N321 Care Plan # 2

Lakeview College of Nursing

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Approved: 1/6/2021

Demographics (3 points)

Date of Admission 10/2/2021	Patient Initials WE	Age 65	Gender M
Race/Ethnicity White	Occupation Unemployed	Marital Status Married	Allergies None
Code Status Full	Height 6'2	Weight 177lbs	

Medical History (5 Points)

Past Medical History: Anticoagulated, Calculus of kidney, diffuse large B cell lymphoma, DVT, Hyperlipidemia, Kidney stones, pulmonary embolism, Spinal stenosis, Gastrocnemius equinus of R lower extremity.

Past Surgical History: Bone marrow aspiration, bone marrow biopsy, hydrocelectomy, lithotripsy, parotidectomy.

Family History: Rheumatic Fever – Father. Ovarian Cancer – Mother.

Social History (tobacco/alcohol/drugs): Former Smoker 0.50 packs a day cigarettes. 10 beers per week. Past use of cocaine.

Assistive Devices: None

Living Situation: Lives with wife at Home.

Education Level: Highschool Education

Admission Assessment

Chief Complaint (2 points): Bleeding per rectum and anemia.

History of present Illness (10 points): Pt is a 65 y/0 Caucasian male with history of DVT PE high on Eliquis, history of large cell lymphoma, history or alcohol use who presented to OSF Heart of Mary with epigastric pain and near syncope was transferred to Care UGI bleed, anemia. He has been having black, sometimes bright red stools since 1 month. Keeps having dizziness on-off. He feels his exercise tolerance has reduced and is not as well as before. But he is still able to do all his routine activities. Abdominal pain, increase associated with food, especially spicy food, not so much greasy food. A/w loose stools since around 2-3 weeks. No chest pain/sob. No swelling/no nausea/ last vomit 2 weeks ago. Last colonoscopy a long while back. Pt had a normal INR on 9/12, one done outside 3.5 Hemoglobin was 14 1 week back. Pt has been on Eliquis for DVT, history of prothrombin gene mutation, hasn't taken Eliquis since sometime. Diagnosed with follicular lymphoma in 2018. Received radiation with surgery in 2018. PMH is also significant for degenerative joint disease.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):Upper GI Bleed

Secondary Diagnosis (if applicable):Anemia

Pathophysiology of the Disease, APA format (20 points): The presence of bleeding in the esophagus, stomach, or duodenum is classified as an upper gastrointestinal bleed (UGIB). The bleeding can occur from a lesion, erosion, ulceration, varicosed vein, or tear to the GI lining. The incidence of UGIB is approximately 100 cases per 100,000 population per year. Bleeding from the upper GI tract is four times more common than bleeding from the lower GI tract, and mortality rates from UGIB are 6% to 10% overall.

Etiology. Several disorders, such as PUD, esophageal varices, Mallory–Weiss syndrome, Boerhaave syndrome, esophageal cancer, and hemorrhagic gastritis, can cause UGIB. The morbidity of GI bleeding is directly associated with the amount of blood loss.

Pathophysiology: UGIB can be classified as chronic or acute. An acute bleed is associated with a rupture, tear, or perforation in the esophageal or gastric lining, resulting in blood loss. The severity of clinical symptoms is associated with the amount of blood lost; for example, a large blood loss causes sudden hypotension and hypovolemia. An acute UGIB can quickly develop into hypovolemic shock. A chronic bleed is the result of a small tear or opening in the GI tract that causes a gradual, small amount of blood loss. A chronic bleed causes complaints of fatigue, low hemoglobin, and low iron levels. Slow UGIB often leads to iron-deficiency anemia. The stool contains blood in chronic blood loss, a condition referred to as melena.

Clinical Presentation: Classic symptoms of UGIB include hematemesis, melena, and occult blood. Hematemesis is vomitus with bright-red, bloody streaks or a dark, coffee-ground appearance. The presence of bright-red blood indicates a current bleed. Melena is occult blood in the stool that causes a black, tarry appearance. Occult blood is the presence of blood in the stool that is not visible. Individuals experiencing a slow, chronic GI bleed may have vague symptoms of fatigue and lethargy. Pain may or may not be present.

A sudden or massive UGIB may present with rapid onset of anxiety, dizziness, weakness, shortness of breath, or change in mental status. Tachycardia and tachypnea will occur

because of decreased cardiac output. The skin will be pale and clammy as a result of the body's effort to shut down peripheral blood flow.

