N431 Care Plan #2

Lakeview College of Nursing

Morgan Drennan

Demographics (3 points)

Date of Admission 10/29/20	Patient Initials LS	Age 76	Gender Female
Race/Ethnicity Caucasian/Non-Hispanic	Occupation Self-employed	Marital Status Widowed	Allergies Novocain; codeine; propoxyphene; sulfa antibiotics
Code Status Full	Height 5'5"	Weight 165 lbs 14.4 oz	

Medical History (5 Points)

Past Medical History: CAD, COPD, atrial fibrillation, arthritis, carotid atherosclerosis, cataract in both eyes, hypertension, and colonic mass

Past Surgical History: splenectomy, cholecystectomy, tonsillectomy, cataract removal with implant (both eyes), carotid enterectomy, pacemaker insertion

Family History: Maternal- COPD, CHF, HTN.

Paternal- cancer (unspecified). Two brothers had MI's

Social History (tobacco/alcohol/drugs): Patient quit smoking in January of 2020. She was smoking 1.5 packs/day of cigarettes. Patient refused to specify for how long she had been smoking. The patient reported that she did not drink alcohol or do drugs.

Assistive Devices: wheelchair, walker, handheld shower, oxygen concentrator, bath chair, raised toilet seat.

Living Situation: Patient lives at home in Tilton, Illinois with one of her daughters.

Education Level: High School until sophomore year. Patient states she "completed sophomore year, then dropped out to help mother".

Admission Assessment

Chief Complaint (2 points): Bleeding from abdominal wound

History of present Illness (10 points): Patient presented to the emergency department on 10/29/20 because she was experiencing bleeding from a wound in her abdomen. Patient states that she had been bleeding for four days prior to going to the emergency department, which means she started noticing bleeding and discharge on 10/25/20. The location of the wound is on the patient's abdomen. Patient states that the discharge from wound was "red and bloody" and that movement made the bleeding worse. The patient states that she used a pillow to brace her abdomen and sitting still helped but she was "still bleeding some". The treatment she had been using was moving the least amount possible and trying to clean her wound with water.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):Abdominal wound dehiscence

Secondary Diagnosis (if applicable): Subfascial hematoma

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

Pathophysiology

Wound dehiscence occurs when there is an open in the wound's suture line. The cell cycle occurs to heal the wound after a surgery is performed. The cell cycle includes the cells synthesizing the parts of the cell that are needed for DNA replication. The DNA is then replicated, the preparation for mitosis occurs, and then the cell divides. The cell cycle was interrupted in this patient's wound healing due to her wound dehiscence. A wound dehiscence is considered a secondary intention which means that there is lost tissue in the wound and the repair of the wound is more complicated. Granulation and fibrous tissue

have to restore the tissue structure of the wound (Capriotti & Frizzell, 2016). The wound dehiscence can occur if there is an infection, an injury, early stitch removal, or weak tissue in the wound area (Nemours, 2020). In the case of this patient, she also had suspected cellulitis in the abdominal area so it is assumed that the cellulitis impacted the wound healing.

Signs and Symptoms

Signs and symptoms of wound dehiscence include the presence of an open wound, broken sutures, pain at the wound site, bleeding from the wound, and/or drainage from the wound (Wound Care Centers, 2020). In the case of this patient, she indicated that she noticed bleeding, but thought it was related to her incision healing. The patient's home health nurse then assessed the drainage, dressing and wound. The nurse advised the patient to go to the emergency room because the patients' wound "did not look good".

