

N431 Care Plan # 1
Lakeview College of Nursing
Morgan Wagner

Demographics (3 points)

Date of Admission 10/09/21	Patient Initials B.R.	Age 62-years-old	Gender female
Race/Ethnicity African American	Occupation Unable to assess	Marital Status single	Allergies allopurinol, amlodipine, Bactrim, ciprofloxacin, lisinopril
Code Status Full code	Height 5'7"	Weight 71 kg	

Medical History (5 Points)

Past Medical History: angiodysplasia, chronic anticoagulation, chronic gastritis, chronic kidney disease (stage 3), congestive heart failure, reduced ejection fraction, deep vein thrombosis, esophageal strictures, essential hypertension, gout, left bundle branch block, nonischemic cardiomyopathy, paroxysmal atrial fibrillation, progressive systemic sclerosis, pulmonary hypertension, chronic anemia, dehydration

Past Surgical History: colonoscopy, esophagogastroduodenoscopy (EGD), upper gastrointestinal endoscopy

Family History: mother = hypertension and diabetes

Social History (tobacco/alcohol/drugs): according to patient and the information provided, she has never smoked tobacco, does not drink consistently, and avoids the use of recreational drugs

Assistive Devices: None

Living Situation: Lives at home alone

Education Level: high school graduate with some college

Admission Assessment

Chief Complaint (2 points): vomiting blood (hematemesis)

History of present Illness (10 points): Patient is a 62-year-old African American female who presented to the emergency department with a chief complaint of vomiting blood. Patient states she woke up around 4 AM on 10/09 and vomited blood. Patient has a history of upper gastrointestinal bleeds, chronic kidney disease, and chronic anemia. Upon admission, patient had multiple episodes of hematemesis. Patient also states nausea. In the emergency department, she was given Pepcid, Rocephin, and orders of nothing by mouth. An EGD was scheduled and performed on patient the following day.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Esophagitis

Secondary Diagnosis (if applicable): Upper GI bleed, hematemesis

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

Pathophysiology References (2) (APA):

Infectious esophagitis is an infection that can be caused by bacteria, fungus, parasites, or viral microorganisms (Antunes & Sharma, 2021). Esophagitis may also be due to radiation, eosinophils, medication, and acid reflux (Antunes & Sharma, 2021). Infectious esophagitis is most typically caused by *Candida albicans* bacteria (Antunes & Sharma, 2021). The bacteria first colonizes with mucosal adherence and proliferation (Antunes & Sharma, 2021). Next, the bacteria impair the host's defense mechanisms (Antunes & Sharma, 2021). *Candida albicans* is a standard component of oral flora, but it can become a medical concern if their number increases or if the patient is immunocompromised (Antunes & Sharma, 2021).

Esophagitis is the inflammation of the esophagus that may damage the tissues (Mayo Clinic Staff, 2021). The esophagus is a muscular tube that directly delivers food from the mouth

to the stomach (Mayo Clinic Staff, 2021). Esophagitis can cause painful inflammation, making it more difficult to swallow and creating chest pain (Mayo Clinic Staff, 2021). The signs and symptoms of esophagitis include difficult or painful swallowing, chest pain, particularly behind the breastbone, heartburn, acid regurgitation, and food impaction (Mayo Clinic Staff, 2021). The esophagitis risk factors and causes include smoking, obesity, excessively large and fatty meals, and excessive caffeine and alcohol intake (Mayo Clinic Staff, 2021).

A physician will usually diagnose esophagitis based on a physical exam and one or more different diagnostic tests (Mayo Clinic Staff, 2021). A barium x-ray can be used by having a patient drink a solution or pill with barium that coats the stomach and esophagus; this makes the organs visible and easier to see (Mayo Clinic Staff, 2021). A physician may utilize an endoscopy, which involves a thin tube equipped with a tiny camera that goes down the throat into the esophagus (Mayo Clinic Staff, 2021). Laboratory tests may also be used to diagnose the type of esophagitis. The treatment for esophagitis is intended to lessen a patient's symptoms, manage complications, and treat the underlying causes of the disorder (Mayo Clinic Staff, 2021). Over-the-counter medications, such as Mylanta, may be used to help reduce acid production and heal the esophagus (Mayo Clinic Staff, 2021). Nexium, Protonix, or Prilosec may also be utilized as proton-pump inhibitors (Mayo Clinic Staff, 2021). Steroids and antibiotics are often used to treat the disorder (Mayo Clinic Staff, 2021).

