N321 Care Plan 1

Lakeview College of Nursing

Tuan Nguyen

Demographics (3 points)

Date of Admission 2/20/21	**Patient Initials** B.D	**Age** 62	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Unemployed due to disability	**Marital Status** Married	**Allergies** N/A
Code Status Full	**Height** 6'1" (188 cm)	**Weight** 99.7 kg (219.3 lbs)	

Medical History (5 Points)

Past Medical History: Client has history of hyperlipidemia, hypothyroidism, atrial fibrillation, arthritis, type 2 diabetes, and hypertension.

Past Surgical History: Client had neck surgery in 2020, hand surgery in 2018, knee surgery in 2017, and toe surgery in 2021.

Family History: Client's father and brother have history of lung cancer. Client's mother has history of breast cancer, arthritis, hyperlipidemia, hypertension, and a heart valve replacement.

Social History (tobacco/alcohol/drugs): Client quit tobacco use nine years ago and has been sober for the past three years. Gave a rough estimate of a pack a week and a drink "every once in a while". Pt denies drug use.

Assistive Devices: Client wears glasses and uses a walker, gait belt, and commode at the hospital and a cane at home.

Living Situation: Client lives at home with wife. He states that his living conditions are tidy and clean.

Education Level: Client received associates degree from college. Denies any learning disabilities.

Admission Assessment

Chief Complaint (2 points): Left Knee pain.

History of present Illness (10 points): Client is a 62-year-old Caucasian male was admitted on 2/20/2021 with chief complaints of left knee pain. Client stated that onset of pain occurred in the afternoon of 2/20/2021 after he “bent down to pick up something for his daughter”, lost balance, fell and broke his left knee. The location for reported pain is mostly localized in his left knee with some also being in his right leg where his toe was amputated. Client said that pain was present since he was admitted and has remained ever since. He described the pain in his left knee as a sharp pain and rated it a “9 out of 10” on the numeric pain scale. An 8 was given for his amputated toe which he described as a dull pain. The pain is aggravated when client moves or applies pressure to the left knee and right toe. Due to pain, client states that he is short of breath when he tries to stand up for too long. Client states that laying down and being still helps reduce pain. Sleeping also helps distract the client from the pain. He says that the nurses give him morphine whenever he’s in pain. He denies taking any medication at home for his pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Left knee effusion

Secondary Diagnosis (if applicable): Great toe amputation

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

Pathophysiology

A knee effusion is the swelling of the joints within and around the knee. This happens when there is a leakage of fluid from a vein, synovial membrane, artery, or lymph vessel that leaks into the tissue surrounding the joint (Eustice, 2020). This leakage is usually caused by multiple factors such as traumatic injury, arthritis and even septic arthritis (Eustice, 2020). Typically, a client will experience a knee effusion through a traumatic injury such as falling on

the knee which causes a localized inflammatory reaction to occur at the joint site. This inflammation response dilates the vessels to allow for plasma carrying white blood cells to the site to heal; however, sometimes severe inflammation can occur and can cause an overabundance of fluid to accumulate at the joint. When this happens, excess fluid accumulates at the joint and can leak into the joint and even into surrounding tissues (Eustice, 2020). Arthritis will cause knee effusion through inflammation of joints over time, and it can cause effusion at any joint in the body affected by arthritis. Septic arthritis characterized by a pathogen getting into the bloodstream and invading the knee joint can also cause knee effusion, but it has the potential to carry systemic consequences as it can cause fevers as well as cause local effects such as redness, warmth and pain (Nagar, n.d).

Signs and Symptoms

Signs and symptoms related to knee effusion will depend on the exact cause whether it is due to trauma or bacteria. The general symptoms due to trauma consist of swelling, pain, stiffness, redness and warmth, bruising (Eustice, 2020). Symptoms that are caused by septic arthritis and infections include signs and symptoms from trauma induced knee effusion but with addition of fever, an inability to bear weight on the affected extremity, loss of distal pulses and sensation to the knee (Nagar, n.d). In relation to the client, symptoms such as stiffness, and pain were exhibited.

