4.4-12%	3.8%	N/A	The patient's monocyte levels are decreased due to using chemotherapy to treat his malignancies (Van Leeuwen and Bladh, 2017).
Eosinophils	0.0-6.3%	N/A	N/A	N/A
Bands	0.0-5.0%	N/A	N/A	N/A

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

Lab	**Normal Range**	**Admission Value (10/06/20)**	**Today's Value (10/06/20)**	**Reason For Abnormal**
Na-	135-145 mmol/L	125 mmol/L	N/A	The patient's sodium level is decreased due to the current IV therapy of insulin (Van Leeuwen and Bladh, 2017).
K+	3.5-5.0 mmol/L	4.2 mmol/L	N/A	N/A
Cl-	98-106 mmol/L	68 mmol/L	N/A	The patient's chloride level is low due to his recent diagnosis of diabetic ketoacidosis (Van Leeuwen and Bladh, 2017).
CO2	21-31 mmol/L	13 mmol/L	N/A	The patient's carbon dioxide level is decreased due to his recent

				diagnosis of diabetic ketoacidosis (Van Leeuwen and Bladh, 2017).
Glucose	74-109 mg/dL	753 mg/dL	256 mg/dL	The patient's carbon glucose levels are increased due to diabetes mellitus type I. (Van Leeuwen and Bladh, 2017).
BUN	7-25 mg/dL	49 mg/dL	N/A	The patient's BUN level is due to diabetes mellitus type I and his recent diagnosis of diabetic ketoacidosis (Van Leeuwen and Bladh, 2017).
Creatinine	0.05-0.90 mg/dL	2.28 mg/dL	N/A	The patient's creatinine level is increased due to dehydration from vomiting (Van Leeuwen and Bladh, 2017).
Albumin	3.5-5 g/dL	4.2 g/dL	N/A	N/A
Calcium	9.0-10.5 mEq/dL	9.1 mEq/dL	N/A	N/A
Mag	1.3-2.1 mEq/dL	2.1 mEq/dL	N/A	N/A
Phosphate	2.5-4.5 mg/dL	N/A	N/A	N/A
Bilirubin	0.3-1 mg/dL	1.0 mg/dL	N/A	N/A
Alk Phos	35-105 units/L	120 units/L	N/A	This patient's alkaline phosphatase level is increased due to his stage IV renal cell carcinoma with metastasis to the lungs (Van Leeuwen and Bladh, 2017).
AST	0.0-32 units/L	13 units/L	N/A	N/A
ALT	4-33 units/L	15 units/L	N/A	N/A
Amylase	30-220 units/L	N/A	N/A	N/A
Lipase	0.0/160 units/L	N/A	N/A	N/A
Lactic Acid	0.5-1 mmol/L	4.5 mmol/L	N/A	The patient's lactic acid level is increased due to diabetes mellitus type I and his secondary diagnosis oflactic acidosis (Van Leeuwen and Bladh, 2017).

Troponin	>0.03	< 0.010	N/A	N/A
CK-MB	>90	2.17	N/A	N/A
Total CK	30-170 mmol/L	52 mmol/L	N/A	N/A

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 (10/06/20)	Today's Value (10/06/20)	Reason for Abnormal
INR	0.8-1.1	0.96	N/A	N/A
PT	11-12.5	13.1	N/A	The patient's PT level is increased due to the current pharmacological therapy of heparin (Van Leeuwen and Bladh, 2017).
PTT	30-40 sec	25.2 sec	N/A	N/A
D-Dimer	< 0.4 mcg/mL	N/A	N/A	N/A
BNP	0.5-30 pg/mL	N/A	N/A	N/A
HDL	>55 mg/dL	N/A	N/A	N/A
LDL	<130 mg/dL	N/A	N/A	N/A
Cholesterol	50-60 mg/dL	N/A	N/A	N/A
Triglycerides	35-135 mg/dL	N/A	N/A	N/A
Hgb A1c	>55 mg/dL	N/A	N/A	N/A
TSH	0.4-4.2 mU/L	N/A	N/A	N/A

