

N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 10/19/2020	Patient Initials RF	Age 66	Gender Male
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Married	Allergies Codeine (stomach cramps)
Code Status Full Code	Height 185 cm	Weight 122.5 kg	

Medical History (5 Points)

Past Medical History: hematuria, H/O squamous cell carcinoma, fall risk, cough, advanced COPD, lung cancer, HTN, hyperlipidemia, lumbar herniated disc disease, morbid obesity, chronic GERD, osteoarthritis, sinusitis, wheezing, right subscapular pain, pain in left hand

Past Surgical History: Left upper lobectomy (2017), EGD biopsy (11/14/ 2018) colonoscopy polypectomy with snare (11/06/2019), Dates unknown for: ankle, shoulder, tonsillectomy, herniorrhaphy, colonoscopy

Family History: Father: bone cancer, Mother: cervical cancer, colon cancer, Brother: prostate cancer

Social History (tobacco/alcohol/drugs): Patient is a former smoker, he quit in 2018. Patient admits to drinking a beer daily. Patient denies the use of illicit drugs.

Assistive Devices: Patient has glasses and an upper set of dentures.

Living Situation: Patient lives at home with his spouse.

Education Level: N/A

Admission Assessment

Chief Complaint (2 points): Patient came into the ED with complaint of abdominal pain and nausea and vomiting.

History of present Illness (10 points): Patient arrived at the ED complaining of severe abdominal pain that comes and goes. Patient stated he had similar abdominal pain about a month prior; however, the problem went away on its own. Patient admits to nausea and vomiting twice before coming into the ED. Patient describes the pain as diffuse abdominal cramping that caused him so much pain he thought he would pass out. Patient rates his pain as a 10/10. Patient has not been able to relieve the abdominal pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Splenic Laceration

Secondary Diagnosis (if applicable): Abdominal pain

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

According to Hinkle & Cheever (2018), the spleen is made up of lymphoid tissue and acts as a filter by collecting and destroying old red blood cells in the spleen's red pulp portion. The spleen also contains B and T lymphocytes found in the white pulp and are responsible for fighting infection (Hinkle & Cheever, 2018). Due to the high vascularity of the spleen, injury can cause extreme blood loss. Damage to the spleen often occurs during some form of abdominal trauma. Types of trauma include penetrating, blunt and indirect trauma. An example of penetrating trauma would be a gunshot wound. An example of blunt trauma would be a direct blow to the upper left quadrant of the abdomen, and indirect trauma would be a tear in the splenic capsule, resulting from a colonoscopy or traction (Waseem & Bjerke, 2020).

Symptoms of splenic laceration or injury include left upper quadrant pain and abdominal distension. RF complained of severe abdominal pain, especially on his left side. There is also the possibility of the patient experiencing left shoulder pain. Patients may also present with tenderness or rigidity upon palpation. RF complained of tenderness upon palpation and

percussion of his abdomen. If the patient has internal bleeding, they can show hypovolemic shock symptoms such as hypotension and tachycardia. RF did present with tachycardia; his heart rate never dropped below 100 beats per minute. The patient may also complain of left-sided chest pain (Waseem & Bjerke, 2020). Splenic injury can also present with rebound tenderness, guarding, nausea, diaphoresis, syncope, fatigue, and blurred vision (University of Connecticut, 2020). Patients with splenic laceration and hemorrhage may also have decreased hemoglobin. If there is an infection, it is also possible to have elevated WBCs. Elevated RBCs may also be present. RF did have a high WBC count.

Diagnostics for splenic laceration or injury include focused assessment with sonography for trauma (FAST). This test quickly identifies intraperitoneal fluid and is useful in hemodynamically unstable patients. Computed tomography (CT) is also essential with diagnostics.

A CT scan can locate hematomas and abnormal splenic structure (Waseem & Bjerke, 2020). RF had a CT angiography of the chest and abdomen. An MRI may also be utilized and is a good option for those who are allergic to the contrast dye often used with CT scans. A chest x-ray may also be used to identify a broken rib or other broken bone, which may have caused the splenic injury. Chest x-rays can also determine the heart's size, the diaphragm, and pleural effusion or pneumothorax (Hinkle & Cheever, 2018). RF had a chest x-ray to rule out complications.

