N431 Care Plan 1

Lakeview College of Nursing

Koti York

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2/26/21	**DK**	**51 years old**	**Male**
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	**McLane Midwest**	**Single**	**NKA**
Code Status	**Height**	**Weight**	
Full	**5'11"**	**292 lbs**	

Medical History (5 Points)

Past Medical History: Closed tibia fracture on the left leg, history of alcoholism, hypertension, kidney disease, and a new diagnosis of diabetes

Past Surgical History: Tonsillectomy

Family History: Coronary artery disease in his mother, diabetes in both parents, hypertension in both parents, and kidney disease in both parents

Social History (tobacco/alcohol/drugs): Stopped smoking in 2000, denies every using smokeless tobacco, has a past history of alcoholism. Currently uses marijuana.

Assistive Devices: None

Living Situation: Lives on his own in a house.

Education Level: College level

Admission Assessment

Chief Complaint (2 points): Generalized fatigue and left leg pain

History of present Illness (10 points): The client states that the onset of fatigue began the night before his admission, but his leg pain has been going on since he fractured it four months ago. When he has pain, it is in his left leg and is a dull aching. The client reports that the duration has been ongoing since he found out that it was fractured four months ago. The characteristic of his pain is a dull aching pain that goes from his hip to his feet. The client reports there are no

aggravating factors, and the relieving factors are rest and recreational use of marijuana. Treatment during his hospital stay was acetaminophen as needed. The client reports no pain 0 out of 10 during clinical, so we did not administer acetaminophen.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute kidney failure stage three developing into chronic kidney disease.

Secondary Diagnosis (if applicable): Chronic hypertension

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

Acute renal failure has four stages initial, oliguria, diuresis, and recovery (Capriotti & Frizzell, 2016). The initial phase lasts hours to days and is determined from the precipitating insult until the initial manifestations (Capriotti & Frizzell, 2016). Oliguria is associated with a decreased GFR, retention of urea, potassium, sulfate, and creatinine (Capriotti & Frizzell, 2016). The diuretic phase is when the kidneys begin to recover from the initial insult where healing occurs, and fibrotic tissue forms where there are damaged nephrons (Capriotti & Frizzell, 2016). The recovery phase is the time needed for the repair and damage and starts with the onset of increased urine output (Capriotti & Frizzell, 2016). Clinical manifestation includes oliguria, fluid overload, nitrogenous waste buildup, encephalopathy, anemia, hyperkalemia, metabolic acidosis, thrombocytopenia, and neuromuscular irritability (Capriotti & Frizzell, 2016). Fluid overload symptoms include edema of the face and extremities, pulmonary edema, and respiratory distress (Capriotti & Frizzell, 2016). Diagnosis includes urinalysis, serum electrolytes, serum creatinine, serum BUN, arterial blood gases, and CBC. Treatment includes fluid administration until oliguria occurs, then a diuretic needs to be implemented. Electrolytes need to be routinely

monitored, and if symptoms worsen, dialysis may need to be an option. Expected vital sign trends would include high blood pressure readings (Fruchter, 2021). My patient has routine labs, hypertensive medications, and a consult with nephrology. His abnormal labs include low lymphocytes, RBC, Hgb, Hct, and potassium. He has high neutrophils, BUN, creatinine, and urine glucose, and protein. He has an abnormal blood pressure of 149/108 at 0730 and 171/104 at 1030, consistent with kidney failure and hypertension.

Hypertension harms the cardiovascular system by exerting high damaging forces against the arteries' endothelial lining (Capriotti & Frizzell, 2016). Hypertension also causes high resistance against the left ventricle of the heart. The left ventricle hypertrophies because there is excessive resistance in the aorta (Capriotti & Frizzell, 2016). Once the left ventricle's enlarged muscle occurs, there is a need for extra blood flow because of increased energy (Capriotti & Frizzell, 2016). There is not enough supply of additional blood flow, and that leads to left ventricle ischemia and infarction (Capriotti & Frizzell, 2016). RAAS helps play a role in the regulation of blood pressure when there is an elevation. The clinical presentation of hypertension does not exist until the disease has affected other organs in the body. Organ damage symptoms include chest pain, dyspnea on exertion, palpitations, headache, visual disturbances, dizziness, weakness in an extremity, leg pain, or edema (Capriotti & Frizzell, 2016). Expected findings in vital signs would elevate blood pressure, but the readings have to be high on two separate days for it to be diagnosed. Standard testing done for hypertension includes 12 lead ECGs, urinalysis, CBC, blood glucose, serum potassium, serum creatinine, and serum calcium (Capriotti & Frizzell, 2016). Treatment should include lifestyle modifications such as diet, stress reduction, physical activity, and smoking cessation (Capriotti & Frizzell, 2016). The diet should be a DASH diet which is low sodium, low-fat foods that consist mainly of fruits, vegetables, whole