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 (10/06/20)	Today's Value (10/06/20)	Reason for Abnormal
Color & Clarity	Yellow and clear	Straw/clear	N/A	N/A
pH	5.0-8.0	5.0	N/A	N/A
Specific Gravity	1.005-1.035	1.017	N/A	N/A
Glucose	Normal	> 500	N/A	The patient has a presence of increased glucose in the urine due to his diabetes mellitus type I (Van Leeuwen and Bladh, 2017).
Protein	Negative	Negative	N/A	N/A
Ketones	Negative	2+	N/A	The patient has a presence of ketones in the urine due to the recent diagnosis of diabetic ketoacidosis (Van Leeuwen and Bladh, 2017).
WBC	> 5	N/A	N/A	N/A
RBC	0-3	N/A	N/A	N/A
Leukoesterase	Negative	Negative	N/A	N/A

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	N/A	N/A	N/A
PaO2	80-100 mmHg	N/A	N/A	N/A
PaCO2	35-45 mmHg	N/A	N/A	N/A
HCO3	21-28 mEq/L	N/A	N/A	N/A
SaO2	95-100%	N/A	N/A	N/A

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 (10/06/20)	Today's Value (10/06/20)	Explanation of Findings
Urine Culture	Negative	Negative	N/A	N/A
Blood Culture	Negative	Negative	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M.L. (2017). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implications.* F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): On 10/06/2020, this patient had undergone a chest x-ray to visualize the respiratory and cardiovascular systems and the results were negative for any abnormalities. The same day, an EKG was ordered and the results showed abnormalities like sinus tachycardia and bilateral enlargement.

Diagnostic Test Correlation (5 points): An electrocardiogram was ordered to assess the patient's heart rhythm due to his lab values showing electrolyte imbalances. Sinus tachycardia and bilateral enlargement were noted; therefore, requiring closely monitoring the patient (Van Leeuwen and Bladh, 2017). Additionally, the chest x-ray was ordered. This allows the physician to diagnose abnormalities to the lungs or heart (Van Leeuwen and Bladh, 2017). In this case, there were no noted abnormalities and a pulmonary embolism was ruled out.

Diagnostic Test Reference (APA):

Van Leeuwen, A. M., & Bladh, M.L. (2017). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implications.* F.A. Davis Company.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	zolpidem tartrate (Ativan)	citalopram hydrobromide (Celexa)	hydrocodone-acetaminophen (Vicodin)	levothyroxine sodium (Levoxyl)	prochlorperazine (Compazine)
Dose	10 mg	20 mg	10 mg-325 mg	100 mcg	10 mg
Frequency	PRN HS	Daily	PRN Q4H	Daily	PRN
Route	PO	PO	PO	PO	PO
Classification	Sedative	Antidepressant	Analgesics	Thyroid hormone replacement	Antiemetic
Mechanism of Action	This medication binds to benzodiazepine receptors in the CNS, the GABAs inhibitory effects are increased. This blocks cortical and limbic arousal allowing deep sleep to be preserved.	This medication blocks serotonin reuptake by adrenergic nerves. The blocked reuptake allows the serotonin levels to increase, thus increasing mood and reducing depression.	This medication is an opioid analgesics agonist and decreases the chemical transmission throughout the CNS. This inhibits pain sensation.	This medication replaces endogenous thyroid hormone. Examples of the function of this drug include regulating growth, increases energy, decreases blood and hepatic cholesterol concen-trations.	This medication alleviates nausea and vomiting by blocking the dopamine receptors in the medullary chemorecepto rs and blocking the vagus nerve the GI tract.

