N431 Care Plan #2

Lakeview College of Nursing

Lindsay Cox

Demographics (3 points)

Date of Admission 9/15/21	Patient Initials DS	Age 53	Gender Male
Race/Ethnicity Caucasian	Occupation Collects and melts scrap metal.	Marital Status Divorced	Allergies Zosyn
Code Status FULL	Height 172.7 cm	Weight 104.5 kg	

Medical History (5 Points)

Past Medical History: Hypertension (HTN)

Past Surgical History: Appendectomy, carpal tunnel repair bilaterally.

Family History: The patient did not have any family history in his chart. When asked, the patient stated that he wasn't close to his family.

Social History (tobacco/alcohol/drugs): The patient denies using tobacco, alcohol, or drugs.

Assistive Devices: The patient does not utilize any assistive devices.

Living Situation: The patient states that he lives alone.

Education Level: The patient states that he graduated high school and went to college for welding.

Admission Assessment

Chief Complaint (2 points): Pain from a crush accident.

History of present Illness (10 points):

The patient is a 53 y/o Caucasian male with a history of hypertension. He was brought to the emergency department on 9/15/21 after obtaining an acute crush injury. While at work, the patient was pinned by a forklift against a counter where they set the metal scraps to be melted. He rates his pain a 5/10 on a numeric scale. The patient denies any nausea or vomiting. The patient did not receive any treatment before arriving at the emergency department.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Multiple rib fractures, lumbar fracture from a crush accident.

Secondary Diagnosis (if applicable): N/A

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

A fracture is the breaking of a bone. (Capriotti, 2020). Fractures usually result from trauma to the bone or osteoporosis. (Capriotti, 2020). Trauma fractures result from the bone exceeding its physical capacity. (Capriotti, 2020). Fractures can be classified depending on how the bone is broken and whether it is a thin crack or a complete break. (Capriotti, 2020). Common fractures are complete, incomplete, compound, compression, transverse, spiral, comminuted, and stress. (Capriotti, 2020). A complete fracture is where the bone fragments in half entirely but does not break through the skin. (Capriott, 2020). Incomplete fractures result from the bone just partially breaking. (Capriotti, 2020). Compound fractures result from the broken bone protruding from the skin. (Capriotti, 2020). Compression fractures result from the bone being crushed. (Capriotti, 2020). Transverse fractures are where the bone breaks straight across. (Capriotti, 2020). Comminuted fractures result from the bone being shattered or crushed into more than two pieces. (Capriotti, 2020). Spiral fractures result from the twisting of bone and resemble a corkscrew. (Capriotti, 2020). And finally, stress fractures are tiny cracks in the bone that occur from repetitive activity. (Capriotti, 2020).

The signs and symptoms of a fracture depend on how the break happened, where the fragmentation is, and how bad the split is. (Capriotti, 2020). The classic signs are tissue disturbance, swelling, redness, pain, and potentially bleeding, depending on the significance of

the trauma. (Capriotti, 2020). Knowing how the break occurred can help identify the fracture type and provide a guide for treatment until a diagnostic study can be performed. (Capriotti, 2020). The diagnostic studies used to identify fractures are x-rays (XR) and computerized tomography (CT) scans. An x-ray is used to depict bone structures. (Capriotti, 2020). A CT scan can detect injuries that range from subtle to complex traumas. (Capriotti, 2020). Once a diagnosis has been confirmed, treatment can begin. An advanced trauma support algorithm is used to assess the neurological and vascular system of the patient to determine if the injury requires emergency treatment. (Capriotti, 2020). Anticoagulant therapy is initiated to prevent deep vein thrombosis (DVT) and pulmonary embolism (PE). (Capriotti, 2020). Acetaminophen is used as a first-line defense for the treatment of pain. (Capriotti, 2020). Other therapies that may be utilized include physical therapy, massage, acupuncture, transcutaneous electrical nerve stimulation (TENS), or chiropractic care. (Capriotti, 2020). In order to realign the structure of bones to ensure optimal healing, the treatment process of reduction is implemented. (Capriotti, 2020). The two types of reduction are closed reduction, where a device such as a cast or brace is used to keep the bone in place, and an open reduction where surgery is needed to realign and apply hardware to keep the bone in place. (Capriotti, 2020).