According to Mayo Clinic (2019), treatment for splenic injury can be surgical or non, depending on the severity of the damage. For patients who do not require surgery, they stay in the hospital under observation. RF was in the hospital under observation. During this time, patients may receive blood transfusions as necessary. Surgical intervention may involve suturing

the spleen to repair the laceration or rupture. Removal of part of the spleen or the complete removal of the spleen is another surgical intervention that may be an option for those who have injury beyond repair (Mayo Clinic, 2019).

Pathophysiology References (2) (APA):

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

Korey Stringer Institute. (2020). Splenic Injury. *University of Connecticut*. <https://ksi.uconn.edu/emergency-conditions/internal-trauma/splenic-injury/#>

Mayo Clinic Staff. (2019). Ruptured spleen. *Mayo Clinic*. <https://www.mayoclinic.org/diseases-conditions/ruptured-spleen/diagnosis-treatment/drc-20352322>

Waseem M., Bjerke S. (2020). Splenic injury. *StatPearls Publishing*
<https://www.ncbi.nlm.nih.gov/books/NBK441993/>

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	3.9 – 4.98	3.98	4.05	
Hgb	12 – 15.5g/dl	12.5	12.5	
Hct	34 – 45%	36.5	37.1	
Platelets	150 - 400	377	296	
WBC	4.0 – 9.0	9.6	11.1	Patient may have possible infection (Hinkle & Cheever, 2018).
Neutrophils	40 – 70%	90.2	89.3	Patient may have possible infection (Hinkle & Cheever, 2018).
Lymphocytes	20 – 50%	7.1	3.8	Patient's lymphocyte count may be low due to splenic laceration. The spleen contains lymphocytes and the damage has caused the numbers to reduce (Hinkle & Cheever, 2018).

Monocytes	2 - 12%	2.2	6.4	
Eosinophils	0- 6.3%	0.1	0.1	
Bands	0 - 6	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	Today's Value	Reason For Abnormal
Na-	135 -145	135	134	
K+	3.5 – 5	4.0	4.6	
Cl-	98 – 107	102	101	
CO2	22 – 30	25	22	
Glucose	70 -99	141	150	Patient's blood glucose levels are likely elevated due to prescribed methylprednisolone (Hinkle & Cheever, 2018).
BUN	6 - 20	16	23	
Creatinine	0.5 – 1.2	0.89	1.12	
Albumin	3.5 – 5.2	3.5	N/A	
Calcium	8.4 – 10.5	8.5	7.7	Patient may have insufficient intake of calcium (Hinkle & Cheever, 2018).
Mag	1.6 – 2.4	N/A	1.6	
Phosphate	2.5 – 4.5	N/A	N/A	
Bilirubin	0 – 1.2	1.2	N/A	
Alk Phos	35 - 105	N/A	N/A	
AST	0 – 32	N/A	N/A	

ALT	24 - 26	N/A	N/A	
Amylase	23 - 85	N/A	N/A	
Lipase	0 - 160	N/A	N/A	
Lactic Acid	0.5 - 1	N/A	N/A	
Troponin	<0.03 ng/ml	N/A	N/A	
CK-MB	0%	N/A	N/A	
Total CK	30 – 170 units/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	Today's Value	Reason for Abnormal
INR	0.8 – 1.2	1.12	N/A	
PT	11.5 – 15 sec	14.8	N/A	
PTT	23.5 – 37.5 sec	32.7	N/A	
D-Dimer	< 0.4	N/A	N/A	
BNP	0 -100	N/A	N/A	
HDL	>40 mg/dl	N/A	N/A	
LDL	<130 mg/dl	N/A	N/A	
Cholesterol	<200 mg/dl	N/A	N/A	
Triglycerides	<150 mg/dl	N/A	N/A	
Hgb A1c	0 – 5.7	5.7	N/A	
TSH	0.45 – 5.33	5.47	N/A	Patient may have hypothyroidism (Hinkle & Cheever, 2018).