In hematemesis, blood that has a coffee-ground appearance indicates the blood has mixed with the stomach's acid. If bright-red blood is apparent, bleeding is currently occurring from a blood vessel.

Diagnosis and Treatment: A slow GI bleed may reveal low hemoglobin and low iron levels, which confirm the presence of anemia. A stool guaiac test, also known as a fecal occult blood test (FOBT), can determine the presence of blood in a stool sample. BUN levels will be elevated secondary to decreased fluid volume and the absorption of blood proteins into the small intestine. Diagnostic tests include endoscopy, CBC, and stool samples for occult blood. A videocapsule endoscopy can visualize the entire GI tract, including the walls of the small intestine. However, it does not offer the option to obtain biopsy or perform any surgical repair, as compared with traditional endoscopic procedures.

Treatment for an acute GI bleed includes rapid fluid replacement, insertion of a nasogastric tube to prevent abdominal distention from accumulation of blood, and administration of blood transfusions. Numerous therapeutic endoscopic strategies can be used for hemostasis of an UGIB. These include injection of sclerosing agents or fibrin glue, electrocoagulation, laser and argon coagulation, band ligation, and application of hemoclips. Insertion of a TIPS is recommended for some patients with esophageal varices. Transcatheter angiographic embolization is recommended for patients with bleeding peptic ulcers who are poor surgical candidates. Laparoscopy and surgical repair at the site of the

bleeding are often done for acute episodes with large amounts of blood loss. A chronic UGIB is treated primarily with PPIs such as omeprazole (PrilosecR) for 4 to 8 weeks. Sucralfate is a viscous adhesive medication that can be used to augment the gastric lining if ulceration is present.

Pathophysiology References (2) (APA):

Capriotti, Theresa M. "Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives" 2nd ed. (2020). *F.A Davis Company.*

All-in-One Nursing Care Planning Resource 5th Edition by Pamela Swearingen,

Jacqueline Wright and Publisher Elsevier (HS-US)

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	4.0-4.9 10^6/uL	N/A	2.87	Decreased RBC due to the paitent having a GI Bleed.(Capriotti & Frizzell, 2016)
Hgb	12.0-16.0 g/ dL	9.4	8.8	Decreased Hgb due to patient being anemic. (Capriotti & Frizzell, 2016)
Hct	37.0-48.0%	28.0	26.1	Decreased Hct due to the paitent having a GI Bleed.(Capriotti &

				Frizzell, 2016)
Platelets	150-400 10^3/uL	N/A	243	
WBC	4.1-10.9 10^3u/L	N/A	4.76	
Neutrophils	1.50-7.70 10^3/uL	N/A	N/A	
Lymphocytes	1.00-4.90 10^3/uL	N/A	N/A	
Monocytes	0.00-.0.80 10^3/uL	N/A	N/A	
Eosinophils	0.00-0.50 10^3/uL	N/A	N/A	
Bands	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 mmol/L	138	142	
K+	3.5-5.1 mmol/L	4.1	3.8	
Cl-	98-107 mmol/L	110	111	Increased Cl- due to the patient being dehydrated. (Capriotti &

				Frizzell, 2016)
CO2	**21.0-32.0**	**23.0**	**22.0**	
Glucose	**60-99 mg/ dL**	**99**	**66**	
BUN	**5-20 mg/ dL**	**35**	**6**	**Increased BUN levels due to the patient being dehydrated. (Capriotti & Frizzell, 2016)**
Creatinine	**0.5-1.5 mg/ dL**	**1.27**	**0.74**	
Albumin	**N/A**	**N/A**	**N/A**	
Calcium	**8.5-10.1 mg/dL**	**8.3**	**8.0**	**Decreased calcium levels due to the patient having alcoholism. (Capriotti & Frizzell, 2016).**
Mag	**1.6-2.6 mg/ dL**	**1.6**	**1.7**	
Phosphate	**3-4.5 mg/dL**	**N/A**	**N/A**	
Bilirubin	**0.3-1 mg/dL**	**N/A**	**N/A**	
Alk Phos	**30-120 U/L**	**30**	**33**	
AST	**0-35 U/L**	**13**	**22**	
ALT	**4-36 U/L**	**6**	**9**	
Amylase	**60-120 U/L**	**N/A**	**N/A**	