There are five stages of fracture healing: inflammatory, granulation formation, callus formation, lamellar bone deposition, and remodeling. (Capriotti, 2020). In the inflammatory phase, which happens around 48 hours after the break and can last up to a week, a hematoma can occur due to bleeding around the broken edges of the bone. (Capriotti, 2020). The second phase, which lasts for two weeks, is where the granulation of tissue forms, and the tissue must receive nutrients and oxygen during this time. (Capriotti, 2020). The third phase, which happens six weeks after the injury, produces new mineralized bone. (Capriotti, 2020). The fourth phase is

where the bone becomes more substantial; it occurs shortly after the third, with the length of time depending on the extent of the injury. (Capriotti, 2020). The fifth and final phase entails the remodeling and healing of the bone break. (Capriotti, 2020). For these phases to transition adequately, the patient needs to consume an appropriate amount of calcium. (Capriotti, 2020). Other factors that impact bone healing are the type of break, the patient's age, what medications they are on, if they smoke or use nicotine products, and if they contract an infection. (Capriotti, 2020).

My patient, upon admission, sustained injuries from a crush accident. In order to determine the extent of his injuries and the best treatment for his recovery, an x-ray and CT scan were ordered. An x-ray was ordered for his chest, right femur, and right wrist to assess potential injuries. A CT scan was ordered for his head and spine to evaluate for possible damages. He was diagnosed with multiple rib fractures and a lumbar fracture. The treatment my patient underwent under his initial admittance was treatment for his superficial burn on his abdomen, abrasions across his thigh area, and he had to undergo extensive debridement of skin and subcutaneous fat in the right flank. Since being moved from the emergency department, the patient now has a brace on his right wrist.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed). F.A. Davis Company.

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

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.9-5.4	3.49	4.05	This abnormal value may be due to excessive bleeding from his injuries. (Lab Tests Online, 2021).
Hgb	12-16	9.5	10.8	This abnormal value may be due to excessive bleeding from his injuries. (Lab Tests Online, 2021).
Hct	36-48	30.8	34.6	This abnormal value may be due to excessive bleeding from his injuries. (Lab Tests Online, 2021).
Platelets	150-450	321	327	This lab value is within normal range. (Lab Tests Online, 2021).
WBC	4.5-10.8	8.5	8.6	This lab value is within normal range. (Lab Tests Online, 2021).
Neutrophils	40-80	82.5	N/A	This abnormal value may be due to trauma from his injuries, the burn on his abdomen, inflammation, or stress. (Lab Tests Online, 2021).
Lymphocytes	13-48	8.7	N/A	This abnormal lab may be due to trauma from his injuries or stress. (Lab Tests Online, 2021).
Monocytes	2-12	8.4	N/A	This lab value is within normal range. (Lab Tests Online, 2021).
Eosinophils	0-8	0.0	N/A	This lab value is within normal range. (Lab Tests Online, 2021).
Bands	0.0-10.0	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-	134-144	137	134	This lab value is within normal range. (Lab Tests Online, 2021).
K+	3.5-5.2	4.5	4.61	This lab value is within normal range. (Lab Tests Online, 2021).
Cl-	96-106	105	99	This lab value is within normal range. (Lab Tests Online, 2021).
CO2	20-29	22.3	23.8	This lab value is within normal range. (Lab Tests Online, 2021).