grains, poultry, fish, and low-fat dairy products (Capriotti & Frizzell, 2016). Pharmacological include diuretics, ACE inhibitors, angiotensin receptor blockers, or BETA blockers (Capriotti & Frizzell, 2016). My patient had routine labs down that showed his baseline on admission and then compared them daily to see the fluctuation. He is also on amlodipine and hydralazine for his blood pressure. His blood pressure was still reading high at 149/108 at 0730 and 171/104 at 1030. He was given medication to reduce the readings.

Pathophysiology References (2) (APA):

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

Fruchter, A. (2021). Chronic kidney disease. Retrieved from https://www.vitalsignsmed.com/PracticeManager/patient_v2/instructions.php?id=2037525&iid=3574

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	4-4.9 million/ mm3	4.36	3.70	A low red blood cell level can be related to kidney diseases because the appropriate red blood cells are not being produced (Pagana et al., 2019).
Hgb	12-18 g/dL	12.9	11.2	A low hemoglobin level can be related to kidney diseases because the appropriate red blood cells are not being produced (Pagana et al., 2019).
Hct	36-50 mL/dL	37.7	31.9	A low hematocrit level can be related to low vitamin and mineral levels and he has a new diet (Pagana et al., 2019).
Platelets	150,000-350,000 mm3	213	238	
WBC	4,500-11,000 mm3	10.20	8.80	
Neutrophils	52-62%	78.7	N/A	The reason for high neutrophils can be related to his weight or him smoking (Pagana et al., 2019).
Lymphocytes	25-33%	12.1	N/A	The reason for low lymphocytes can be related to his late-stage kidney disease which reduces the number of T cells in the blood (Pagana et al., 2019).
Monocytes	3-7%	6.4	N/A	
Eosinophils	1-3%	1.9	N/A	
Bands	3-5%	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 mEq/L	139	139	

K+	**3.5-5.0 mEq/L**	**3.3**	**3.5**	**The reason for low potassium could be related to his alcoholism, diabetes, or chronic kidney disease because he was not getting enough potassium in his diet to keep up the levels (Pagana et al., 2019).**
Cl-	**98-108 mEq/L**	**102**	**106**	
CO2	**22-32 mEq/ L**	**24**	**22**	
Glucose	**70-99 mg/dL**	**221**	**163**	**The reason glucose is high is because the patient based new diagnosis of diabetes that he was unaware of, so it was not controlled (Pagana et al., 2019).**
BUN	**10-25 mg/dL**	**79**	**73**	**The reason BUN is high is due to the patient's kidney disease and it not filtering out the waste product (Pagana et al., 2019).**
Creatinine	**0.2-0.9 mg/ dL**	**7.40**	**6.46**	**The reason creatinine is high is due to the patient's kidney disease because it is being held in the kidneys (Pagana et al., 2019).**
Albumin	**3.5-5.0 g/dL**	**3.8**	**3.5**	
Calcium	**8.5-10.5 mg/dL**	**8.7**	**8.7**	
Mag	**1.5-2.5 mg/ dL**	**1.5**	**1.6**	
Phosphate	**2.5-4.5 mg/ dL**			
Bilirubin	**0.1-1.3 mg/ dL**	**0.4**	**N/A**	
Alk Phos	**40-120 u/L**	**102**	**N/A**	
AST	**10-40 u/L**			
ALT	**7-56 u/L**			
Amylase	**30-100 u/L**			

Lipase	**0-160 u/L**			
Lactic Acid	**0.5-1 mmol/ L**			
Troponin	**0-0.4 ng/mL**			
CK-MB	**0-5 ng/mL**			
Total CK	**22-198 u/L**			

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**	**1.1**	**N/A**	
PT	**10-13 sec**	**13**	**N/A**	
PTT	**25-36 sec**			
D-Dimer	**<500 ng/mL**	**496**	**N/A**	
BNP	**0-100 pg/mL**			
HDL	**60- above mg/dL**			
LDL	**Less than 100 mg/dL**			
Cholesterol	**Less than 200 mg/dL**			
Triglycerides	**Less than 150 mg/dL**			
Hgb A1c	**Less than 5.7%**			
TSH	**0.4-4.0 mU/ L**			