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	Yellow & clear	N/A	
pH	6.0	6.0	N/A	
Specific Gravity	1.005-1.034	>1.055	N/A	Patient may have dehydration (Hinkle & Cheever, 2018).
Glucose	Normal	Normal	N/A	
Protein	Negative	1+	N/A	Patient may have acute kidney injury related to dehydration (Hinkle & Cheever, 2018).
Ketones	Negative	Negative	N/A	
WBC	<5	Negative	N/A	
RBC	0-3	1	N/A	
Leukoesterase	Negative	Negative	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	
PaO ₂	80 – 100 %	N/A	N/A	
PaCO ₂	35 – 45	N/A	N/A	
HCO ₃	22 -26	N/A	N/A	
SaO ₂	92 – 100%	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	Value on	Today's	Explanation of Findings
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	Range	Admission	Value	
Urine Culture	No growth	N/A	N/A	
Blood Culture	No growth	N/A	N/A	
Sputum Culture	No growth	N/A	N/A	
Stool Culture	No growth	N/A	N/A	

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Diagnostic Test Correlation (5 points):

- CT angiography chest aorta with contrast (10/19/2020)
 - A CT of the chest allows for visualization of soft tissue and areas of volume changes. An angiography focuses more so on the vasculature, which can identify vascular obstruction or vascular abnormalities (Hinkle & Cheever, 2018). The CT angiography is pertinent to this patient to rule out vascular abnormalities such as an aneurysm or a PE. Dr. Ahmed indicated that the results showed a normal aorta and a negative CT for acute abnormality. However, pulmonary embolism could not be excluded.
- CT angiography pelvis and abdomen with contrast (10/19/2020)
 - A CT of the pelvis and abdomen allows for identification of the soft tissues and volume changes within this region of the body. The angiography can discern any issues of the vasculature within these cavities (Hinkle & Cheever, 2018). The CT angiography of the pelvis and abdomen can rule out vascular abnormalities such as AAA, clot or hemorrhage. Dr. Ahmed read the images and reported diffuse

abnormality of the spleen likely due to splenic laceration. Active bleeding was noted with a small subscapular hematoma and a small amount of free pelvic fluid.

- Chest x-ray (10/19/2020)
 - o Results reviewed by Dr. Ahmed indicated that the patient’s heart size was normal. There was volume loss on the left with mid elevation of the left hemidiaphragm concurrent with past surgical history. There was no visualized pneumothorax or pleural effusion and osseous structures were intact. A chest x-ray was pertinent to this patient to rule out complications related to the heart, lungs, and bones in the chest.

Diagnostic Test Reference (APA):

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

**Current Medications (10 points, 1 point per completed med)
*10 different medications must be completed***

Home Medications (5 required)

Brand/ Generic	Lipitor/ atorvastatin	Medrol/ methylprednis olone	Amrix/ cyclobenzaprine	Flonase/ fluticasone	Cozaar/ Losartan
Dose	20 mg	4 mg	10 mg	1 spray 50 mg	25 mg
Frequency	Daily	PRN	BID, PRN	BID	Daily
Route	PO	PO	PO	Nasal	PO
Classification	HMG-CoA reductase Inhibitor	Anti- inflammatory, immunosuppre ssant, synthetic glucocorticoid	Skeletal muscle relaxant, tricyclic amine salt	Anti- inflammato ry, anti- asthmatic, trifluorinate d corticostero id	Angiotensin II receptor blocker
Mechanism	Decreases	Methylprednis	Cyclobenzaprine	Fluticasone	Prevents

of Action	plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and the synthesis of cholesterol in the liver. It also decreases LDL production (SBLH, 2020).	olone binds to glucocorticoid receptors and suppress immune and inflammatory processes by preventing the accumulation of monocytes and neutrophils (Jones & Bartlett, 2019).	relieves skeletal muscle spasms by primarily acting upon the CNS (SBLH, 2020).	inhibits the inflammatory response related to asthma and inhibits the production of chemical mediators (Jones & Bartlett, 2019).	angiotensin II from binding to receptor sites which results in the reduction of BP (Jones & Bartlett, 2019).
Reason Client Taking	Hyperlipidemia	COPD	Skeletal muscle relaxant	Allergies	HTN
Contraindications (2)	-active liver disease - Hypersensitivity	-fungal infection -idiopathic thrombocytopenic purpura	-hyperthyroid -CHF or arrhythmias	- Hypersensitivity -untreated nasal mucosal infection	-concurrent aliskiren therapy - hypersensitivity
Side Effects/ Adverse Reactions (2)	-Diarrhea -pain in extremities	-exophthalmos -abdominal distension	-dry mouth -dizziness	- aggressiveness - bronchospasm	-back pain -cough
Nursing Considerations (2)	-Use with caution in patients who consume large amounts of alcohol or have a history of liver	-Administer methylprednisolone with food to prevent indigestion and GI upset. -Closely monitor patient for signs of infection	-Use caution in patients with low seizure threshold. -Avoid giving cyclobenzaprine to older patients due to anticholinergic effects.	-If patient is taking a corticosteroid, expect to taper the dose after fluticasone therapy begins. -Use cautiously	-Be aware that losartan may be administered in 2 divided doses to cause a greater effect. -Observe