With the number of medical problems my patient seemed to have, I found nothing in the chart leading to the direct cause of the esophagitis. She has had upper gastrointestinal bleeds and esophagitis multiple times, directly related to her current medical conditions. My patient was vomiting blood before arrival at the emergency department, where the physicians performed an endoscopy and discovered she had a GI bleed and inflammation of the esophagus. Because the

inflammation and swelling were severe, the patient had to be sedated and intubated to maintain her airway. The physicians had her on antibiotics to help control the inflammation. The patient was scheduled for another endoscopy with hopes of reducing the sedation and taking out the intubation tube.

Antunes, C., & Sharma, A. (2021). Esophagitis. In *StatPearls*. StatPearls Publishing.

(Antunes & Sharma, 2021).

Mayo Clinic Staff. (2021, February 23). *Esophagitis - Symptoms and causes*. Mayo Clinic.

<https://www.mayoclinic.org/diseases-conditions/esophagitis/symptoms-causes/syc>

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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	3.5-5.2	2.74	N/A	Decreased RBC count may be due to patient's chronic anemia and chronic kidney disease (Pagana et al., 2021).
Hgb	11-16	7.7	8.9	Decreased Hgb count may be due to patient's chronic anemia and chronic kidney disease (Pagana et al., 2021).
Hct	34-47%	24.7%	28.8%	Decreased Hct % may be due to patient's chronic anemia and chronic kidney disease (Pagana et al., 2021).
Platelets	140-400	211	N/A	

WBC	4-11	6.24	N/A	
Neutrophils	1.6-7.7	7.6	N/A	
Lymphocytes	20-40%	N/A	N/A	
Monocytes	2-8%	N/A	N/A	
Eosinophils	1-4%	N/A	N/A N/A	
Bands	<10%	N/A	N/A	

normal lab ranges per Epic

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	144	145	
K+	3.5-5.1	4.0	4.3	
Cl-	98-107	110	117	Elevated chloride levels may be due to kidney dysfunction and anemia (Pagana et al., 2021).
CO2	22-29	26	19	Decreased CO2 may be due to renal failure and chronic kidney disease (Pagana et al., 2021).
Glucose	74-100	107	103	Elevated glucose may be due to patient's chronic kidney disease or acute stress in response to her health (Pagana et al., 2021).
BUN	10-20	31	37	BUN may be elevated due to congestive heart failure, GI bleeding, renal failure, and/or dehydration (Pagana et al., 2021).
Creatinine	0.55-1.02	2.3	2.16	Creatinine may be elevated due to reduced renal blood flow secondary to congestive heart failure (Pagana et al., 2021).
Albumin	3.4-4.8	2.9	N/A	Decreased albumin levels may be due to congestive heart failure and the inflammation of the esophagus (Pagana et al., 2021).
Calcium	8.8-10	8.8	8.8	

Mag	1.6-2.6	N/A	1.8	
Phosphate	3-4.5	N/A	N/A	
Bilirubin	0.2-1.2	0.2	N/A	
Alk Phos	40-150	103	N/A	
AST	5-34	14	N/A	
ALT	0-55	13	N/A	
Amylase	30-220	N/A	N/A	
Lipase	8-78	38	N/A	
Lactic Acid	0.5-2	1.16	N/A	
Troponin	0-0.03	0.05	N/A	Troponin may be elevated because of the patient's congestive heart failure or chronic kidney disease (Pagana et al., 2021).
CK-MB	0.55-1.02	2.3	2.16	Elevated CK-MB may be due to renal failure or the inflammation of the esophagus (Pagana et al., 2021).
Total CK	22-198	N/A	N/A	

normal lab ranges per Epic

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	0.9-1.1	2.5	N/A	Elevated INR can be due to many health conditions including kidney disease (Pagana et al., 2021).
PT	11.7-13.8	26.8	N/A	Elevated PT can be due to many health conditions including kidney disease (Pagana et al., 2021).
PTT	25-35	N/A	N/A	

