N431 Care Plan #1

Lakeview College of Nursing

Airelle Mitchell

Demographics (3 points)

Date of Admission 01/28/2022	**Client Initials** B.A.	**Age** 67	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Divorced	**Allergies** Penicillin – unknown Sulfa drugs – unknown Clindamycin – vomiting/diarrhea Sulfones - unknown
Code Status Full code	**Height** 170 cm – 5’5” ft.	**Weight** 54.700 kg – 120.59 lbs.	

Medical History (5 Points)

Past Medical History: Chronic obstructive pulmonary disease, atrial septal defect, carotid stenosis, chronic diastolic heart failure, chronic respiratory failure with hypoxia, congenital mitral insufficiency, coronary artery disease, emphysema, asthma, history of congestive heart failure, history of CABG x 4, hyperlipidemia, hypertensive cardiovascular disease, anemia, ischemic cardiomyopathy, paroxysmal atrial fibrillation, cardiac pacemaker, sleep apnea, and unspecified atrial fibrillation.

Past Surgical History: colonoscopy with biopsy (11/30/2021), esophagogastroduodenoscopy biopsy (11/30/2021), hip joint injection with fluoroscopy left (10/20/2021), cardioversion (12/28/2018), cholecystectomy laparoscopic, possible cholangiogram (11/14/2018), appendectomy, CABG x 4, cardio pacemaker, cardio catheter, repair of mitral valve, tubal ligation.

Family History: N/A – the client did not know about her past family medical history.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use):

Tobacco: 1 pack of cigarettes per day since she was 20 years old. She quit in 2015.

Alcohol: Drinks a glass of wine about 3 times a month (1 glass of red wine) and one margarita about once a year. She states has been drinking since she was about 25 years old.

Drugs: Denies use

Assistive Devices: Walker and a cane.

Living Situation: Lives at home alone.

Education Level: Graduated college with a bachelor's degree.

Admission Assessment

Chief Complaint (2 points): Presented to ER with a low platelet count

History of Present Illness – OLD CARTS (10 points): The client is a 67-year-old female who presented to the emergency department on 01/28/2022 by recommendation from her hematology doctor. She was getting routine lab results when her point of care platelet count came back at 10,000. The client stated she was then recommended by the doctor to go straight to the emergency room because her platelets were very low. She stated she was very nervous and had anxiety about going to the emergency room. The client states she was not in any pain when presenting to the emergency room.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Thrombocytopenia

Secondary Diagnosis (if applicable): Hemolytic anemia

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

Thrombocytopenia is a condition where the client has developed a platelet count of less than 149,000/uL. Platelets begin as immature cells in the bone marrow and then mature into

platelets that contain procoagulant substances (Capriati, 2020). After turning into platelets, they form from the stimulation of a hormone called thrombopoietin. Thrombopoietin is synthesized in the liver, and a reduction in platelets stimulates this hormone to be produced (Capriati, 2020). Platelets are also used to assist in hemostasis and makeup clots. Many medications can cause thrombocytopenia and can generate hematologic cancers such as leukemia. Thrombocytopenia can also develop from decreased platelet life span and increased isolation of platelets in the spleen (Capriati, 2020). When the body does not have enough platelets, this can lead to a significant risk for bleeding.

Signs and symptoms are bleeding, fatigue, ecchymosis, considerable bruising, petechiae, or purpura (Hinkle & Cheever, 2018). Although these symptoms can be present, many clients are asymptomatic and find out through a routine blood test. A point of care blood test revealed a platelet count of 10,000. She was unaware because she did not have any new symptoms. The client did bruise very quickly, which is usually the first symptom of low platelet levels. Laboratory tests showing thrombocytopenia are a complete blood count, aPTT, and PT/INR. (Capriati, 2020). complete blood count can test the blood for how many counts of platelets, red blood cells, hematocrit, and hemoglobin are in the blood. The client had a decreased platelet count, red blood cell count, decreased hematocrit, and hemoglobin. These tests can show an increased risk for bleeding and anemia. Treatment for clients with thrombocytopenia are blood transfusions and medications like steroids such as prednisone (Hinkle & Cheever, 2018). Platelet transfusions can increase platelet counts and will help stop bleeding. The client was given 1 unit of platelets on 01/28/2022. The client is also taking prednisone. To reduce the risk of bleeding, the client can prevent fall injuries and use bleeding precautions.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology* (2nd ed.). F. A. Davis.