Glucose	**65-99**	**128**	**122**	**This abnormal lab value may be due to the patient taking lisinopril or stress from his injuries. (Lab Tests Online, 2021).**
BUN	**8-27**	**10**	**21**	**This lab value is within normal range. (Lab Tests Online, 2021).**
Creatinine	**0.57-1**	**1.05**	**0.87**	**This abnormal lab value may be due to his hypertension or the acute injury of being crushed. (Lab Tests Online, 2021).**
Albumin	**3.8-4.9**	**3.4**	**3.9**	**This abnormal lab value may be due to inflammation from his injuries. (Lab Tests Online, 2021).**
Calcium	**8.7-10.2**	**7.8**	**8.8**	**This abnormal lab value may be due to low albumin or his injuries from being crushed. (Lab Tests Online, 2021).**
Mag	**1.6-2.3**	**1.8**	**2.0**	**This lab value is within normal range. (Lab Tests Online, 2021).**
Phosphate	**3-4.3**	**3.0**	**3.2**	**This lab value is within normal range. (Lab Tests Online, 2021).**
Bilirubin	**0-1.2**	**0.7**	**0.5**	**This lab value is within normal range. (Lab Tests Online, 2021).**
Alk Phos	**48-121**	**124**	**160**	**This abnormal lab value may be due being crushed. (Lab Tests Online, 2021).**
AST	**0-40**	**28**	**40**	**This lab value is within normal range. (Lab Tests Online, 2021).**
ALT	**0-32**	**39**	**44**	**This abnormal lab value may be due to inflammation and trauma from being crushed. (Lab Tests Online, 2021).**
Amylase	**60-100**	**N/A**	**N/A**	**N/A**
Lipase	**0-160**	**22**	**N/A**	**This lab value is within normal range. (Lab Tests Online, 2021).**
Lactic Acid	**0.5-1.5**	**N/A**	**N/A**	**N/A**
Troponin	**0-0.04**	**16**	**28**	**This abnormal lab value may be related to the patient having hypertension or a severe crushing injury. (Lab Tests Online, 2021).**
CK-MB	**5-25**	**N/A**	**N/A**	**N/A**

Total CK	**22-198**	**3278**	**170**	**This abnormal lab value may be due to the recent compression of muscles, the burn on his abdomen or the trauma from being crushed. (Lab Tests Online, 2021).**

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**	**N/A**	**N/A**	**N/A**
PT	**11-13.5**	**N/A**	**N/A**	**N/A**
PTT	**25-35**	**N/A**	**N/A**	**N/A**
D-Dimer	**Negative, less than 250**	**N/A**	**N/A**	**N/A**
BNP	**<100**	**73.1**	**50.9**	**This lab value is within normal range. (Lab Tests Online, 2021).**
HDL	**60**	**N/A**	**N/A**	**N/A**
LDL	**100**	**N/A**	**N/A**	**N/A**
Cholesterol	**200**	**N/A**	**N/A**	**N/A**
Triglycerides	**150**	**N/A**	**N/A**	**N/A**
Hgb A1c	**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 and clear**	**Yellow and clear**	**N/A**	**This lab value is within normal range. (Lab Tests Online, 2021).**
pH	**5-7**	**5.0**	**N/A**	**This lab value is within normal range. (Lab Tests Online, 2021).**
Specific Gravity	**1.001-1.030**	**1.035**	**N/A**	**This abnormal lab value may be due to shock from an acute injury**

				to his kidneys or bladder from being crushed. (Lab Tests Online, 2021).
Glucose	**NEG**	**Negative**	**N/A**	**This lab value is within normal range. (Lab Tests Online, 2021).**
Protein	**NEG**	**Negative**	**N/A**	**This lab value is within normal range. (Lab Tests Online, 2021).**
Ketones	**NEG**	**Negative**	**N/A**	**This lab value is within normal range. (Lab Tests Online, 2021).**
WBC	**0-5**	**Negative**	**N/A**	**This lab value is within normal range. (Lab Tests Online, 2021).**
RBC	**0-2**	**2 +**	**N/A**	**This abnormal lab value may be due to shock from an acute injury to his kidneys or bladder from being crushed. (Lab Tests Online, 2021).**
Leukoesterase	**NEG**	**Negative**	**N/A**	**This lab value is within normal range. (Lab Tests Online, 2021).**