Diagnostic Tests and Labs

A CT and MRI can indicate if there is an underlying issue or abnormality that caused the wound to dehisce. A vascular ultrasound can be done to indicate that there is a vascular issue that caused the wound to open. A biopsy can be done to see if there is a bacterial or viral infection in the wound that could have impaired wound healing. A CBC will also be done to assess for anemia or a high WBC. The serum protein and albumin levels, included in a CMP, can help to assess the patient's nutritional status, because if the patient has a low protein, high fat diet their wound is not going to heal as well or as fast as it would if they were on a high protein, low fat diet (Daley, 2020). This patient had a CT of the abdomen done which showed that there was a large hematoma in the pelvic area that measured at 11x8cm. There was also an impression on the bladder caused by the

hematoma. The patients' albumin level was also low at 2.9 on a scale pf 3.5-5.7 (Pagana & Pagana, 2010).

Treatment

The treatment of a wound dehiscence includes irrigating the wound, treating the underlying infection, ensuring adequate nutrition, ensuring adequate oxygenation, and dressing changes. By irrigating the wound, it washes out some of the pus and blood and helps to cleanse the wound before dressing it. If the patient has an underlying infection, then the infection will have to be treated before the wound will start to heal. The underlying condition must be treated before the wound will be treated. Ensuring adequate nutrition will help to promote wound healing. Adequate oxygenation needs to be administered because this will help to oxygenate the blood and promote wound healing (Daley, 2020). This patient was receiving oxygenation therapy via nasal cannula at 3L. This patient had a wound vac in place to remove blood and pus from the site. Irrigation of the wound also occurred twice daily prior to the dressing change of the wound.

Pathophysiology References (2) (APA):

Capriotti, T. & Frizzell, J. P. (2016). ***Pathophysiology: Introductory Concepts and Clinical Perspectives*****. F. A. Davis.**

Daley, B. (2020). ***Wound Care Treatment & Management*****. https://emedicine.medscape.com/article/194018-treatment.**

Nemours. (2020). ***A to Z: Wound Dehiscence*****. https://kidshealth.org/Nemours/en/parents/az-wound-dehiscence.html#:~:text=Wound%20dehiscence%20usually%20happens%20within,%2C%20vomiting%2C%20or%20coughing%20violently.**

Pagana, K. & Pagana, T. (2010). *Mosby's Manual of Diagnostic and Laboratory Tests.* (4th ed.). Elsevier.

Wound Care Centers. (2020). *Dehisced Wounds*. https://www.woundcarecenters.org/article/wound-types/dehisced-wounds.

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	3.80-5.30	3.35	3.11	The patient is experiencing bleeding (Pagana & Pagana, 2010).
Hgb	12-15.8	9.3	8.8	The patient is experiencing bleeding (Pagana & Pagana, 2010).
Hct	36-47	28.4	26.1	The patient is experiencing bleeding (Pagana & Pagana, 2010).
Platelets	140-440	376	338	
WBC	4-12	13	9.20	WBC's are increased related to stress (Pagana & Pagana, 2010).
Neutrophils	40-68	71.5	78.8	The neutrophils are increased related to stress and trauma (Pagana & Pagana, 2010).
Lymphocytes	19-49	11.2	9.1	The patient uses bronchodilators which include steroids in them on a daily basis (Pagana & Pagana, 2010).
Monocytes	3-13	15.1	11.7	The patient's incision is inflamed and the body is under stress (Pagana & Pagana, 2010).
Eosinophils	0-8	1.5	0.0	
Bands	<10	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-	133-144	132	138	The patient is on diuretics (Pagana & Pagana, 2010).
K+	3.5-5.1	4.2	3.5	
Cl-	86-107	90	95	
CO2	21-31	35	29	The patient has COPD (Pagana & Pagana, 2010).
Glucose	70-99	108	110	This patient could be having a response to stress, diuretic therapy, or corticosteroid therapy (Pagana & Pagana, 2010).
BUN	7-25	35	34	This patient has dehydration related to reduced blood volume (Pagana & Pagana, 2010).
Creatinine	0.50-1.00	2.14	2.41	This patient is experiencing dehydration (Pagana & Pagana, 2010).
Albumin	3.5-5.7	3.0	2.9	This patient is experiencing an inflammatory response increasing the albumin level (Pagana & Pagana, 2010).
Calcium	8.8-10.2	8.9	8.8	
Mag	1.6-2.6	1.8	n/a	
Phosphate	2.5-4.5	n/a	n/a	
Bilirubin	0.2-0.8	0.8	0.6	
Alk Phos	34-104	88	77	
AST	13-39	15	16	
ALT	7-52	15	15	
Amylase	23-85	n/a	n/a	