Reason Client Taking	Tx insomnia	Tx depression	Tx pain	Tx hypothyroidism	Tx GI symptoms from chemotherapy
Contrain-dications (2)	Hypersensitivity, severe hepatic impairment	Congenital long QT syndrome, hypersensitivity	Patients with severe respiratory depression, GI obstruction	Acute MI, uncorrected adrenal insufficiency	Less that two years old, coronary artery disease
Side Effects/Adverse Reactions (2)	Abnormal thinking, hallucinations	Agitation, angina	Hallucinations, bradycardia	Anxiety, dyspnea	Hypotension, blurred vision
Nursing Considerations (2)	Use cautiously in patients with respiratory impairment, be aware of the drug's rapid onset	Monitor patient for serotonin syndrome, use cautiously in patients with cardiac conditions	Assess bowel function, assess heart rate	Use cautiously in elderly patients and patients with underlying conditions, administer 30-60 minutes prior to breakfast	Inject IM form slowly, protect from direct light
Key Nursing Assessment(s) Prior to Administration	Assess respiratory rate	Monitor for suicidal tendencies, assess for low heart rate	Assess pain rating	Check thyroid function test results	Assess IV site or IM injection site
Client Teaching needs (2)	Caution the patient to take exactly as prescribed, report symptoms such as nausea, abdominal tightness, fatigue, flushing, or light-headedness to the provider.	Inform patient that full effect of drug may not take effect for four weeks, do not stop abruptly	Advise them that it may cause them drowsiness, avoid using alcohol with this medication	Inform the patient that this will be taken for the rest of their life, do not take antacids for at least four hours from last dose	Take with food or full glass of milk/water, report involuntary movements and restlessness to the provider

Hospital Medications (5 required)

Brand/Generic	heparin sodium (Heparin Sodium Injection)	insulin detemir (Levemir)	pantoprazole sodium (Protonix)	promethazine hydrochloride (Phenergan)	ondansetron (Zofran)
Dose	5000 units/1 mL	0.5-1 unit/kg/day	40 mg	12.5 mg/0.5 mL	4 mg/2 mL
Frequency	BID	BID	Daily	PRN Q4H	PRN Q6H
Route	SubQ	SubQ	PO	IM	IV push
Classification	Anticoagulant	Antidiabetic	Gastric acid proton pump inhibitor	Antiemetic	Antiemetic
Mechanism of Action	This medication inhibits factor Xa and prevents the conversion of prothrombin to thrombin. Thrombin is needed for converting fibrinogen to fibrin; thus stopping clots from forming.	This medication regulates glucose metabolism within the body	This medication inhibits the proton pump in the gastric parietal cells. In turn, this leads to a decrease in gastric acid production and secretion.	This medication acts centrally on the medullary chemoreceptive trigger zone.	This medication acts centrally on the medullary chemoreceptive trigger zone. It acts to reduce nausea and vomiting.
Reason Client Taking	Tx clot prophylaxis	Tx diabetes mellitus type I	Tx ulcer prophylaxis	Tx nausea and vomiting	Tx nausea and vomiting
Contraindications (2)	Breastfeeding, history of heparin-induced	Ethanol, hypersensitivity	Concurrent therapy with rilpivirine products,	angle-closure glaucoma, coma	Hypomagnesemia, hypersensitivity

	thrombocyto-penia		hypersensitivity		
Side Effects/Adverse Reactions (2)	Chills, chest pain	Low blood sugar, weight gain	Anxiety, hyper-glycemia	Akathisia, hyperglycemia	Headache, dizziness
Nursing Considerations (2)	Use heparin cautiously in alcoholics, give only by subcutaneous or IV	Check expiration date, rotate injection sites	Monitor intake and output, do not crush	Use cautiously in elderly patients, administer IM form deep into muscle and rotate sites	Reduce dose with severe hepatic impairment, should not be used instead of NG suction
Key Nursing Assessment(s) Prior to Administration	Assess IV site	Assess injection sites or IV access	Monitor PT and INR	Monitor hematologic status	Monitor magnesium levels
Client Teaching needs (2)	Explain that heparin cannot be taken orally, inform patient of the increased risk of bleeding	Avoid drinking alcohol, report any signs of anxiety, blurred vision, confusion, or depression	Expect relief within two weeks of therapy, swallow medication whole	Avoid alcohol, avoid excessive sun exposure	Report chest pain to the provider, take as prescribed