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	**Light yellow/pale and clear**	**Yellow/ hazy**	**Yellow/clear**	
pH	**4.6-8**	**5**	**5**	
Specific Gravity	**1.001-1.035**	**1.012**	**1.009**	
Glucose	**Negative**	**1+**	**3+**	**The reason glucose shows in the urine is because he has high blood glucose and kidney damage (Pagana et al., 2019).**
Protein	**Negative**	**3+**	**3+**	**The reason protein shows in the urine is due to kidney disease because they cannot excrete it (Pagana et al., 2019).**
Ketones	**Negative**	**Negative**	**Negative**	
WBC	**Negative**	**Negative**	**Negative**	
RBC	**Negative**	**Negative**	**Negative**	
Leukoesterase	**Negative**			

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**			
PaO2	**80-100 mm Hg**			
PaCO2	**35-45 mm Hg**			
HCO3	**22-26 mEq/L**			
SaO2	**95-100%**			

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	**(-) <10,000 mL (+) >100,000 mL**			
Blood Culture	**Negative**			
Sputum Culture	**Normal upper respiratory tract**			
Stool Culture	**Normal intestinal flora**			

Lab Correlations Reference (1) (APA):

Pagana, K.D., Pagana, T.J., and Pagana, T.N. (2019). *Mosby's Diagnostic and Laboratory Test Reference.* St. Louis, MO: Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): X-ray, US Renal Complete, US left duplex of lower extremities

Diagnostic Test Correlation (5 points):

X-ray: no fracture or dislocation, no bony abnormalities, no joint abnormalities.

US renal complete: AKI, R & L kidney- no significant evidence of hydronephrosis bilaterally.

Bladder: not well assessed due to under distension. Prevoid of 63 cc.

Other: cholelithiasis without evidence of cholecystitis

Impressions: no significant evidence of hydronephrosis bilaterally, there are sub centimeter bilateral renal cysts, there is cholelithiasis without evidence of cholecystitis, and bladder is not well assessed due to under distention.

US left duplex of lower extremities: Impressions: veins assessed include common femoral, profunda femoral, femoral, popliteal, distal posterior tibial.

Superficial veins visualized greater saphenous from saphenous femoral junction to knee.

All visualized compressibility and color follow.

No evidence of DVT or superficial thrombophlebitis.

X-rays use electromagnetic energy to produce images of bones, tissue, and organs on a film or digital imagery (Johns Hopkins Medicine, n.d.). If a bone is broken, then the x-ray beams will pass through the area, and it will be a darkened area instead of the white area of the bone (Johns Hopkins Medicine, n.d.). X-rays can pass through soft tissues and show only bones, organs, and tumors (Johns Hopkins Medicine, n.d.). My patient received an x-ray because he presented to the emergency department with complaints of left leg pain. The x-ray ruled out a break or fracture to the left leg bone.

A US renal complete is also known as a kidney ultrasound. This is a noninvasive diagnostic exam that produces images of the kidneys' size, shape, and location (Johns Hopkins Medicine, n.d.). Ultrasounds can also show the blood flow to the kidneys (Johns Hopkins Medicine, n.d.). They can detect cysts, tumors, abscesses, obstructions, fluid collection, infections, and calculi within the kidneys (Johns Hopkins Medicine, n.d.). If fluid would need to be drained or a biopsy would need to be performed, ultrasound technicians would use an ultrasound to ensure they are in the correct location for the procedure. My patient received this exam because he is in acute renal failure, and they were viewing the kidneys and looking for any abnormalities that may cause problems. The ultrasound concluded renal cysts and cholelithiasis bilaterally.

A US duplex of the lower extremities shows the blood flow through the arteries and veins (Medlineplus medical encyclopedia, n.d.). This ultrasound combines traditional and doppler to see and record the soundwaves reflecting on objects (Medlineplus medical encyclopedia, n.d.). My patient received this test because he had left leg pain upon admission, and this test can rule out DVT or blood clots within that area. His test results came back normal, resulting in no DVT, blood clots, and regular blood flow within the extremities.

Diagnostic Test Reference (1) (APA):

Johns Hopkins Medicine. (n.d.). *Kidney ultrasound.* Retrieved from https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/kidney-ultrasound#:~:text=What%20are%20the%20reasons%20for,within%20or%20around%20the%20kidneys.

