N321 Care Plan # 1

Lakeview College of Nursing

Emily Melecosky

Demographics (3 points)

Date of Admission 1/31/22	Client Initials MH	Age 69	Gender Male
Race/Ethnicity White/ Caucasian	Occupation Not employed	Marital Status divorced	Allergies Allergic rhinitis
Code Status Full (no ACP docs)	Height 190.5 cm (6'3")	Weight 112.7 kg (248 lbs 6.4 oz)	

Medical History (5 Points)

Past Medical History:

The patient has a past medical history of allergic rhinitis, renal cell cancer, anemia, gastritis, HNT, LAFB, low HDL, tinnitus, and vitamin deficiency. Dates for the past medical history weren't listed. When the patient was asked, he stated "I don't know, sometime during my life."

Past Surgical History:

The patient underwent Anterior cervical diskectomy on 2/23/16; left shoulder arthroscopy on 5/9/16; gallbladder removal with no date listed; lung surgery with no specification of what procedure, which lung, or date of surgery; right thumb surgery with no specification for surgery or date; bilateral nonspecific eye surgery in 1960.

Family History:

Type II diabetes on the maternal side, stroke on the maternal side, HNT on the maternal side, CAD on the maternal side, and lung cancer on the paternal side.

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

The patient does not use alcohol or drugs but is a former smoker of 20 years. He would smoke 8 packs of cigarettes a week. The patient stopped smoking in 2003.

Assistive Devices:

The patient uses hearing aids in the left and right ears for diminished hearing, as well as eyeglasses to help with sight.

Living Situation:

The patient lives alone in a 1 story house outside of Rantoul and does not have any pets in the home. The patient claims that “he doesn’t have any assistive devices such as handrails in the home”.

Education Level:

The patient stated that he “attended Parkland University to obtain a GED in 1971, after not being able to finish high school from being sick with the Spanish flu.”

Admission Assessment

Chief Complaint (2 points): Confusion after falling

History of Present Illness – OLD CARTS (10 points):

The patient, a 69-year-old male, with a history of HTN and renal cell carcinoma on oral chemotherapy, was brought into the ED by his grandson on 1/31/21. The patient presented with mild confusion and disorientation after a fall. The patient states that “he was on the carpeted floor for 10 hours,” while the grandson states that the patient was found “in bed.” The patient was unaware of how he was able to get into bed by himself. He was admitted for further workup and treatment.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Shock

Secondary Diagnosis (if applicable): No secondary diagnosis listed.

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

What is shock:

Shock, which is comparable to severe hypertension, refers to when the peripheral tissues of the body cannot meet their metabolic and oxygen needs. Despite this, blood pressure usually remains low in shock but does not always occur - at least initially; While heart rate levels can be elevated, but not consistently for every case.

Signs and symptoms of shock:

Shock has a variety of symptoms, depending on the type of shock that is present in the body. Some generalized symptoms that may occur for more serious patients include an increase in temperature, elevated pulse, increased respiration, and decreased blood pressure. Some other symptoms that may occur are an increase or a decrease in white blood cells count, with lab test indicating no sign for infection. Blood cultures, however, may present either a positive or negative reading for sepsis/septic shock.

Stages of Shock:

Like many other diseases and disorders in the medical field, the shock comes in stages, to help the doctor determine how severe the situation is and how critical the patient can become. Shock appears in three stages: initial, progressive, and irreversible.

The initial stage of shock refers to when there is a sudden decrease in tissue perfusion. This initiation of the shock will instruct the sympathetic nervous system and the renin-angiotensin-aldosterone system to stimulate a faster heart rate, increase blood pressure, and vasoconstrict the blood vessels to neutralize the situation and try to bring it back to normal. During this stage, a person might begin to appear pale, clammy, anxious, and might begin to get cold.

During the progressive stage, which occurs if the initial stage can't be regulated, the lungs, kidney, gut, pancreas, and liver will experience a decrease in oxygen and blood perfusion, in order to save more vital organs, such as the heart and brain. The kidneys will begin to start experiencing failure after 20 to 30 minutes of a lack of blood and oxygen perfusion. This in turn will prevent waste from being excreted from the body and create a great potential for sepsis to occur in the body. Along with the kidneys, the liver and gastrointestinal systems become motionless, which can lead to ischemia. Finally, the liver will not be able to clear out any toxins from the blood, which can then accumulate the body.

The final stage, the irreversible stage, occurs if the prior two stages aren't fixed in the body. During this stage, perfusion to the heart and brain is finally affected, leading to myocardial (heart attack) and cerebral infarction (stroke). Hypoxia will then occur, and the body will start to deteriorate until eventually the body completely shuts down until death.