Lipase	**0-160**	**n/a**	**n/a**	
Lactic Acid	**0.5-2.0**	**0.9**	**n/a**	
Troponin	**0.0-0.040**	**n/a**	**n/a**	
CK-MB	**0-4**	**n/a**	**n/a**	
Total CK	**30-223**	**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	**0.8-1.1**	**1.2**	**n/a**	**The has patient lost blood from her wound (Pagana & Pagana, 2010).**
PT	**10.1-13.1**	**14.5**	**n/a**	**The has patient lost blood from her wound (Pagana & Pagana, 2010).**
PTT	**25-36**	**32**	**n/a**	
D-Dimer	**<0.5**	**n/a**	**n/a**	
BNP	**0-100**	**n/a**	**1,147**	**This value is elevated related to the patient's recent pacemaker insertion (Pagana & Pagana, 2010).**
HDL	**>60**	**n/a**	**n/a**	
LDL	**<100**	**n/a**	**n/a**	
Cholesterol	**<200**	**n/a**	**n/a**	
Triglycerides	**<150**	**n/a**	**n/a**	
Hgb A1c	**4-5.6**	**n/a**	**n/a**	
TSH	**0.4-4**	**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	Today's Value	Reason for Abnormal
Color & Clarity	Yellow and clear	n/a	n/a	
pH	5-9	n/a	n/a	
Specific Gravity	1.003-1.030	n/a	n/a	
Glucose	Negative	n/a	n/a	
Protein	Negative	n/a	n/a	
Ketones	Negative	n/a	n/a	
WBC	negative	n/a	n/a	
RBC	Negative	n/a	n/a	
Leukoesterase	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	
PaO2	80-95	n/a	n/a	
PaCO2	35-45	n/a	n/a	
HCO3	22-26	n/a	n/a	
SaO2	95-99	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

	Range	Admission	Value	
Urine Culture	**No growth**	**n/a**	**n/a**	
Blood Culture	**No growth**	**No growth**	**n/a**	
Sputum Culture	**No growth**	**n/a**	**n/a**	
Stool Culture	**No growth**	**n/a**	**n/a**	

Lab Correlations Reference (APA):

Pagana, K. & Pagana, T. (2010). *Mosby's Manual of Diagnostic and Laboratory Tests.* (4th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-ray on 10/31 and 11/2, CT of the abdomen, US Bilateral Duplex of the lower extremity, and NM lung perfusion scan.

Diagnostic Test Correlation (5 points): The patient received a chest X-ray for complaints of shortness of breath which showed that she had congestion and effusions in the lungs bilaterally. The consolidation in the lungs has improved between the 10/31 scan and the 11/2 scan. The CT of the abdomen was done to determine the presence and size of a hematoma. This hematoma is large, and the measurements of the hematoma is 11x8 cm but is showing signs of improvement. A US Bilateral Duplex was done of the lower extremities to determine if there were any blood clots present in the legs. The patient does not have any signs of DVT and there is adequate visualization of the veins in the lower extremities. A NM lung perfusion scan was done related to the patients' shortness of breath and need for 3L of oxygen. The lung perfusion showed to be within normal limits and the changes in the respiratory status could be related to CHF which the patient has not been diagnosed with

but has a familial history of. The lung perfusion shows a low probability of a pulmonary embolism (Pagana & Pagana, 2010).

Diagnostic Test Reference (APA):

Pagana, K. & Pagana, T. (2010). *Mosby's Manual of Diagnostic and Laboratory Tests.* (4th ed.). Elsevier.