Johns Hopkins Medicine. (n.d.). *X-rays*. Retrieved from https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/xrays#:~:text=Standard%20X%2Drays%20are%20performed,internal%20structures%20for%20diagnostic%20purposes.

Medlineplus medical encyclopedia. (n.d.). *Duplex ultrasound*. Retrieved from https://medlineplus.gov/ency/article/003433.htm

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

Home Medications (5 required)

Brand/Generic	**acetaminophen (Tylenol)**	**insulin isophane (Humulin)**	**insulin lisinopril (Humalog)**	**magnesium oxide (Mag-Ox)**	**Escitalopram oxalate (Lexapro)**
Dose	**650 mg**	**30 u**	**2-6 u**	**400 mg**	**10 mg**
Frequency	**Every 4 hours PRN**	**2 times daily**	**Nightly**	**Daily**	**Daily**
Route	**Oral**	**Subcutaneous**	**Subcutaneous**	**Oral**	**Oral**
Classification	**Nonsalicylate, para-aminophenol derivative (Jones and Bartlett, 2019, pg 12).**	**Antidiabetic**	**Antidiabetic**	**Antacid, antiarrhythmic, anticonvulsant, electrolyte replacement, laxative**	**Antidepressant**
Mechanism of Action	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2 (Jones and Bartlett, 2019, pg 13).**	**Lower blood glucose by stimulating peripheral glucose uptake especially by skeletal muscle and fat by inhibiting hepatic glucose production. Insulin inhibits lipolysis and proteolysis and enhances protein synthesis.**	**Lower blood glucose by stimulating peripheral glucose uptake especially by skeletal muscle and fat by inhibiting hepatic glucose production. Insulin inhibits lipolysis and proteolysis and enhances protein synthesis.**	**Assists all enzymes involved in phosphate transfer reactions that use ATP. Magnesium is required for normal function of the ATP dependent sodium-potassium pump in muscle membranes (Jones and Bartlett, 2019, pg 732).**	**Inhibits reuptake of the neurotransmitter serotonin by CNS neurons, increasing the amount of serotonin available in nerve synapse. An elevated serotonin level may result in elevated mood and reduced anxiety or depression (Jones and Bartlett, 2019, pg 433)**
Reason Client Taking	**To relieve moderate to**	**To improve glycemic**	**To improve glycemic**	**To correct magnesium**	**To treat anxiety or**

	mild pain (Jones and Bartlett, 2019, pg 12).	**control in diabetes mellitus.**	**control in diabetes mellitus.**	**deficiency caused by alcoholism.**	**depression**
Contraindications (2)	**Hypersensitivity to acetaminophen or its components, severe hepatic impairment (Jones and Bartlett, 2019, pg 13).**	**Hypersensitivity to Humalog or its components. Can cause hypoglycemia.**	**Hypersensitivity to Humalog or its components. Can cause hypoglycemia.**	**Hypersensitivity to magnesium salts. Renal impairment.**	**Hypersensitivity to escitalopram, citalopram, or its components. Use within 14 days of MAO inhibitor therapy**
Side Effects/Adverse Reactions (2)	**Hypertension and agitation (Jones and Bartlett, 2019, pg 13).**	**Swelling in hands or feet and hypokalemia**	**Swelling in hands or feet and hypokalemia.**	**Muscle cramps and confusion**	**DVT and diabetes mellitus**
Nursing Considerations (2)	**Monitor renal function in patient with long term therapy. Do not exceed daily dosage or mix other medications with acetaminophen at the same time (Jones and Bartlett, 2019, pg 14).**	**If drawing up with other insulin draw up insulin lispro first to avoid contamination. Administer 15 minutes before a meal and rotate injection sites.**	**If drawing up with other insulin draw up insulin lispro first to avoid contamination. Administer 15 minutes before a meal and rotate injection sites.**	**Provide adequate diet, exercise, and fluids for patient being treated for constipation. Monitor serum electrolyte levels in patients with renal insufficiency because they are risk for magnesium toxicity.**	**Monitor patient for bleeding especially in patients taking NSAIDs, anticoagulant, and aspirin. Watch for signs of abuse or misuse.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assessing renal and liver function as it can**	**Assessing the client's glucose level before administrati**	**Assessing the client's glucose level**	**Assessing the client's electrolyte levels and renal**	**Look to see if patient is taking NSAIDs as they can**