Lipase	**0-160 U/L**	**N/A**	**N/A**	
Lactic Acid	**0.5-2.2 mmol/L**	**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	**0.8 – 1.1**	**2.5**	**1.2**	**Slightly elevated INR due to the patient taking heparin (Capriotti & Frizzell, 2016).**
PT	**11-12.5 seconds**	**N/A**	**N/A**	
PTT	**60-70 seconds**	**N/A**	**N/A**	
D-Dimer	**Greater then 0.4 mcg/mL or greater than 250 ng/mL**	**N/A**	**N/A**	
BNP	**Less than 100 pg/mL**	**N/A**	**N/A**	
HDL	**Male: greater than 45 mg/dL Female: greater than 55 mg/dL**	**N/A**	**N/A**	
LDL	**Adult: less than 130 mg/dL Children: less than 110 mg/dL**	**N/A**	**N/A**	
Cholesterol	**Less than 200 mg/dL**	**N/A**	**N/A**	
Triglycerides	**40-180 mg/dL**	**N/A**	**N/A**	
Hgb A1c	**Below 5.7%**	**N/A**	**N/A**	

TSH	**2-10 mU/L**	**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		**N/A**	**N/A**	
pH		**N/A**	**N/A**	
Specific Gravity		**N/A**	**N/A**	
Glucose		**N/A**	**N/A**	
Protein		**N/A**	**N/A**	
Ketones		**N/A**	**N/A**	
WBC		**N/A**	**N/A**	
RBC		**N/A**	**N/A**	
Leukoesterase		**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		**N/A**	**N/A**	
Blood Culture		**N/A**	**N/A**	
Sputum Culture		**N/A**	**N/A**	
Stool Culture		**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives.* Philadelphia: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT SCAN of Chest/abdomen/pelvis with contrast.

Upper GI Endoscopy.

ORDERED/NO RESULTS.

Diagnostic Test Correlation (5 points): CT Scan:

CT scanning is fast, painless, noninvasive, and accurate. Because it is able to detect exceedingly small nodules in the lung, chest CT is especially effective for diagnosing GI Bleeds. The purpose of a non-contrast CT is to not give the patient any contrast media in situations, where it is not really needed (Capriotti, 2020).

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 <u>different</u> medications must be completed

Hospital Medications (5 required)

Brand/ Generic	**Pantoprazole (Protonix)**	**Thimine Vitamin B1**	**Heparin Injection**	**Acetaminophen rectal suppository**	**Apixaban (Eliquis)**
Dose	**40mg**	**200mg**	**5000 units**	**650mg**	**5mg**
Frequency	**2x daily before**	**Daily**	**Every 8 hrs**	**Every 4 hrs**	**2x a day**
Route	**Oral**	**IV**	**IV**	**Rectal**	**Oral**
Classification	**Proton pump in-hibitor. Antiulcer**	**Vitamin(B)**	**Anticoagulant**	**No salicylate, par aminophenol derivative.**	**Factor Xa inhibitor. Anticoagulant.**
Mechanism of Action	**Interferes with gas-tric acid**	On endothelial cells is related to a reduction in intracellula	**Binds with antithrombin III, enhancing antithrombin IIIs inactivation of the**	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin**	Inhibits free and clot-bound factor Xa and prothrombinase

	secretion by inhibiting the hydrogen potassium adenosine triphosphate enzymes system or proton pump in gastric parietal cells.	r protein glycation by redirecting the glycolytic flux. Thiamine is mainly the transport form of the vitamin, while the active forms are phosphorylated thiamine derivatives. Natural derivatives of thiamine phosphate, such as thiamine monophosphate (ThMP), thiamine diphosphate (ThDP), also sometimes called thiamine pyrophosphate (TPP), thiamine triphosphate (ThTP), and thiamine triphosphate (AThTP), that act as	**coagulation enzymes thrombin and factors Xa and Xia. At low doses, heparin inhibits factor Za and prevents conversion of prothrombin to thrombin.**	**production and interfering with pain impulse generation in peripheral nervous system.**	activity . Although apixaban has no direct effect on platelet aggregation , it does indirectly inhibit platelet aggregation induced by thrombin . By inhibiting factor Xa, apixaban decreases thrombin generation and thrombus development.