Diagnosis of Shock:

For a patient to be diagnosed with a variant of shock, first, he/she must experience or display certain signs and symptoms. These include either a fast or slow heart rate than normal, fast breathing, poor circulation of the body causing bluing of the body, metabolic acidosis, change in alertness and orientation, a decrease in urine output, an ECG change, either an increase or decrease to cardiac output, either too high or too low of central venous pressure, and usually a decrease in blood pressure.

If the provider thinks there is a possibility for shock, he/she will use a variety of scores and scales to look further into the level of risk to severely ill patients. These scores and scales include a standard blood test, Glasgow Coma Scale score, and past medical history. These tests are all completed within the first 24 hours of admission. Other tests that can be performed and

ordered by the provider are X-ray, CT scan, MRI, and Ultrasound. Usually, these tests do not help the doctors diagnose shock, but rather help the doctor look for any internal injuries that may have occurred from the shock.

Major types of shock:

1) **Obstructive shock:**

Obstructive shock may occur when blood flow in the body is occluded and not able to get where it needs to go. An example of this is a pulmonary embolism, as the embolus (clot in the lungs) blocks proficient blood flow to the lungs. Another reason for an obstructive shock to occur is due to an accumulation of fluid and air in the chest cavity, such as pneumothorax (a collapsed lung).

2) **Cardiogenic shock:**

Cardiogenic shock occurs when there is damage to the heart muscles or tissue, which results from an insufficient amount of blood being transported to the heart. A couple of signs that might occur with this are irregular heart rhythm or a very slow heart rhythm.

3) **Distributive shock:**

Distributive shock is a condition in which the blood vessels in the body to lose their tone and become open and floppy. These open and floppy blood vessels don’t allow for proper blood flow to be transported to organs. There are three forms of distributive shock: anaphylactic shock, septic shock, and neurogenic shock,

Anaphylactic shock occurs in the body when there is a severe allergic reaction to a substance in the body as mistakenly harmful. This is usually caused by foods, latex, venom, and medications. Septic shock, poisoning in the bloodstream, is caused by an infection and bacteria to enter the bloodstream. These bacteria and their toxins will cause serious tissue damage and

organs, resulting in the process of septic shock. Neurogenic shock refers to damage caused to the central nervous system. This damage causes a dilation of the blood vessels, which will decrease the heart rate and blood pressure. These decreases in the body can cause a decrease in blood perfusion, thus eventually shutting down the body.

4) **Hypovolemic Shock:**

The final form of shock that can happen in the body is hypovolemic shock. This takes place when there is a lack of enough blood in the body, and your organs can't get enough oxygen carried to them to maintain sufficient functions.

Treatment of shock:

Depending on the cause of your shock, your doctor will devise a treatment plan. Each type of shock requires a different approach. Your doctor may use the following treatment plans:

- Drugs for treating anaphylactic shock, including epinephrine
- Blood transfusion to replace lost blood and treat hypovolemic shock
- Cardiogenic shock treatment may involve medications, heart surgery, or other interventions
- Interventions for treating septic shock include medications, heart surgery, or other interventions

Type of shock the patient might have been experiencing:

Due to evidence in the patient's chart, lab results, and diagnostic procedure results, I believe that this patient had suffered from cardiogenic shock. Evidence of this can be seen in the INR and PT ranges, as they were elevated in the labs, as well as the patient's history of hypertension and low HDL (good cholesterol that decreases fats in the bloodstream

As a nurse, I understand I am not supposed to medically diagnose, but there was no specific diagnosis for the shock in the chart, so I am basing off what I learned and putting it into a diagnosis.

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). *PATHOPHYSIOLOGY: introductory concepts and clinical perspectives.* (2nd ed., pp. 1154–1164). F A Davis.

Khan, A. (2018, July 27). *What You Should Know About Shock*. Healthline; Healthline Media. https://www.healthline.com/health/shock

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	**4.10-5.70 10^6/uL**	**4.32**	**4.16**	
Hgb	**12.0 – 18.0 g/dL**	**9.1**	**8.6**	**The low hemoglobin levels in this patient is due to his renal cell carcinoma, as well as experiencing anemia ("Understanding Routine Lab Test Results - Lab Test Errors, Abnormalities -AARP", 2021).**
Hct	**37.0-51.0 %**	**31.8**	**31.5**	**The low hematocrit levels are caused by anemia ("Understanding Routine Lab Test Results - Lab Test Errors, Abnormalities -AARP", 2021).**
Platelets	**140-400 10^3/uL**	**41.9**	**57.0**	
WBC	**4.00-11.00 10^3u/L**	**12.33**	**14.69**	**Increased white blood cells are an indication of an infection or inflammation, but in this patient, it is caused from the renal cell carcinoma and chemotherapy ("Understanding Routine Lab Test Results - Lab Test Errors,**