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**	**7.489**	**7.3**	**This abnormal lab value may be due to hyperventilating after being crushed or being in pain. (Lab Tests Online, 2021).**
PaO2	**80-100**	**121**	**253**	**This abnormal lab value may be due to chest trauma. (Lab Tests Online, 2021).**
PaCO2	**35-45**	**30.5**	**42.6**	**This abnormal lab value may be**

				due to hyperventilating after being crushed or being in pain. (Lab Tests Online, 2021).
HCO3	**22-26**	**23.2**	**21.4**	**This abnormal lab value may be due to dehydration or medications. (Lab Tests Online, 2021).**
SaO2	**95-100**	**99**	**100**	**This lab value is within normal range. (Lab Tests Online, 2021).**

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/no growth**	**N/A**	**N/A**	**N/A**
Blood Culture	**Negative/no growth**	**N/A**	**N/A**	**N/A**
Sputum Culture	**Negative/no growth**	**N/A**	**N/A**	**N/A**
Stool Culture	**Negative/no growth**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (1) (APA):

Lab Tests Online. (2021). *Patient education on blood, urine, and other lab tests*. https://labtestsonline.org/.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

CT scan of chest is used to visualize injuries that range from subtle to complex traumas to the chest. (Capriotti, 2020).

CT cervical spine w/o IV contrast used to detect injuries that range from subtle to complex traumas to the cervical spine. (Capriotti, 2020).

CT head w/o IV contrast used to detect injuries that range from subtle to complex traumas to the head. (Capriotti, 2020).

XR chest used to depict bone structures in the chest such as the ribs. (Capriotti, 2020).

XR femur 2 view right- used to depict bone structures of the right femur. (Capriotti, 2020).

XR wrist 2 view right- used to depict bone structures of the right wrist. (Capriotti, 2020).

EKG- used to visualize the electrical signals to detect heart conditions. (Capriotti, 2020).

Diagnostic Test Correlation (5 points):

The CT scan of chest could be to reveal if the patient has any rib fractures or a punctured lung.

The CT scan of the cervical spine w/o IV contrast could have been ordered to ensure there was no fracture or trauma to the spine and if there is the scan will show the extent of the damage.

The CT scan of the head w/o IV contrast could have been ordered to ensure that there was not damage or hemorrhaging of the brain.

The chest XR could have been ordered to ensure that the patient doesn't have pneumothorax from his rib fractures.

The XR of the right femur could have been ordered to visualize the damage from the crush accident.

The right wrist XR wrist could have been ordered to identify any fractures to the wrist.

The EKG could have been ordered to ensure that the heart was beating at a normal sinus rhythm and that no STEMI resulted from the accident.

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed). F.A. Davis Company.

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

Home Medications (5 required)

Brand/Generic	Prinivil/ lisinopril	The patient was only taking one home medication.	The patient was only taking one home medication.	The patient was only taking one home medication.	The patient was only taking one home medication.
Dose	20 mg	N/A	N/A	N/A	N/A
Frequency	daily	N/A	N/A	N/A	N/A
Route	orally	N/A	N/A	N/A	N/A
Classification	Pharmacologic: Angiotensin-converting enzyme (ACE) inhibitor Therapeutic: Antihypertensive	N/A	N/A	N/A	N/A
Mechanism of Action	May reduce blood pressure by inhibiting conversion of	N/A	N/A	N/A	N/A