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters 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	3.80-5.41	2.22	2.18	This client has a history and present illness of anemia which can cause low red blood cells (Pagana et al, 2021).
Hgb	11.3-15.2	6.3	7.1	Decreased red blood cells can cause low hemoglobin and can indicate anemia. The client's secondary diagnosis is hemolytic anemia which could be the cause of decreased hemoglobin (Pagana et al, 2021).
Hct	33.2-45.3	21.9	21.9	Due to the red blood cells and hemoglobin being low, this will also cause a decrease in hematocrit due to the client's hemolytic anemia (Pagana et al, 2021).
Platelets	149-393	56	52	Due to many of the client's drugs having side effects of thrombocytopenia, this can cause a significant decreased number of platelets in the blood. Also, some hemolytic anemia can cause a decrease in platelet count (Pagana et al, 2021).
Point if care (ONC) platelets	149-393	10	N/A	The client's medications or her secondary diagnosis of hemolytic anemia could cause decreased number of platelets. Immune diseases can also cause a decrease in platelet counts (Pagana et al, 2021).
WBC	4.0-11.7	6.2	7.8	
Neutrophils	45.3-79.0	87.6	86.9	High neutrophils can be an indication

				the client has an infection (Pagana et al, 2021).
Lymphocytes	11.8-45.9	9.0	7.5	Low levels can possibly indicate an autoimmune disorder or blood disease (Pagana et al, 2021).
Monocytes	4.4-12.0	2.0	5.5	The client is taking prednisone which can cause a decrease in monocytes (Pagana et al, 2021).
Eosinophils	0.0-6.3	0.6	N/A	
Bands	0.2-1.6	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	138	138	
K+	3.5-5.1	4.5	5.0	
Cl-	98-107	98	102	
CO2	21-31	38	32	Increased CO2 levels due to the client having emphysema. Emphysema has an impaired gas exchange at the alveoli causing carbon dioxide retention (Pagana et al, 2021).
Glucose	74-109	174	109	The client had anxiety and was very nervous upon admission which can cause stress on the body and increase the client's glucose (Pagana et al, 2021).
BUN	7-25	25	24	
Creatinine	0.84-1.21	1.25	1.04	Slightly increased due to dehydration from taking torsemide which is a loop diuretic. Taking a loop diuretic pushes out excess water and salt out from your kidneys and can cause dehydration (Pagana et al, 2021).

Albumin	3.5-5.2	3.6	3.7	
Calcium	8.6-10.3	8.6	8.7	
Mag	1.6-2.1	2.2	N/A	
Phosphate	45-117	N/A	N/A	
Bilirubin	0.3-1.0	1.4	1.1	The client has hemolytic anemia which can cause an increased bilirubin (Pagana et al, 2021).
Alk Phos	30-120	82	72	
AST	0.3-1.0	18	29	
ALT	13-39	13	29	
Amylase	30-110	N/A	N/A	
Lipase	11-82	N/A	N/A	
Lactic Acid	0.5-1.0	N/A	N/A	
Troponin	0.0-0.030	N/A	N/A	
CK-MB	0.60-6.30	N/A	N/A	
Total CK	30-223	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	Normal: 1 Therapeutic 2-3	N/A	N/A	
PT	10-12 seconds	N/A	N/A	
PTT	30-45 seconds	N/A	N/A	