	disease. -Be aware that patients who take gemfibrozil , tipranavir plus ritonavir or telaprevir should not take atorvastatin due the risk of rhabdomyol ysis with acute renal failure.	because methylprednis olone can mask signs and symptoms.		in patients with ocular herpes simplex, pulmonary tuberculosis , or untreated infection.	patients for muscle pain due to the chance of rhabdomyol ysis.
Key Nursing Assessment(s) Prior to Administration	Liver function tests Lipid levels Blood glucose BP electrolytes	Liver enzymes Thyroid function test CBC	Vital signs: HR, BP	adrenal function BP electrolytes	BP Renal function Potassium levels
Client Teaching needs (2)	-Notify the doctor immediately of muscle pain, tenderness, or weakness. -Many drugs interact with atorvastatin so be sure to consult with your doctor before taking new medications	-Educate the patient on the importance of not stopping methylprednis olone abruptly. -Inform the patient that they need to inform the provider immediately if they have dark or tarry stools.	-Educate patients on the importance of avoiding alcohol and CNS depressants. -Inform the patient about the need for assistance when participating in potentially hazardous activities.	- Shake well before use -Instruct patient to clean inhaler at least once a week and per the manufacturer guidelines.	-Educate the patient about avoiding excessively hot environments and drinking large quantities of alcohol. -Inform the patient on the necessity of avoiding potassium containing salt

	.				substitutes.
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Hospital Medications (5 required)

Brand/ Generic	Norco/ hydrocodone- acetaminophen	Zofran/ ondansetron	Ultram/ tramadol	Kenalog/ triamcinolon e	AccuNeb/ albuterol sulfate
Dose	5 mg	4 mg	50 mg	Apply sparingly	2 puffs, 90 mg
Frequency	Q4, PRN	Q6, PRN	Q6, PRN	TID	TID, PRN
Route	PO	IV	PO	Topical	Inhalation
Classification	Opioid analgesic	Carbazole, antiemetic	Analgesic, opioid agonist	Corticosteroi d	Selective beta 2 adrenergic agonist
Mechanism of Action	Hydrocodone- acetaminophen is an opioid agonist that blocks mu receptors and inhibits brain prostaglandin synthesis (SBLH, 2020).	Ondansetron prevents the release of serotonin into the small intestine which results in a reduction of nausea and vomiting (SBLH, 2020).	Tramadol inhibits the reuptake of serotonin and norepinephr ine by binding with mu receptors (SBLH, 2020).	The exact process is unknown; however, triamcinolon e inhibits inflammator y cytokines and causes glucocorticoi d and mineralocorti coid effects (Epocrates, 2020).	Albuterol relaxes bronchial smooth muscle by binding to beta 2 receptors which causes a decrease in intracellular calcium and an increase in levels of cAMP (Jones & Bartlett Learning, 2019).
Reason Client Taking	Pain	Nausea	pain	rash	COPD
Contraindica tions (2)	-respiratory depression -Known or suspected GI obstruction	- hypersensitivit y -use with apomorphine	-alcohol intoxication - hypersensiti vity	- hypersensitiv ity -skin infections	- Hypersensiti vity to albuterol or its components