	impair how they work	**on**		**function**	**interact and cause bleeding**
Client Teaching needs (2)	**Do not exceed the recommended dosage or take other medications containing acetaminophen at the same time. Signs of hepatotoxicity include bleeding, easy bruising, and malaise**	**Do not shake and draw up insulin with bubbles because it can affect the dosing. Keep unopened insulin refrigerated until first use.**	**Store opened insulin in a climate that is 65-80 degrees F. Check expiration date before administering medication.**	**Prevent constipation by increasing dietary fiber and fluid intake. Magnesium supplements used to replace electrolytes can cause diarrhea.**	**Alcohol intake is not recommender when taking this medication. Advise patient to avoid hazardous activities until drugs CNS effects are known.**

Hospital Medications (5 required)

Brand/Generic	**allopurinol (Zyloprim)**	**Amlodipine besylate (Norvasc)**	**Atorvastatin calcium (Lipitor)**	**heparin sodium**	**hydralazine hydrochloride (Apresoline)**
Dose	**100 mg**	**10 mg**	**10 mg**	**7500 u**	**75 mg**
Frequency	**Daily**	**Daily**	**Daily**	**3 times daily**	**3 times daily**
Route	**Oral**	**Oral**	**Oral**	**Subcutaneous**	**Oral**
Classification	**Antigout**	**Antihypertensive**	**Antihyperlipidemic**	**Anticoagulant**	**Antihypertensive**
Mechanism of Action	**Inhibits uric acid production by inhibiting xanthine**	**Binds to dihydropyridine and nondihydropyridine cell**	**Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA**	**Binds with antithrombin 3, enhancing antithrombin 3 inactivation of**	**May act in a manner that resembles organic nitrates and**

	oxidase, the enzyme that converts hypoxanthine and xanthine to uric acid (Jones and Bartlett, 2019, pg 41).	**membrane receptor sites on myocardial and vascular smooth-muscle cells and inhibits influx of extracellular calcium ions across slow calcium channels (Jones and Bartlett, 2019, pg 65).**	**reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown (Jones and Bartlett, 2019, pg 108).**	**the coagulation enzymes thrombin and factors Xa and XIa (Jones and Bartlett, 2019, pg 579).**	**sodium nitroprusside, expect that hydralazine is selective for arteries (Jones and Bartlett, 2019, pg 582). Exerts a direct vasodilation effect on vascular smooth muscle, interferes with calcium movement, and dilates arteries (Jones and Bartlett, 2019, pg 582).**
Reason Client Taking	**To treat hyperuricemia**	**To treat hypertension**	**To control lipid levels**	**To provide anticoagulation with dialysis**	**To manage hypertension**
Contraindications (2)	**Hypersensitivity to allopurinol. Hypersensitivity to its components**	**Aliskiren therapy in patients with diabetes or renal impairment. Hypersensitivity to amlodipine or its components.**	**Active hepatic disease. Hypersensitivity to atorvastatin or its components.**	**Hypersensitivity to heparin or its components. Severe thrombocytopenia.**	**Coronary artery disease. Hypersensitive to hydralazine or its components.**
Side Effects/Adverse Reactions (2)	**Exacerbated renal calculi and nausea.**	**Headache and elevated liver enzymes.**	**Depression and elevated CK levels**	**Elevated liver enzymes and dizziness.**	**Edema and headache.**
Nursing Considerations (2)	**Obtain baseline CBC and uric acid levels. Maintain a fluid intake to produce a daily**	**Assess patient frequently for chest pain. Use medication cautiously in patients with renal**	**Use cautiously in patients who consume alcohol. Monitor blood glucose levels because it can affect**	**Use heparin cautiously in alcoholics and severe hypertensive patients. Avoid injecting any drugs I.M.**	**Monitor ANA titer, CBC, and lupus erythematosous cell preparation before therapy.**