				Abnormalities -AARP", 2021).
Neutrophils	**1.60 – 7.70 10^3/uL**	**6.68**	**N/A**	
Lymphocytes	**1.00-4.90 10^3/uL**	**1.17**	**N/A**	
Monocytes	**0.0 – 1.10 10^3/uL**	**1.29**	**N/A**	**An increase in monocyte count can be due to the patient's current diagnosis of cancer ("Complete Blood Count (CBC) Analyzer: Decode Your Results", 2021).**
Eosinophils	**0.0 – 0.50 10^3/uL**	**0.07**	**N/A**	
Bands	**0.0 – 0.09 10^3/uL**	**0.09**	**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	137	137	
K+	3.5 – 5.1 mmol/L	5.1	4.8	
Cl-	98-107 mmol.L	102	101	
CO2	22.0 – 29.0 mmol/L	23.0	22.0	
Glucose	74 – 100 mg/dL	85	87	
BUN	8-26 mg/dL	18	18	
Creatinine	**0.55 – 1.30 mg/dL**	0.58	0.60	
Albumin	**3.5-5.2 mg/dL**	**N/A**	**N/A**	
Calcium	**8.9 – 10.6 mg/dL**	7.3	8.6	**The decrease in calcium in the patient can be caused by older age, vitamin deficiency, or chemotherapy ("Understanding Routine Lab Test Results - Lab Test Errors, Abnormalities - AARP", 2021).**

Mag	**1.6-2.6 mg/dL**	1.9	N/A	
Phosphate	**2.5-4.5 mg/dL**	4.1	N/A	
Bilirubin	**0.2 – 1.2 mg/dL**	0.3	N/A	
Alk Phos	**40-150 U/L**	120	N/A	
AST	**5-34 U/L**	22	N/A	
ALT	**0-55 U/L**	12	N/A	
Amylase	**30 - 110 U/L**	N/A	N/A	
Lipase	**0-160 U/L**	N/A	N/A	
Lactic Acid	**0.5 to 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	**0.9 – 1.1**	**1.2**	**N/A**	**Increased INR can be due to chemotherapy ("Understanding Routine Lab Test Results - Lab Test Errors, Abnormalities - AARP", 2021).**
PT	**11.7-13.8**	**14.8**	**N/A**	**Increased INR can be due to chemotherapy ("Understanding Routine Lab Test Results - Lab Test Errors, Abnormalities - AARP", 2021).**
PTT	**22.4-35.9**	**35.5**	**N/A**	
D-Dimer	**≤250 ng/mL**	**N/A**	**N/A**	
BNP	>100 ng/ml	**N/A**	**N/A**	
HDL	**> 60 mg/dL**	**N/A**	**N/A**	

LDL	**< 130 mg/dL**	**N/A**	**N/A**	
Cholesterol	**< 200 mg/dL**	**N/A**	**N/A**	
Triglycerides	**< 150 mg/dL**	**N/A**	**N/A**	
Hgb A1c	**4% to 5.6%**	**N/A**	**N/A**	
TSH	**0.5 to 5.0 mLU/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	Yellow & Clear or cloudy	**Yellow and clear**	**N/A**	
pH	**5.0 – 7.0**	**5.2**	**N/A**	
Specific Gravity	**1.003 – 1.035**	**1.018**	**N/A**	
Glucose	**Negative**	**Negative**	**N/A**	
Protein	**Negative**	**negative**	**N/A**	
Ketones	**Negative**	**negative**	**N/A**	
WBC	**0.0-20.0**	**19.0**	**N/A**	
RBC	**0.0-20.0**	**11**	**N/A**	
Leukoesterase	**Negative**	**negative**	**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	**4.5-8.0 pH**	**N/A**	**N/A**	
Blood Culture	**7.35-7.45 pH**	**N/A**	**N/A**	

Sputum Culture	**7.00 pH**	**N/A**	**N/A**	
Stool Culture	**6.5-7.5 pH**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Complete Blood Count (CBC) Analyzer: Decode Your Results. Verywell Health. (2021). Retrieved 15 February 2021, from https://www.verywellhealth.com/cbc-test-analyzer-4768236.

Understanding Routine Lab Test Results – Lab Test Errors, Abnormalities -AARP. AARP. (2021). Retrieved 17 February 2021, from https://www.aarp.org/health/doctors-hospitals/info-02-2012/understanding-lab-test-results.html

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

The patient was sent to CT on 1/31/22 and the results came back on 2/1/22. There were no abnormal findings on the results. The patient was also swabbed for Covid-19 during his admission through the ED, the results came back later 1/31/22 as negative for Covid-19. An ECG was run on 1/31/22, and the results were later analyzed that day, and the PQRST waves on the ECG were normal.