D-Dimer	<200	1.21	N/A	
BNP	0-100	N/A	N/A	
HDL	23-92	N/A	N/A	
LDL	<100	N/A	N/A	
Cholesterol	<199	N/A	N/A	
Triglycerides	0-149	N/A	N/A	
Hgb A1c	<6.4	N/A	N/A	
TSH	0.45-5.33	1.57	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	Pale yellow/ clear	N/A	N/A	
pH	5-8	N/A	N/A	
Specific Gravity	1.005-1.030	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0-5	N/A	N/A	
RBC	0-6	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.32 - 7.41	N/A	N/A	
PaO2	40-50	N/A	N/A	
PaCO2	40 -50	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	92-100%	N/A	N/A	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	N/A	N/A	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2021). *Mosby's diagnostic & laboratory test reference* (15th ed.) Elsevier.

Sarah bush reference information: Cerner 2022

Diagnostic Imaging

All Other Diagnostic Tests (5 points): N/A – The client was sent to the emergency room from recommendation of a doctor at the cancer center because of her low platelet count. She did not need any diagnostic tests done during her stay in the hospital.

Diagnostic Test Correlation (5 points): N/A

Diagnostic Test Reference (1) (APA): N/A

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

Home Medications (5 required)

Brand/Generic	Metoprolol / Lopressor	Albuterol / ProAir HFA	Apixaban / Eliquis	Potassium Chloride / Klor-con	Torsemide / Demadex
Dose	200 mg	90 mcg	5 mg	20 mEq	20 mg
Frequency	Once daily	2 puffs Q4H	BID	Once daily	Once daily
Route	PO	Inhaled	PO	PO	PO
Classification	Pharmacological: Beta adrenergic Therapeutic: Antianginal, antihypertensive	Pharmacological: Adrenergic Therapeutic: Bronchodilator	Pharmacological: Factor Xa inhibitor Therapeutic: Anticoagulant	Pharmacological: electrolyte cation Therapeutic: electrolyte replacement	Pharmacological: Loop diuretic Therapeutic: Antihypertensive, diuretic
Mechanism of Action	Decrease in cardiac excitability, cardiac output, and myocardial oxygen demand and reduces	Albuterol attaches to the receptors to stimulate the adenylate cyclase into ATP and is CAMP. This	Inhibits free and lot bound FXa and prothrombinase activity to decreases thrombin development.	Potassium chloride is a major cation in the intracellular fluid, that activates many enzymatic	Medication blocks chloride and sodium reabsorption and promotes rapid excretion resulting in

	blood pressure by lowering renin released by the kidneys.	will relax the bronchial muscles.		reactions that is important for physiological processes such as the cardiac and skeletal muscles to produce contraction.	lower blood pressure and reduces preload and afterload of the heart.
Reason Client Taking	Hypertension	Exercise induced bronchospasms	Prevent blood clots due to client's history of atrial fibrillation.	To prevent hypokalemia	To treat edema in heart failure
Contraindications (2)	Heart rate less than 45 beats per minute and heart block greater than the first degree.	Hypersensitivity to albuterol or its components.	Acute pathological bleeding or severe hypersensitivity to apixaban or its components.	Acute dehydration or hyperkalemia	Anuric clients and hypersensitivity to its components or sulfonamides
Side Effects/Adverse Reactions (2)	Arterial insufficiency and bronchospasm	Arrhythmias and bronchospasms	Thrombocytopenia and hemorrhagic anemia	GI bleeds and angioedema	Hypotension and ECG abnormalities
Nursing Considerations (2)	Clients with heart failure develops symptomatic bradycardia, expect to taper the dosage.	Make sure the client is well educated on the proper use of an inhaler. Monitor serum potassium levels because albuterol could cause hypokalemia	Monitor closely for bleeding and use bleeding precautions. Prevent falls, use a soft bristle toothbrush, and use an eclectic razor. If needed the antidote is andexanet alfa if	Regularly assess signs of hypokalemia such as fatigue, arrhythmias, and paresthesia.	Monitor the client's serum electrolyte levels and fluid intake and output to manage dehydration and watch for hypokalemia and hypomagnesemia. Expect