D-Dimer	<0.50	N/A	N/A	
BNP	<100	N/A	N/A	
HDL	40-59	N/A	N/A	
LDL	<100	N/A	N/A	
Cholesterol	<200	N/A	N/A	
Triglycerides	<150	130	N/A	
Hgb A1c	11-16	7.7	8.0	Decreased Hgb A1c may be due to chronic kidney disease or low levels of RBCs (Pagana et al., 2021).
TSH	0.35-4.94	N/A	N/A	

normal lab ranges per Epic

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	Clear, yellow, colorless	N/A	N/A	
pH	5-7	N/A	N/A	
Specific Gravity	1.003-1.035	N/A	N/A	
Glucose	(-)	N/A	N/A	
Protein	(-)	N/A	N/A	
Ketones	(-)	N/A	N/A	
WBC	0-25	N/A	N/A	
RBC	0-20	N/A	N/A	
Leukoesterase	(-)	N/A	N/A	

normal lab ranges per Epic

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	7.45	7.363	
PaO2	75-100	144.9	104.1	Elevated PaO2 may be because patient is on oxygen therapy (Pagana et al., 2021).
PaCO2	38-42	30.7	35.3	Decreased PaCO2 may be due to stress, anemia, or congestive heart failure (Pagana et al., 2021).
HCO3	22-26	21.7	19.6	Decreased HCO3 may be due to patient's GI bleed or chronic kidney disease (Pagana et al., 2021).
SaO2	92-100%	98%	99%	

normal lab ranges per Epic

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	(-)	N/A	N/A	
Blood Culture	(-)	N/A	N/A	
Sputum Culture	(-)	N/A	N/A	
Stool Culture	(-)	N/A	N/A	

normal lab ranges per Epic

Lab Correlations Reference **(1)** (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic and laboratory test reference*. St. Louis, MO: Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X-Ray and EGD were performed on the patient.

Diagnostic Test Correlation (5 points):

The chest x-ray showed grossly unchanged left lower lobe pleural parenchymal opacity and was taken because of the patient’s history of left lower infiltrate (Pagana et al., 2021). The EGD was performed because of the patient’s hematemesis, and it showed esophagitis (Pagana et al., 2021).

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic and laboratory test reference*. St. Louis, MO: Elsevier.

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

Home Medications (5 required)

Brand/Generic	Lipitor / atorvastatin	Coreg / carvedilol	Catapres / clonidine	Cozaar / losartan	Xarelto / rivaroxaban
Dose	40mg	25 mg	0.2mg	50mg	15mg
Frequency	Take 1 tablet by mouth every day with evening meal	Take 1 tablet by mouth twice daily with meals	Take 1 tablet by mouth twice daily	Take 1 tablet by mouth every day	Take 1 tablet by mouth every day with evening meal
Route	Oral	Oral	Oral	Oral	Oral
Classification	Lipid-lowering agent, statin, HMG-CoA	Beta-blocker, beta-adrenergic	Centrally acting alpha-agonist	Angiotensin II receptor antagonist	Direct oral anticoagulant, latest

	reductase inhibitor	blocking agents	hypotensive agent		generation blood thinners, selective inhibitor of factor Xa
Mechanism of Action	Lowers plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver (Jones & Bartlett Learning, 2019).	Blocks the actions of certain natural substances of the body, such as epinephrine on the heart and blood vessels; lowers heart rate, blood pressure, and strain on heart (Jones & Bartlett Learning, 2019).	Stimulates alpha-adrenoceptors in the brain stem; results in reduced sympathetic outflow from the central nervous system and decreases in peripheral resistance, renal vascular resistance, heart rate, and blood pressure (Jones & Bartlett Learning, 2019).	Blocks the vasoconstrictor and aldosterone – secreting effects of angiotensin II by selectively blocking the binding of angiotensin II to the AT1 receptor found in many tissues (Jones & Bartlett Learning, 2019).	Inhibits free FXa and prothrombinase activity (Jones & Bartlett Learning, 2019).
Reason Client Taking	The patient does not have a direct medical condition for this medication; it may be used to treat high cholesterol and to lower the risk of a stroke or heart attack	Patient is taking to treat diagnosed hypertension and may also be taking for heart failure	Patient is taking to treat diagnosed hypertension	Patient may be taking to treat diagnosed hypertension and heart failure	Patient may be taking to reduce the risk of stroke and blood clots due to atrial fibrillation
Contraindications (2)	-patients with severe decreased kidney function	-severe hepatic impairment -second- or third-degree	-chronic kidney disease (stage 5) -diminished blood flow	-mild to moderate kidney impairment -decreased	-bleeding -chronic kidney disease (stage 4)