Diagnostic Test Correlation (5 points):

The reason for the CT test to be done due to a fall is to roll out any form of head trauma that could have occurred because of the fall. A CT will be performed on anyone of age 60 and older who has fallen to ensure there is no internal trauma (Capriotti, 2020, p. 829). A routine covid test was performed when entering the hospital to find out if the patient is covid-positive or negative, to prevent exposure to others whenever possible. The ECG was run to test for any

abnormalities in the heart rhythm, which could result in the patient falling. This ECG could also have been performed to assess for shock (Capriotti, 2020, p. 371).

Diagnostic Test Reference (1) (APA):

Capriotti, T. M. (2020). *PATHOPHYSIOLOGY : introductory concepts and clinical perspectives.* (2nd ed., pp. 371, 829). F A Davis.

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

Home Medications (5 required)

Brand/Generic	**Acetaminophen (Tylenol) tablet**	**Cyclobenzaprine (Flexenil)**	**Loratadine (Claratin)**
Dose	**500 mg**	**10 mg x 1 tablet**	**10 mg x 1 tablet**
Frequency	**Q4hr PRN**	**Daily PRN**	**Daily PRN**
Route	**oral**	**Oral**	**Oral**
Classification	**Analgesic/ non-salicylare**	**Skeletal Muscle Relaxant**	**2nd generation antihistamines**
Mechanism of Action	**Inhibits the enzymes cyclooxygenase, blocking prostaglandins production and interfering with pain impulse generation in the peripheral nervous system.**	**Helps to relieve skeletal muscle spasms locally without inhibiting the function of the muscles.**	**Activates peripheral histamine H1 receptors by activating tricyclic antihistamines with a long-acting reaction.**
Reason Client Taking	**Moderate – mild pain**	**Muscle spasms**	**Allergic Rhinitis**
Contraindications (2)	**1. Hypersensitivity to acetaminophe**	**1. Heart failure 2. Hyperthyroidis**	**1. Hypersensitivity to loratadine and**

	n with any other medication **2. Severe hepatic impairment** **3. Severe active liver disease**	**m**	**it's components** **2. Could worsen asthma attacks**
Side Effects/Adverse Reactions (2)	**1. Hypertension** **2. Constipation** **3. Muscle spasms**	**1. Muscle twitches** **2. Unusual muscle weakness** **3. diarrhea**	**1. Rash** **2. Itching** **3. Swelling** **4. Trouble breathing**
Nursing Considerations (2)	**1. Use acetaminophen cautiously in patients with severe renal impairment** **2. Tell the patient that tablets may be crushed or swallowed whole** **3. Instruct the patient to read the manufacturers' label and follow dosage guidelines precisely.**	**1. This medication is not recommended for older adults due to a greater risk of side effects while using the drug** **2. Do no crush or chew the capsule** **3. This medication should be used short-term (for 3 weeks or less), unless specified by a doctor**	**1. Do not use while breastfeeding** **2. Monitor for signs of an allergic reaction such as breathing issues, hallucinations, tremors, loss of coordination, and irregular heartbeat.**

Calcium carbonate (Tums)	**Magnesium oxide (Uro-Mag)**
500 mg x 1 tablet	**500 mg**
daily PRN	**Daily every morning**
Oral	**Oral**
Pharmacological: calcium salts **Therapeutic: Antacids**	**Pharmacological: mineral** **Therapeutic class: electrolyte replacement**
Neutralizes stomach acid to relieve comfort caused by hyperacidity	**To relieve constipation**
Taken for upset stomachs and heartburn relief	**To relieve constipation – stool softener** **Patient is elderly – patient having trouble having bowel movements**
1. Hypersensitivity to calcium salts and their components **2. Renal caniculi**	**1. Acute abdominal problems (nausea and vomiting)** **2. Fecal impaction**
1. Nausea **2. Vomiting**	**1. Flatulence** **2. vomiting**
1. encourage patient to chew the chewable tablets thoroughly	**1. This drug isn't metabolized It remains in the GI tract**

before swallowing and drink a glass of water afterwards **2. Instruct patient to take calcium carbonate tablets 1-2 hours after meals**	**and produces watery stool within 30 minutes to 3 hours after consumption.** **2. Avoid giving other oral drugs within 2 hours of magnesium-containing antacids**

Hospital Medications (5 required)