		.	hemorrhaging occurs.		to monitor renal functions.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess blood pressure systolic less than 100 and heart rate that is less than 45 beats per minute.	Listening to the lung sounds and respirations prior to administering.	Monitor blood test INR and should be 2-3 times the normal amount.	Monitoring potassium levels or signs of hyperkalemia	Assess blood pressure periodically because it can cause hypotension.
Client Teaching Needs (2)	Educating the client on how to assess blood pressure at home and if the systolic pressure is less than 100 it should be held. Caution the client to not stop taking the drug abruptly because it can cause severe hypertension or MI.	Teach client to wash mouthpiece once a week and let it airdry. Teach client to wait at least 1 minute between inhalations if dosing requires more than one inhalation.	Educate the client about bleeding and the use of bleeding precautions. Avoid large amounts of foods high in vitamin K such as leafy greens.	This should be taken with meals or right after meals. Potassium pill should be taken with a full glass of water. Educate the client that there are many foods that contain potassium that she should watch her intake to not exceed the normal daily amount.	Maintain adequate fluid intake to prevent dehydration and to watch for diarrhea, excessive vomiting because this drug can lead to low blood pressure and result in fainting. Teaching the client to move positions slowly because of orthostatic hypotension can occur.

Hospital Medications (5 required)

Brand/ Generic	Amiodarone / Cordarone	Budesonide / Pulmicort respules	Formoterol / Perforomoist	Pantoprazole / Protonix	Prednisone / Prednisone intensol
Dose	200 mg	0.25 mg	20 mcg	40 mg	100 mg
Frequency	Once daily	BID	BID	BID	Once daily
Route	PO	Nebulized inhalation	Nebulized inhalation	PO	PO
Classification	Pharmacological: Benzofuran derivative Therapeutic: Class III antiarrhythmic	Pharmacological: Corticosteroid Therapeutic: Antiasthmatic, anti-inflammatory	Pharmacological: Selective beta-adrenergic agonist Therapeutic: Bronchodilator	Pharmacological: Proton pump inhibitor Therapeutic: Antiulcer	Pharmacological: Glucocorticoid Therapeutic: immunosuppressant
Mechanism of Action	Relaxes smooth muscles of the vascular walls, decreases afterload, and increases the cardiac index.	Inhibits the inflammatory cells and decreases inflammation in the nasal and airways and inhibits mucus secretion in the airways.	Attaches to bronchial membranes to relax bronchial smooth muscle cells and stabilizes mast cells.	Proton pump inhibitors block gastric acid production to prevent more stomach acid from forming.	Suppresses inflammatory and immune response to inhibit synthesis of inflammatory response mediators.
Reason Client Taking	Preventing arrhythmias	Asthma / emphysema	Asthma / COPD	Prophylaxis for GI ulcer	Can help increase platelet count and used for chronic inflammatory disease.
Contraindications (2)	Cardiogenic shock or hypersensitivity to its components	Status asthmatics or trauma from nasal sprays	Hypersensitivity to formoterol or for clients who	Concurrent therapy with rilpivirine containing	Hypersensitivity to prednisone or systemic fungal