	angiotensin I to angiotensin II.				
Reason Client Taking	To treat hypertension	N/A	N/A	N/A	N/A
Contraindications (2)	- Hypersensitivity to lisinopril or other ACE inhibitors, or their components. -Use of a neprilysin inhibitor such as sacubitril within 36 hours.	N/A	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	-Hyperglycemia -Chest pain	N/A	N/A	N/A	N/A
Nursing Considerations (2)	-Use cautiously in patient's with fluid volume deficit, heart failure, impaired renal function, or sodium depletion. -Monitor blood pressure often.	N/A	N/A	N/A	N/A
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Monitor for dehydration, which can lead to hypotension.	N/A	N/A	N/A	N/A
Client Teaching needs (2)	-Explain that lisinopril helps control, but doesn't cure, hypertension and that patient may need lifelong therapy. -Warn patient to	N/A	N/A	N/A	N/A

	seek immediate emergency treatment if he experiences difficulty breathing or swallowing or notices swelling of his eyes, extremities, face, lips, or tongue.				

Hospital Medications (5 required)

Brand/ Generic	Lovenox/ enoxaparin	Aldactone/ spironolactone	Tylenol/ acetaminophen	Lexapro/ escitalopram	Dulcolax/ bisacodyl
Dose	40mg	25mg	650mg	10mg	10 mg
Frequency	daily	Twice daily	Every four hours	daily	Twice a day
Route	Subcutaneous injection	orally	orally	orally	Rectally
Classification	Pharmacologic: low-molecular-weight heparin Therapeutic: anticoagulant	Pharmacologic: potassium-sparing diuretic Therapeutic: diuretic	Pharmacologic: nonsalicylate, para-aminophenol derivative Therapeutic: antipyretic, nonopioid analgesic	Pharmacologic: selective serotonin reuptake Therapeutic: antidepressant	Pharmacologic: surfactant Therapeutic: laxative

Mechanism of Action	Enoxaparin rapidly binds with antithrombin III and inactivates clotting factors.	Spironolactone competes with aldosterone for the receptors on the walls of distal convoluted tubule cells, thereby preventing sodium and water reabsorption and causing their excretion through the distal convoluted tubules. Increased urinary excretion of sodium and water reduces blood volume and blood pressure.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Inhibits reuptake of the neurotransmitter serotonin by CNS neurons, thereby increasing the amount of serotonin available in nerve synapses.	Stimulates enteric neurons to cause peristalsis.
Reason Client Taking	To prevent deep vein thrombosis.	To treat hypertension.	To relieve mild to moderate pain.	To treat general anxiety.	To treat constipation.
Contraindications (2)	-Active major bleeding. - hypersensitivity to enoxaparin, heparin, pork products, or their components.	-Hyperkalemia - Hypersensitivity to spironolactone or its components.	- Hypersensitivity to acetaminophen or its components. -Severe hepatic impairment.	- Concomitant therapy with pimozide. - Hypersensitivity to escitalopram, citalopram, or its components.	-Rectal bleeding. -Severe impaction.
Side Effects/ Adverse Reactions (2)	-Elevated liver enzymes.	-Hypotension. - Hyperglycemia.	- Hypertension. -Anxiety.	-Deep vein thrombosis. -	-Nausea -Diarrhea

	- Hyperlipidemia.			Constipation.	
Nursing Considerations (2)	-Use cautiously in those with uncontrolled hypertension. -Watch closely for bleeding.	-Expect to evaluate the patient's serum potassium level 1 week after spironolactone therapy begins. -Evaluate spironolactone's effectiveness by assessing blood pressure.	-Monitor renal functions. -Do not confuse a dose in milligrams with a dose in milliliters when preparing and administering a parenteral form of acetaminophen.	-Watch for signs of abuse or misuse. -Monitor patient for bleeding.	-Monitor fluid and electrolyte levels. -Expect long term use to cause dependence on laxatives for bowel movements.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Check serum potassium level for elevation, especially in patients who are currently using potassium-sparing diuretics.	-Assess the patient's blood pressure.	-Know before and during long-term therapy, liver function test results, including AST, ALT, bilirubin, and creatinine levels, as ordered must be monitored because acetaminophen may cause hepatotoxicity.	-Expect to taper dosage to avoid serious adverse reactions when therapy is no longer needed.	-Assess for abdominal distention and bowel function.
Client Teaching needs (2)	-Advise patient to notify prescriber about adverse reactions, especially bleeding. -Review bleeding	-Instruct patient to take the medication with meals or milk. -Teach the patient how to measure their blood pressure and to monitor it regularly.	-Tell patients that tablets may be crushed or swallowed whole. -Caution patient not to exceed recommended dose because	-Tell the patient that improvement may not be noticed for 1 to 4 weeks after therapy begins. -Instruct patient to notify	-Encourage patient to retain suppository for 15-30 minutes before expelling. -Encourage patient to drink 1500-