		coenzymes in addition to their each unique biological functions.			
Reason Client Taking	**To treat erosive esophagi- tis associated with gastroe- sophageal reflux dis- eases short term**	Treatment and prophylaxis of beriberi, to correct anorexia due to thiamine deficiency states, and in treatment of neuritis associated with pregnancy, pellagra, and alcoholism, including Wernicke-Korsakoff syndrome.	**To prevent and treat peripheral arterial embolism, pulmonary embolism, thromboembolic complications associated with atrial fibrillation.**	**To relieve mild to moderate pain; to manage moderate to severe pain with adjunctive opioid analgesics.**	**To reduce the risk of stroke and and systemic embolism in patients with nonvalvular atrial fibrillation.**
Contraindications (2)	**Concur- rent therapy with rilpivirine containing products, hypersen- sitivity to pantop**	**None**	**Breastfeeding, infants, neonates, or pregnant woman; history of heparin induced thrombocytopenia or heparin induced thrombocytopenia.**	**Hypersensitivity to acetaminophen or its components, severe hepatic impairment, severe active liver disease.**	Active hepatic disease, breast feeding, hypersensitivity to atorvastatin or its component, pregnancy, unexplained persistent rise in serum transaminase levels.

	ra-zole, sub-stitute d benzimi - dazoles or their com-ponent s.				
Side Effects/Adver se Reactions (2)	**Anxiety asthenia, confusion, depres-sion, dizzine ss, fatigue, fever, hal-lucina-tions, headac he, hyperto - nia.**	**Blue colored lips, chest pain, feeling short of breath, black bloody stools, coughing up blood, nausea, tight feeling in throat, sweating, feeling warm, mild rash, itching, tenderness.**	**Chills, dizziness, fever, headache, peripheral neuropathy, chest pain, rebond hyperlipemia, thrombosis. Asthma, dyspnea, wheezing.**	**Agitation, anxiety, fatigue, fever, headache, insomnia. CV: Hypotension , Hypertensio n, peripheral edema.**	Abnormal dreams, depression, dizziness, asthenia, cognitive impairment, emotional lability.
Nursing Consideration s (2)	**Advise patient to avoid alcohol and foods that may cause an increase in GI irritation. Instruct patient to**	**Record patient's dietary history carefully as an essential part of vitamin replacement therapy. Collaborate with**	**Know that heparin sodium injection, USP, preserved with benzyl, alcohol, should not be given to infants, neonates,**	**History: Allergy to acetaminop hen, impaired hepatic function, chronic alcoholism, pregnancy, lactation Physical:**	Educate patients about signs and symptoms of bleeding and bleeding precaution s.

	report botherso me or prolon ged side effects, including headache or GI effects (diarrhea, flatulence, belching, abdomina l pain).	**physician, dietitian, patient, and responsible family member in developing a diet teaching plan that can be sustained by patient.**	**pregnant women or women who are breastfeeding the can result in death.**	**Skin color, lesions; T; liver evaluation; CBC, LFTs, renal function tests**	Instruct patients not to double up on dosing in an attempt to make up a missed dose. Stress to patients the importanc e of informing healthcare providers that they're taking apixaban due to increased bleeding risk.

Home Medications (5 required)

Brand/ Generic	**Acetaminophen Tablet**	**Cholecalciferol (vitamin D3)**	**Folic Acid Tablet**	**Thymine Vitamin B1**	**Melatoni n**

Dose	**500mg**	**25mg**	**1mg**	**100mg**	**3mg**
Frequency	**Every 4 hours**	**Daily**	**Daily**	**Daily**	**@ Bedtime**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**oral**
Classification	**No salicylate, para aminophenol derivative.**	**vitamin D analogs.**	**Vitamins, Water-Soluble.**	**Vitamins(B)**	**Neurology and Psychiatry, Herbals**
Mechanism of Action	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in peripheral nervous system.**	**The activated form of cholecalciferol binds to vitamin D receptors and modulates gene expression. This leads to an increase in serum calcium concentrations by increasing intestinal absorption of phosphorus and calcium, promoting distal renal tubular reabsorption of calcium and increasing osteoclastic resorption.**	**Folic acid, as it is biochemically inactive, is converted to tetrahydro folic acid and methyl tetrahydrofolate by dihydrofolate reductase (DHFR). These folic acid congeners are transported across cells by receptor-mediated endocytosis where they are needed to maintain normal erythropoiesis, synthesize purine and thymidylate nucleic acids, interconvert amino acids, methylate tRNA, and generate and**	**It is thought that the mechanism of action of thiamine on endothelial cells is related to a reduction in intracellular protein glycation by redirecting the glycolytic flux. Thiamine is mainly the transport form of the vitamin, while the active forms are phosphorylated thiamine derivatives. Natural derivatives of thiamine phosphate, such as thiamine monophosphate (ThMP), thiamine diphosphate (ThDP), also sometimes called thiamine**	**Melatonin is a derivative of tryptophan. It binds to melatonin receptor type 1A, which then acts on adenylate cylcase and the inhibition of a cAMP signal transduction pathway. Melatonin not only inhibits adenylat**

