N431 Care Plan 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9/26/21	J. F.	77	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Married	Penicillin-palpitation
Code Status	**Height**	**Weight**	
Full	175.5 cm	87.3 kg	

Medical History (5 Points)

Past Medical History: A-fibrillation, Chronic anticoagulation, Hyperlipidemia, HTN, BPH

Past Surgical History: Knee, Shoulder, Eye, Tonsillectomy (this is all I could get, he did not remember when or what exactly was done).

Family History: Brother had cancer

Social History (tobacco/alcohol/drugs): Denies use of any.

Assistive Devices: None

Living Situation: Lives at home with wife.

Education Level: Highschool diploma

Admission Assessment

Chief Complaint (2 points): Blood in stools.

History of present Illness (10 points): A 77 y/o patient with a history of Afib, chronic anticoagulation, hyperlipidemia, HTN, and BPH presented to the ED via ambulance on 9/26/21. Patient claims that there was a lot of bright red blood per rectum. Patient denies any pain while defecating or wiping. He also denies stool abnormalities or any N/V/D. Patient states that he a colonoscopy 3 ½ years ago that was unremarkable. He also states that he has a history of hemorrhoids.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute lower GI bleed (possibly due to hemorrhoids).

Secondary Diagnosis (if applicable): N/A

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

As a child we have all fallen off a bike or some other activity and scraped up our knees or elbows. From there we run inside in tears for our mommy to make the boo boo go away. Mom gets us a band-aid and some anti-infection cream and sends us on our way. Bleeding is not too much of a concern most of the time. However, excessive bleeding and internal bleeding are much more important and problematic than those of the external nature. Here we will be speaking specifically on hemorrhoids which is a bleed of the lower GI tract.

Hemorrhoids, in short, are dilated and swollen venous blood vessels in the lower rectum (Capriotti, 2020). It is believed that close to 13% of the population are affected by these, however, only 1/3 of people seek medical attention (Capriotti, 2020). Most just medicate with over-the-counter drugs.

Hemorrhoids are caused by a decrease in venous blood return (Capriotti, 2020). This results in pooling of blood in the blood vessels near and around the rectum. The number one cause of hemorrhoids is high venous pressure (Capriotti, 2020). This pressure is caused by several things including, but not limited to constipation, straining during defecation, high pressure within the portal vein of the liver, anal intercourse, pregnancy, prolonged sitting, and old age (Capriotti, 2020).

Hemorrhoids only cause symptoms when they become inflamed, thrombosed, or prolapsed (Capriotti, 2020). The type of symptoms experienced depend on whether it is an

external or internal blood vessels that are affected (Capriotti, 2020). Internal hemorrhoids become symptomatic when straining or irritation of the veins occur. This happens when the passing of stool damages the surface of the hemorrhoids (Capriotti, 2020). This will lead to bright-red blood being present in stool, this is known as hematochezia. This is what my patient claimed it looked like after he defecated. It is very common for the hemorrhoids to then be pushed outside of the rectum causing it to become a prolapsed hemorrhoid. External hemorrhoids are exactly what they sound like. They lie outside and around the rectum (Capriotti, 2020). These become symptomatic when irritated and can cause bleeding and extreme itching of the area (Capriotti, 2020). My patient did not have external for sure but could possibly have internal bleeding hemorrhoids. We must wait for GI to come and see him before finalizing the diagnosis.

Diagnosing can be tricky. One can use a colonoscopy, flexible sigmoidoscopy, anoscopy, and a digital rectal examine (Capriotti, 2020). These are the only reliable diagnoses for hemorrhoids. Treatment for hemorrhoids is typically quite simple as well. Non-invasive treatment options include over-the-counter hemorrhoid cream, a hydrocortisone containing suppository, or pads with witch hazel or a numbing agent (Mott, et al., 2018). More invasive treatment options include sclerotherapy, rubber band ligation, coagulation techniques with the use of laser or infrared light, or a hemorrhoidectomy (Mott, et al., 2018).

Pathophysiology References (2) (APA):

Capriotti, T. (2020). Common Disorders of the Large Intestine. In *Davis advantage for pathophysiology: introductory concepts and clinical perspectives* (2nd ed., pp. 747). F.A. Davis Company.

