N431 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 10-08-2020	**Patient Initials** S.S	**Age** 70 years	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Plumbing & Heating	**Marital Status** Married	**Allergies** No Allergies
Code Status Full Code	**Height** 171.5 cm	**Weight** 91.5 kg	

Medical History (5 Points)

Past Medical History: Hyponatremia, hypotensive episode, chemotherapy, anemia, adenocarcinoma of colon, colon cancer stage III, cough, fever, arthritis, at risk for infection, fall risk, hypercholesteremia, hypertension, impaired gas exchange, impaired mobility, impaired skin integrity, mass of hepatic flexure of colon, rectal bleeding, right colectomy, & blood clot in vein

Past Surgical History: Colonoscopy with biopsy, colon resection of small intestine, excision of ileum, partial excision of stomach, excision of transverse colon, partial resection of large intestine, colonoscopy high risk, & esophagogastroduodenoscopy biopsy

Family History: Mom- had cancer (unknown what kind) Dad- had cancer (unknown what kind)

Social History (tobacco/alcohol/drugs): The patient is a past user of alcohol for 35 years. The patient has never used tobacco or taken any drugs.

Assistive Devices: The patient currently does not use any types of assistive devices.

Living Situation: The patient currently lives at his home with his wife. S.S feels safe at his home.

Education Level: S.S highest level of education is high school.

Admission Assessment

Chief Complaint (2 points): Fever, cough, hypotension

History of present Illness (10 points): The patient came into the emergency department due to not feeling well in the past week. S.S reported having symptoms such as a fever and a cough. Along with that, he states his systolic blood pressure has been running in the ’80s. S.S included that he has not drunk many fluids or eaten much food due to feeling nauseated. He states food aggravated his nausea, and he has been using acetaminophen to control his fever. The patient said that he was never in any pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Hyponatremia

Secondary Diagnosis (if applicable): Orthostatic Hypotension

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

S.S came into the hospital due to having low blood pressure and a fever. After arriving at the hospital, he took blood work to determine that his low sodium levels caused the problem. Dehydration can cause a loss of sodium, and it is known as hypovolemic hyponatremia (Capriotti & Frizzell, 2016). Low sodium levels can occur due to adrenal insufficiency, osmotic diuresis, diuretic use, and salt-losing nephritis (Capriotti & Frizzell, 2016). Some of the causes of hyponatremia are vomiting, diarrhea, sweating, cystic fibrosis, gastric lavage, fistulas, burns, and wounds (Capriotti & Frizzell, 2016). Hyponatremia will ultimately cause the patient's heart to work harder and cause the patient to hypotension (Capriotti & Frizzell, 2016). With the hypotension, the patient can experience neurologic problems such as a change in the mental status and status epilepticus (Hinkle & Cheever, 2018). Also, hyponatremia affects the kidneys due to low urinary output because of the decrease of fluid in the body (Capriotti & Frizzell, 2016).

Along with that, SIADH can also cause hyponatremia (Hinkle & Cheever, 2018). The SIADH disturbances include an excessive amount of ADH activity, water retention, and an inappropriate urinary output of sodium (Hinkle & Cheever, 2018). ADH's sustained release by the hypothalamus or production of ADH-like substance from a tumor can cause a decrease in sodium (Hinkle & Cheever, 2018). The SIADH disturbance ultimately will cause the patient to have hyponatremia (Hinkle & Cheever, 2018).

Hyponatremia will cause the patient to experience multiple signs and symptoms. The patient could have poor skin turgor, dry mucosa, headaches, decreased saliva production, nausea, vomiting, and orthostatic hypotension (Hinkle & Cheever, 2018). A hyponatremic patient can also experience an altered mental status, seizures, and possibly a coma (Hinkle & Cheever, 2018). The patient that has hyponatremia will have tachycardia and orthostatic hypotension (Capriotti & Frizzell, 2016). Decreased serum and urine sodium, decreased urine specific gravity, and osmolality is some labs that correspond with low sodium levels (Hinkle & Cheever, 2018). The test that will help diagnose low sodium levels is a complete metabolic panel, a urine sodium test, and a urinalysis (Hinkle & Cheever, 2018).