			use formate. Using vitamin B12 as a cofactor, folic acid can normalize high homocysteine levels by remethylation of homocysteine to methionine via methionine synthetase.	**pyrophosphate (TPP), thiamine triphosphate (ThTP), and thiamine triphosphate (AThTP), that act as coenzymes in addition to their each unique biological functions.**	**e cyclase, but it also activates phosphil pase C. This potentiat es the release of arachido nate. By binding to melatoni n receptor s 1 and 2, the downstr eam signalllin g cascades have various effects in the body. The melatoni n receptor s are G protein-coupled receptor s and are expresse d in various tissues of the body.**

					There are two subtypes of the receptor in humans, melatonin receptor 1 (MT1) and melatonin receptor 2 (MT2). Melatonin and melatonin receptor agonists, on market or in clinical trials, all bind to and activate both receptor types.
Reason Client Taking	**To relieve mild to moderate pain; to manage moderate to severe pain with adjunctive opioid analgesics**	**Vitamin D helps your body absorb calcium. Cholecalciferol is used as a dietary supplement in people who do not get enough vitamin D in their diets to maintain adequate health**	**folic acid is used to treat folic acid deficiency and certain types of anemia (lack of red blood cells) caused by folic acid deficiency**	**Treatment and prophylaxis of beriberi, to correct anorexia due to thiamine deficiency states, and in treatment of neuritis associated with pregnancy, pellagra, and alcoholism,**	**used to treat delayed sleep phase and circadian rhythm sleep disorders in the**

				including Wernicke-Korsakoff syndrome.	**blind and provide some insomnia relief**
Contraindications (2)	**Hypersensitivity to acetaminophen or its components, severe hepatic impairment, severe active liver disease.**	**You should not use cholecalciferol if you have had an allergic reaction to vitamin D, or if you have:high levels of vitamin D in your body (hypervitaminosis D); high levels of calcium in your blood (hypercalcemia); or any condition that makes it hard for your body to absorb nutrients from food (malabsorption). Sarcoidosis, high amount of phosphate in the blood, high amount of calcium in the blood, excessive amount of vitamin D in the body, kidney stones., decreased kidney function**	**Folic acid hypersensitivity. Folic acid is contraindicated for use in patients with folic acid hypersensitivity, Pernicious anemia, Benzyl alcohol hypersensitivity, neonates, premature neonates,** **Pregnancy,** **Breast-feeding, Renal disease, renal failure, renal impairment.**	**None**	**Concurrent use with immunosuppressive treatment. Effects of drug abuse. Short term effects.**
Side Effects/ Adverse Reactions (2)	**Agitation, anxiety, fatigue, fever, headache, insomnia. CV: Hypotension, Hypertension, peripheral edema.**	**Abdominal or stomach pain. Apathy. Bone pain.** **BUN and creatinine increased.** **Cardiac arrhythmia, Changes in behavior,**	**nausea, loss of appetite; bloating, gas, stomach pain;** **bitter or unpleasant taste in your mouth; confusion, trouble**	**Blue colored lips, chest pain, feeling short of breath, black bloody stools, coughing up blood, nausea, tight feeling in throat, sweating,**	**abdominal cramps** **alertness decreased** **circadia**

		Constipation, Decreased sex drive (libido)	**concentrating. sleep problems. depression; or. feeling excited or irritable.**	**feeling warm, mild rash, itching, tenderness.**	**n rhythm disruption daytime fatigue depression (temporary), dizziness, drowsiness unease or dissatisfaction (dysphoria) in depressed patients headache irritability**
Nursing Considerations (2)	**History: Allergy to acetaminophen, impaired hepatic function, chronic alcoholism, pregnancy, lactation Physical: Skin color, lesions; T;**	**Cholecalciferol is more effective than ergocalciferol at raising total serum levels of vitamin D. Vitamin D3 has increased binding to tissue vitamin D receptors, and increased half-life**	**The use of vitamins as general pick-me-ups is of unproven value and, in the NHS, they should only be prescribed to prevent or to**	**Record patient's dietary history carefully as an essential part of vitamin replacement therapy. Collaborate with physician, dietitian, patient,**	**Benzodiazepine Withdrawal in Elderly with Insomnia, Cluster headach**