Mott, T., Latimer, K., & Edwards, C. (2018). Hemorrhoids: Diagnosis and Treatment Options. *American family physician*, *97*(3), 172–179.

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	**4.28-5.56 g/dL**	4.41	3.68	This could be indicative of an internal bleed (
Hgb	**13-17 g/dL**	12.8	10.9	This could be indicative of an internal bleed (
Hct	**38.1-48.9%**	38.2	31.8	This could be indicative of an internal bleed (
Platelets	**149-393 mL**	278	220	N/A
WBC	**4-11.7 g/dL**	11.4	9.3	N/A
Neutrophils	**45.3-79%**	73.9	78.6	N/A
Lymphocytes	**11.8-45.9%**	14.3	10.7	
Monocytes	**4.4-12%**	9.4	8.2	N/A
Eosinophils	**0-6.3%**	1.6	1	N/A
Bands	**0-5%**	N/A	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 mEq/L**	128	129	This could possibly be because he is on pain medications (
K+	**3.5-5.1 mmol/L**	3.9	4.4	N/A
Cl-	**98-107 mEq/L**	94	95	
CO2	**21-31 mEq/ L**	24	26	N/A
Glucose	**74-109 mg/ dL**	120	96	This could just be because he was in a very stressful situation (
BUN	**7-25 mg/dL**	19	18	N/A
Creatinine	**0.7-1.3 mg/ dL**	0.89	0.83	N/A

Albumin	**3.5-5.2 g/dL**	4.1	N/A	N/A
Calcium	**8.6-10.3 mg/dL**	9	8.7	N/A
Mag	**1.7-2.2 mg/ dL**	N/A	N/A	N/A
Phosphate	**2.5-4.5 mg/ dL**	N/A	N/A	N/A
Bilirubin	**0.3-1 mg/dL**	0.7	N/A	N/A
Alk Phos	**34-104 IU/L**	67	N/A	N/A
AST	**13-39 U/L**	17	N/A	N/A
ALT	**7-52 U/L**	15	N/A	N/A
Amylase	**40-140 U/L**	N/A	N/A	N/A
Lipase	**24-151 U/L**	N/A	N/A	N/A
Lactic Acid	**4.5-19.8 mg/dL**	N/A	N/A	N/A
Troponin	**0-0.04 ng/mL**	N/A	N/A	N/A
CK-MB	**5-25 IU/L**	N/A	N/A	N/A
Total CK	**22-198 U/L**	N/A	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**0.86-1.14**	1.68	N/A	
PT	**11.9-15 seconds**	20.4	N/A	
PTT	**22.6-35.3**	44.9	N/A	
D-Dimer		N/A	N/A	N/A

BNP		N/A	N/A	N/A
HDL		N/A	N/A	N/A
LDL		N/A	N/A	N/A
Cholesterol		N/A	N/A	N/A
Triglycerides		N/A	N/A	N/A
Hgb A1c		N/A	N/A	N/A
TSH		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 and clear**	N/A	N/A	N/A
pH	**4.6-8**	N/A	N/A	N/A
Specific Gravity	**1.005-1.030**	N/A	N/A	N/A
Glucose	**Negative**	N/A	N/A	N/A
Protein	**Negative**	N/A	N/A	N/A
Ketones	**Negative**	N/A	N/A	N/A
WBC	**Negative**	N/A	N/A	N/A
RBC	**Negative**	N/A	N/A	N/A
Leukoesterase	**Negative**	N/A	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	N/A
PaO2	**>90 mmHg**	N/A	N/A	N/A
PaCO2	**35-45 mmHg**	N/A	N/A	N/A
HCO3	**18-24 mEq/ L**	N/A	N/A	N/A
SaO2	**>92 mmHg**	N/A	N/A	N/A

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**Negative**	N/A	N/A	N/A
Blood Culture	**Negative**	N/A	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):

Sarah Bush Lincoln Health Reference Guide. (2021). Sarah Bush Lincoln: Cerner.

https://www.sarahbush.org/

Diagnostic Imaging

All Other Diagnostic Tests (5 points): EKG

Diagnostic Test Correlation (5 points): He is on an EKG so that we can monitor his heart. This is important for this patient because of his past medical history of Afib. Afib can devolve into a much more emergent cardiac rhythm more easily than a healthy NSR.