Expected Vital Signs, Laboratory Findings, and Clinical Data

Inflammation often accompanies knee effusion. A prominent symptom of inflammation is pain, which was an evident symptom of the client. A pain score of 9 out of 10 was given to rate his pain. Pain is known to affect several of the vital signs such as heart rate, blood pressure, and breathing. The client exhibited an abnormally high heart rate of 109 bpm at 0756 hours. At

1145 hours, a heart rate of 94 bpm was collected, and while it falls within normal range, it is still slightly high and close to going past the normal heart rate. A pulse of 132/63 mmHg was also collected at 1145 hours which is abnormally high. The client also had a respiration rate of 18 rpm, and while this is within normal range, it is on the higher end of the normal range. Labs like the X-ray was carried out on the client's left knee which shows moderate effusion as well as knee effusion. The client also has arthritis, which puts him at risk for joint effusions.

Diagnostic Testing

A general approach to diagnose knee effusion would be to carry out an X-ray of the knee or desired area. X-rays can reveal bone features and details as well as fluids in the joints which is helpful to check for potential fluid accumulation in knee effusion (Hinkle & Cheever, 2018). Once knee effusion has been diagnosed, an arthrocentesis can be done in order to determine the cause of the effusion. An arthrocentesis is a procedure that involves sticking a needle into the joint of the knee to aspirate and collect the excess synovial fluid so that it can be checked for any bacteria that could have caused the effusion (Hinkle & Cheever, 2018). Should an invasive form of treatment be used, then an arthroscopy can be done to help further diagnose as well as help perform repairs on any damaged tissue (Hinkle & Cheever, 2018). In relation to the client, an X-ray on his left knee was done, and results did show knee effusion as well as moderate joint effusion present.

Treatment

Treatment for knee effusion can involve corticosteroids to help reduce inflammation within the knee joint, but it can also involve surgical procedures. Procedures such as arthrocentesis are a good beginning approach as it aims to remove fluid from the knee which helps relieve swelling and pressure in the knee (mayoclinic, 2020). Arthroscopies can also be

done by inserting a fiberoptic endoscope, which tools can be attached to, into an incision made in the knee joint. These tools can then be used to remove and repair any damage to the knee (mayoclinic, 2020). Joint replacement surgery can also be done if weight bearing becomes too difficult on the affected knee (mayoclinic, 2020). At 1330 hours the client was prepared for a arthrocentesis procedure to be carried out to remove fluid from his left knee.

Pathophysiology References (2) (APA):

Eustice, Carol. (2020). What is Joint Effusion?. Verywell health. Retrieved February 28, 2021 from https://www.verywellhealth.com/what-is-joint-effusion-189282#joint-effusion-symptoms

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 Staff. (2020). Swollen Knee. Mayoclinic. Retrieved February 28, 2021 from https://www.mayoclinic.org/diseases-conditions/swollen-knee/symptoms-causes/syc-20378129

Nagar, Priyanka. (n.d). Effusion of Knee and its Homoeopathic Management. Homeobook.com. Retrieved February 28, 2021 from https://www.homeobook.com/effusion-of-knee-and-its-homoeopathic-management/amp/

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	3.80-5.41x10^6/mcL	4.87	4.65	**N/A**
Hgb	11.3-15.2 g/dL	13.8	13.3	**N/A**
Hct	33.2-45.3%	43.3	39.8	**N/A**
Platelets	149-393 K/mcL	232	215	**N/A**
WBC	4.0-11.7	24.3	15.1	Client is fighting off potential

	K/mcL			bacterial infection related to toe amputation (Pagana, 2018)
Neutrophils	45.3-79.0%	**N/A**	81.4	Client is fighting off potential bacterial infection related to toe amputation and may be experiencing physical stress (Pagana, 2018).
Lymphocytes	11.8-45.9%	**N/A**	12.4	**N/A**
Monocytes	4.4-12.0%	**N/A**	11.8	**N/A**
Eosinophils	0.0-6.3%	**N/A**	0.3	**N/A**
Bands	0.0-10.0%	9.0	**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-	136-145 mmol/L	133	134	Client has high glucose levels which pulls in water and dilutes sodium levels (Pagana, 2018).
K+	3.5-5.1 mmol/L	4.0	2.8	Client received insulin, which can decrease potassium levels (Pagana, 2018).
Cl-	98-107 mmol/L	99	98	**N/A**
CO2	21-31 mmol/L	13	25	Client was experiencing distress and acute pain related to broken left knee (Pagana, 2018).
Glucose	74-109 mg/dL	264	194	Client may have stress related to infection due to toe amputation. Client also has history of diabetes mellitus (Pagana, 2018).
BUN	7-25 mg/dL	29	16	Client may have experienced shock when he injured his left knee (Pagana, 2018).
Creatinine	0.70-1.30 mg/dL	1.04	0.66	Client has been on bedrest since the 20th. He is short of breath and his