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

Home Medications (5 required)

Brand/Generic	**Lasix/ furosemide**	**Prinivil/ lisinopril**	**Lipitor/ atorvastatin**	**65 Fe/ ferrous sulfate**	**Klorcon M/ potassium chloride SA**
Dose	**40 mg**	**10 mg**	**20 mg**	**325 mg**	**10 mEq**
Frequency	**BID**	**daily**	**daily**	**daily**	**BID**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Antihypertensive; diuretic**	**Antihypertensive; vasodilator**	Antihyperlipidemic	Anti-anemic	**supplement**
Mechanism of Action	**Inhibits sodium and water reabsorption into the Loop of Henle; increases fluid excretion**	**Decreases the release of aldosterone which reduces water and sodium reabsorption, reducing BP**	**Increases number of LDL receptors to enhance LDL uptake and breakdown**	**Normalizes RBC's binding to hemoglobin**	**Cation that is essential for conducting impulses in the heart and the brain**
Reason Client Taking	**Hypertension**	**hypertension**	**atherosclerosis**	**Low RBCs, Hct, and Hgb causing**	**Decreasing potassium levels in**

				low iron	**the blood**
Contraindications (2)	**Anuria unresponsive to furosemide; hypersensitivity to furosemide**	**Hypersensitivity to lisinopril; hereditary or idiopathic angioedema**	Active hepatic disease; unexplained rise in serum transaminase level	**Hemolytic anemias; hemosiderosis**	Hyperkalemia; renal failure
Side Effects/Adverse Reactions (2)	**Elevated cholesterol; tachycardia**	**Fluid overload; angina**	**Colitis; dysphagia**	**Hypertension; dyspnea**	Abnormal heart rhythm; muscle weakness
Nursing Considerations (2)	**Monitor for signs of hypokalemia; obtain a daily weight on this client**	**Notify the provider of a persistent, nonproductive cough; crackles may be present in the lungs**	**Monitor blood glucose; use caution in patients who drink alcohol**	**Give with a full glass of water; give 1 to 2 hours before meals**	**An EKG will most likely be conducted; place patient on telemetry**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor BP**	**Monitor BP**	**Liver function tests; lipid panel**	**Monitor BP**	**Monitor heart rhythm and pulse**
Client Teaching needs (2)	**Teach client how to take their blood pressure; advise the client to take this medication in the morning to avoid interrupted sleep.**	**Teach the client how to take their blood pressure; educate client on how to record her blood pressure and the normal parameters of blood pressure**	**Educate client about a low-fat diet; instruct the client to take the medication at the same time every day.**	**Instruct patient to not chew the iron tablet; encourage Vitamin C intake**	Educate patient to not chew medication; encourage the patient to take with food (Jones & Bartlett, 2019).

Hospital Medications (5 required)

Brand/Generic	**Bumex/ bumetanide**	**Plavix/ clopidogrel**	**Lopressor/ metoprolol tartate**	**Cordarone/ amiodarone**	**Duo-Neb/ ipratropium-albuterol**
Dose	**1 mg**	**75 mg**	**25 mg**	**200 mg**	**3 mL**
Frequency	**Q8H**	**Daily**	**Daily**	**Daily**	**QID**
Route	**IV**	**PO**	**PO**	**PO**	**INH**
Classification	**Loop diuretic**	Platelet aggregation inhibitor	antihypertensive	**antiarrhythmic**	**Bronchodilator**
Mechanism of Action	**Inhibits reabsorption of sodium, chloride, and water**	**Binds with ADP receptors on platelets, which blocks fibrinogen from forming, so a clot cannot form**	**Inhibits the stimulation of Beta-1 receptors to decrease cardiac excitability and output**	**Prolongs refractory period and raises the ventricular fibrillation threshold; relaxes vascular smooth muscles**	**Blocks acetylcholine effects which relaxes smooth muscle**
Reason Client Taking	**Decrease fluid in lungs**	**Prevent clots**	**hypertensive**	**A-fib**	**Shortness of breath and COPD**
Contraindications (2)	**Severe electrolyte depletion; anuria**	**Active bleeding; allergic to clopidogrel**	**Pulse less than 60bpm; acute heart failure**	**Hypokalemia; bradycardia**	**Hypersensitivity to atropine; hypersensitivity to peanuts**
Side Effects/Adverse Reactions (2)	**Hypotension; headache**	**Chest pain; edema**	**Bronchospasm; dyspnea**	**Coagulation abnormalities; edema**	**A-fib; bronchospasm**