Medications Reference (APA):

Jones & Bartlett Learning. (2018). *2018 Nurse's drug handbook* (17th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is A&O x 4. He is lying flat in his bed and on his left side. The patient seems fatigued but pleasant. The patient is in moderate pain; no acute distress is noted. Overall appearance x 2.
INTEGUMENTARY (2 points): **Skin color:** Normal for ethnicity **Character:** Pink, dry, and warm to touch **Temperature:** 37.6 **Turgor:** Good **Rashes:** None present **Bruises:** None present **Wounds:** Diabetic wounds present **Braden Score:** 13 **Drains present: Y☐ N■** **Type:**	Patient is Caucasian and presents with a fair complexion. Skin is pink, dry, and warm to touch. The skin turgor and its elasticity is normal with no tenting or abnormal textures present. No rashes or bruises present. There are noted to be diabetic wounds forming on the feet bilaterally. Braden score: 13
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head is normocephalic. The neck is slightly discolored and supple. Ears show no abnormal drainage; the tympanic membrane is visible and pearly grey. Hair is an ash brown color and oily. PERRLA is noted with normal conjunctiva. Nose shows the turbinates equal bilaterally. Oral mucosa is pink and moist with no abnormalities. Patient does not currently wear glasses. It is noted that some teeth are missing on the upper and lower row.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** < 3 seconds **Neck Vein Distention: Y ☐ N■** **Edema Y ☐ N■** **Location of Edema:** N/A	The patient is not currently on telemetry. Heart sounds auscultated and S1 and S2 sounds noted. No murmur is present. Dorsalis pedis pulses graded at 2+ and present bilaterally. Capillary refill was < 3 seconds on the right hand. Patient does not currently have edema. No signs of neck vein distention.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N■**	The lungs were auscultated anteriorly and posteriorly. Lung sounds were noted to be clear,

Breath Sounds: Location, character **ET Tube:** N/A **Size of tube:** N/A **Placement (cm to lip):** N/A **Respiration rate:** N/A **FiO2:** N/A **Total volume (TV):** N/A **PEEP:** N/A **VAP prevention measures:** N/A	but diminished. The patient has no present accessory muscle use when breathing. He reports no shortness of breath at this time.
GASTROINTESTINAL (2 points): **Diet at home:** Regular **Current Diet** **Height:** 182 cm **Weight:** 53.5 kg **Auscultation Bowel sounds:** **Last BM:** 10/06/2020 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ■** **Nasogastric: Y ☐ N ■** **Size:** **Feeding tubes/PEG tube Y ☐ N ■** **Type:**	Patient's current diet is regular at home and in the hospital. He states that he drinks alcohol one-two times per year. Upon auscultation, bowel sounds are active in all four quadrants. He states he does not have pain upon palpation. Abdomen is flat and non-distended. A scar is present on the side of his torso due to a right unilateral nephrectomy performed in 2014. No masses present. No ostomy, nasogastric, or PE tubes present. The patient denies any rapid or current weight loss.
GENITOURINARY (2 Points): **Color:** Straw **Character:** Clear **Quantity of urine:** 500 mL **Pain with urination: Y ☐ N ■** **Dialysis: Y ☐ N ■** **Inspection of genitals:** Not performed **Catheter: Y ☐ N ■** **Type:** **Size:** **CAUTI prevention measures:** N/A	Urine is straw-colored and clear; there was 500 mL voided in my shift. Patient says he feels no pain, hesitancy, or urgency upon urination. Patient's genitals were not assessed. There is no dialysis or catheter present. Patient is on I's and O's.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:**	This patient requires one assist upon albumation. He shows no signs or neurovascular deficit. He exhibits an active range of motion bilaterally. The fall risk score is 45; concluding he is a fall