				strength and muscle mass may be diminished (Pagana, 2018).
Albumin	3.5-5.2 g/dL	3.4	**N/A**	Client may be stressed and experiencing infection due to toe amputation (Pagana, 2018).
Calcium	8.6-10.3 mg/dL	9.1	7.6	Client experienced low albumin levels, which can also lower calcium levels (Pagana, 2018).
Mag	1.5-2.5 mg/dL	**N/A**	1.9	**N/A**
Phosphate	2.4-4.5 units/L	**N/A**	**N/A**	**N/A**
Bilirubin	0.3-1.0 mg/dL	1.0	**N/A**	**N/A**
Alk Phos	34-104 units/L	151	**N/A**	Client has healing left knee injury, which can increase alkaline phosphatase (Pagana, 2018).
AST	13-39 U/L	31	**N/A**	**N/A**
ALT	7-52 U/L	44	**N/A**	**N/A**
Amylase	60-100 U/dL	**N/A**	**N/A**	**N/A**
Lipase	0-160 U/L	**N/A**	**N/A**	**N/A**
Lactic Acid	0.5-1.5 mEq/L venous	**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	1-2	N/A	N/A	N/A
PT	10-12 seconds	N/A	N/A	N/A

PTT	30-45 seconds	N/A	N/A	N/A
D-Dimer	Negative, less than 250 mg/mL	N/A	N/A	N/A
BNP	Less than 100 pg/mL	N/A	N/A	N/A
HDL	Less than 60 md/dL	N/A	N/A	N/A
LDL	Less than 100 mg/dL	N/A	N/A	N/A
Cholesterol	Less than 200 mg/dL	N/A	N/A	N/A
Triglycerides	Less than 150 mg/dL	N/A	N/A	N/A
Hgb A1c	Less than 5.7%	N/A	N/A	N/A
TSH	0.5-5.0	N/A	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow, clear	N/A	Light Yellow	N/A
pH	5.0 – 8.0	N/A	8.0	N/A
Specific Gravity	1.005 – 1.034	N/A	1.037	Client has traces of glucose and protein in urine, which can increase specific gravity (Pagana, 2018).
Glucose	Negative	N/A	1000	Client has diabetes (Pagana, 2018).
Protein	Negative	N/A	Trace	Client has diabetes and high glucose levels and may have diabetic glomerulosclerosis (Pagana, 2018).
Ketones	Negative	N/A	Trace	N/A
WBC	0-0.5	N/A	< 1	N/A
RBC	0 - 3	N/A	2	N/A

Leukoesterase	Negative	N/A	Negative	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	N/A	N/A	N/A
Blood Culture	Negative	Negative	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Lakeview College of Nursing Diagnostic Lab Value Sheet

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). Mosby's diagnostic and laboratory test reference (6th ed.). St. Louis, Mo.: Mosby.

Sarah Bush Lincoln Center Hospital System. Medical Values

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1. **X-Ray Foot Complete**
    - Extensive tissue edema surrounding the right great toe. No acute fracture or malignant found.
2. **X-Ray Knee**
    - Knee effusion and moderate joint effusion were present. No acute fractures found.

3. **Venous Duplex of Left Lower Leg**
    - In Progress
4. **Echo of Heart and Great Vessels**
    - Heart was pumping at 60-70% ejection fraction. Trileaflet aortic valve operating absent of significant stenosis or regurgitation. Atrial fibrillation found with mild tricuspid valve regurgitation.
5. **Arthrocentesis**
    - In Progress

Diagnostic Test Correlation (5 points):

1. X-Rays not only look at bones to see the density, texture, erosion, and overall changes, but they can also look at joints individually. Joint x-rays can show fluid accumulation, irregularities, narrowing, or spur formations in the joint structure (Hinkle & Cheever, 2018). A joint X-ray was done on the client to determine the extent of damage to his left knee and the region of his amputated great toe. Results show visible knee effusion, which is the accumulation of fluid in his left knee joint, and extensive tissue edema surrounding the site of the amputated great toe. This could affect the client's ability to walk. No malignant or fractures were found.
2. A venous duplex is a noninvasive procedure that creates images of tissues, organs, and blood vessels (Hinkle & Cheever, 2018). A doppler is used which can help detect occlusions, stenosis (Hinkle & Cheever, 2018). A venous duplex was ordered for the client's left lower leg to check for potential occlusions and damage done to surround tissue. The results were yet to be determined during shift.