	-major traumatic injury	AV heart block	through arteries of the heart	blood volume	
Side Effects/Adverse Reactions (2)	-constipation -headache	-may cause reduction of blood flow to hands and feet -dizziness	-anxiety -general feeling of discomfort or illness	-nausea and vomiting -fast or irregular heartbeat	-bleeding -bowel and bladder dysfunction
Nursing Considerations (2)	-monitor for rhabdomyolysis -consult with dietician for management of diet	-monitor BP and pulse frequently during dose adjustment periods -monitor intake and output daily	-after administering, monitor blood pressure and pulse rate frequently -assess dizziness and drowsiness	-monitor daily weights with congestive heart failure -monitor renal and liver functions	-prepare to teach patient about the risks associated with taking this drug -may cause bleeding
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-monitor serum cholesterol before, about 4 weeks after starting, and frequently during drug therapy -obtain baseline renal and liver labs	-obtain baseline vitals for patient to compare -check pulse and heart rate before admission	-assess pulse and heart rate -obtain baseline vitals for comparison	-obtain baseline vital signs for comparison -monitor labs for high potassium levels	-obtain baseline PT and INR values -confirm hepatic and renal function are adequate for the use of the drug
Client Teaching needs (2)	-instruct patient to report muscle weakness -do not take two doses at one time	-take with food at the same time every day -tell your doctor or get medical help right away if experiencing high/low blood sugar or loss of consciousness	-avoid large amounts of alcohol -best if taken in the morning and at bedtime	-instruct patient on how to take blood pressure at home -teach patient how to take heart rate and pulse	-teach the patient to watch for manifestations of bleeding -make lifestyle changes to reduce the risk of bleeding

Hospital Medications (5 required)

Brand/Generic	Maxipime / cefepime	Protonix / pantoprazole	Peridex / chlorhexidine gluconate mouth rinse	Apresoline / hydralazine	Diprivan / propofol
Dose	1g	40mg	0.12%	10mg	10mg/ml
Frequency	Inject 1g IV push every 12 hours	Inject 40mg IV push every 12 hours	Use 15 ml of mouth rinse to brush teeth and provide oral care every 2 hours as needed	Inject 10mg IV push every 3 hours as needed	5-50mg /kg /min on a continuous IV drip
Route	Intravenous piggyback	Intravenous flush	Oral	Intravenous	Intravenous
Classification	Cephalosporin antibiotics	Proton pump inhibitors	Antimicrobial	Vasodilator, Hydrazinoph - thalazine	Lipophilic Intravenous General Anesthetic
Mechanism of Action	Inhibits bacterial cell wall synthesis by covalently binding enzymes responsible for the final step in transpeptidation during peptidoglycan wall synthesis (Jones & Bartlett Learning, 2019).	Suppresses the final step in gastric acid production by forming a covalent bond to two sides of the (H⁺,K⁺) - ATPase enzyme system at the secretory surface of the gastric parietal cell (Jones & Bartlett Learning, 2019).	Binds to the negatively charged bacterial cell walls and extra microbial complexes (Jones & Bartlett Learning, 2019).	Lowers blood pressure by exerting a peripheral vasodilating effect through a direct relaxation of vascular smooth muscle (Jones & Bartlett Learning, 2019).	Increases GABA – mediated inhibitory tone in the central nervous system, decreasing the rate of dissociation of the GABA from the receptor (Jones & Bartlett Learning, 2019).
Reason Client Taking	Patient is taking this medication to treat infection and	Patient may be taking this drug to help heal acid	Patient may be using to help reduce swelling and	Patient is taking to help control	Patient is taking to keep her in a