			have asthma and are not taking an inhaled treatment of asthma monotherapy	products, or hypersensitivity to pantoprazole	infection
Side Effects/Adverse Reactions (2)	Arrhythmias (Av block, bradycardia, and ventricular fibrillation/tachycardia) and thrombocytopenia	Hypertension and bronchospasms	Arrythmias and prolonged QT interval	Thrombocytopenia and clostridium difficile	Heart failure and GI bleeding
Nursing Considerations (2)	Checking the client's pacemaker because the drug can affect pacing or defibrillating threshold. Monitor continuous ECG to check for an increased PR and QRS intervals and heart rate below 60 bpm.	Administer repulse by a jet nebulizer that is attached to an air compressor. Monitor the patient due to having hypertension because as glucocorticosteriods increase adverse effects.	This should not be used in clients for monotherapy to treat asthma. Watch for paradoxical bronchospasms and notify the provider right away.	Administer 30 minutes before a meal. Monitor the patient for fractures because this drug can increase the risk for osteoporosis related fractures of the hip, spine, and wrist.	Administer once daily preferably in the morning to match the body's normal secretion schedule. Watch for adverse effects because prednisone can cause heart failure and hypertension.
Key Nursing Assessment(s) /Lab(s) Prior to Administration	Heart rate below 60 beats per minute.	Assess lung sounds before and after use.	Watch for an increase in heart rate or blood pressure.	Monitor PT or INR in a client taking an oral anticoagulant	Monitor fluid intake and output and daily weight.
Client Teaching Needs (2)	Educate the client to take the medication with meals consistently.	Instruct he client to rise her mouth out with water and to	Teach the client that she should follow the manufactur	Teach the client to swallow the medication whole and to	Have the client take with food because it will prevent

	Teach the client that she will need frequent monitoring and laboratory testing during treatment.	spit out the water after each use to prevent infection. Talk to the client about not using this for as a rescue inhaler.	er's directions and not use a spacer. Teach the client that she should only inhale not exhale through the device.	not crush or chew drug. If there is severe diarrhea for a prolonged period, they should notify the provider.	GI upset. Instruct the client to take the dose as prescribed and to make sure she is taking the right amount to decrease the risk of severe adverse reactions.

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert & oriented to time, place, date, and situation A & O x 4 The client was not in any distress. Client responds to stimuli. She was calm and in a great

	mood. Her overall appearance she was well groomed.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 20** **Drains present: Y☐ N ☒** **Type:** N/A	 Pink Dry and intact, with no moisture present. Warm on anterior and posterior sides of the extremities. +3 turgor / sluggish No rashes or wounds present. She had many bruises from the tourniquet being so tight and needle stick attempts for IV's. 20
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck were normocephalic, symmetrical, and within normal range of motion. Was able to feel the thyroid rise and fall upon swallowing. No drainage or inflammation noted in the ears. Both the left and right eyes were 3mm, equal round, and reactive to light. She wears glasses as daily use. The sclera was white, no drainage present, and the conjunctiva was pink. The nose was midline and symmetrical, with no drainage. Some of her lower and upper teeth were missing and had some discoloration.
CARDIOVASCULAR: **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:** lower extremities	Heart sounds of S1 and S2 heard. Regular rhythm due to the client's permanent pacemaker. No murmurs, gallops, or friction rubs present when auscultating the aortic, pulmonic, Erb's point, tricuspid, and mitral locations. Cardiac rhythm N/A. Peripheral pulses palpable 3+ on right and left sides of the body bilaterally by the carotid arteries, radial arteries, popliteal arteries, posterior tibial arteries, and dorsalis pedis arteries. All locations were easily palpable and brisk. Capillary refill was less than 3 seconds in all extremities. Slight edema 1+ in lower extremities bilaterally.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Slight wheezing sounds when auscultating anteriorly and posteriorly, the upper and lower lobes on the left and right side. Respirations were 18 bpm nonlabored and were equal. Accessory muscles were not in use due to continuous oxygen supply of 2 L via nasal cannula.
GASTROINTESTINAL: **Diet at home:** Low sodium diet	