3. An echocardiogram is a procedure that delivers high frequency sound waves through the chest wall into the heart. Echoes of the waves are picked up and converted into electrical pulses that are displayed to create a spatially accurate image of the heart (Hinkle & Cheever, 2018). An echocardiogram was ordered for the client. Even with a 60-70% ejection fraction, atrial fibrillation was found with mild tricuspid valve regurgitation. This could potentially explain the client's shortness of breath.
4. An arthrocentesis is a procedure done to aspirate excess fluid out of a joint effusion. This is done to relieve the join of pressure and to determine what was the cause of the effusion (Hinkle & Cheever, 2018). The client was prepared for his arthrocentesis procedure at 1330 hours due to his knee effusion. Results are to be determined.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	**Simvastatin ZOCAR**	**Gabapentin NEURONTIN**	**Benazepril LOTENSIN**	**Levothyroxine LEVO-T**	**Fluoxetine PROZAC**
Dose	20 mg	100 mg	20 mg	50 mcg	40 mg
Frequency	Nightly	Q8H	BID	Daily	Daily
Route	Oral	Oral	Oral	Oral	Oral

Classification	Antilipemic (Jones, 2020)	Anticonvulsant (Jones, 2020)	Antihypertensive (Jones, 2020)	Thyroid hormone replacement (Jones, 2020)	Antidepressant (Jones, 2020)
Mechanism of Action	Interrupts the formation of mevalonic acid, which stops cholesterol synthesis. (Jones, 2020)	Inhibits rapid firing of neurons associated with seizures and exaggerated responses to painful stimuli (Jones, 2020)	Binds to alpha subunit of human interleukin-5 receptor which prevents inflammatory process. (Jones, 2020)	Replaces endogenous thyroid hormone (Jones, 2020)	Boosts mood by inhibits reuptake of serotonin, increasing the amount of serotonin in nerve synapses (Jones, 2020)
Reason Client Taking	To treat hyperlipidemia	To control diabetic neuropathy (MedlinePlus, 2021)	To control hypertension alone or with a thiazide diuretic (Jones, 2020)	To treat mild hypothyroidism (Jones, 2020)	To treat depression
Contraindications (2)	Active hepatic disease; hypersensitivity to simvastatin or its products (Jones, 2020)	Hypersensitivity to gabapentin; hypersensitivity to components of gabapentin (Jones, 2020)	Hypersensitivity to benazepril or its components; history of angioedema (Jones, 2020)	Acute MI; hypersensitivity to levothyroxine or its components (Jones, 2020)	Concurrent therapy with pimozide or thioridazine; hypersensitivity to fluoxetine or its components. (Jones, 2020)
Side Effects/Adverse Reactions (2)	Atrial fibrillation; hepatic failure (Jones, 2020)	Suicidal ideation; psychosis (Jones, 2020)	Angina; hypotension (Jones, 2020)	Arrhythmias; angioedema (Jones, 2020)	Seizures; hypoglycemia (Jones, 2020)
Nursing Considerations (2)	Use cautiously in patients with hepatic or renal impairment; do not exceed 80 mg of simvastatin. Can cause	Monitor patient for suicidal thinking or behavior; gabapentin capsules may be opened and mixed with applesauce, juice, and water before	Have patients sit up slowly and sit on edge of bed before walking; evaluate blood pressure of patient when sitting, lying,	Do not give this medication for weight loss or obesity treatment; use cautiously in elderly patients with	Use cautiously in children and people with history of seizures; Monitor clients closely for depression and suicidal

	myopathy. (Jones, 2020)	giving to patient (Jones, 2020).	and then standing (Jones, 2020)	cardiovascular disease. (Jones, 2020)	tendencies after administration. (Jones, 2020)

Hospital Medications (5 required)