Brand/ Generic	**CefTRIAXone (Rocephin)**	**Ferrous sulfate (CAN)**	**Folic acid (Ferraplus)**
Dose	**1 g : 120ml/hr**	**324 mg x 1 tablet**	**1 mg x 1 tablet**
Frequency	**IV push**	**Every other day**	**Daily**
Route	**IV push**	**Oral**	**Oral**
Classification	**Cephalosporin antibiotic – 3rd generation**	**Iron replacement**	**Folic acid preparation**
Mechanism of Action	**Interferes with the bacteria cell wall by preventing cross-link of peptidoglycan strands**	**Regulates RBC production by combining with hemoglobin or by being oxidized and stored in the bone marrow, liver, and spleen**	**Methyl groups are used to create homocysteine during the methylation cycle, while utilizing methionine.**
Reason Client Taking	**To fight bacteria since chemo destroyed his immune system**	**Anemia**	**To replenish the folic acid in the body – vitamin deficient**
Contraindications (2)	**1. Hypersensitivity to ceftibuten, cephalospori**	**1. Hemolytic anemia** **2. Hypersensitivity to iron salts or their**	**1. Hypersensitivity to folic acid and its components**

	n, or their components 2. Decreased immune response to bacteria	component 3. anemic conditions unless in companied by iron	2. Neuropathy 3. Anemia
Side Effects/Adverse Reactions (2)	1. Anaphylaxis 2. Hemolytic anemia 3. Seizures	1. hemolysis 2. Hypertension 3. hypotension	1. Difficulty sleeping 2. Allergic reaction 3. Irritability
Nursing Considerations (2)	1. allergic reaction may occur days after administration 2. Assess for signs of superinfection, such as cough, diarrhea, fever, rash, itching, and swelling	1. give iron tablets and capsules with a full glass of juice or water. Don't crush in trick coated tablets or open capsule. 2. Iron salt should be given one hour before or two hours after meals	1. Check vitamin B12 levels in the body prior to starting folic acid to check for anemia to prevent neuropathy. 2. Monitor patient for hypersensitivity reactions

Furosemide (Lasix)	**Polyethylene glycol (Miralax)**
20 mg	**17 g**
Daily	**2 x daily**
IV push	**Oral**
Loop diuretic	**Laxative and cathartics**
Interferes with sodium and water reabsorption in the loop of Henle and increases urine formation.	**Osmotic laxative that causes increased water retention in the lumen of the colon by binding to water molecules, thereby producing loose stools.**
To reduce edema	**Old age – hospital**

	protocol
1. Anuria **2. Hypersensitivity to furosemide or its components**	**1. Dehydration** **2. Abdominal pain and cramping**
1. toxic epidermal necrolysis **2. hyponatremia** **3. fluid volume depletion**	**1. constipation** **2. dehydration and fluid depletion**
1. prepare the drug for infusion with normal saline solution, elected ringer solutions, or D5W **2. Monitor potassium levels** **3. Monitor blood pressure and renal functions as well as BUN, blood glucose, and serum creatine, electrolytes, and uric acid levels as appropriate**	**1. Check how many bowel moments patient had prior to administering** **2. Regularly check intake and output of the patient to make sure they are retaining adequate fluid levels**

4. **Drugs should be given in the morning so patients sleep won't be interrupted but increase need to urinate**	

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2021). *2021 Nurse's Drug Handbook*. (pp. 8- 10, 88, 95-96,378-379, 457-458).Burlington, MA: Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:**	The patient is alert and sitting up in bed, watching MythBusters on the television.
Orientation:	Orient x 4
Distress:	No acute distress
Overall appearance:	Well developed, hydrated, and nourished
INTEGUMENTARY: **Skin color:**	Skin is appropriate for ethnicity. Skin appeared pale.
Character:	Dry and intact without rashes or lesions
Temperature:	Skin is cool to the touch.

Turgor:	Normal turgor found near right clavicle bone.
Rashes:	No rashes were found on the body.
Bruises:	Many small normal bruising found on the legs accompanied by age and pitting edema, ranging in color from light blue to yellowish-brown, all with diameters smaller than a quarter. The patient had no major bruising from the fall at home.
Wounds:	No External wounds found on the patient
Braden Score:	18
Drains present: Y☐ N ☐ **Type:**	No drains present.
HEENT: **Head/Neck:**	The head is normocephalic and atraumatic without tenderness, visible or palpable masses, depressions, or scarring. Hair is of normal texture and evenly distributed. The neck appeared normal in size without abnormal swelling glands. The trachea is midline. The carotid pulse was not taken.
Ears:	Ears are symmetrical to the patient's head. No ear drainage was noted. The external ear was not tender to the touch, nor was there any skin break down from the nasal cannula noted. The hearing was diminished bilaterally, but the patient has access and was using his hearing aids for assistance.
Eyes:	Eyes located in the proper place on the patient's face. No eye drainage was noted. Eyelids are normal in appearance without swelling or lesions. Sclera appears to be white in color. EOMs are intact and PERRLA is normal. Eyesight seems to be normal as the patient can see approximately 10 feet away to see the T.V., with the assistance of prescription eyeglasses.
Nose:	Nose located in the proper place on the patient's face. The nasal septum is in midline. No nose drainage or mucous was noted. No breakdown of skin tissue surrounding the nose from the nasal cannula.