Strength: **ADL Assistance: Y☐ N■** **Fall Risk: Y☐ N☐** **Fall Score:** 45 **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk■**	risk. He does not require assistive devices. He does not need ADL assistance.
NEUROLOGICAL (2 points): **MAEW: Y■ N☐** **PERLA: Y■ N☐** **Strength Equal: Y■ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	This patient can move all extremities well with some overall malaise present. PERRLA is noted and present upon assessment. He appears fatigued and sleeping. A&O x 4 and LOC x 3. He speaks English well.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient states that he "enjoys watching television and visiting with his parents." His developmental level is noted to be normal. Patient states that he is of the Christian religion. Patient appears to have family support by mention of living with his parents and occasionally seeing his daughter and granddaughter.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0916	94 bpm	102/67 mmHg	30 breaths/ minute	37.7 C	98%
1200	89 bpm	104/68 mmHg	15 breaths/ minute	37.6 C	94%

Vital Sign Trends/Correlation:

Vital sign observations include that at the 0916 check the patient's respiration rate was increased to 30 breaths/minute. Following this, the nurse intervened and placed the patient in

high-Fowler's and continued to monitor him. At the second vital sign check at 1200, his respiration rate was 15 breaths/minute.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	Numeric pain scale	N/A	0	N/A	N/A
1215	Numeric pain scale	Lower back	6	Dull	Administration of acetaminophen 650 mg, reassess pain in one hour

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g **Location of IV:** L. peripheral **Date on IV:** 10/06/2020 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No signs of erythema, drainage or complications present. **IV dressing assessment:** IV dressing is clean, dry, and intact.	Normal saline 0.45% 250 mL/hr
Other Lines (PICC, Port, central line, etc.)	
Type: Implanted port **Size:** N/A **Location:** L. side of chest **Date of insertion:** 10/06/2020 **Patency:** Patent **Signs of erythema, drainage, etc.:** No signs of erythema, drainage or complications present. **Dressing assessment:** Dressing was replaced during my shift. It is now clean, dry, and intact. **Date on dressing:** 10/06/2020 **CUROS caps in place: Y ☐ N** [redacted]	Saline lock

CLABSI prevention measures: N/A	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1,955.4 mL	500 mL

Nursing Care

Summary of Care (2 points)

Overview of care: During my shift, I administered medications orally and heparin subcutaneously to the patient. This patient was ordered to have his intake and output monitored and I documented the amounts during my shift. I completed a head-to-toe assessment on this patient as well. At 0900, the patient did not complain of any pain. Upon assessment of pain at 1215, the patient reports a pain rating of 6/10. I administered Tylenol 650 mg orally and the nurse was to reassess in an hour. Blood glucose monitoring is ordered prior to meals and bedtime.

Procedures/testing done: No procedures or testing done during my shift.

Complaints/Issues: No current complaints or issues present from the patient or his family during my shift.

Vital signs (stable/unstable): After obtaining his vital signs at 0916, his respiration rate was documented at 30 breaths/minute. Following this, the nurse placed him in high-Fowler's and continued to monitor him. After monitoring and a second vital assessment at 1200, his respiration rate had decreased to 15 breaths/minute. No further trends were noted.

Tolerating diet, activity, etc.: The patient is tolerating his regular diet in the hospital well. A gait belt and one assist is needed for ambulation with no ADL assistance needed.

Physician notifications: There are no current notes from the physician regarding this patient at this time.

Future plans for patient: Future plans for this patient include education on stabilizing blood glucose levels, medication compliance, and comfort measures.

Discharge Planning (2 points)

Discharge location: The location of his discharge will be his home where he lives with his elderly parents.

Home health needs (if applicable): There are no home health needs for this patient.

Equipment needs (if applicable): There is no additional equipment needed for this patient.

Follow up plan: The patient is to follow up with his PCP upon discharge to assess his A1C at Sarah Bush Lincoln Health Center in Mattoon, Illinois. He is to continue his chemotherapy.