	urinary output of 2 L daily.	**failure.**	**blood glucose control.**	**during heparin therapy to decrease bleeding and hematoma.**	**Monitor blood pressure and pulse regularly and weigh patient daily.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Get CBC, uric acid, and electrolyte levels before administering.**	**Check blood pressure before administration so that hypotension does not occur**	**Monitor with the usage of amlodipine because it can increase atorvastatin levels.**	**Monitor for bleeding and encourage not doing things to cause bleeding.**	**Look at labs and blood pressure before administration.**
Client Teaching needs (2)	**Take medication after meals and drink 8-10 glasses of water. Report usual bleeding or bruising, fever, chills, numbness, and tingling**	**Tell patient to take missed dose as soon as remembered and next dose in 24 hours. Take medication with food to reduce GI upset.**	**Take the drug at the same time each day to maintain its effects. Immediately notify patient if they experience unexplained muscle pain, tenderness, or weakness.**	**Inform patient about increased risk of bleeding and urge to avoid injuries, use of soft-bristles toothbrush, and an electric razor. Avoid drugs that interact with heparin (aspirin and ibuprofen)**	**Instruct patient to take medication with food. Advise patients to change positions slowly especially in the morning.**

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and Oriented to person, place, time, and situation During assessment alert and oriented times 4 No distress Overall appearance is appropriate for race
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Appropriate for race Warm, moist and pink Turgor intact No rashes present No bruises present No wounds present Braden Score 22 No drains present
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Normal cephalic No lymph nodes palpable Trachea is in line No drainage from ears PERRLA, conjunctiva pink and moist No drainage from nose and septum in line Good dentation
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 normal No murmur heard Peripheral pulses bilateral times two throughout, no bounding or slowed pulses Capillary refill normal No vein distention present No edema present
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	No use of accessory muscles present Good air movement with no adventitious lung sounds bilaterally
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:**	Diet at home is regular Current diet is a diabetic, low carb diet (newly diagnosed) Height 5’11” Weight 292 lbs Bowel sounds normal

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:**	Last BM was 3/3/21 No pain or masses when palpating There was no distention, incisions, scars or drains present No wounds present No ostomy present No nasogastric present No feeding tube 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 color is yellow Character is clear Quantity of urine is 650 mL No pain with urination is present No dialysis—consult with nephrology scheduled Genitals look normal within defined limits No catheter present
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 good ROM is within defined limits No supportive devices needed Strength is equal bilaterally ADL is not needed Fall risk Fall score is 1 Activity is as tolerated with no assistance needed Mobility is independent No assistance with equipment No support to stand and walk
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:**	Can move all extremities PERRLA intact Strength is equal throughout Orientated times four Mental Status is alert and easily aroused Speech is audible and easily understood Client has no sensory devices No LOC present

LOC:	
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):**	Coping method is too smoke marijuana Developmental level is appropriate for age No practicing religion at this time Client lives alone, but has a girlfriend that he can talk to and is supportive of him

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	**80**	**149/108**	**18**	**98.2**	**96%**
1030	**81**	**171/104**	**18**	**97.8**	**96%**

Vital Sign Trends: The client's vital signs are within normal limits besides his blood pressure. He has high blood pressure that is being monitored because he is non-compliant with his medications at home. He is getting his hypertension medication in the hospital to get his high readings under control.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	**0-10**	**N/A**	**0**	**N/A**	**N/A**
1030	**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 g **Location of IV: cephalic vein in the left arm** **Date on IV: 2/26/21** **Patency of IV: IV is patent during clinical via saline push** **Signs of erythema, drainage, etc.: No signs of erythema or drainage** **IV dressing assessment: Dressing clean, dry, and intact**	Saline Lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
360 mL	**650 mL**

Nursing Care

Summary of Care (2 points)

Overview of care: The client is independent and walking in the hallways to get exercise. He watched television and did his grooming on his own throughout the day. The client did not experience any pain during clinical and did not receive any pain medications. The client was mellow and did not need much unless it was his food tray and fresh ice water.

Procedures/testing done: Routine labs were drawn, x-ray, US renal complete, and US left duplex of lower extremities were done during his hospital stay. The patient did not go off the unit for any new testing.

Complaints/Issues: Client had no complaints or issues during clinical time.

Vital signs (stable/unstable): Vital signs during the day were within defined limits besides his blood pressure, and those readings were high. He has a diagnosis of hypertension and stated he was non-compliant with his medication at home. He is receiving amlodipine and

hydralazine daily to control his blood pressure. His blood pressure is getting monitored throughout the day, and the nurse is aware of his high readings.

Tolerating diet, activity, etc.: He tolerated a diabetic diet well but was unaware of diabetes until his hospital stay. He handled his activities, and he was motivated to walk the hallways. He did a lap around the unit and stopped to look out the windows on the fourth floor. He is independent at lib and did not need help throughout the day.

Physician notifications: The physician was not notified during clinical.