	liver evaluation; CBC, LFTs, renal function tests	**and increased potency when compared to vitamin D2.**	**treat deficiency.** **- Most causes of folate deficiency are self-limiting and therefore folic acid has few indications for long-term use.** **- Women who are planning a pregnancy should be advised to take folic acid daily before conception to prevent occurrence of neural tube defects.** **- Women who are receiving antiepileptic therapy need individual counselling before starting folic acid.** **- Women who have not been taking folic acid supplements and who suspect they are pregnant should start at once.**	**and responsible family member in developing a diet teaching plan that can be sustained by patient.**	**e, preventi on, Migrain e Headach e, insomnia , Difficult y maintain ing sleep.**

Medications Reference (1) (APA): (Jones & Bartlett Learning, 2020)

Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (20th ed.). Jones & & Bartlett Learning.

Drugs.com. (n.d.). *Prescription drug information, Interactions & Side effects*. Drugs.com. Retrieved October 12, 2021, from https://www.drugs.com/.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: A&O x 3** **Orientation: Oriented to person, place, time.** **Distress: mild distress** **Overall appearance: looks older than staged age.**	
INTEGUMENTARY (2 points): **Skin color: pale pink/dry** **Character: Appears hydrated, clean. Temperature: Warm.**	

Turgor: Rapid recoil. **Rashes: None noted.** **Bruises: From IV. L wrist** **Wounds: None** **Braden Score: 18** **Drains present: None** **Drains present: Y☒ N ☐** **Type: NG Tube**	**Branden score:18**
HEENT: **Head/Neck: Symmetrical. No JVD, no LAD, no thyromegally.** **Ears: Auricle was pink, moist, with no rashes or lesions.** **Eyes: Sclera white, cornea clear, con- junctiva pink with no lesions** **Nose: Septum midline. No drainage Teeth: decay teeth missing.**	.
CARDIOVASCULAR (2 points): **Heart sounds: s1,s2 clear with no mur- murs or gallops.** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 92bpm** **Radial Capillary refill: less than 2 seconds on fingers and toes bilaterally** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character:** **Lung sounds are normal bilaterally.** **Good respiratory effect, CTAB, no wheezes, no crackles. Shallow.**	.
GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current Diet: Regular** **Height: 6'2** **Weight:177**	.

Auscultation Bowel sounds: present in all 4 quadrants. Normoactive **Last BM: 10/6/21 Brown color and non bloody/black.** **Palpation: Pain, Mass etc.: no pain or masses noted** **Inspection:** **Distention: No Distention in abdomen.** **Incisions:None** **Scars:None** **Drains: None** **Wounds:None** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size: n/a** **Feeding tubes/PEG tube Y ☐ N ☒** **Type: n/a**	
GENITOURINARY (2 Points): **Color:clear light, yellow** **Character:no cloudiness or sediment in urine.** **Quantity of urine: spontaneous** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: n/a** **Catheter: Y ☐ N ☒** **Type: n/a** **Size: n/a**	
MUSCULOSKELETAL (2 points): **Neurovascular status: no deficits noted** **ROM: Pt performed flexion/extension, doris/planter independently without pain.** **Supportive devices: None** **Strength: overall good.** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 33** **Activity/Mobility Status: ambulate as tolerated** **Independent (up ad lib) ☐**	.

Needs assistance with equipment ☐ **Needs support to stand and walk☐ no**	
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: oriented to person, time, place and current events x 3.** **Mental Status: normal** **Speech:normal without slurring** **Sensory:slightly confused.** **LOC: Alert, slightly confused.**	.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): Calm environment.** **Developmental level: None noted** **Religion & what it means to pt.: none noted.** **Personal/Family Data (Think about home environment, family structure, and available family support): His wife, selfcare.**	.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
8:00	**92**	**104/64**	**18**	**98.1**	**96**
11:00	**93**	**105/65**	**20**	**98.3**	**96**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
7:03	**0**	**N/A**	**N/A**	**N/A**	**N/A**
11:09	**0**	**N/A**	**N/A**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV: L wrist** **Date on IV:10/6//21** **Patency of IV: yes** **Signs of erythema, drainage, etc.: No** **IV dressing assessment: Transparent.** **Clean, dry and intact.**	**None**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
100% food 320mL	**300mL**

Nursing Care

Summary of Care (2 points)

Overview of care: I helped pass medications to the patient with the oversee of the nurse.