Diagnostic Test Reference (1) (APA):

Cheever, J.L.H. K. H. *Lippincott coursePoint enhanced for brunner & buddarth's textbook of medical-surgical nursing*. [VitalSource Bookshelf]. Retrieved from https://bookshelf.vitalsource.com/#/books/9781975123383/

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

Brand/Generic	Norvasc, amlodipine	Microzide, hydrochlorothiazide	Xarelto, rivaroxaban	Zestril, lisinopril	Proscar, finasteride
Dose	10 mg	12.5 mg	20 mg	40 mg	5 mg
Frequency	Daily	Daily	Daily	Daily	Daily
Route	PO	PO	PO	PO	PO
Classification	Dihydro-pyridine/ CCB	Benzothiazide diuretic/ antihypertensive	ACE inhibitor	ACE inhibitor	Synthetic 4-azasteriod compound
Mechanism of Action	This acts by inhibiting the transmembrane influx of calcium into the smooth muscle and cardiac muscle.	This acts by inhibiting the sodium chloride transport system in the distal convoluted tubules.	This acts by inhibiting both free Xa and Factor Xa bound in the prothrombinase.	This acts by blocking the action of angiotensinogen-converting enzyme.	This acts by blocking the action of 5-alpha-reductase.
Reason Client Taking	HTN	HTN	HTN	HTN	BPH
Contraindications	Hypotension,	Anuria, Allergic	Angioedema,	Hyperkalemia,	Allergic,

(2)	Allergic		Aliskeren medications	Renal failure	Pregnancy
Side Effects/Adverse Reactions (2)	Edema, Fatigue	Hyperglycemia, Hypokalemia	Hypotension, Angina	Cough, Headache	Impotence, ED
Nursing Considerations (2)	Caution of arrhythmias, Watch BP	Monitor for mental changes, and muscle cramps	Care if breast feeding, Give with food	Monitor renal labs, Watch BP	May need to ask uncomfortable questions about libido, Urinary system will need checked as well
Key Nursing Assessment(s)/Lab(s) Prior to Administration	EKG	Electrolyte panel	BP	ALT, AST, BUN, Creatinine	Blood and Urine
Client Teaching needs (2)	Store at room temperature, Take with other regimen of BP reduction strategies	Take in am, Use regularly for best effect	Take missed doses immediately, Take at same time everyday	Drink plenty of water, Take with or without meals	Drink a lot of water, Take at the same time everyday

Home Medications (5 required)

Hospital Medications (5 required)

Brand/Generic	Protonix, pantoprazole	Colace, docusate	Vicodin, hydrocodone-acetaminophen	Ultram, tramadol	Zofran, ondansetron
Dose	40 mg	100 mg	1 tab Norco-5 mg 325 mg	Q6H PRN	4 mg=2 mL
Frequency	Daily	BID PRN	Q4H PRN	Q6H PRN	Q6H PRN
Route	PO	PO	PO	PO	IV Push
Classification	PPI	Laxative	Analgesic/ antipyretic and opioid analgesic	Opioid agonist	Selective 5-HT3-receptor antagonist
Mechanism of	This acts by	This acts by	Not completely	Acts by binding	This acts by

Action	suppressing the final step in gastric acid production by forming a covalent bond.	increasing the amount of water that enters the stools by lowering the surface tension.	known. Believed to act on opiate receptors in the CNS.	onto parent and M1 metabolite inhibiting norepinephrine and serotonin.	blocking the action of serotonin.
Reason Client Taking	Lower GI bleed	Constipation	Pain	Pain	Nausea
Contraindications (2)	Allergic, taking rilpivirine	N/V/D	Respiratory depression, GI obstruction	Under 12, GI obstruction	Allergic, apomorphine
Side Effects/Adverse Reactions (2)	Headache, diarrhea	GI cramping, rash	Light-headedness, dizziness	Constipation, dry mouth	Headache, drowsiness
Nursing Considerations (2)	Monitor for adverse reactions, Dosage may change often in beginning	Find underlying cause behind constipation, Evaluate therapeutic response	Be on the lookout for changes in mood or behavior, Watch for respiratory depression	Watch for excessive sedation, Caution for mood change	Watch for adverse reactions, Find underlying cause of nausea
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Watch INR and PTT	Electrolyte panel	Respiratory assessment	Liver function, BP, Respiratory, and mental status.	Mag, CMP
Client Teaching needs (2)	Take 30 min before meal, Swallow whole	Do not use for more than 1 week, BM within 72 hours	Take exactly as prescribed, Take with food I nausea occurs	Take the same way every time, Do not crush/chew/break/ or open	Drowsiness may occur so no driving, Avoid alcohol