Future plans for patient: The plans are to get discharged, but at this time, it is not known where he will be going. It is also essential for him to follow his medication regimen to keep his hypertension under control.

Discharge Planning (2 points)

Discharge location: There are no discharge plans at this time. They were to come back on 3/3/21 to make a plan but did not come during clinical times.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Has a consult with nephrology.

Education needs: His educational needs would be his compliance with his medications.

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with “related to” and “as evidenced by” components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to

			plan.
1. **Risk for decreased cardiac tissue perfusion related to hypertension as evidence by being noncompliant with medication.**	**This nursing diagnosis was chosen because the patient has uncontrolled hypertension that can lead to heart failure in the future if it continues to be unmanaged.**	**1.Getting a set schedule for medication administration so that the patient can remember to take the medication** **2.Having the spouse involved in the treatment plan so that she can support him in taking his medication.**	**The patient did not seem interested about taking his medication as prescribed. The patient was told his blood pressure readings and how the medication can help reduce his high readings. He is aware of the outcomes of uncontrolled hypertension and that he needs to be compliant with the medication.**
2. **Risk for electrolyte imbalance related to renal failure as evidence by not being on dialysis.**	**This diagnosis was chosen because the patient is not on dialysis which can impair his kidney function and he can not properly exchange potassium and sodium.**	**1. Getting him scheduled with nephrology to talk about his options** **2.Ensure adequate fluid intake and output.**	**The patient is aware that he needs to consult with nephrology and agreed to the decision. When he gets discharged from the hospital he will follow up and get a treatment plan in place.**
3. **Risk for ineffective renal perfusion related to stage three acute renal failure as evidence by not being on dialysis.**	**This diagnosis was chosen because he is in stage three renal failure that is leading to stage four. He has no treatment of dialysis to help the perfusion of the kidneys to ensure they are working properly.**	**1.Has a consult with nephrology to get a plan in action.** **2. Drinking the appropriate amount of fluids.**	**The patient is compliant with the decision of his future care. He seems to want the help, so that he does not get worse. He was set up an appointment to attend when he gets discharged from the hospital.**
4. **Noncompliance related to hypertension as evidence by**	**This diagnosis was chosen because the patient is noncompliant with**	**1.Give the appropriate amount of medication to**	**The patient understood that he needed to take his medication but**

refusing to take medication at home.	**his medication regimen at home.**	**control his hypertension.** **2. Educate the patient on the importance of being compliant with medication.**	**chose to do other activities to control it. He was educated on the reason he was on the medication and the risk factors that uncontrolled hypertension can lead to.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

During clinical the client stated he had no pain rating it a 0 out 10. He did not complain of anything and only needed ice water. When he came into the emergency room he was complaining of generalized fatigue and left leg pain. That has since subsided, and he is doing activity as tolerated.

Nursing Diagnosis/Outcomes

Risk for decreased cardiac tissue perfusion measured by increasing and decreasing lab values prior to discharge.
Risk for electrolyte imbalance measured by chemistry labs routinely and need to be close to normal prior to discharge.
Risk for ineffective renal perfusion measured by lab values and the holding of fluids.
Noncompliance related to hypertensive medications measured by high blood pressure reading that need to be lowered before discharge.

Objective Data

Two blood pressure readings of 149/108 and 171/104. He was given amlodipine 10 mg and hydralazine 75 mg for his high readings.
Abnormal labs- RBC 3.70, Hgb 11.2, Hct 31.9, Neutrophils 78.7, Lymphocytes 12.1, K+ 3.3, Glucose 163, BUN 73, Creatinine 6.46, PT 14, D-dimer 496, Urine glucose 3+, and urine protein 3+. The patient was independent and had no assistive devices.

Patient Information

51-year-old male with acute kidney failure stage three leading to chronic kidney failure. Uncontrolled hypertension with noncompliant to medication. He is a full code with no known allergies. He has a history of diabetes, alcoholism, and kidney disease.

Nursing Interventions

Getting a set schedule for medication administration so that medication will be taken daily. Involve his girlfriend in the plan of care so that she can encourage him.

Schedule a consult with nephrology to get a treatment plan in place. Ensure that fluid intake and output are with in defined limits.

Set up an appointment to see if dialysis is necessary for a treatment plan. Drink appropriate number of fluids to ensure that fluid overload does not occur.

Give the appropriate amount of medication to control his hypertension. Educate the patient on the importance of being compliant with a medication regimen.