Education needs: It is vital for this patient to leave the hospital educated on medication compliance, cessation of tobacco, and resources for cessation of substance abuse.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis ● Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** ● Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Ineffective tissue perfusion related to interrupted venous or arterial flow occurring with increased blood viscosity, increased platelet aggregation/ adhesiveness, and patient immobility as evidence by increased BUN and dorsalis pedis pulse grade of 2+.	Following treatment and intervention, the patient's BUN levels decrease and his pedal pulse grade increase.	**1.** Encourage the patient to exercise the extremities Q2H. **2.** Assess peripheral pulses Q2-4H and report significant findings.	During my shift, the patient was instructed to exercise his extremities and was educated on certain exercises to do. He responded well to this intervention. The nurse and I assessed his dorsalis pedis pulse and graded them at 2+. The patient denied any tingling or numbness of the extremities.
2. Deficient knowledge related to unfamiliarity	Within 24 hours of discharge, the patient verbalizes understanding of	**1.** Assess the patient's healthcare literacy.	During my shift, the nurse and I assess the patient's healthcare literacy and overall understanding of his

with the cause, prevention, and treatment of DKA as evidence by his current hospitalization.	the cause, prevention, and treatment of DKA.	**2.** Explain the importance of blood glucose monitoring during episodes of stress, injury, and illness. Caution that DKA necessitates professional medical management and cannot be self-treated.	immunodeficiency. We explained the importance of closely monitoring his blood glucose in times of stress, illness, and his chemotherapy appointments. He was not discharged during my shift; therefore, discharge education had not been performed.
3. Risk for shock related to failure of regulatory mechanisms or decreased circulatory volume occurring with hyperglycemia as evidence by his recent diagnosis of diabetic ketoacidosis.	The patient becomes normovolemic within 10 hours of treatment, as evidence by BP 90/60 mmHg or greater, HR 60-100 bpm, good skin turgor, moist and pink mucous membranes, specific gravity of less than 1.020, and electrolytes are within normal limits.	1. Assess for poor skin turgor, dry mucous membranes, sunken and soft eyeballs, tachycardia, and orthostatic hypotension. **2.** Administer insulin as prescribed**.**	During my shift, the nurse and I monitored his vital signs for indications of hypovolemic shock. We also assessed his skin turgor and mucous membranes for signs of hypovolemia. No signs of hypovolemia were present. He was administered insulin via IV for fast-acting intervention.
4. Risk for electrolyte imbalance related to failure of regulatory mechanisms or decreased circulatory volume occurring with hyperglycemia as evidence by his recent diagnosis of diabetic ketoacidosis	The patient's lab values noted to show electrolyte imbalance upon arrival to the ED. Upon discharge, the goal is to have his electrolytes levels within normal limits.	1. Administer IV fluids as prescribed. 2. Assess for signs and symptoms of hypovolemic shock, which include changes in vital signs.	During my shift, the patient was administered 0.45% NS via IV. His vital signs were assessed Q2-4H and no indication of hypovolemic shock was present.

and unbalanced levels of electrolytes.			
5. Risk for injury related to altered cerebral function occurring with dehydration or cerebral edema associated with DKA as evidence by his report of overall weakness and increased levels of BUN**.**	The patient verbalizes orientation to person, place, and time and doesn't demonstrate significant change in mental status. Normal breath sounds are auscultated over the patient's airway.	1. Assess the patient's mental status, orientation, and LOC. Assess respiratory status and airway patency. **2.** Maintain bed in lowest position, monitor the patient closely, and keep the side rails up at all times.	During my shift, the patient's mental status and level of consciousness were noted to be normal. LOC x 3. His respiratory status and airway patency were **a**ssessed Q2-4H. His bed was in the lowest position and he was on fall precautions. He was placed in a room that was closest to the nurses' station and monitored closely.

Other References (APA):

Swearingen, P. L. (2016). *All-in-one care planning resource: Medical-surgical, pediatric, maternity & psychiatric nursing care plans.* Elsevier/Mosby.

Concept Map (20 Points):

Attached separately

Subjective Data **Nursing Diagnosis/Outco**