<p>Side Effects/ Adverse Reactions (2)</p>	<p>- lightheadedness -N/V</p>	<p>-headache -constipation</p>	<p>-nausea -vertigo</p>	<p>-burning -itching</p>	<p>- hyperglycemia -muscle cramps</p>
<p>Nursing Considerations (2)</p>	<p>-Use extreme caution when administering to patients with COPD. -Monitor patient for decreased bowel motility.</p>	<p>-Dilute in 50 mL of D5W or normal saline when instructed -Monitor patients for signs of hypersensitivity including anaphylaxis and bronchospasm, discontinue if this occurs.</p>	<p>- Avoid administering tramadol to patients with acute abdominal conditions because it may alter their abdominal assessment. -Be aware that excessive use of tramadol can lead to addiction.</p>	<p>-Wash hands before and after administering triamcinolone. -Be aware that the use of triamcinolone can increase the patient's blood glucose levels.</p>	<p>-Know that prolonged use can lead to drug tolerance. -Use cautiously in patients with diabetes, HTN, cardiac disorders, hyperthyroidism, digitalis intoxication, or history of seizures.</p>
<p>Key Nursing Assessment(s) Prior to Administration</p>	<p>Respiration Oxygen saturation</p>	<p>Electrolytes EKG</p>	<p>Respirations Serotonin syndrome s/s</p>	<p>Blood glucose levels Assessment of skin</p>	<p>Potassium levels</p>
<p>Client Teaching needs (2)</p>	<p>-Do not drink alcohol while taking this medication. -Seek help immediately if issues with breathing arise.</p>	<p>-This medication may cause drowsiness. -Educate patient on the importance of notifying the doctor of lightheadedness, syncope or changes in HR.</p>	<p>-Do not stop taking tramadol abruptly. -Tramadol can cause constipation, therefore, it is important to remain hydrated, consume more fiber, and contact the doctor</p>	<p>- Do not cover the area of application with a bandage or other covering. -Apply a thin layer of the medication and avoid covering large areas of the skin unless</p>	<p>-Educate the patient about cleaning the mouth piece with water at least once per week and letting it air dry. -Instruct the patient to wait at least 1 minute in between puffs.</p>

			if constipation does not improve.	directed by your doctor.	
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Medications Reference (APA):

Epocrates. (2020). Kenalog- triamcinolone topical.

<https://online.epocrates.com/drugs/84207/Kenalog/Pharmacology>

Jones & Bartlett Learning. (2019). *2019 Nurses Drug Handbook*.

Sarah Bush Lincoln Hospital. (2020). Drug reference.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient is alert and oriented x4. Patient appears to be in minor distress when changing positions due to abdominal discomfort. Overall patient appears relaxed.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin color is appropriate for ethnic background. Skin is elastic and intact. Skin is warm to the touch. Turgor is good, less than 3 seconds. Patient has no rashes, bruises or wounds present upon inspection. Braden score is 21. Patient has no drains present.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head is normocephalic. Ears are intact with no visible drainage or discharge. Eyes are symmetric. PERRLA. Nose is midline with no complaint of epistaxis, polyps, deviated septum or drainage. Patient states he has upper dentures, but does not wear them. Some teeth are present. Oral mucosa is pink, moist, and intact.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc.</p>	<p>S1 and S2 heard upon auscultation. No murmurs, gallops or rubs heard. Cardiac rhythm is regular. Rate is tachycardic. Peripheral pulse are equal</p>

<p>Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema: N/A</p>	<p>bilaterally and 3+. Capillary refill is good, less than 3 seconds in all extremities. No neck vein distension or edema present upon inspection.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character ET Tube: Size of tube: Placement (cm to lip): Respiration rate: FiO2: Total volume (TV): PEEP: VAP prevention measures:</p>	<p>Patient is not using accessory muscles. Breath sounds are equal bilaterally and clear except for the left upper lobe. The patient had a lobectomy in 2017. Left upper lobe sounds absent upon auscultation. Patient is on 2 L of oxygen via nasal cannula. No ET tube present.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: 185 cm Weight: 122.5 kg Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Patient's diet at home is regular. Patient's current diet in the hospital is NPO except for ice chips and sips of water. Patient is 185 cm tall and weighs 122.5 kg. Bowel sounds are present and normoactive in all four quadrants. Patient complains of tenderness upon palpation. No distension, incisions, scars, drains or wounds present upon inspection. Patient does not have an ostomy, nasogastric tube or feeding tube.</p>
<p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Urine is clear and yellow. Patient states he voided once during the shift. Patient denies pain with urination. Patient is not on dialysis. Genitalia intact and pink. Patient does not have a catheter.</p>

<p>Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: N/A Size: N/A CAUTI prevention measures: N/A</p>	
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 60 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input checked="" type="checkbox"/></p>	<p>Patient has active range of motion. Patient denies use of supportive devices. Strength is equal bilaterally and in all extremities. Patient does not require assistance with ADLs but is a fall risk due to history of falls and requires standby assistance. Patient's fall score is 60.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Patient moves all extremities well. PERRLA. Strength is equal in all extremities. Patient is alert and oriented x4. Patient speaks clearly and easily. Sensory intact. Patient wears glasses for reading.</p>
<p>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):</p>	<p>Patient appears to be coping well. When asked about coping mechanisms patient states he usually takes a break to drink a beer. Patient is Christian and believes in God. Patient lives at home with his wife who seems to be a good support system. She has called in to check on him several times.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0845	103	117/62	22	37.5	92%
1215	107	115/64	22	37.2	92%

Vital Sign Trends/Correlation: Patient’s heart rate remains tachycardic. BP is stable and within normal limits. Respirations are elevated. Patient states he is in some pain and has a cough.