S.S. received a CMP and a urinalysis to help find the diagnosis of hyponatremia. He also received sodium chloride fluids at a continuous rate for his treatment plan. Along with that, S.S. receives acetaminophen to help lower his fever and receive a C.T. scan of his abdomen to visualize his bowel and organs. He came into the hospital with a sodium level at 125 and having orthostatic hypotension. After giving him fluids to correct hyponatremia, the sodium levels have risen to 131, and so did his blood pressure.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives.* F.A. Davis Company.

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

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	3.80-5.41	3.40	2.86	The patient is experiencing a loss of red blood cells due to having colon cancer (Healthline, 2019).
Hgb	11.3-15.2	12.0	10.1	The patient has a low hemoglobin count due to having stage III colon cancer (Mayo Clinic, 2020).
Hct	33.2-45.3%	33.7	28.2	The patient has a decreased hematocrit count due to his cancer (Hinkle & Cheever, 2018).
Platelets	149-493	106	80	The patient has a decrease in platelets due to taking rivaroxaban and heparin (Hinkle & Cheever, 2018).
WBC	4-11.7	3.7	4.3	The patient has a decrease in white blood cells due to having cancer and receiving chemotherapy treatments (Mayo Clinic, 2018).
Neutrophils	45.3-79	N/A	N/A	N/A
Lymphocytes	11.8-45.9	N/A	N/A	N/A
Monocytes	4.4-12.0	N/A	N/A	N/A
Eosinophils	0.0-6.3	N/A	N/A	N/A
Bands	<1.0	0.0	1.0	The patient has a slight increase in bands due to having colon cancer (Hinkle & Cheever, 2018).

Chemistry 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
Na-	135-145	125	131	The patient has hyponatremia due to being dehydrated (Capriotti & Frizzell, 2016).
K+	3.5-5.1	3.7	3.4	S.S has low potassium due to not consuming any food in the past week (Capriotti & Frizzell, 2016).
Cl-	98-107	97	107	The patient has low chloride levels due to not having much to drink in the past week (Hinkle & Cheever, 2018).
CO2	22-29	22	20	The patient has low carbon dioxide levels in the blood due to having a history of impaired gas exchange (Hinkle & Cheever, 2018).
Glucose	70-99	127	106	The patient has elevated glucose due to being slightly ill and inactive (Mayo Clinic, 2020).
BUN	6-20	18	8	Lab value was normal
Creatinine	0.5-0.9	0.9	0.5	Lab value was normal
Albumin	3.5-5.2	3.3	N/A	The patient has low albumin level due to having a chronic infection such as cancer (Healthline, 2018).
Calcium	8.6-10.4	8.3	7.6	The patient has hypocalcemia levels due to having an inadequate diet of vitamin D (Capriotti & Frizzell, 2016). The patient has not eaten or drank very much in the past week.
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	0.9	N/A	Lab value was normal
Alk Phos	35-105	125	N/A	High levels of alkaline phosphatase are elevated due to having stage III colon cancer (Healthline, 2019).

AST	0-32	68	N/A	The patient has elevated aspartate transaminase levels due to taking acetaminophen (Mayo Clinic, 2020).
ALT	0-33	44	N/A	S.S has an increase in alanine transaminase levels due to taking acetaminophen (Mayo Clinic, 2020).
Amylase	30-110	N/A	N/A	N/A
Lipase	12-70	N/A	N/A	N/A
Lactic Acid	0.5-2.4	1.0	N/A	Lab value was normal
Troponin	0-0.4	0.01	N/A	Lab value was normal
CK-MB	0-4.9	N/A	N/A	N/A
Total CK	22-198	N/A	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	Today's Value	Reason for Abnormal
INR	0.86-1.14	N/A	N/A	N/A
PT	11.9-15	N/A	N/A	N/A
PTT	25-40	N/A	N/A	N/A
D-Dimer	<500	N/A	N/A	N/A
BNP	<125	N/A	N/A	N/A
HDL	40-80	N/A	N/A	N/A
LDL	85-125	N/A	N/A	N/A
Cholesterol	<170	N/A	N/A	N/A
Triglycerides	50-150	N/A	N/A	N/A
Hgb A1c	<6%	N/A	N/A	N/A
TSH	0.5-5	1.91	N/A	Lab value was normal