Teeth:	No abnormal discoloration of the mouth was noted. The oral mucosa was pink and moist throughout the mouth. No lesions or sores were noted. Posterior pharynx and tonsils are moist and pink without exudate noted. Tonsils were +2 bilaterally. The uvula is midline; the soft palate rises and falls symmetrically. An absence of all teeth was noted, and the patient does not have dentures for the assistance of chewing and communicating
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):**	The external chest is normal in appearance without lifts or heaves. PMI is not visible and is palpated over the 5th intercostal space. No murmurs, gallops, or rubs were found during auscultation. S1 and S2 are heard and are of normal intensity. The patient does have a pacemaker on the left side of her chest.
Peripheral Pulses:	The peripheral pulses were equal x 2.
Capillary refill:	Capillary refills are less than 2 seconds. The nail beds do not appear to have any cyanosis, pitting, or clubbing.
Neck Vein Distention: Y ☐ N ☐	No jugular vein distension was noted.
Edema Y ☐ N ☐ **Location of Edema:**	Moderate edema was observed at the legs, ankles, wrists, and arms bilaterally and scored at a +2. Pillows were being utilized for support.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐**	No accessory muscles used to breathe
Breath Sounds: Location, character	The chest wall is symmetric and without deformities. No signs of trauma or respiratory distress. The chest wall is not tender. Lungs sound clear in all the lobes, found on the right and left anterior sides of the body. No crackling or wheezing was noted. The patient did experience SOB when talking.
GASTROINTESTINAL: **Diet at home:**	The patient has no restrictions on foods but tends to stay away from hard and chewy food due to a lack of teeth and assistive devices for chewing.

Current Diet	The patient is not on a diet restriction while at the hospital.
Height:	190.5 cm (6’3”)
Weight:	112.7 kg (248 lbs 6.4 oz)
Auscultation bowel sounds:	Bowel sounds are present and normoactive in all four quadrants
Last BM:	The day before (2/09/22) during the prior night shift, so Polyethylene glycol was not administered during the shift, to prevent excessive fluid loss through defecation.
Palpation: Pain, Mass etc.: **Inspection:**	The abdomen is soft and symmetrical. The LLQ, near the umbilicus, was tender to deep direct pressure during the head-to-toe assessment. Umbilicus does not have herniation and is located midline. A normal pulse was found in the midline of the abdomen. No masses, enlarged liver, enlarged spleen are noted.
Distention:	No distention was observed.
Incisions:	No incisions were found.
Scars:	There was a minor scar located on the RUQ, resulting from prior gallbladder surgery. The star was white in color and was 3.81 centimeters in length. No significant discoloration, swelling, or sign of infection was noted around the scar.
Drains:	The patient does not have any drains.
Wounds:	The patient does not have any visible wounds in any quadrants on the stomach.
Ostomy: Y ☐ N ☐	The patient does not have an ostomy.
Nasogastric: Y ☐ N ☐ **Size:**	The patient is not on a nasogastric tube.
Feeding tubes/PEG tube Y ☐ N ☐ **Type:**	The patient is not on a feeding tube/ PEG tube.

GENITOURINARY: **Color:**	Bright yellow
Character:	hazy
Quantity of urine:	The patient excreted 200 mL of urine in a 6 hour time frame.
Pain with urination: Y ☐ N ☐	The patient did not experience any pain with urine.
Dialysis: Y ☐ N ☐	The patient was not on dialysis.
Inspection of genitals:	Normal rectal sphincter tone. No external masses or lesions. External genitalia was normal in appearance without lesions, swelling, masses, or tenderness.
Catheter: Y ☐ N ☐ **Type:** **Size:**	The patient did not have a catheter present
MUSCULOSKELETAL: **Neurovascular status:**	Appropriate mood, good judgment, and insight. No visual or auditory hallucinations were noted. No suicidal or homicidal ideation. The patient behaves appropriately according to his age
ROM:	The patient had a normal range in motion.
Supportive devices:	The patient does not use any supportive devices when active and mobile.
Strength:	The patient has equal strength of +5 bilaterally in both upper and lower extremities.
ADL Assistance: Y☐ N ☐	The patient can get up and down with help of hospital staff during his stay at the hospital, but is able to get up and down by himself at home.
Fall Risk: Y ☐ N☐ **Fall Score:**	18
Activity/Mobility Status:	The patient needs assistance to stand and walk in the hospital.