Medications Reference (1) (APA):

Sarah Bush Lincoln Health Reference Guide. (2021). Sarah Bush Lincoln: Cerner.

https://www.sarahbush.org/

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:**	Patient is alert and responsive. He is A&Ox4 to person, place, time, and situation. He seems upset

Orientation: **Distress:** **Overall appearance:**	about the amount of time spent waiting for the doctor to come and see him. Appearance is as expected in a hospital gown.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin is warm, dry, elastic, and usual for ethnicity. Bruise to his left eye. No other rashes or wounds noted. Has a Braden score of 20.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head symmetrical. Neck supple and symmetrical with no signs of tracheal deviation. TM grey. Eyes PERLA. No sign of polyps or others inhibitory factors of the nares. Teeth slightly yellowed.
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:**	He has a history of Afib, however, during the entire time I was there he only showed a NSR. S1 and S2 noted upon auscultation. Pulses are 3+ in all extremities. Cap refill in all extremities are <3 seconds. No edema noted anywhere.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular with equal aeration into both lungs. Breath sounds are clear and unlabored.
GASTROINTESTINAL (2 points): **Diet at home:** Regular **Current Diet:** NPO **Height:** 175.5 cm **Weight:** 87.3 **Auscultation Bowel sounds:** **Last BM:** 9/26/21 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:**	Bowel sounds active in all quadrants. No distension, incisions, scars, drains, or wounds noted.

Scars: **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
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 clear and yellow. Quantity not measured. No abnormalities noted with genitals.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** 35 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	Pulses 3+ in all extremities. Cap refill <3 seconds in all extremities. Active ROM. His strength is 5 in all extremities except for his right arm. Claims that it is just super weak from arthritis and age. He is a fall risk with a score of 35. He is independent and up ad lib.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☒ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	All extremities except for right arm are moved well and strong. He is A&Ox4 to person, place, time, and situation. No neurological deficit noted. Speech is clear and well-articulated. No deficits to his sensory or LOC (Awake and alert).
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:**	Patient states that he was a catholic but does not participate in any religious activities. When he feels down, he speaks with his wife. He lives at home with his wife.

Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1100	59 bpm	125/72 mmHg	16 rpm	36.5 C	96%
1500	50 bpm	153/76 mmHg	16 rpm	36.6 C	95%

Vital Sign Trends: VS are stable except for the patient's BP. He does have a history of high BP and is on many drugs to help with this. This reading may be high because the medications are not working as well as they should be. He also seems upset that the doctor has not come to see him which may raise the BP.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1230	Numeric	Upper to mid abdominal area	4	Cramp-like	Hydrocodone-acetaminophen was administered.
1500	Numeric	N/A	0	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:** Left AC **Date on IV:** 9/27/21 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No signs of erythema, drainage, or infiltration. **IV dressing assessment:** Clean with no obstructions.	Saline Lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
O (NPO)	Patient is up ad lib. Said that he voided twice.

Nursing Care

Summary of Care (2 points)

Overview of care: We are just monitoring VS until GI can see him.

Procedures/testing done: No procedures have been done yet. Waiting for GI to come up and scope him.

Complaints/Issues: Complained of abdominal pain. Pain medication given and it helped relieve said pain.

Vital signs (stable/unstable): VS are stable. BP high, however, he has a known history of pretty high BP.

Tolerating diet, activity, etc.: All independent.

Physician notifications: Waiting on the GI consult.

Future plans for patient: Waiting for GI.

Discharge Planning (2 points)

Discharge location: Home w/ wife.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: No plan is put into place until GI sees him.