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	Yellow, Clear	Amber/ Hazy	N/A	The patient has amber color of urine due to being slightly dehydrated (Hinkle & Cheever, 2018).
pH	5.0-8.0	5.0	N/A	Lab value was normal
Specific Gravity	1.005-1.034	1.024	N/A	Lab value was normal
Glucose	normal	Normal	N/A	Lab value was normal
Protein	Negative-Normal	1+	N/A	The patient has protein in his urine due to the fever he had when he was admitted (Mayo Clinic, 2020).
Ketones	Negative	Negative	N/A	Lab value was normal
WBC	<5	3	N/A	Lab value was normal
RBC	0-3	<1	N/A	Lab value was normal
Leukoesterase	Negative	Negative	N/A	Lab value was normal

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	N/A	N/A	N/A
PaCO2	35-45	N/A	N/A	N/A
HCO3	22-26	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	Today's Value	Explanation of Findings
Urine Culture	Negative	Negative	N/A	Lab value was normal
Blood Culture	Negative	Negative	N/A	Lab value was normal
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (APA):

ATI (2019). *Content mastery series review module: RN adult medical surgical nursing* (11th ed.). Assessment Technologies Institute, LLC.

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives.* F.A. Davis Company.

Healthline. (2019, January 24). ALP (alkaline phosphatase level) test. https://www.healthline.com/health/alp#results

Healthline. (2019, June 26). *Understanding the connection between anemia and cancer.* https://www.healthline.com/health/cancer/anemia-cancer#:~:text=Colon%20cancer%20is%20caused%20by,cells%2C%20which%20commonly%20causes%20anemia.

Healthline. (2018, September 2). What is hypoalbuminemia and how is it treated. https://www.healthline.com/health/hypoalbuminemia#causes-and-risk-factors

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

Mayo Clinic. (2020, March 5). *Elevated liver enzymes.* https://www.mayoclinic.org/symptoms/elevated-liver-enzymes/basics/causes/sym-20050830

Mayo Clinic. (2020, June 27). *Hyperglycemia in diabetes.* https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631

Mayo Clinic. (2020, September 22). *Low hemoglobin count causes.* https://www.mayoclinic.org/symptoms/low-hemoglobin/basics/causes/sym-20050760

Mayo Clinic. (2018, November 30). *Low white blood cell count causes.* https://www.mayoclinic.org/symptoms/low-white-blood-cell-count/basics/causes/sym-20050615

Mayo Clinic. (2020, April 21). *Protein in urine.* https://www.mayoclinic.org/symptoms/protein-in-urine/basics/causes/sym-20050656

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's comprehensive handbook of laboratory and diagnostic tests with nursing implications* (7 ed.). F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1. The patient received a CT of the abdomen and the pelvis due to having a fever.
2. The patient received a chest x-ray due to having a cough.
3. S.S had an EKG done to visualize the electrical activity of the heart.

Diagnostic Test Correlation (5 points):

1. A CT scan of the abdomen and pelvis help detect a disease caused by the colon, bowel, and the other internal organs (Radiological Society of North America and

American College of Radiology, 2018). The provider had this done to find out the reason the patient has a fever. S.S also has stage three colon cancer. The results showed a mildly enlarged spleen, linear bibasilar opacities, and mild retroperitoneal adenopathy.

2. A chest x-ray is essential to help diagnose infections in the respiratory tract. With a chest, x-ray foreign bodies can be readily visible, indicating an infection in the lungs (Hinkle & Cheever, 2018). The patient's x-ray results showed no infection signs, no pneumothorax, and no signs of a pleural effusion.
3. An electrocardiogram is a graphic representation of the heart's electrical activity (Hinkle & Cheever, 2018). An electrocardiogram is essential to diagnose dysrhythmias, conduction abnormalities, chamber enlargement, and myocardial infarction (Hinkle & Cheever, 2018). S.S electrocardiogram showed sinus rhythm with first-degree heart block.

