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 (Jones & Bartlett, 2020, P. 9-12).**	**Naproxen (Naprosyn) (Jones & Bartlett, 2020, P. 854-857).**	**Prochlorperazine/ Compazine (Jones & Bartlett, L, 2020, P. 1036-1039)**	**Folic acid/ Folicet (Jones & Bartlett, L, 2020)**	**Calcium carbonate (Jones & Bartlett, L, 2020, 171-173)**
Dose	**650 mg tablet**	**500 mg**	**5 mg**	**1 mg**	**1000 mg**
Frequency	**Every 4 hours PRN**	**Twice a day.**	**Every 6 hours**	**Daily**	**Every 8 hours**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**oral**
Classification	**Antipyretic, nonopioid analgesic.**	**NSAID**	**Antiemetic**	**Vitamins, water soluble.**	**Antacid**
Mechanism of Action	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral**	**Blocks cyclooxygenase, the need to synthesize prostaglandins, which mediate the inflammatory response and cause local pain, swelling, and vasodilatio**	**This drug alleviates psychotic symptoms by blocking dopamine receptors, depressing release of selected hormones and producing alpha adrenergic**	**Folic acid an exogenous source of folate required for nucleoprotein synthesis and maintenance of normal erythropoiesis. It stimulates**	**Increases levels of intracellular and extracellular calcium, which is needed to maintain homeostasis, especially in the nervous and musculoskeletal system.**

	nervous system.	**n. It reduces the inflammation and relieves pain.**	**blocking effect in the brain.**	**the production of red blood cells, white blood cells, and platelets.**	**Also plays a role in normal cardiac and renal function, respiration, coagulation, and cell membrane and capillary permeability.**
Reason Client Taking	**To relieve pain and fever.**	**The client is taking to relieve pain.**	**To control nausea and vomiting.**	**To treat Anemia**	**To treat heart burn and hypocalcemia with oral supplement.**
Contraindications (2)	**Sever hepatic impairment & active liver disease.**	**Asthma & bronchospasm.**	**Bonne marrow depression & Severe hypertension.**	**Hypersensitivity to folic acid & use caution in client with undiagnosed anemia.**	**Hypercalcemia & hypophosphatemia**
Side Effects/Adverse Reactions (2)	**Neutropenia & hemolytic anemia**	**Seizure & GI bleeding**	**Hypotension & akathisia**	**Stomach upset & confusion.**	**Hypotension & hypercalcemia**
Nursing Considerations (2)	**Long-term use monitor liver enzyme (AST, ALT) and renal function.**	**Do not give Naproxen to client who have heart failure and GI ulcers.**	**Avoid contact with skin & expect antipsychotic effects to occur in 2 to 3 weeks.**	**Do not administer more than 1 mg when administering by moth. Instruct patient to take the drug at the same time each day.**	**Store the medicine at room temperature, and protect from heat, moisture, and direct light. Do not freeze.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Monitor for liver and renal function**	**Assess for GI bleeding and hepatorenal test**	**Monitor for CNS and blood pressure.**	**Check CBC count before. administration and during**	**Monitor serum calcium level.**

		during therapy.		**treatment.**	
Client Teaching needs (2)	**Teach client to recognize signs of hepatoxicity & do not exceed the prescribed dose, take as directed.**	**Take the drug with food to avoid GI bleeding & Observe signs of GI bleeding such as fecal cult and hematemesis.**	**Take the medicine with drug & avoid alcohol.**	**This medicine causes unpleasant taste in the moth & take exactly as directed.**	**Teach patient to shew tablets before swallowing & avoid taking calcium 2 hours before another oral medication.**

Hospital Medications (5 required)