Education needs: N/A

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 fluid volume deficit related to possible lower GI bleed as evidenced by client statement of "there was bright red blood in my stools".	If he does in fact have a lower GI bleed, then the possibility of hypovolemia is high. Hypovolemia can lead to many other problems and can even lead to death.	**1.** VS monitoring looking for signs of hypovolemia such as tachycardia or hypotension. **2.** Monitor serum electrolyte values and urine osmolarity.	Patient does not seem to disagree with chosen path of care. Decreased blood volume will result in a low BP, a weak and rapid pulse, high blood urea nitrogen, and a high specific gravity of urine can indicate hypovolemia.
2. Risk for infection related to possible lower GI bleed as evidenced client statement of "there was bright red blood in my stools".	This diagnosis was chosen because a GI bleed can lead to a systemic infection. The risk of death in a systemic infection is high.	**1.** Temperature monitoring Q4H. **2.** Monitorization of WBCs.	Patient does not seem to disagree with chosen path of care. An elevated temperature and an abnormal WBC count are early indications of an infection.
3. Risk for imbalanced nutrition related to possible lower GI bleed as evidenced by being NPO.	This diagnosis was chosen because with him being NPO the chance of electrolyte imbalances is high.	**1.** Promotion of proper positioning. **2.** Provide a pleasant environment.	Patient does not seem to disagree with chosen path of care. Both interventions will make the NPO order less of a hassle which is our current goal since we are not able to feed him anything.

4. Acute pain related to possible lower GI bleed as evidenced by the patient rating his pain at a 4 out of 10.	This diagnosis was chosen because pain is what people come to the hospital for to get fixed. Where there is pain, there is something wrong.	**1.** Provide medications as prescribed and required. **2.** Evaluate the effectiveness of medications.	Patient does not seem to disagree with chosen path of care. The administration of medication should greatly reduce the amount of pain felt. Evaluation of the effectiveness will be able to discern whether the dosage is good or needs modified.

Other References (APA):

Concept Map (20 Points):

Subjective Data

Patient claims that he had blood in stools.
Patient claims that he is in pain at a 4 of 10.

Objective Data

VS are stable beside BP which is 153/76.
This is high but he does have a history o
HTN.

Patient Information

A 77 y/o patient with a history of Afib, chronic anticoagulation, hyperlipidemia, HTN, and BPH presented to the ED via ambulance on 9/26/21. Patient claims that there was a lot of bright red blood per rectum. Patient denies any pain while defecating or wiping. He also denies stool abnormalities or any N/V/D. Patient states that he a colonoscopy 3 ½ years ago that was unremarkable. He also states that he has a history of hemorrhoids.

Nursing Diagnosis/Outcomes

Risk for fluid volume deficit related to possible lower GI bleed as evidenced by client statement of "there was bright red blood in my stools".
Patient does not seem to disagree with chosen path of care. Decreased blood volume will result in a low BP, a weak and rapid pulse, high blood urea nitrogen, and a high specific gravity of urine can indicate hypovolemia.
Risk for infection related to possible lower GI bleed as evidenced client statement of "there was bright red blood in my stools".
Patient does not seem to disagree with chosen path of care. An elevated temperature and an abnormal WBC count are early indications of an infection.
3. Risk for imbalanced nutrition related to possible lower GI bleed as evidenced by being NPO.
Patient does not seem to disagree with chosen path of care. Both interventions will make the NPO order less of a hassle which is our current goal since we are not able to feed him anything.
4. Acute pain related to possible lower GI bleed as evidenced by the patient rating his pain at a 4 out of 10.
Patient does not seem to disagree with chosen path of care. The administration of medication should greatly reduce the amount of pain felt. Evaluation of the effectiveness will be able to discern whether the dosage is good or needs modified.

Nursing Interventions

1. VS monitoring looking for signs of hypovolemia such as tachycardia or hypotension.

2. Monitor serum electrolyte values and urine osmolarity.

1. Temperature monitoring Q4H.

2. Monitorization of WBCs.

1. Promotion of proper positioning.

2. Provide a pleasant environment.
1. Provide medications as prescribed and required.

2. Evaluate the effectiveness of medications.