Diagnostic Test Reference (APA):

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

Radiological Society of North America and American College of Radiology. (2018, June 18). *Abdominal and pelvic CT*. https://www.radiologyinfo.org/en/info.cfm?pg=abdominct

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

Home Medications (5 required)

Brand/Generic	Xarelto/ rivaroxaban	Feosol/ ferrous sulfate	Tylenol/ acetaminophen	Lidopril /lidocaine-	Prinivil/ lisinopril

				prilocaine	
Dose	20 mg	325 mg	1000 mg	2.5%-2.5%	10 mg
Frequency	1 tablet daily	1 tablet TID	2 tablet every 6 hours PRN	One application PRN	1 tablet daily
Route	PO	PO	PO	Topical	PO
Classification	Anticoagulant	Trace element, mineral	Nonnarcotic analgesic antipyretic	Amides	ACE Inhibitor
Mechanism of Action	Selectively blocks the active site of factor Xa.	Acts to normalize RBC production by binding with hemoglobin.	Acts directly on the hypothalamus to increase vasodilation and sweating.	Diminishes pain by blocking nerve conduction.	Blocks the enzyme that normally converts angiotensin I to the potent vasoconstrictor angiotensin II.
Reason Client Taking	Prevention of DVT and PE	To treat iron deficiency	Fever	To numb the skin before invasive procedure like IV insertion or injections	Hypertension
Contraindications (2)	1.Bleeding 2.GI ulcerations	1.Hemolytic anemias 2.Hemochromatosis	1.Severe hepatic impairment 2.Severe active liver disease	1.Severe heart block (without pacemaker) 2.Adams-Stokes Syndrome	1.Patients with Renal Impairment 2.Hereditary or idiopathic angioedema
Side Effects/Adverse Reactions (2)	1.Abdominal Pain 2.Pulmonary hemorrhage	1.Chest pain 2.Hypotension	1.Oliguria 2.Pruritus	1.Respiratory arrest 2.Swelling	1.Arrhythmias 2.Cough
Nursing Considerations (2)	1.Be aware the rivaroxaban can not be given with prosthetic heart valves. 2. Provide bleeding precautions when providing care	1.Unabsored iron can turn the black or green. 2.Don’t give the patient dairy products within one hour before administration and two hours after	1.The antidote for acetaminophen is acetylcysteine 2.Blood or albumin in the urine may indicate nephritis	1.Apply the ointment to gauze or bandage before applying to skin 2.Apply the ointment about 1/8 inch	1.Use lisinopril cautiously in patients with fluid volume deficit 2.Notify the provider if the patient has a nonproductive cough

				thick.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1.Monitor the patient for bleeding 2.Monitor the patient platelet counts	1.Assess the patient for signs of iron overdose. 2. Monitor for an increase in RBC's, hematocrit, hemoglobulin, and reticulocyte count.	1.Monitor AST and ALT levels. Monitor the patient's creatinine levels.	1.Monitor the patients vital signs 2.Assess the patient for signs of malignant hyperthermia	1.Monitor the patients blood pressure before administering 2.Monitor the patients serum potassium level
Client Teaching needs (2)	1.Advise the patient to report any unusual bleeding 2.Take this medication with food	1. Urge the patient to eat chicken, fish, lean, and red meat. 2. Caution the patient to not take antacids or calcium supplements within one hour before administration and two hours after	1.Teach the patient to not exceed recommended dosage. 2.Teach the patient the sign of hepatotoxicity, such as bleeding and easy bruising.	1.Tell the patient the are will become numb in 20 to 60 minutes 2.Caution the patient to keep topical preparations out of reach of children and pets.	1.Advise the patient to take lisinopril at the same time everyday 2.Caution the patient to use salt substitutes that contain potassium

Hospital Medications (5 required)

Brand/Generic	Rocephin/ ceftriaxone	Flagyl/ metronidazole	Kato/ potassium chloride	Vancocin/ vancomycin	Hepalean/ heparin
Dose	1000 mg/ 100 mL	500 mg/ 100 mL	20 meq	1250 mg/ 250 mL	300 units/ 3mL
Frequency	200 mL/hour every 24 hours	200 mL/hour every 8 hours	One time only	250 mL/hour every 12 hours	PRN
Route	IV piggy back	IV piggy back	PO	IV piggy back	IV push
Classification	Cephalosporin	Nitroimidazole derivative	Electrolyte cation	Carbapenems	Anticoagulant