Patient states he has a hard time coughing up his secretions. Temperature is within normal range as well as oxygen saturation.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0845	0-10 pain scale	abdomen	3/10	Gnawing intermittent	N/A Pt states this is tolerable
1215	0-10 pain scale	abdomen	3/10	Gnawing Intermittent	N/A Pt states this is tolerable

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
<p>Size of IV: 18 G, 20G</p> <p>Location of IV: Left antecubital, right forearm</p> <p>Date on IV: 10/19/2020 for both</p> <p>Patency of IV: Both IV’s are patent and infuse well.</p> <p>Signs of erythema, drainage, etc.: No erythema, drainage, phlebitis, or infiltration present in either.</p> <p>IV dressing assessment: Dressings are clear, dry, and intact for both.</p>	<p>Left antecubital = saline locked</p> <p>Right forearm= 0.9% NaCl 100 mL/hr</p>
Other Lines (PICC, Port, central line, etc.)	N/A
<p>Type:</p> <p>Size:</p> <p>Location:</p> <p>Date of insertion:</p> <p>Patency:</p> <p>Signs of erythema, drainage, etc.:</p> <p>Dressing assessment:</p> <p>Date on dressing:</p> <p>CUROS caps in place: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>CLABSI prevention measures:</p>	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
100 mL of water PO, 700 mL 0.9% NaCl IV	Patient states he voided once.

Nursing Care**Summary of Care (2 points)**

Overview of care: Patient remained in bed during the shift. In the morning he rated his pain as a 3/10 and stated it was tolerable. Patient requested pain meds later in the morning. Patient rated his pain 8/10. After administration, patient stated his pain was back at a 3/10 and was tolerable. Patient is cooperative and is waiting to be moved upstairs for observation.

Procedures/testing done: Patient had labs drawn early this morning (10/20/2020).

Complaints/Issues: Patient complains of tenderness in his abdomen and the inability to completely cough up his secretions. Patient states the issue with secretions has been ongoing since his lobectomy in 2017.

Vital signs (stable/unstable): Vital signs are stable.

Tolerating diet, activity, etc.: Patient is tolerating diet and activity well with no complaints.

Physician notifications: N/A

Future plans for patient: Patient will be moved upstairs on telemetry for observation.

Discharge Planning (2 points)

Discharge location: Patient will discharge home with his wife.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Patient will schedule a follow-up appointment with his primary care provider within 5 days of discharge.

Education needs: Patient will receive education on the importance of infection prevention.

Nursing Diagnosis (15 points)

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

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Intervention (2 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for impaired gas exchange due to excessive secretions as evidenced by patient stating difficulty in expectorating.</p>	<p>This nursing diagnosis was chosen because it is very important to monitor the patient’s gas exchange to ensure they are receiving an adequate amount of oxygen to prevent damage to their cells.</p>	<p>1. Monitor oxygen saturation and maintain levels above 92%. 2. Assist patient into semi-fowler’s position to promote drainage by gravity.</p>	<p>Patient was tolerable of actions. Patient is maintaining proper oxygen saturation and continues to sit upright. Will continue to monitor and promote oxygenation.</p>
<p>2. Potential for hemorrhage due to abdominal trauma as evidenced by CT showing findings consistent with splenic laceration.</p>	<p>This nursing diagnosis was chosen because hemorrhage can be detrimental to the patient if intervention is not taken quickly.</p>	<p>1. Monitor patient’s BP and make sure it does not drop below 90/60. 2. Monitor for tachycardia. HR above 100 is considered tachycardia.</p>	<p>Patient is tolerating interventions well. Patient’s BP and heart rate has remained stable. Patient is tachycardic with heart rate in the low 100’s. Will continue to monitor for significant changes.</p>
<p>3. Acute pain due to abdominal</p>	<p>Pain is important to treat because it</p>	<p>1. Monitor patient’s pain using the 0-10</p>	<p>Patient is cooperative. Patient states that a 3/10 is</p>