	precautions with patient.		of risk of liver damage.	prescriber promptly of any persistent, severe, or unusual signs and symptoms.	2000 mL/day during the therapy.

Medications Reference (1) (APA):

Jones and Bartlett Learning. (2020). *Nurse's drug handbook* (19th ed). Jones and Bartlett Publishers.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented to person and reason for visit, but he thought he was at Carle hospital since he is not from this area. He does not appear to be in any apparent distress. His appearance is slightly unkempt.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:**	The patient's skin is warm, pink, and dry. He has some bruises on his left arm from the IV. He has abrasions on his right thigh and shin but appears to be healing. The patient's skin turgor was assessed with delayed recoil. The Braden score is

Rashes: **Bruises:** **Wounds:** . **Braden Score: 18** **Drains present: Y☐ N ☒** **Type:**	18, indicating that the patient has an average risk for pressure sores or impaired skin integrity.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is round and bilaterally equal with no apparent abnormalities. The patient has no tracheal deviation. The patient's ears are symmetrical bilaterally. The patient does have abundant debris in his ear canals bilaterally but no apparent redness or drainage. The tympanic membranes were pearly and gray bilaterally. Both of his eyes were symmetrical and proportionally placed. His sclera was white, and the conjunctiva was red in both eyes without any drainage present. The patient's nares are equal bilaterally. There is debris in both nostrils but no apparent redness or drainage. The patient's septum shows no deviation. There was no apparent discomfort noted upon palpation of the sinuses. The patient's gums are pink and moist. There were no dental carries noted, but there was slight discoloration of the teeth. The patient was able to stick out his tongue and say "Ah." His tongue was covered in patches of yellow film. The patient's soft palate rose and fell equally. The uvula and tonsils were pink and moist with no deviation.
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 sounds were present. No S3 sounds, S4 sounds, or murmurs were heard. Both carotid pulses were palpated one at a time and 2+. Radial, brachial, posterior tibial, popliteal, dorsalis pedis pulse sites were 2+ bilaterally. The femoral pulses were 1+ bilaterally. The patient's capillary refill was less than 3 seconds on their fingers and toes bilaterally. No pitting edema was present when assessing the patient's extremities. Although, there was slight swelling on the right thigh around the abrasions.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Upon auscultation, the patient's breath sounds were clear and even bilaterally without any use of accessory muscles.
GASTROINTESTINAL (2 points): **Diet at home:**	The patient states that he is "a single guy and usually eats fast food and tv dinners."