Brand/Generic	**lidocaine XYLOCAINE**	**Polyethylene glycol MIRALAX**	**Potassium chloride APO-K**	**Morphine ROXANOL**	**Ondansetron ZOFRAN**
Dose	200 mg (20 mL)	17 g	20 mEq (100 mL)	2 mg	4 mg
Frequency	Once	Daily	Q2H	Q6H	Q6H PRN
Route	SubQ	Oral	IV piggyback	IV push	IV push
Classification	Anesthetic (Rxlist.com, 2021)	Osmotic laxative (MedlinePlus, 2021)	Electrolyte replacement (Jones, 2020)	Opioid analgesic (Jones, 2020)	Antiemetic (Jones, 2020)

Mechanism of Action	Inhibits ionic fluxes that initiate conduction of impulses, reducing pain (Rxlist.com, 2021)	Causes water retention in stools and softens them (MedlinePlus, 2021)	Acts as the major cation in intracellular fluid activating essential physiologic processes, such as nerve impulse transmission, cardiac and skeletal muscle contractions. (Jones, 2020)	Binds and activates opioid receptors in brain and spinal cord to produce analgesia and euphoria (Jones, 2020)	Reduces nausea by blocking serotonin receptors centrally in chemoreceptor rigger zone and peripherally at vagal nerve in the intestines. (Jones, 2020)
Reason Client Taking	To control pain	To treat constipation	To treat hypokalemia	To control pain	Prevent nausea and vomiting
Contraindications (2)	Hypersensitivity to lidocaine and its products; patients with heart block (Rxlist.com, 2021)	Hypersensitivity to Miralax or its components; pregnant patients should avoid taking. (MedlinePlus, 2021)	Acute dehydration, Addison's disease, concurrent use with amiloride or triamterene; hypersensitivity to potassium chloride or its components. (Jones, 2020)	Acute alcoholism; hypersensitivity to morphine or its components (Jones, 2020)	Hypersensitivity to ondansetron or its components; concomitant use of apomorphine or congenital long QT syndrome. (Jones, 2020)
Side Effects/Adverse Reactions (2)	Weak pulse, blurred vision (Rxlist.com, 2021)	Nausea; Cramping (MedlinePlus, 2021)	Hyperkalemia; ventricular fibrillation (Jones, 2020)	Bradycardia; hypotension (Jones, 2020)	Hypotension; arrhythmias (Jones, 2020)
Nursing Considerations (2)	Administer lidocaine in lowest effective dosage; Use	Store medication at room temperature; monitor	Administer oral potassium with or immediately	Use cautiously in patients about to go into surgery;	Correct any electrolyte imbalances such as hypokalemia

	caution in patients with severe shock or heart block (Rxlist.com, 2021)	symptoms of overdose such as diarrhea, thirst, confusion and seizure. (MedlinePlus , 2021)	after meals; regularly assess patients for signs of hypokalemia , such as arrhythmia, fatigue, and weakness. (Jones, 2020)	makes sure medical equipment for oxygen delivery are available before administering. (Jones, 2020)	or hyperkalemia before administering ondansetron; monitor clients for hypersensitivity reactions because they can be deadly. (Jones, 2020)

Medications Reference (1) (APA):

Jones, D. W. (2020). *Nurse's drug handbook*. (A. Barlett, Ed.) (19th ed.). Jones & Bartlett Learning.

MedlinePlus. (updated 2021, February 24). MedlinePlus. U.S National Library of Medicine. https://medlineplus.gov/

RxList. (2021). RxList. WebMD. Retrieved 27 February 2021 from https://www.rxlist.com/script/main/hp.asp

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Client was alert and oriented to person, place, time, and situation (x4). He appeared to be calm but expressed distress during physical activity when lower extremities were moved. Client's hair appeared to be disheveled.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** .	Client's skin was warm, pink, dry and intact with skin turgor less than three seconds. Skin was absent of rashes, bruises, or wounds. No drains present. Client has a Braden score of 13 (high risk for skin breakdown) and does not change positions frequently due to pain in left and right lower