Nursing Considerations (2)	**Expect to administer PO; be aware that high doses can cause diuresis**	**Discourage the use of NSAID; expect to give aspirin with clopidogrel**	**Use with caution in patients who have a bronchospastic disease; use with caution in patients who have hypertension and CHF**	**Be aware that this medication can worsen pulmonary disorders; administer EKG**	**Apply mouthpiece so that the medication gets into the airway; monitor patient for hypersensitivity reaction**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor potassium and electrolytes**	**Monitor CBC**	**Assess EKG or telemetry; assess for PVD symptoms such as pallor and coldness; assess pulse**	**Monitor vital signs; monitor EKG; monitor liver enzymes**	**Listen to lung sounds; monitor O2 saturation**
Client Teaching needs (2)	**Educate on how to monitor fluid intake; encourage potassium rich foods**	**Educate the patient that bleeding time could be longer; advise patient to tell all healthcare providers that the patient is on clopidogrel**	**Instruct the patient to take the medication at the same time every day; teach and instruct the client to take their pulse every day**	**Instruct the patient to report abnormal bleeding; educate the patient that they will need frequent lab monitoring**	**Educate the patient on how to use an inhaler; advise patient to rinse her mouth after the nebulizer treatment** **(Jones & Bartlett, 2019).**

Medications Reference (APA):

Jones & Bartlett Learning. (2019). ***2019 Nurses drug handbook (18th ed).*** **Burlington, MA.**

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**AOx4** **Patient is in no apparent distress and does not report any distress.** **Patient's appearance is appropriate for the ethnicity, age, and medical circumstances**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type: wound vac**	**Skin color is appropriate for ethnicity. The skin is intact and dry. The skin is warm to the touch. Turgor is loose on the hands as expected for age. There are no rashes present. There is a wound on the abdomen that has opened but is dressed properly. There is a healing incision from a pacemaker being placed. There is generalized bruising on the patients' arms. A wound vac is present and is being used in the abdominal wound. The Braden score for this patient is 21**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head, ears, eyes and nose are symmetrical. The thyroid is midline. Sclera is white, and conjunctiva is pink and moist. There is no drainage present. External ear is intact. Dentition is not intact; the patient has dentures. Mucous membranes are pink and moist. Airway is patent.**
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:**	**S1 and S2 are present with no gallops or murmurs present. A cardiac monitor is being used and is presenting a normal sinus rhythm upon assessment. Peripheral pulses are present and strong. Capillary refill is < 3 seconds. Slight edema is present in the feet.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Patient presents with crackles in the lower lobes of both lungs upon auscultation which correlates with the chest XR that was done showing infiltrates. Patient is on 3L of O2 via nasal cannula.**

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:**	**Diet at home is a regular diet and the current diet is a cardiac diet. The patient's height is 5'5" and her weight is 165 lbs 14.4 oz. There are bowel sounds heard in all four quadrants. The last bowel movement was on 11/2/20 at 1456. There is pain upon palpation in relation to the incision, so deep palpation was not done, and light palpation was minimal. There is no distention or scars present. There is an incision and wound on the abdomen that has dehisced. There is a wound vac being used in relation to the abdominal wound.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Color and character of urine is yellow and clear. The quantity of urine is 200 mL. There is no pain with urination and the patient is not on dialysis. The genitals are intact. There is not a catheter being used.**
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☐**	**Active ROM, except for the left arm related to the pacemaker insertion. The patient does not want to use the left arm very much. Patient uses a walker and wheelchair when not in the hospital. Strength is unequal. The left-hand strength is weaker than the right hand. Patient receives help with ADLs from her daughter who is living with her. The fall score for this patient is 50.**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐**	**Patient does not want to move the left arm in relation to her pacemaker placement. The left arm and hand strength is weaker than the**