Independent (up ad lib) ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	. The patient can move all extremities well. EOM are intact and PERLA is normal, with the pupils constricting appropriately to light. Muscle strength in both arms and hands are equal and strong. Leg and feet strength both equal and strong. The patient is awake and oriented x 4. The patient appears to behave as stated age. The patient uses logical and comprehendible speech when communicating Memory is normal and the thought process is intact. No sensory deficits were noted. The patient has not experienced any loss of consciousness recently.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:**	The patient states that he “hardly ever gets mad or stressed out” and he states that people claim he is “the calmest person they know.” He said “if he were to get stressed or angry though, he would just leave the situation, rather than deal with the problem.” He states that he “leaves every problem to God.” The patient appears to act and think as stated age would behave. The patient is associated with the “Methodist faith. He believes in going to church weekly, to St. James’ Methodist church, where he has attended for 24 years.”

Personal/Family Data (Think about home environment, family structure, and available family support):	The patient is divorced, but he was priorly married for 23 years. Both the patient and his ex-wife are on good terms but hardly talk at all. He lives alone in a one-story house on the outside of Rantoul, IL. He has no pets in the home. He is really close with his 28-year-old grandson, who had taken him to the hospital.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0710	**80**	**111/65**	**18**	**36.7 C (98.1 F) temporally**	**Percentage: 99% Device: nasal canula Flow rate: 2 L/min**
0947	**80**	**112/68**	**16**	**36.8 C (98.2 F) temporally**	**Percentage: 98% Device: nasal canula Flow rate: 2 L/min**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0710	**1-10**	**abdomen**	**4**	**Intense with deep pressure on LLQ**	**Administer pain medication PRN and avoid direct deep pressure to LLQ when possible**
0947	**1-10**	**Abdomen and lower leg bilaterally**	**Abdomen: 4** **Legs: 3**	**Abdomen: Intense, sharp pain with deep pressure on LLQ** **Legs: Pins and needle pain when touched**	**Abdomen: Administer pain medication PRN and avoid direct deep pressure to LLQ when possible** **Leg: Avoid direct pressure, use pillow for support and elevate, administer pain meds PRN to control pain**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:**	The patient was on a port for ongoing chemotherapy treatment. It was located as a

Date on IV: **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	central port over the vena cava. The area around the port did not show any sign of inflammation or redness. The dressing around the port appeared dry and intact with no discharge noted.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
480 mL	**200 mL**

Nursing Care

Summary of Care (2 points)

Overview of care:

The patient was brought into the ED on 1/31/22 for confusion after a fall. The patient was admitted to the hospital later that day to find out why the fall had occurred. Routine blood work was taken, as well as an ECG, CT scan, and a routine covid test. Lab work came back with some abnormalities, while the ECG and CT came back with normal results. The covid test was negative. During the clinical rotation on 2/10/22, the patient's vitals remained stable constantly, medication was administered at 0900 orally and through his central port, a head-to-toe assessment was performed, and intake and output were measured. The doctor was updated daily on the patient's condition and was being kept until oxygen saturation increased on room air.

Procedures/testing done:

Routine blood work was taken, as well as an ECG, CT scan, and a routine covid test. Lab work came back with some abnormalities, while the ECG and CT came back with normal results. The covid test was negative

Complaints/Issues:

The patient did not have any complaints about the hospital so far during his stay.

Vital signs (stable/unstable):

The vital signs remained stable throughout the shift.

Tolerating diet, activity, etc.:

The patient had no restrictions to a diet and ate pancakes, an orange, a cinnamon roll, milk, and a pudding cup during the shift. The patient was not active during the shift

Physician notifications:

The doctor was updated daily on the patient's condition and was being kept until oxygen saturation increased on room air.

Future plans for client:

The patient will be discharged to a nursing home temporarily rehabilitation after surgery. The patient will then follow up with care provider within 48 hours of discharge.

Discharge Planning (2 points)

Discharge location:

The hospital was trying to find a nursing home to accept the patient for temporary housing/ rehab after discharge. The hospital asked 4 nursing homes, 2 had not gotten back to the hospital and 2 had declined because of insurance problems due to the patient having cancer.

Home health needs (if applicable):

No health needs apply to this patient.

Equipment needs (if applicable):

No equipment necessity was listed in the care for discharge.

Follow up plan:

Follow up with primary doctor within 48 hours after discharge. Also, the patient is to follow up with rehab for 2 weeks after hospitalization to build up muscle strength.

Education needs:

The patient needs to be educated on the age-related complications that may occur while living alone, and that equipment such as handrails or an alert necklace might be useful to prevent falls in the future.