Braden Score: **Drains present: Y☐ N ☒** **Type:**	extremity.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Client's head and neck appeared to be midline with no deviations or bruises. His ears were intact and symmetrical with no drainage. Client was able to hear well being able to respond to questions when whispered. Client wears glasses and eyes exhibited PERRLA and six cardinal fields. Eyes appeared to be symmetrical with no drainage. Client's nose was midline and absent of deviated septum. Client's teeth were intact with none missing. Tongue appeared to be pink in color and midline. Mucosa was pink and moist. .
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 heard. Client had a regular heartbeat. Peripheral pulses were palpable at carotid (bilaterally), radial and left brachial at a +2. Right brachial was avoided due to bandage and lower extremities were avoided due to pain. Capillary refill was less than three seconds. No edema upon assessment.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No abnormal lung sounds heard upon assessment. Client has a respiratory rate of 18 breaths per minute. No chest deformities noted. Client's chest raised and lowered evenly and deeply with no accessory muscles used. Client denied coughing.
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 ☒**	Client eats a cardiac diet in the hospital. Client states that he eats well at home but should stay away from sodium. Client weighs 99.7 kg (219.8 lbs) Client stands at 6'1" (188 cm) Client's bowels sounds were active with about 5 to 30 sounds a minute. Client stated that his last bowel movement prior movement at 1330 hours was on the 21st of February. There was no pain or mass upon palpation, but abdomen appeared distended prior bowel movement at 1330 hours. Client stated that he felt much better after bowel movement. No

Nasogastric: Y ☐ N ☒ **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	scars, drains, or wounds present. No ostomy, NG, or feeding tubes present.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine was yellow, and clear. 997 mL of urine was collected and measured. Client denied any pain or burning during voiding. Abdomen was distended prior administration of Miralax and bowel movement at 1330 hours. Client stated that he felt much better after bowel movement. No dialysis or catheters in place upon assessment of genitals.
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☒**	Neurovascular status is intact; client has control of senses. Client's ROM is limited due to pain in lower extremity. He has full ROM in upper extremities bilaterally. Movement is slow but deliberate. Client uses a walker, gait belt, immobilizer, and a commode in the hospital and a cane at home. Upper extremity strength is equal and can go against opposite force for a short period before fatigue. Lower extremities strength is diminished and not equal. Client is a high fall risk with a fall score of 90. Client requires assistance with ambulation and using the commode. He has trouble moving both legs independently and needs help moving his legs as well as standing and walking.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Client has difficulties moving lower extremities well but moves upper extremities well. Strength is equal in upper extremities bilaterally but limited and not equal in lower extremities. Client exhibited PERLA. Client is alert and oriented to time, place, person, situation (x4). Mental status is appropriate for his age; can respond to questions well and has adequate comprehension. Speech is loud and

	audible; no mumbling, or slurring. Sensory is intact with no loss of consciousness assessed.
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):**	Client lives at home with his wife who is his support system. He is proud of his long-lasting marriage. States that his home is nice and tidy. He is a Southern Baptist and likes to go to church every Sunday as a coping mechanism. Looks forward to church. His developmental level is appropriate with no signs or history of depression.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1145	94 bpm	132/63 mmHg	18 rpm	37.3C	98%
0756	109 bpm	124/66 mmHg	18 rpm	36.6 C	94%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	Numeric Pain Scale	Left knee	9	Sharp	Prevent leg from moving with immobilizer.
1625	Numeric Pain Scale	Left knee	10	“Exploding”	Administer pain meds (morphine).

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:**	Client has 20 gauge IV in left and right antecubital. IV were placed on 2/22/2021. IV site was dry, and intact.

Patency of IV: **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	No erythema, drainage, swelling, or warmth upon assessment. IV dressing was clear, and intact. Saline is not locked; potassium chloride is being administered. IV is patent.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
997 mL Oral Intake – 997 mL	1625 mL Void - 1625

Nursing Care

Summary of Care (2 points)

Overview of care: Care provided to client consisted of controlling pain levels, providing comfort bedside care, and administration of scheduled medications; client was assisted to a bedside commode at around 1330 hours and back to bed. Potassium chloride and antibiotics were replaced at around 1245 and 1330 hours respectively. Client was prepared for an ultrasound and to have fluid aspirated from his knee at around 1530 hours. Pain was assessed and morphine was administered to control pain at 1600 hours.

Procedures/testing done: Client was sent down to receive an ultrasound for his left knee and to have fluid aspirated from the same knee during shift at 1530 hours.

Complaints/Issues: Client complained about pain in his left knee and right toe. Described left knee pain as “exploding” after ultrasound and getting fluid removed from his left knee. Morphine was administered. Client stated that he felt better; rated pain at a 7 out of 10**.**

Vital signs (stable/unstable): Vital signs stabilized as day progressed. Client had 109 bpm and oxygen of 94% at 0756 hours which improved to a 94 bpm and 98% at 1145 hours.

Tolerating diet, activity, etc.: Client is on a diabetic diet and states that he is eating everything. He tries not to move to prevent further pain in his left knee.