Brand/Generic	**Hydrocodone/ acetaminophen/ Norco (Jones & Bartlett, L, 2020, P. 585-588).**	**Ondansetron/ Zofran (Jones & Bartlett, L, 2020, P. 794-797).**	**Enoxaparin Sodium/ Lovenox (Jones & Bartlett, L, 2020, P. 404-407).**	**Morphine Sulfate (Jones & Bartlett, L, 2020, P. 828-833).**	**Ketorolac/ Toradol (Jones & Bartlett, L, 2020, P. 659- 662).**
Dose	**5-325 mg**	**20 mg**	**40 mg**	**15 mg**	**30 mg**
Frequency	**Every 4 hours**	**Every 4 hours PRN**	**Daily**	**Every 12 hours**	**Every 6 hours**
Route	**Oral**	**IV**	**Sub cutaneous.**	**Oral**	**IV**
Classification	**Opioid analgesic**	**Antiemetic**	**Anticoagulant**	**Opioid analgesic**	**NSAID**
Mechanism of Action	**Binds to**	**This medicine**	**Enoxaparin potentiates the**	**Binds with and**	**Blocks cyclooxygen**

	and activates opioid receptors at sites in the periaqueductal and periventricular gray matter, the ventromedial medulla, and the spinal cord to produce pain relief.	**blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine.**	**action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors, which prevent clot formation.**	**activates opioid receptors in brain and spinal cord to produce analgesic and euphoria.**	**ase, the need to synthesize prostaglandins, which mediate the inflammatory response and cause local pain, swelling, and vasodilation. It reduces the inflammation and relieves pain.**
Reason Client Taking	**To manage pain.**	**To prevent nausea and vomiting**	**To prevent clots formation**	**To relieve severe pain**	**To manage pain**
Contraindications (2)	**Acute or chronic bronchial asthma & respiratory depression**	**Hypersensitivity to ondansetron & Congenital QT syndrome.**	**Active major bleeding & a history of heparin induced thrombocytopenia.**	**Bronchial asthma & respiratory depression.**	**GI bleeding and renal impairment.**
Side Effects/Adverse Reactions (2)	**Hypotension & coma**	**Hypotension & serotonin syndrome.**	**Hemorrhage & anaphylactic shock.**	**Coma & bradycardia**	**GI bleeding & hepatitis**
Nursing Considerations (2)	**Do not give to patient with impair conscious & use caution in client with COPD.**	**Monitor for torsade de pointes & use oral syringe to monitor dose of oral solution.**	**Use extreme caution in client with an increased risk of hemorrhage and report changes in sensory or motor function.**	**Use caution when giving morphine to client with hypoxia, asthma, and respiratory**	**Avoid NSAID in client with IM & monitor for a history of inflammatory bowel disease.**

				depression. Before giving morphine make sure to have oxygen delivery equipment are available in the room.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor for respiration depression when initiating therapy.**	**Monitor for electrolytes imbalance**	**Assess for bleeding before and during therapy.**	**Assess respiratory rate before initiating therapy and circulatory status.**	**Monitor WBC, IM, and stroke.**
Client Teaching needs (2)	**Take the capsules or tablets as whole & avoid alcohol.**	**Seek of immediate care if worsening of symptoms & This medicine causes transilient blindness that resolves within few minutes.**	**Notify the provider if bleeding occurs & Avoid NSAID or aspirin increasing the risk of GI bleeding. Educate the client how self-administer the medicine.**	**Take the drug exactly as prescribed & change position slowly to avoid orthostatic hypotension.**	**Take the drug with food and a full glass of water. Avoid alcohol.**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). ***Nurse's drug handbook*** **(19th ed.). Burlington, MA.**

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	
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:**	
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:**	

Size: **CAUTI prevention measures:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **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:**	.
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):**	.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
.					

Vital Sign Trends/Correlation:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

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:**	
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

Nursing Care

Summary of Care (2 points)

Overview of care:

Procedures/testing done:

Complaints/Issues:

Vital signs (stable/unstable):

Tolerating diet, activity, etc.:

Physician notifications:

Future plans for client:

Discharge Planning (2 points)

Discharge location:

Home health needs (if applicable):

Equipment needs (if applicable):

Follow up plan:

Education needs:

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. Impaired gas exchange related to increased blood viscosity as evidenced by hypoxia on admission	**This diagnosis was chosen because the patient has difficulty breathing during admission due to occlusion of sickle cells in capillaries.**	**1.Monitor respiration rate, depth, and use of accessory muscles.** **2.Elevate the head of the bed, assist client to assume a position to ease work breathing.**	**1. The client will demonstrate improvement of oxygenation as evidenced by respiratory rate within normal limits, absence of cyanosis and use of accessory muscles, clear breath sounds.**	**Hypoxia was improved and the patient did not show any signs of respiratory distress. Patient was satisfied. There is no need of goal modification currently.**
2. Ineffective tissue perfusion related to Vaso-occlusive	**This diagnosis was chosen because low blood flow result**	**1. Monitor vital signs** **2.Assess skin color for coolness, delayed capillary refill, and cyanosis.**	**1. The patient will demonstrate improved tissue perfusion as**	**Patient shows signs of improving peripheral blood flow and capillary refill**

nature of sickling and inflammation response as evidenced by changes in vital signs.	**in delay capillary refill and low pulse in the extremities.**		**evidenced by stabilized vital signs within normal range.**	**within normal rage.**
3. Acute pain related to vessels occlusion as evidenced by client stated pain was intense, sharp, and stabbing.	**The diagnosis was chosen because pain is one of major signs of sickle cell crisis.**	**1.Assess the pain. Note the location, intensity, duration, using the scale of 0 to 10.** **2 Observe for nonverbal pain cues such as guarding behavior, facial grimacing, gait disturbances, and physiological manifestations of acute pain.**	**1. Patient will demonstrate relaxed body posture, have freedom of movement, and being able to sleep appropriately.**	**After admitting pain medicine, the client states pain being 0, using the scale of 0 to 10.**
4. Fatigue related to decreased normal hemoglobin shape and diminished oxygen-carrying capacity of the blood as evidenced by inability to perform daily activities.	**This diagnosis was chosen because decreased hemoglobin is associated with tissue hypoxia, which causes fatigue.**	**1. Assess the client's ability to participate in self-care.** **2. Educate energy-conservation techniques such as organization and time management to conserve energy and reduce fatigue.**	**1. The patient will demonstrate ability to perform activity of daily living without assistance.**	**Client verbalizes reduction of fatigue as evidenced by increased ability to perform desired activities.**
5. Ineffective coping	**The patient**	**1. Be supportive to the patient**	**1. The client will**	**The client did not agree to**

mechanism related to lack of knowledge as evidenced patient wanted to live the hospital before discharge.	**wanted to go home even though the course of treatment was not done.**	**and use empathetic communication.** **2. Educate the patient on the importance to adhere the provider plan during hospitalization for better outcome.**	**understand the importance of finishing her course of treatment.**	**the provider plan neither nursing education. It is important to update the care plan. After all the staff effort, client decided to go home. Nurses must support client decision. The provider aware to updates a discharge plan.**

Other References (APA):

Concept Map (20 Points):

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

Subjective Data

-Generalized body aches
- “It hurts everywhere, bones, joint, and pain is ongoing”
Intense, sharp, and stabbing pain.
“My pain gets worse during cold weather”

Nursing Diagnosis/Outcomes

Impaired gas exchange
Outcome: The client demonstrated improvement of oxygenation as evidenced by respiratory rate within normal limits, absence of cyanosis, use of accessory muscle, and clear breath sounds.
Ineffective tissue perfusion
Outcome: The patient demonstrates improvement tissue perfusion as evidenced by stabilized vital signs with normal capillary refill.
Acute pain
Outcome: The client will relax, change position freely, and able to sleep appropriately.
Fatigue
Outcome: will expressed ability to perform activity of daily living without assistance.
Ineffective coping
Outcome: Client will understand the importance of finishing her course of treatment.

Objective Data

RBC
Hgb
Hct
Chest X-rays
Troponin
WBC
CO2
Calcium

Client Information

A 25-year female, African American brought to the ED due to generalized pain. The client was admitted for sickle cell anemia. Client has a history of acute chest syndrome, acute PE, anemia, and sepsis.

Nursing Interventions

Comprehensive pain assessment and managing pain
Provide intravenous hydration and administer oxygen.
Preventing and managing infection
Promoting coping skills
Promote home and community-based care
Increase knowledge.
Monitoring and managing potential complications.
Teach client to understand potential triggers and avoidance strategies.
Administer other medication during crisis such as folic acid, analgesics, and make sure the immunization is up to date.