Mechanism of Action	Interferes with bacterial cell wall synthesis by inhibiting cross-linking of peptidoglycan strands	Damages DNA's helical structure and breaks its strands, which stops bacterial nucleic acid synthesis and cause cell death.	A major intracellular cation involved in nerve impulse conduction, cardiac skeletal, smooth muscle contraction, and maintain normal renal fixation	Inhibit synthesis of bacterial cell walls by binding with penicillin-binding proteins	Combines with antithrombin III to inactivate clotting factors IX, X, XI, and XII. Heparin inhibits the conversion of prothrombin to thrombin
Reason Client Taking	To treat an infection of gram-negative and gram-positive bacteria	To treat anerobic infections	To treat hypokalemia	To fight infections, cause by wide range of bacteria	To prevent clotting in the central line IV port
Contraindications (2)	1.Previous severe anaphylactic reaction to penicillin 2.Cephalosporin allergy	1.Hepatic impairment 2.Hypersensitivity to metronidazole or its components	1.Acute dehydration 2.Addisons disease	1.Severe penicillin allergy 2.Hypersensitivity to meropenem	1.history of heparin-induced thrombocytopenia 2.Uncontrolled bleeding
Side Effects/Adverse Reactions (2)	1.Acute renal failure 2.Analphylaxis	1.Confusion 2.Dry mouth	1.Dyspnea 2.Rash	1.Ototoxicity 2.Acute kidney injury	1.Adrenal hemorrhage 2.Easy bruising
Nursing Considerations (2)	1.Calcium-containing products must not be given I.V. within 48 hours. 2.Obtain culture and sensitivity results if possible before giving the drug	1.Use cautiously in patients with central nervous system diseases 2.Use cautiously with patients that have severe liver disease	1.Administer oral potassium with or immediately after meals 2.Do not crush controlled release or extended release tablets	1.Monitor the patient for signs of clostridium difficile 2.Take seizure precaution while the patient is on vancomycin	1.Have protamine sulfated available 2.Make sure all health care providers know the patient is receiving heparin
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1.Monitor BUN and creatinine levels 2.Assess bowel pattern daily	1.Monitor CBC and culture and sensitivity if the therapy is longer than 10 days 2.Assess the patient's neurological status	1.Monitor serum potassium levels before administering 2.Monitor serum creatinine and urine output of the patient	1.Monitor BUN and creatinine levels 2.Assess the patients hearing during therapy	1.Monitor the patient for signs of bleeding 2. Monitor the patient coagulation labs before administering

Client Teaching needs (2)	1.Urge the patient to report watery, bloody diarrhea. 2. Tell the patient to report evidence of blood dyscrasia	1.Tell the patient to take with food to avoid GI upset 2.Avoid alcohol during the drug therapy and 3 days after therapy	1.Avise the patient to watch for stool changes such as black stools 2.Teach the patient how to take her radial pulse and to notify the provider of changes in heart rhythm or rate	1.Instruct the patient to complete the full course of the vancomycin 2.Instruct the patient to notify the provider if he or she develops diarrhea	1.Instruct the patient to watch for any signs of bleeding and notify the provider if excessive bleeding is suspected 2. Encourage the patient to carry an appropriate medical identification card

Medications Reference (APA):

Frandsen, Geralyn. (2020). *Abrams clinical drug therapy: Rationales for nursing practice*. S.l.: Wolters Kluwer Medical.

Jones & Bartlett Learning. (2019). *Nurses drug handbook.*

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was A&O x 4. Overall, he was not under any stress and his overall appearance looked really good.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	S.S skin color was normal for his ethnicity and is warm to touch. His skin was elastic, intact, and returned when it was pulled on. S.S had no apparent bruises, rashes, wounds, or drains. The patient's Braden score is a 21.

HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient head was normocephalic. His ears were intact with slight cerumen and the tympanic membrane was pearly gray. The eyes were intact and PEERLA is noted. There was no nasal drainage or deviations. The patient did have some teeth missing and the patient's trachea was midline. S.S did not have any swollen lymph nodes.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	The patient had normal S1 and S2 sounds. There was no murmur or gallops heard and the rhythm was normal. The patient's peripheral pulses were palpated and they were graded at a 3+. His capillary refill was under 3 seconds. S.S also did not have any neck vein distention or edema on his body.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The patient respiratory sounds were heard in all lobes. S.S did have inspiratory wheezing in all lobes. There was no rhonchi or crackle heard. Along with that, no accessory muscles were used while breathing.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	The patient is on a regular diet currently and at home. His height was 171.5 centimeters and he weighs 91.5 kilograms. The bowel sounds were active in all four quadrants and his last bowel movement was this morning. He did not have any pain or mass when his abdomen was palpated. The patient's abdomen was rounded, did not have any incision, drains, or wounds. He does have some scars due to the bowel resections he had in the past. S.S did not have an ostomy bag, a nasogastric tube, or a feeding tube.
GENITOURINARY (2 Points): **Color:**	The patient's urine color was slightly amber and hazy. He has been able to urinate a normal

Character: **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	amount and states that he has no pain with urination. The patient does not go through dialysis and he does not have a catheter.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	S.S had feeling in all his limb with no signs of discoloration. He had range of motion in all limbs and he does not use any supportive devices. S.S had great strength in all four limbs. Along with that he does not require assistance with his activities of daily living. The patient is not a fall risk and his score are a 35. Overall, he is an independent individual and does not need equipment and he needs very little support to stand and walk.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient is able to move all extremities well and strength was equal in all limbs. He is A & O x 4 and PERLA is noted. His mental status is normal for his age and his speech was not slurred or mumbled. S.S had sensory in his whole body and he was fully conscious.
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):**	The patient is not under any stress and he is developed for his age. S.S is a catholic and his support person is his wife. The patient's wife means a lot to him.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0400	81 BPM	120/69	18 BPM	36.9℃	95%

		mmHg			
0730	78 BPM	130/77 mmHg	22 BPM	37.2℃	96%

Vital Sign Trends:

The patient's 0400 vitals were all at normal levels. At 0730, his pulse, temperature, and oxygen saturation were regular once again. S.S's blood pressure and his respirations did show a slight elevation. His blood pressure was 130/77, and the respiration was 22 breaths per minute.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	Numeric	The patient was not under any pain	0/10	N/A	N/A
1000	Numeric	The patient was not under any pain	0/10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** Implanted port right upper chest **Date on IV:** N/A-patient has had for a long time because of cancer **Patency of IV:** No signs of phlebitis or infiltration **Signs of erythema, drainage, etc.:** No signs of drainage, erythema at the IV site **IV dressing assessment:** The port is intact, dry, and clean	sodium chloride 0.9%-1000mL given IV drip at a continuous infusion at 100 mL/hour ceftriaxone 1000mg/100 mL given IV piggy back at 200 mL/hour every 24 hours metronidazole 500mg/100mL given IV piggy back at 200mL/hour every 8 hours vancomycin 1250mg/250mL given IV piggy back at 250mL/hour every 12 hours

	heparin 300 units/3mL given IV push as needed

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
1050 mL	The patient's output was not recorded

Nursing Care

Summary of Care (2 points)

Overview of care: I first took the patient's vital signs at 0700. His blood pressure and respiration were slightly elevated; other than that, they were normal. I then gave S.S his medication at 0830. The drug that was given to him was ferrous sulfate due to having anemia. After that, I assessed the patient at the bedside. The patient had inspiratory wheezes in all lobes of his lungs. Everything else that I assessed was within normal limits.

Procedures/testing done: The patient did not receive any procedures or test on my shift.

Complaints/Issues: The patient had no complaints during my time with him.

Vital signs (stable/unstable): For the most part, the patient's vital signs were stable. His 0400 vitals were all in the normal ranges. The patient's vital signs at 0730 were all in normal range except for his respiration and blood pressure. His respirations were slightly elevated at 22 breaths per minute, and his blood pressure was also elevated at 130/77 mmHg.