Current Diet: Heart healthy **Height:** 170 cm – 5’5” ft **Weight:** 54.700 kg – 120.59 lbs. **Auscultation Bowel sounds:** active in all 4 quadrants **Last BM:** 01/31/2022 (soft stool) **Palpation: Pain, Mass etc.:** Patient denies any pain, tenderness, and no masses present. **Inspection:** **Distention:** No distention present **Incisions:** No incisions present **Scars:** Chest and abdomen **Drains:** No drains present **Wounds:** No wounds present **Ostomy: Y** ☐ **N** ☒ **Nasogastric: Y** ☐ **N** ☒ **Size:** N/A **Feeding tubes/PEG tube Y** ☐ **N** ☒ **Type:** N/A	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y** ☐ **N** ☒ **Dialysis: Y** ☐ **N** ☒ **Inspection of genitals:** **Catheter: Y** ☐ **N** ☒ **Type:** N/A **Size:** N/A	Medium yellow Clear, not cloudy Urine not measured, but stated she voided x 2. Pink, dry, and clean
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y**☐ **N** ☒ **Fall Risk: Y** ☒ **N**☐ **Fall Score:** 85 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☒ **Needs support to stand and walk**☐	Strength, reflexes within normal limits, active range of motion in upper and lower extremities bilaterally. Strength 5/5 bilaterally in all extremities. Client’s skin is warm with pulses present in all extremities. Client uses a walker and cane for assistance in the hospital and at home. 85
NEUROLOGICAL: **MAEW: Y** ☒ **N**☐ **PERLA: Y** ☒ **N**☐	

Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☒ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Client is alert and oriented x 4 Thinking process is fully intact. Speech is clear and understandable. Sensation on both side of the upper and lower extremities that is equal. The client is alert and oriented with no difficulties.
PSYCHOSOCIAL/CULTURAL: **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 client uses coping methods through crocheting, writing notes on cards to friends, and reads. The client has her degree in management accounting. She does not go to church but does believe in GOD. She has a good support system with her family. Her daughter and son come to help her at her home.

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0853	96 bpm	156/75 mmHg	18 rpm	36.5 C	100 % on 2 L nasal cannula
1105	95 bpm	112/66 mmHg	18 rpm	37.1 C	99 % on 2 L nasal cannula

Vital Sign Trends: The client's blood pressure was high until she was given amiodarone, which brought her blood pressure down. All the other vitals are stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0951	0-10	N/A	0 out of 10	N/A	N/A

1105	0-10	N/A	0 out of 10	N/A	N/A

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:**	18 gauge Left midline IV 01/28/2022 Flushes well, but I removed it right before she discharged around 1500. Dry, clean, and intact before the dressing was removed. Patient was saline locked during my care before the midline IV was removed.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1200 mL	Voided x 2 – unmeasured

Nursing Care

Summary of Care (2 points)

Overview of care: During my shift, I was able to administer medications, do a head-to-toe assessment, and take out her midline IV.

Procedures/testing done: There was no tests or procedures done during my shift. She did have continuous tele monitoring until she was discharged.

Complaints/Issues: The patient had no complaints or issues during my time at the hospital.

Vital signs (stable/unstable): Client’s blood pressure was elevated before her blood presser medication was given, but vitals remained stable during my care.

Tolerating diet, activity, etc.: The client was tolerating the heart healthy diet and getting up and moving a little before she was discharged.

Physician notifications: The physician was notified for her lab results that came back at 0645 to let him know that they have gone up and to see about discharging her.

Future plans for client: There are no future plans for the client's care because she was discharged.

Discharge Planning (2 points)

Discharge location: The patient was discharged home today.

Home health needs (if applicable): She has no home health needs.

Equipment needs (if applicable): The client does not need any equipment because she already has a walker and cane at home.

Follow up plan: The client will follow up with her primary care provider for lab work the next day and then two weeks later with her hematologist.

Education needs: The client was educated on hemoglobin tests, bleeding risk, platelet transfusion, and her diagnosis of hemolytic anemia.