Strength Equal: Y ☐ N ☒ if no - Legs ☐ Arms ☒ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**right arm and hand strength.** **Cognition is appropriate** **Memory is intact during assessment.** **AOx4** **Speech is clear.** **Patient does not have any sensory deficits** **LOC: patient is alert and answering all questions.**
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):**	**Patients family is supportive, and her two daughters are present in her care. She talked highly of the daughter that lives with her. Patient seems to have difficulty coping with her hospital stay and is ready to go home. The patients' developmental level is appropriate for her age. The patient states that she identifies as Methodist, but she does not actively practice the religion.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1456	**72 bpm**	**110/76 mmHg**	**18 breaths/min**	**97.2° F**	**96% nasal cannula with 3L O2**
1721	**76 bpm**	**108/76 mmHg**	**18 breaths/min**	**97.6° F**	**97% nasal cannula with 3L O2**

Vital Sign Trends: No medications or interventions were done between vital signs, so there is no change and vitals are within normal limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1456	**0-10**	**n/a**	**0**	**n/a**	**n/a**
1721	**0-10**	**n/a**	**0**	**n/a**	**n/a**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 gauge
Location of IV:	Left arm
Date on IV:	10/29/20
Patency of IV:	Patent and easily flushed
Signs of erythema, drainage, etc.:	No signs of erythema or drainage
IV dressing assessment:	Clean, dry, and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL PO	**200 mL (urine) and x1 unmeasurable stool**

Nursing Care

Summary of Care (2 points)

Overview of care: There is a limb alert sign (left arm), fall risk sign, yellow fall risk socks, and a bed alarm being used.

Procedures/testing done: There were no procedures or testing done during this student nurses shift.

Complaints/Issues: There are no complaints at this time except for wanting to go home.

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

Tolerating diet, activity, etc.: Patient is tolerating diet and activity well.

Physician notifications: The physician was not notified during this student nurses' shift.

Future plans for patient: Home health will routinely visit this patient and will ensure that her wound is being taken care of. Education related to wound care will be given to the patient.

Discharge Planning (2 points)

Discharge location: Patient will be discharged to her home with her daughter that lives with her.

Home health needs (if applicable): Home health will routinely visit this patient as they were in the past.

Equipment needs (if applicable): walker, oxygen tanks, and a new oxygen concentrator

Follow up plan: Patient has an appointment on 1/5/21 with the pulmonologist and an appointment on 1/25/21 with the pacemaker clinic.

Education needs: Patient needs to be educated on wound cleansing and when to come in if the wound is not healing properly. Patient also needs to be educated on the cardiac diet so that she can continue to eat the proper diet at home.

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

Nursing Diagnosis • Include full nursing diagnosis with	**Rational** • Explain why the nursing	**Intervention (2 per dx)**	**Evaluation** • How did the patient/ family respond to