Tolerating diet, activity, etc.: The patient is on a regular diet and he is tolerating it well. He is also tolerating his activity well.

Physician notifications: The physician did not have any notifications and did not see the patient during my shift.

Future plans for patient: The future plan for S.S are to get him sent back to his home today.

Discharge Planning (2 points)

Discharge location: The patient will be discharged back to his home with his wife.

Home health needs (if applicable): The patient does not need any specific home health needs.

Equipment needs (if applicable): The patient will need a blood pressure cuff to monitor his blood pressure to make sure he does not go into a hypotensive state.

Follow up plan: The patient will likely need a follow up with his primary provider to recheck his labs to make sure they are in the normal ranges.

Education needs: The patient will need to be educated on how to check his blood pressure and how often he should check it. Along with that, he should stay compliant with his medication and go to the emergency room again if his symptoms come back.

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. Dyspnea related to ineffective inspiration and as evidenced by the client have inspiratory wheezes in all lobes.	The patient having wheezes	1. Auscultate the patient's respiratory status every 2-4 hours. 2.Monitor the patient's pulse oximetry continuously.	1.The patients breathing sounds did not worsen throughout the shift. 2.The patients pulse oximetry readings stayed at 95% or better.

2. Potential for bleeding related to thrombocytopenia and as evidenced by the patient's platelet count being at 80.	Thrombocytopenia	1. Perform the baseline physical assessment to assess for any bleeding. 2.Implement and teach the patient measures that will prevent potential bleeding.	1. The client shown no signs of bleeding during the assessment. 2. The patient understood that he should not use an electrical shaver or take NAIDs.
3. Decreased multisystem tissue perfusion related to decreased circulating blood and as evidenced by the client having orthostatic hypotension.	Orthostatic Hypotension	1. Assess the patient's blood pressure routinely. 2. Assess the patient for adequate peripheral perfusion to all limbs.	1.The patient maintained a systolic blood pressure above 90 mmHg. 2.The patient had 3+ pulses on all peripheral sites.
4. Potential for fluid and electrolyte imbalances related to the kidneys inability to maintain biochemical homeostasis and as evidenced by the patient's abnormal electrolyte values.	Hyponatremia	1.Assess for and alert the provider for indicators of alterations in fluids. 2. Maintain an adequate fluid and nutritional intake.	1.The patient sodium levels started to rise and the patient did not show any signs of fluid imbalances. 2.The patient drank an adequate amount of fluid and ate all of his breakfast.

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. Elsevier.

Concept Map (20 Points):

Subjective Data

The patient stated that his pain was a zero
The patient stated that he did not have any pain when palpating his abdomen
S.S stated that he had a bowel movement this morning
He stated that he does not have pain when he urinates

Nursing Diagnosis/Outcomes

Dyspnea due to ineffective inspirations.
Maintain a pulse oximetry of 95% or greater.
Potential for bleeding due to having thrombocytopenia.
The client shown no apparent signs of bleeding.
Decrease tissue perfusion due to a decrease in circulation blood.
The patient had 3+ pules at all peripheral sites.
Potential for fluid and electrolyte imbalances due to the kidneys inability to have a biochemical homeostasis.
The patient drank a good amount of fluid and ate his breakfast.

Objective Data

The patient's sodium levels were 126 & 131
His blood pressure 130/77 mmHg
His respirations are 22 BPM
His RBC was 3.40 & 2.86
The chest x-ray was negative
The abdominal and pelvic CT showed linear bibasilar opacities, a mildly enlarged spleen, and mild retroperitoneal adenopathy
The patient's platelet count was 80

Patient Information

The 70-year-old male is admitted due to having a fever, a cough, and orthostatic hypotension.

Nursing Interventions

Nursing diagnosis #1
Auscultate the patient's lung sounds every 2-4 hours
Monitor the patients pulse oximetry readings
Nursing diagnosis #2
Perform a physical assessment to assess for any bleeding
Teach the patient about bleeding precautions
Nursing diagnosis #3
Check the patient's blood pressure multiple times
Check the patient's peripheral pulses
Nursing diagnosis #4
Alert the provider for signs of fluid imbalances
Encourage the patient to drink a good amount of fluids and eat nutritious food.