	inflammation caused by the esophagitis (Jones & Bartlett Learning, 2019).	damage to the stomach and esophagus	redness of the gums and bleeding	hypertension	sedated state while the inflammation in her throat heals
Contraindications (2)	-increased risk of bleeding -mild to moderate kidney impairment	-nephritis -inadequate vitamin B12	-hypersensitivity to formula ingredients (Other not listed)	-decreased blood volume -coronary artery disease	-seizures -abnormal EKG
Side Effects/Adverse Reactions (2)	-abdominal or stomach cramps -general body welling	-headache -nausea and vomiting	-tooth/tongue staining -increased tartar	-flushing -loss of appetite	-fast or slow heart rate -high or low blood pressure
Nursing Considerations (2)	-monitor for hypersensitivity and allergic reaction -watch for seizure activity	-monitor patient response to the drug -monitor the effectiveness of the drug	-use only the prescribed amount -provide oral care often for sedated patients	-assess for dizziness and drowsiness that might affect gait or balance -monitor for palpitations or headache	-monitor cardiac and respiratory rate -measure input and output
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-check patient allergies -monitor for past seizure history	-check diabetic patients check blood glucose (can cause hyperglycemia) -assess liver enzymes	-assess for potential aspiration -monitor for mouth irritation	-obtain baseline vitals prior to administration -monitor input and output in patients with renal dysfunction	-obtain baseline vitals prior to administration -assess neurologic function
Client Teaching needs (2)	-teach the patient why they need this drug -let provider know if you start to feel uneasy or sick	-instruct patient the side effects to watch for -take on an empty stomach	-instruct patient the proper way to use -advise patient of a potential change in taste	-teach patient how to check their blood pressure at home -instruct patient to weigh themselves twice weekly	-teach patient the medication will cause severe drowsiness -will require someone to drive them home

Medications Reference **(1)** (APA):

Jones & Bartlett Learning. (2019). *2020 Nurse’s Drug Handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Alert and oriented x0 No acute distress Sedated upon assessment Well groomed</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Brown/black skin color Skin is warm and dry upon palpation Skin turgor normal, < 3 seconds No rashes, lesions, bruising, or wounds Normal quantity, distribution, and texture of hair Fingernails and toenails showed no cyanosis or clubbing Braden score of 15 No drains present</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck symmetrical Trachea is midline without deviation Thyroid nonpalpable No nodules noted Bilateral carotid pulses are 2+ No lymphadenopathy noted Bilateral auricles pink and moist without lesions</p>

	<p>Bilateral canals clear with pearly grey tympanic membrane Septum is midline without deviation Turbines are pink and moist with no polyps or bleeding visible Bilateral frontal sinuses are nontender to palpation No congestion or rhinorrhea Bilateral sclera white, cornea clear, conjunctiva pink PERRLA bilaterally EOM intact bilaterally No visible drainage of eyes bilaterally Lids are pink and moist without discharge Unable to assess the inside of the mouth and throat</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	<p>.</p> <p>Clear S1 and S2 without murmurs, gallops or rubs Normal rate and rhythm</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>.</p> <p>Normal rate and pattern of respirations Endotracheal tube for airway Lung sounds diminished anterior and posterior bilaterally No wheezes, crackles, or rhonchi</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains:</p>	<p>.</p> <p>Patient on an NPO diet Unable to assess diet at home 5'7" 71kg Abdomen is soft, nontender No organomegaly or masses noted upon palpation of all four quadrants Bowels sounds are normoactive in all four quadrants No CVA tenderness noted bilaterally No distention, hernia, incisions, drains,</p>

<p>Wounds: Ostomy: Y <input type="checkbox"/> N <input type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>wounds No guarding or rebound NG tube in right nostril, no size indicated Unable to assess last bowel movement</p>
<p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size:</p>	<p>Yellow/clear urine pH not taken 150mL No obvious pain with urination Clean genitals Patient on dialysis Urethral catheter temperature probe 14 Fr.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Altered awareness of immediate physical environment Lack of understanding of one’s physical and cognitive limitations All extremities have full ROM Hand grips and pedal pushes/pulls demonstrate normal and equal strength (2+) No swelling, tenderness, deformity, or signs of injury Bed band and falls meets being used High Fall Risk with a score of 100 Needs assistance with all daily activities while she is sedated</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Alert and oriented x0 Pupils are equal, round, and reactive to light Strength appears to be equal in upper and lower extremities bilaterally Sedated, in and out of consciousness</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home</p>	<p>Unable to assess Just patient present, no family</p>

environment, family structure, and available family support):	
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Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	77	144/65	14	97.2F	99%
1300	82	172-78	14	96.1F	100%

Vital Sign Trends: Blood pressure is slightly elevated, more than likely due to patient’s hypertension.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1000	CPOT	N/A	0	N/A	N/A
1200	CPOT	N/A	0	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g Location of IV: right hand Date on IV: 10/09/21 Patency of IV: flushes without difficult Signs of erythema, drainage, etc.: N/A IV dressing assessment: clean, dry, and intact	Lactated ringers

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
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Not measured in chart	150ml of urine

Nursing Care

Summary of Care (2 points)

Overview of care: Patient overall was improving each day and was soon looking to get the tube removed from her throat and the sedation taken off.