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

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes,

				modifications to plan.
1. Risk for bleeding related to thrombocytopenia as evidenced by decreased platelet count of 5600.	The client is at a high risk of bleeding due to her significantly low platelet count.	1. Assessing the client's skin for bruising, petechia, and hematoma formation. 2. Education the client on precautionary measures to prevent the bleeding risks.	1. The client is free of bleeding by the time she is discharged and understand the importance of bleeding precautions.	The client was educated on bleeding precautions such as using a soft bristle toothbrush, using an electric razor, and taking caution when using knives or scissors. She allowed the nurse to assess her for bleeding and any new signs of bruising. When taking the client's midline out of her arm, pressure was applied for about 2-3 minutes so allow time for clotting and to stop the bleeding.
2. Fatigue related to decreased hemoglobin as evidenced by diminished oxygen carrying capacity of the blood.	Decreased hemoglobin can cause fatigue in a client who has decreased platelets. Although the client has 2L of	1. Giving the client rest periods during ADLs and ambulation. 2. Assessing the clients pulse oximetry and hemoglobin.	1. Increasing client's hemoglobin by 1 and oxygen level above 92% before the client goes	The client was able to take rest periods when needed, she was able to have continuous pulse oximetry reading and labs were drawn to

	oxygen, fatigue still needs to be assessed to prevent injury.		home.	assess her hemoglobin levels to be discharged. Since ethe client has continuous oxygen of 2L via nasal canula, she was able to keep her oxygen levels at 99 – 100%.
3. Risk for injury related to increased potential for bleeding as evidenced by platelet count of 56 upon admission and todays value of 52.	Due to decreased platelet levels, the client will be at a higher risk for bleeding. By preventing injury and using caution with activities can reduce the risk of bleeding.	1. Keeping the bed in a low position, no clutter, oxygen tube is not tangled, and call light in hand. 2. Administering medication for thrombocytopenia.	1. Within 8 hours of nursing intervention, the client will be free of injury upon discharge.	Avoiding strenuous exercise that could cause injury and risk for bleeding out. The client's bed was kept in a low position, call light near her, and no clutter around her bed. During my shift I was able to administer medication to the client. Before discharge the client was free from injury and will continue to practice safety while at home.
4. Risk for infection related to	Clients with anemia are	1. Maintaining sanitation and limiting	1. Having the client practice	The client was educated on her diagnosis

anemia as evidenced by low hemoglobin of 7.1 and hematocrit of 21.9.	more prone to becoming infection with many different diseases.	exposure to individuals who are sick. 2. Educating the client on taking iron supplements and explaining what foods have iron.	preventative action by washing hands properly to lower the risk of infection.	of anemia and will take supplements or eat more foods containing iron as stated by the client. When in the room she wore a mask to protect herself and washed her hands frequently.

Other References (APA):

Concept Map (20 Points):

Subjective Data

Client stated she has no pain on a scale of 0-10.
Client stated her last bowel movement was 01/31/2022 in the morning.
The client stated she had anxiety and was very nervous about the doctor's recommendation of going straight to the emergency room.

Nursing Diagnosis/Outcomes

Risk for bleeding:
Goal met: The client was educated on bleeding precautions such as using a soft bristle toothbrush, using an electric razor, and taking caution when using knives or scissors.
Fatigue related to decreased hemoglobin:
Goal met: The client's hemoglobin went from 6.3 – 7.1. Oxygen stayed about 92% on 2 L via nasal cannula
Risk for injury:
Goal met: During my shift I was able to administer medication to the client. Before discharge the client was free from injury and will continue to practice safety while at home.
Risk for infection:
Goal met: The client was properly educated on preventing infection and promoting sanitization.

Objective Data

The client's platelets levels were 56 upon admission and 52 during before she was discharged. The client had a blood pressure of 112/66 after administration of BP medication. The client is A & O x4.

Client Information

Client is a 67-year-old female who presented to the emergency room from recommendation of her doctor due to low platelet level. The client received 1 unit of platelets after being admitted. The client's platelet levels were being monitored and did increase.

Nursing Interventions

Assessing the client's skin for bruising, petechia, and hematoma formation.
Education the client on precautionary measures to prevent the bleeding risks.
Giving the client rest periods during ADLs and ambulation.
Assessing the clients pulse oximetry and hemoglobin.
Keeping the bed in a low position, no clutter, oxygen tube is not tangled, and call light in hand.
Administering medication for thrombocytopenia.
Maintaining sanitation and limiting exposure to individuals who are sick.
Educating the client on taking iron supplements and explaining what foods have iron.