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 • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. **Risk of decreased cardiac output related to cardiac muscle disease evidence by changes in level of consciousness and pale, cool skin.**	**Confusion and loss of consciousness occur in the later stages of shock. Older clients are especially susceptible to reduced perfusion to vital organs.**	**1. Assess for levels of consciousness** **2. Assess respiratory rate, rhythm, and auscultate breath sounds.**	**1. Client will maintain adequate cardiac output as evidenced by warm and dry skin, and normal level of consciousness.**	**The patient was not observed for any changed or improvement as time did not allow.**
2. Risk of	**The client**	**1. Assess pulse**	**1. Before**	**The patient**

insufficient tissue perfusion related to reduction of blood flow as evidence by dyspnea.	**was experiencing shortness of breath just while talking, even being placed on a nasal canula. This airflow problem can indicate further organ damage from inadequate blood/oxygen perfusion to the tissues.**	**oximeter routinely to monitor adequate oxygen perfusion.** **2. Routinely auscultate the lung sounds to assess for wheezing, crackles, or rhonchi.** **3. Switch the client from a nasal canula to a face respiration mask and increase the volume of airflow** **4. Call the provider to get an order for and administer an albuterol nebulizer to dilate the bronchioles as needed.**	**discharge, the client should be able to maintain an oxygen of 95% or above on room air.**	**was not observed for any changed or improvement as time did not allow.**
3. Risk of fall related to altered mobility secondary to unsteady gait and a previous fall and age, as evidence by patient	The patient is an elderly man, who just experienced a fall prior to coming into the ER, while living alone, which increases the chances for	1. The patient should wear a yellow fall risk bracelet and no-slip socks. **2.** A nurse should assist the patient	**1**. The patient should be able to maintain adequate strength in order to independently get up and down by himself at	The patient was not observed for any changed or improvement as time did not allow.

needing assistance to move from bed to toilet.	injuries to occur.	when moving at all times and a gait belt should be placed on the patient to reduce the risk of falls	home.	

Other References (APA):

NANDA diagnostic List For Basic Human Needs | Nanda Nursing Diagnosis List. (2020). http://nandanursingdiagnosislist.org/nanda-diagnostic-list-for-basic-human-needs/#:~:text=NANDA%20diagnostic%20List%20For%20Basic%20Human%20Needs%201

Swearingen, P. L. (2008). *All-in-one care planning: medical-surgical, pediatric, maternity, and psychiatric nursing care plans*. Mosby/Elsevier.

Concept Map (20 Points):

Subjective Data

- The patient states "I don't know, sometime during my life," referring sot specific dates for patient history.
- The patient claims that "he doesn't have any assistive devices such as handrails in the home".
- The patient stated that he "attended Parkland University to obtain a GED in 1971, after not being able to finish high school from being sick with the Spanish flu."
- The patient states that his pain was a "4 in his abdomen with deep compression," while his leg pain was "rated a 3 with touch."
- The patient states that he "hardly ever gets mad or stressed out" and he states that people claim he is "the calmest person they know." He said "if he were to get stressed or angry though, he would just leave the situation, rather than deal with the problem." He states that he "leaves every problem to God."
- The patient is "Methodist faith. He believes in going to church weekly, to St. James' Methodist church, where he has attended for 24 years."
-

Nursing Diagnosis/Outcomes

- **Risk of decreased cardiac output related to cardiac muscle disease evidence by changes in level of consciousness and pale, cool skin.**
- **Risk of insufficient tissue perfusion related to reduction of blood flow as evidence by dyspnea.**
- **Risk of fall related to the altered mobility secondary to unsteady gait and a previous fall and age, as evidence by patient needing assistance to move from bed to toilet.**

Outcomes:

- **Client will maintain adequate cardiac output as evidenced by warm and dry skin, and normal level of consciousness**
- **Before discharge, the client should be able to maintain an oxygen of 95% or above on room air.**
- **The patient should be able to maintain adequate strength in order to independently get up and down by himself at home**.

Objective Data

- Pulse was 80 @ 0710 & 0947
- Bp: 111/65 @ 0710; 112/68 @ 0947
- RR: 18 @ 0170 & 0947
- Temp: 98.1 F (temporal) @ 0710; 98.2 (temporal) @ 0947
- SpO2: 99% (nasal canula) @ 0710; 98% (nasal canula) @ 0947

Client Information

- Age: 69 years old
- Gender: male
- Race/ethnicity: white/ Caucasian
- Marital status: divorced
- Height: 190.5 cm
- Weight: 112.7 kg
- Code status: full code (no ACP docs)
- Occupation: not employed

Nursing Interventions

- **Assess for levels of consciousness**
- **Assess respiratory rate, rhythm, and auscultate breath sounds.**
- **Assess pulse oximeter routinely to monitor adequate oxygen perfusion.**
- **Routinely auscultate the lung sounds to assess for wheezing, crackles, or rhonchi.**
- **Switch the client from a nasal canula to a face respiration mask and increase the volume of airflow**
- **Call the provider to get an order for and administer an albuterol nebulizer to dilate the bronchioles as needed.**
- The patient should wear a yellow fall risk bracelet and no-slip socks.
- A nurse should assist the patient when moving at all times and a gait belt should be placed on the patient to reduce the risk of falls