"related to" and "as evidenced by" components	diagnosis was chosen		the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Impaired tissue integrity related to a previous surgery as evidenced by wound dehiscence, patient reporting bleeding from wound, RBC, Hct, and Hgb levels being low indicating blood loss	**This rationale was chosen because the patient had an open wound and wound vac present. She also reported bleeding from the open wound.**	**1.Keep the patients dressing clean dry and intact 2.Monitor for proper placement of tubes connected to the wound vac.**	**The patient's dressing is clean, dry and intact upon assessment. She has no complaints of pain. The tube placement was also in the proper position and there was blood present in the tubing between the patient and the wound vac. The client responded well to these interventions and understood that the healthcare staff has to ensure that the dressing is clean to promote wound healing.**
2. Deficient knowledge related to information misinterpretation as evidenced by patient reporting that she her abdomen was cut into initially for a "blood clot" and that is "where her wound came from"	**This nursing diagnosis was chosen because the patient did not understand or was unaware of the root cause of her wound.**	**1. Educate the client on how to care for her dressing prior to discharge 2.Educate the client on the root cause of her wound and ensure that she understands**	**A goal for this patient is for her to understand her condition and the care that will have to be done when she leaves the hospital. The client seems to understand the reasoning that she was cut into originally, but she should be reevaluated on her knowledge prior to discharge. The client seems to understand the wound care that will need to be done, but her daughter and home health will most likely be doing the**

			majority of the wound care.
3. Deficient fluid volume related to low blood volume as evidence by RBC, Hct, and Hgb levels. The patient is also on multiple diuretics that may be causing excess fluid loss.	**The patients' lab values indicate that she is becoming dehydrated. She is also on multiple diuretics to decrease the fluid that is present in the client's lungs.**	**1. Encourage fluid intake** **2. Measure the clients' I & O**	**The patient responds well to the education of fluid intake, but she does not seem adamant about increasing her fluid intake. The patient understands that she needs to keep track of her intake and output, and she thinks that a chart to help keep track may be helpful. This chart was discussed, and she seems happy to have this charting tool. Her intake was 240 mL and her output was 200 mL.**
4. Risk for infection related to the open wound that is present on the abdomen and the patients' inability to care for the wound herself	**This rationale was chosen because the patient is at a high risk for infection since she has an open wound.**	**1. Maintain dependent gravity drainage of wound vac tubing** **2. Apply a sterile dressing to the wound**	**The patient is receptive to the education that she needs the tubing to remain dependent for effective drainage and every time this student nurse went into the clients' room the tubing was in a dependent position. The dressing that has been applied is sterile and clean, dry, and intact. The patient will need to be further educated on wound care.** **(Vera, 2020)**

Other References (APA):

Vera, M. (2020). ***13 Surgery (Perioperative Client) Nursing Care Plans*****.**

https://nurseslabs.com/13-surgery-perioperative-client-nursing-care-plans/5/.

Concept Map (20 Points):

Subjective Data

The client does not have any complaints of pain related to her wound dehiscence. She rates her pain at a 0 on a pain scale of 0-10.

Nursing Diagnosis/Outcomes

Impaired tissue integrity: GOAL maintain a clean, dry and intact dressing with effective drainage via the wound vac. This will be achieved with proper placement of tubing and dependent gravity drainage.
Deficient knowledge: GOAL patient understands the condition that caused her wound dehiscence.
Deficient fluid volume: GOAL The patient understands how to keep track of her intake and output, and she increases her intake of fluids
Risk for infection: GOAL avoid infection by using the wound vac to pull pus and blood out of the wound and using irrigation to cleanse wound. A sterile dressing to reduce bacteria is also being used.

Objective Data

The client presents with blood that is being removed from the wound via wound vac. The patients' blood counts are lower, as expected, with the blood loss that she has experienced. The RBC is 3.11, Hgb is 8.8, and Hct is 26.1. Vitals are all within range. A CT of the abdomen determined that there is a large hematoma in the abdomen.

Patient Information

76-year-old female client with history of CAD, COPD, A-fib, arthritis, carotid atherosclerosis, cataract of the left and right eye, colonic mass, HTN. She was admitted for an abdominal wound dehiscence.

Nursing Interventions

Keep the dressing clean, dry and intact.
Monitor for proper placement of tubes connected to the wound vac.
Educate the client on how to care for her dressing prior to discharge.
Educate the client on the root cause of her wound and ensure that she understands
Encourage fluid intake
Measure the client's I & O's
Maintain dependent gravity drainage of wound vac tubing
Apply a sterile dressing to the wound.