Procedures/testing done: CT Scan/Upper GI endoscopy - no results.

Complaints/Issues: Patient had no complaints at the time of care when I was there.

Vital signs (stable/unstable): Patients vital signs were stable at the time of my care.

Tolerating diet, activity, etc.: Pt is on a regular diet and tolerating.

Physician notifications: None.

Future plans for patient: Patient needs to follow up with the GI outpatient after he is discharged.

Discharge Planning (2 points)

Discharge location: Carle Hospital to Home.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Patient has not yet been discharged and is still being monitored by the physician.

Education needs: Patients education needs the importance of decreasing alcohol intake.

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 Deficient Fluid Volume as evidence by the patient being dehydrated and dry skin.	**Indicates excessive fluid loss or resultant dehydration.**	**1.Observe for excessively dry skin and mucous membranes, decreased skin turgor.** **2.Assess vital signs (BP, pulse, temperature)**	**Patients skin turgor was normal. Patient also had a less than 2 capillary refill. Goals met.** **Patients vitals were all normal, patient is stable. Goals met.**
2. Risk for bleeding related to GI bleed as evidence by anemia.	Information about precautionary measures lessens the risk for bleeding.	**1.** Educate the at-risk patient about precautionary measures to prevent tissue trauma or disruption of the	**1.) Patient was able to understand precautionary measures.** **2.) Patient was able to understand to cautious when brushing his teeth. Goals met.**

		normal clotting mechanisms. 2.Use a soft-bristled toothbrush and nonabrasive toothpaste. Avoid the use of toothpicks and dental floss.	
3. Risk for fatigue related to decreased hemoglobin as evidence by inability to maintain usual level of physical activity.	**Patient stated he was tired and does not have energy like he usually does.**	**21.monitory hemoglobin, hematocrit, RBC count, and reticulocyte counts.** **2.Assist the client in developing a schedule for daily activity and rest. Stress the importance of frequent rest periods.**	**Patient is getting blood tests every day for updated results. Goals met** **Educated the patient for scheduled daily activities.** **Goals met.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

Pt states "I was brought in because I had stomach pain and blood in my stool."
Patient stated upon arrival his pain level was a 7/10.

Nursing Diagnosis/Outcomes

Risk for Deficient Fluid Volume as evidence by the patient being dehydrated and dry skin.
Risk for bleeding related to GI bleed as evidence by anemia.
Risk for fatigue related to decreased hemoglobin as evidence by inability to maintain usual level of physical activity.

Objective Data

Patients pain level is 0/10.
A & O x 3
IV: R forearm.
Vitals:

Patient Information

It is a 65 y/o Caucasian male with history of DVT PE high on Eliquis, history of large cell lymphoma, history or alcohol use who presented to OSF Heart of Mary with epigastric pain and near syncope was transferred to Care UGI bleed, anemia. He has been having black, sometimes bright red stools since 1 month. Keeps having dizziness on-off. He feels his exercise tolerance has reduced and is not as well as before. But he is still able to do all his routine activities. Abdominal pain, increase associated with food, especially spicy food, not so much greasy food. A/w loose stools since around 2-3 weeks. No chest pain/sob. No swelling/no nausea/ last vomit 2 weeks ago. Last colonoscopy a long while back. Pt had a normal INR on 9/12, one done outside 3.5 Hemoglobin was 14 1 week back. Pt has been on Eliquis for DVT, history of prothrombin gene mutation, hasn't taken Eliquis since sometime. Diagnosed with follicular lymphoma in 2018. Received radiation with surgery in 2018. PMH is also significant for degenerative joint disease.

membranes, decreased skin turgor.

Nursing Interventions

Assess vital signs (BP, pulse, temperature)

Educate the at-risk patient about precautionary measures to prevent tissue trauma or disruption of the normal clotting mechanisms.

Use a soft-bristled toothbrush and nonabrasive toothpaste. Avoid the use of toothpicks and dental floss.

Monitory hemoglobin, hematocrit, RBC count, and reticulocyte counts.

Assist the client in developing a schedule for daily activity and rest. Stress the importance of frequent rest periods.