Physician notifications: There were no physician notifications during shift.

Future plans for patient: Client is to be prepared for surgery the following morning.

Discharge Planning (2 points)

Discharge location: Client is to go home with wife after discharged.

Home health needs (if applicable): Client will need caretaker to monitor and assist him with walking to prevent any further falls.

Equipment needs (if applicable): Client will need to use a walker and cane to assist him with ambulating.

Follow up plan: Follow up plans are to be determined at this time.

Education needs: Client will need to be educated on how to use a walker and cane correctly, how to care for feet due to neuropathy from diabetes, and how to reduce left knee pain.

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. Risk for falls related to impaired movement	The client's left knee is in acute pain and he states that pain is	**1.** Assess the patient's fall risk using a fall risk assessment tool.	**1.** Goal met. High fall risk score of 90 was determined for client. Client states that he needs

as evidenced by inability to move lower extremities without assistance and shortness of breath.	present when he tries to move it. There is also an immobilizer leg brace worn on the left knee, which impair movement in the left leg. Client also is short of breath when attempted to stand on his own. Assistance was needed to help client move. Client safety is priority.	**2.** Provide assistance with ambulation.	assistance in order to ambulate and use the commode. **2.** Goal met. Assistance was provided during ambulation to the commode. Client expressed distress when standing for too long.
2. Risk for skin breakdown related to bedbound as evidenced by high Braden score	Client is bedbound due to impaired movement related to acute pain. He states that he tries to move as little as possible to avoid pain. Client does not change positions due to left knee pain and is in one position throughout the shift.	**1.** Place pads or pillows under bony prominences. **2.** Encourage the client to change positions every two hours.	**1.** Goal met. Patient verbalized relief after pillow was placed underneath his right heel. **2.** Goal not met. Client verbalized that he understood the reason to change positions, and states that he will try, but did not change positions once.
3. Risk for constipation related to bedbound as evidenced by struggling on commode.	Client is immobilized and is sedentary. Opioids such as morphine was administered to client which is known to slow gastric activities.	**1.** Assess bowel sounds and for distention in abdomen. **2** Encourage client to drink at least 1000 mL of fluids.	**1.** Goal met. Active bowel sounds of roughly around 5 to 30 bowel sounds a minute heard upon assessment. Distention was noted before and after commode use; distention decreased after commode use. Client states that he feels decreased distention. **2.** Goal met. Client is aware of necessity of

			drinking fluids. States that he will drink more fluids.

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

Client rates his left knee pain a 9 out of 10 and an 8 out of 10 for his right amputated great toe.
Client states that he needs assistance ambulating.
Complains of shortness of breath when standing for too long.
States that he keeps lower extremities as still as possible to reduce pain.
Says that his last bowel movement was on the 21st of February.
Reported that he struggled to use the commode due to constipation.

Nursing Diagnosis/Outcomes

Risk for falls related to impaired movement as evidenced by inability to move lower extremities without assistance and shortness of breath.
Outcome: Client will let the student nurse know when he needs assistance to get up and use the commode during clinical.
Risk for skin breakdown related to bedbound as evidenced by high Braden score
Outcome: Client will change positions with or without assistance at least once during clinical.
Risk for constipation related to bedbound as evidenced by struggling on commode.
Outcome: Client will drink at least 1000 mL of fluid during clinical

Objective Data

Client was given opioid (morphine) for his pain.
Abdomen was distended.
Client was on commode for about ten minutes.
X-ray of lower extremities show knee effusion and edema in tissue surrounding the right great toe.
Echocardiogram found atrial fibrillation with mild tricuspid valve regurgitation.
S1 and S2 heard. Client has history of atrial fibrillation.
Client was short of breath

Patient Information

Client is a 62-year-old Caucasian male with a history of arthritis, hyperlipidemia, atrial fibrillation. He was admitted due to a broken left knee after he bent over and fell. Chief complaint is acute left knee pain which he rates at a 9 out of 10 on a pain scale. Client also had his right great toe amputated which he rates an 8 out of 10 pain.

Nursing Interventions

Assess the patient's fall risk using a fall risk assessment tool.
Provide assistance with ambulation.
Place pads or pillows under bony prominences.
Encourage the client to change positions every two hours.
Assess bowel sounds and for distention in abdomen.
Encourage client to drink at least 1000 mL of fluids.