<p>trauma as evidenced by patient rating his pain as an 8/10.</p>	<p>can be debilitating and cause alterations in vital signs.</p>	<p>pain scale. 2 Discern what level of pain is tolerable for the patient.</p>	<p>tolerable for him. Patient notified the nurse when his pain changed to an 8/10. Will continue to monitor pain status.</p>
<p>4. Constipation due to opioid analgesics as evidenced by patient stating in ability to have a bowel movement.</p>	<p>This nursing diagnosis was chosen because untreated constipation can lead to further complications.</p>	<p>1.Encourage fluids to prevent dehydration and worsening of constipation. 2. Encourage the patient to move to promote motility of the bowel.</p>	<p>Patient is tolerating actions to the best of his ability. Patient states he is not a big water drinker and is having difficulty consuming proper amounts of water. Patient states that he does not want to move due to the abdominal discomfort. Will continue to monitor and provide further interventions to promote bowel motility. Will ask provider for prescribed stool softener.</p>
<p>5. Risk for skin breakdown due to immobility as evidenced by patient stating it hurts to move.</p>	<p>Skin breakdown is important to prevent because it increases the patient's risk of infection.</p>	<p>1.Assist the patient to change position every 2 hours. 2.Keep skin clean and dry.</p>	<p>Patient is not tolerating position changes in bed. Patient states he needs to remain on his left side to make it easier to breath and prevent abdominal discomfort. Patient is cooperative with keeping skin clean and dry. Will continue to monitor and assist patient to find different positions that can at least shift the patient's weight throughout the day.</p>

Other References (APA):

Swearingen, P. L. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Concept Map (20 Points):

Subjective Data

Patient locates a gnawing pain in the upper left quadrant of his abdomen. Patient states that the pain is intermittent. Patient states tenderness upon palpation of the abdomen and with changing positions. Patient states that a 3/10 pain is tolerable for him. Patient states difficulty clearing secretions from his lungs since his lobectomy. Patient denies the use of oxygen at home.

Nursing Diagnosis/Outcomes

Risk for impaired gas exchange due to splenic laceration as evidenced by patient stating difficulty in expectorating.
Patient will maintain oxygen saturation above 92% until discharge.
Risk for hemorrhage due to abdominal trauma as evidenced by CT showing findings consistent with splenic laceration.
Patient's vital signs will be monitored for heart rate greater than 100 and BP less than 90/60 until discharge.
Acute pain due to abdominal trauma as evidenced by patient rating his pain as an 8/10. Patient will maintain pain at a level of 3/10 or less until discharge.
Constipation due to opioid analgesics as evidenced by patient stating in ability to have a bowel movement.
Patient will have a bowel movement by tomorrow evening after taking a stool softener.
Risk for skin breakdown due to immobility as evidenced by patient stating it hurts to move.
Patient will not develop any changes in skin integrity from now until discharge.

Objective Data

Patient's oxygen saturation is consistent at 92% on 2 L oxygen via nasal cannula, respirations are slightly elevated at 22, temperature is within normal limits, heart rate is tachycardic, but stable in the low 100's. BP is stable and presents in the one-teens over 60's. Patient's CT angiography shows splenic laceration with some fluid and a small hematoma. Patient has elevated WBCs and decreased lymphocytes. Hgb is within normal limits.

Patient Information

Patient is a 66 year old male admitted with severe abdominal pain, nausea and vomiting. Patient was diagnosed with a splenic laceration. Patient has history of falls, COPD, left lung lobectomy and lung cancer. Patient is a former smoker.

Nursing Interventions

Monitor oxygen saturation and maintain levels above 92%.
Assist patient into semi-fowler's position to promote drainage by gravity.
Monitor patient's BP and make sure it does not drop below 90/60.
Monitor for tachycardia. HR above 100 is considered tachycardia.
Monitor patient's pain using the 0-10 pain scale. Discern what level of pain is tolerable for the patient.
Encourage fluids to prevent dehydration and worsening of constipation.
Encourage the patient to move to promote motility of the bowel.
Assist the patient to change position every 2 hours.
Keep skin clean and dry.