Procedures/testing done: general labs, EGD, chest-Xray, intubation

Complaints/Issues: unable to assess

Vital signs (stable/unstable): stabler, BP slightly elevated due to hypertension

Tolerating diet, activity, etc.: NPO, slightly agitated

Physician notifications: Continue with current orders

Future plans for patient: Repeat scope on 10/14, oral care and reposition every 2 hours

Discharge Planning (2 points)

Discharge location: Home with family

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: After discharge, follow up with primary care provider after 2 days

Education needs: Patient needs to be educated about her GI bleed and proper management of her health

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	• Explain why		• How did the

<p>diagnosis with “related to” and “as evidenced by” components</p>	<p>the nursing diagnosis was chosen</p>		<p>patient/family respond to the nurse’s actions? <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan. </p>
<p>1. Impaired spontaneous ventilation related to decreased PaCO₂ levels and respiratory muscle fatigue as evidenced by consistent vomiting of blood and inflammation of the throat</p>	<p>Patient is intubated on mechanical ventilation because of the GI bleed causing her to continually throw up blood, thus causing inflammation with respiratory difficulty</p>	<p>1. Monitor ABG levels and report deviations promptly 2. Elevate the head of bed</p>	<p>Unable to evaluate response with patient; elevation of the head of bed did seem to comfort her</p>
<p>2. Risk for deficient fluid volume related to blood loss from the GI bleed and NPO status as evidence by patient’s sedated level of consciousness and elevated BUN</p>	<p>Patient has a GI bleed and is unable to in take any fluids by mouth due to her sedated level of consciousness</p>	<p>1. Maintain accurate input and output daily 2. Monitor electrolyte levels</p>	<p>Although the patient was not fully aware of her surroundings, she shook her head and nodded when we discussed her current treatment plan</p>
<p>3. Decreased cardiac output related to congestive heart failure as evidence by reduced ejection fraction</p>	<p>Patient has a diagnosis of congestive heart failure and reduced ejection fraction, therefore leadings to decreased cardiac output</p>	<p>1. Monitor heart rate, rhythm, and blood pressure every 2-4 hours 2 Weight patient daily before breakfast</p>	<p>Unable to completely assess patient’s response, but she did seem okay with continuous vitals</p>

<p>4. Self-care deficit related to altered level of consciousness as evidence by the RASS scale of -2 (light sedation)</p>	<p>Patient is unable to attend to all self-care needs including bathing, oral care, and voiding due to sedation</p>	<p>1. Provide privacy when performing self-care activities</p> <p>2. Assess patient's functional, cognitive, and perceptual level at periodic intervals</p>	<p>Patient seemed aware when we had to bathe or change her; she could not respond, but she nodded her head and acknowledged it</p>
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Other References (APA):

Phelps, L. (2020). *Sparks & Taylor's nursing diagnosis reference manual*. Lippincott Williams & Wilkins.

Concept Map (20 Points):

Subjective Data

Patient stated she was throwing up blood the morning of admission
Patient also mentioned she was experiencing nausea along with the vomiting

Nursing Diagnosis/Outcomes

Objective Data

Vitals at 0900: HR 77, BP 144/65, respirations 14, 97.2 F, O2 99%
Vitals at 1300: HR 82, BP 172/78, respirations 14, 96.1 F, O2 100%
Alert and oriented x0
High Fall Score of 100
Braden Score of 15
Decreased RBC, Hgb, Hct
Elevated Cl-, BUN, Glucose, and Creatinine
Abnormal ABG values

Patient Information

African American
Female
62 years old
Single
Full Code
5'7"
71 kg
chronic kidney disease, congestive heart failure, hypertension

Nursing Interventions