Current Diet **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains: wound vac** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	His current diet consists of chicken tenders and honey mustard. He appears to be tolerating food well but states that he "hasn't had much of an appetite." Height: 172.7 cm Weight: 104.5 kg Bowel sounds were auscultated in all four quadrants but delayed sounds in the lower right quadrant. I assisted the patient to the bathroom shortly after for a bowel movement. The last bowel movement was today (10/06/21). The patient has a surgical incision midline on the abdomen that is covered with a dressing. He has sutures on his right flank that was partially uncovered and fixed upon inspection. He has a wound vac on his anterior abdomen near the umbilicus. There was slight edema of the abdomen upon palpation. The patient was current in pain, so deep palpation was not performed.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: French full catheter** **Size: 16 g**	The patient's urine was clear and dark yellow. He voided 1000 mL total during my clinical rotation. The patient denied any pain, burning, hesitancy, or urgency during urination. The patient denies being on dialysis. Upon inspection, the patient's genitals were slightly red and swollen. The crease on the left side of his groin was somewhat red. The patient has a 16-gauge French urinary catheter.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices: rolling walker.** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 45** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☒**	The patient can sit up by himself but needs assistance standing. Under supervision, the patient utilizes a rolling walker to walk to the bathroom. The patient admits to needing help with daily activities such as wiping. He moves all of his extremities without difficulty except for his right wrist, which is in a brace. He has equal strength and grip in hands and feet bilaterally. With the patient's Morse fall risk score being 45, he has a high risk for falls and needs to utilize his call light before getting out of bed.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☐ N☒** **Strength Equal: Y ☒ N ☐ if no -**	He moves all of her extremities without difficulty, except for his right wrist in a brace. He has equal strength and grip in hands and feet bilaterally. His pupils are equal, round, and

Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	reactive to light and accommodation. He is alert and oriented to person, place, time, and reason for the visit. He does not appear to have any impaired mental status. His speech is clear and concise, without any slurring, but with minimal stuttering. He denies any loss of consciousness.
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):**	The patient states that he has a "just deal with it" mentality about things that upset him. His developmental level seems appropriate for his age. He says that he went to college for welding but cannot find anyone to hire him as a welder. The patient identifies as Baptist and goes to church every Sunday and Wednesday. The patient states that he doesn't have a support system near him. His kids live in Jackson, Il. He states he doesn't see them often because he works a lot. He states he is close with his boss, but only at work. He states he doesn't know who he would call if he ever needed help.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
08:00	**99**	**114/83**	**20**	**98.2**	**96%**
16:00	**80**	**130/88**	**21**	**98.2**	**96%**

Vital Sign Trends: The patient's temperature and oxygen stayed the same. His respiration and blood pressure increased, possibly due to him being in pain. His pulse was higher in the morning than it was in the evening. I didn't highlight his pulse because it is still within the normal range.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
14:02	0-10	On lower back near	2	Sharp, radiating	The patient watched the

		spine.			television show "Friends" to distract himself.
17:04	0-10	On lower back near spine.	5	Sharp, radiating	The patient was given pain medication as prescribed.

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	The patient has a 17.5-gauge intravenous (IV) catheter in his right brachial vein that was placed on 10/01/21 as indicated by the tape over the insertion site. He was not currently receiving any infusions. His IV flushed without any difficulty. No drainage, swelling, warmth, or redness was present. The dressing was dry and intact.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
240 mL iced tea. Food: The patient consumed two chicken tenders with honey mustard.	1000 mL urine was excreted upon catheter insertion. The patient had a bowel movement shortly after his assessment.

Nursing Care

Summary of Care (2 points)

Overview of care: I assisted the patient to the bathroom, changed his bed linens, and administered medication.

Procedures/testing done: The nurse inserted a urinary catheter during my clinical rotation.

Complaints/Issues: The patient complained of lower back pain near his spine.

Vital signs (stable/unstable): The patient's vitals stayed within normal range, besides his blood pressure and respiration, which could be due to his hypertension or pain.

Tolerating diet, activity, etc.: The patient seems to be tolerating food but states they have no appetite. The patient tolerates minimal activity, but with pain.

Physician notifications: The physician was not notified about my patient at all while I was at clinical.

Future plans for patient: The patient is awaiting placement for rehabilitation.

Discharge Planning (2 points)

Discharge location: The patient plans to be transferred to Memorial hospital for rehabilitation.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: The patient will follow up with a provider at Memorial hospital.

Education needs: The patient needs education on wound care, sitting precautions, and intaking adequate nutrition.

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 falls related to altered mobility as evidenced by unsteady gait.**	**I chose this nursing diagnosis because the patient's fall score is 45, and he needs assistance when getting out of bed.**	**1. The nurse will move items within the patient's reach, such as call light, water, and telephone.** **2. The nurse will keep the bed in the lowest position.**	**The patient will be free from falls during his hospitalization. The patient responded well to the interventions, but the status is still ongoing.**
2. **Risk for impaired skin integrity related to moist skin as evidenced by redness and irritation in his left groin area.**	**I chose this nursing diagnosis because, upon inspection, there was redness, moisture, and irritation in his groin area on his left side, which led me to think that there could be a potential for skin breakdown if there wasn't an intervention.**	**1. The nurse will apply baby powder to prevent the skin from rubbing together.** **2. The nurse will continue to monitor for skin breakdown.**	**The patient will not have any further skin breakdown during his hospital stay. The patient responded well and was appreciative of the interventions, but the status is still ongoing.**
3. **Imbalanced nutrition less than body requirements related to pain as evidenced by the patient reporting that he has no appetite.**	**I chose this nursing diagnosis because the patient states that he hasn't been eating enough.**	**1. Determine the time of day when the patient's appetite is at its peak and offer the highest calorie meal at that time.** **2. Administer pain medication as prescribed and offer liquid energy supplements.**	**The patient will regain his appetite. The patient responded well by ordering dinner, but the status is still ongoing.**

4. **Deficient knowledge related to lack of recall as evidenced by inaccurate follow-through of instructions.**	**I chose this nursing diagnosis because the patient did not reach behind him to feel for the bed before sitting, which increases his chance of injury.**	**1. Assess the patient's willingness to learn.** **2. Encourage the patient to verbalize his understanding of the potential complications.**	**The patient will correctly perform necessary procedures and explain the reasons for his actions. The patient had a good attitude and was appreciative of the care and concern. However, the status is still ongoing.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient rated their pain on a scale of 2/10 at the beginning of my clinical rotation and then a 5/10 at the end of my clinical rotation. The patient distracted himself by watching television and talking on the phone until it was time to take his pain medication as prescribed.

Nursing Diagnosis/Outcomes

Risk for falls related to altered mobility as evidenced by unsteady gait.

- The patient will be free from falls during his hospitalization. The patient responded well to the interventions, but the status is still ongoing.

Risk for impaired skin integrity related to moist skin as evidenced by redness and irritation in his left groin area.

- The patient will not have any further skin break down during his hospital stay. The patient responded well and was appreciative of the interventions, but the status is still ongoing.

Imbalanced nutrition less than body requirements related to pain as evidenced by the patient reporting that he has no appetite.

- The patient will regain his appetite. The patient responded well by ordering dinner, but the status is still ongoing.

Deficient knowledge related to lack of recall as evidenced by inaccurate follow through of instructions.

- The patient will correctly perform necessary procedures and explain reasons for his actions. The patient had a good attitude and was appreciative of the care and concern. However, the status is still ongoing.

Objective Data

Pulse: 80
BP: 130/88
RR: 21
Temp: 98.2 degrees Fahrenheit
O2: 96%

The patient has a wound vacuum on the upper quadrants of his abdomen. The patient has sutures on his right flank. There was slight edema of the abdomen.

Patient Information

The patient is a 53 y/o Caucasian male who was brought to the emergency department on 9/15/21 after obtaining a crush injury. The treatment my patient underwent under his initial admittance was treatment for his superficial burn on his abdomen, abrasions across his thigh area, and he had to undergo extensive debridement of skin and subcutaneous fat in the right flank. The patient has a history of hypertension. The patient is compliant.

Nursing Interventions

- The nurse will move items within the patient's reach such as call light, water, and telephone.
- The nurse will keep the bed in the lowest position.
- The nurse will apply baby powder to prevent the skin from rubbing together.
- The nurse will continue to monitor for skin break down.
- Determine the time of day when the patient's appetite is at its peak and offer the highest calorie meal at that time.
- Administer pain medication as prescribed and offer liquid energy supplements.
- Assess the patient's willingness to learn.
- Encourage the patient to verbalize his understanding of the potential complications