N431 Care Plan #1

Lakeview College of Nursing

Cheyenne Gardner

Demographics (3 points)

Date of Admission 02/11/2022	**Client Initials** G.D.	**Age** 88 years old	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Married	**Allergies** Aleve (rash), Amitriptylin (swelling), Sulfa drugs (swelling)
Code Status Full code	**Height** 157 cm 5’ 2”	**Weight** 83.8 kg 184.7 lbs	

Medical History (5 Points)

Past Medical History: Bilateral pleural effusion, Bilateral renal stones, Coagulopathy, Congestive heart failure, COPD, Hypertensive cardiovascular disease, Persistent atrial fibrillation

Past Surgical History: Cystoscopy ureteroscopy, Lumpectomy of breast (2010), Appendectomy, Cancer of skin, Hysterectomy, Knee replacement, Tonsillectomy and Adenoidectomy

Family History: Mother - heart attack and heart failure; Father - heart disease

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

Tobacco: Denies use.

Alcohol: Denies use.

Drugs: Denies use.

Assistive Devices: The client uses a walker and a cane.

Living Situation: The client lives at home with her husband.

Education Level: The client graduated high school.

Admission Assessment

Chief Complaint (2 points): Dizziness and black stools

History of Present Illness – OLD CARTS (10 points): The client is an 88-year-old female who presented to the emergency room on 02/11/22 with complaints of dizziness and black stools. The housekeeper found her on the floor and took her to the emergency room. The client was getting out of bed to go to the bathroom when she "began to feel dizzy." She then fell and hit her right rib cage and hip. Upon admission, the client stated her pain level was a 7/10 on a numeric pain scale. The pain was dull and constant in her rib cage and hip. The client did not have any aggravating factors with her pain. The client did not use any relieving factors or pain medication before arriving at the emergency room.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): N/A

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

An upper gastrointestinal (GI) bleed can be bleeding in the esophagus, stomach, or duodenum. A gastrointestinal bleed can occur from a lesion, erosion, tear to the lining of the gastrointestinal tract, or ulceration (Capriotti, 2020). An upper GI bleed is more common than a lower gastrointestinal bleed. This is because the stomach containing the ulcer is higher in the GI system causing bleeding if ruptured or torn. Peptic ulcers are the number one cause of a gastrointestinal bleed. The client has a peptic ulcer which could have caused the gastrointestinal bleed.

Signs and symptoms of an upper gastrointestinal bleed include hematemesis, melena, and occult blood (Capriotti, 2020). Clients can also experience anxiety, dizziness, weakness, shortness of breath, and a change in mental status. Signs that she was experiencing were melena,

dizziness, and weakness. Tachycardia and tachypnea can appear because of decreased cardiac output (Capriotti, 2020). Expected lab findings include low hemoglobin and iron levels. BUN levels will be elevated secondary to reduced fluid volume and blood absorption into the small intestine (Capriotti, 2020). The client had low hemoglobin levels and elevated BUN levels. Diagnostic testing to diagnose a GI bleed includes endoscopy, CBC, and stool samples for occult blood (Capriotti, 2020). The client had an endoscopy that revealed a peptic ulcer, and a biopsy was taken to test for helicobacter pylori. The results of the biopsy have not come back yet.

Treatment for an acute GI bleed includes fluid replacement, a nasogastric tube to prevent abdominal distention from the accumulation of blood, and administration of blood transfusions (Capriotti, 2020). The client received a blood transfusion of 2 liters on 02/12/2022. The client was on IV normal saline when she was first admitted to replace the fluids she had lost, but she was no longer on fluids during my care. A chronic upper gastrointestinal bleed is treated with proton pump inhibitors. The client is taking pantoprazole daily for treatment.

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	2.93	3.09	The client has a GI bleed which can cause acute blood loss anemia

				resulting in decreased red blood cells (Pagana et al, 2021).
Hgb	11.3-15.2	8.2	8.9	The client lost a lot of blood due to the hemorrhage in the GI system causing low hemoglobin levels (Pagana et al, 2021).
Hct	33.2-45.3	23.9	26.9	The client's low level of hematocrit could be due to the loss of blood from her hemorrhage in the GI tract (Pagana et al, 2021).
Platelets	149-393	186	169	N/A
WBC	4.0-11.7	5.5	5.4	N/A
Neutrophils	45.3-79.0	76.4	N/A	N/A
Lymphocytes	11.8-45.9	11.9	N/A	N/A
Monocytes	4.4-12.0	10.4	N/A	N/A
Eosinophils	0.0-6.3	1.5	N/A	N/A
Bands	0.2-1.6	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	142	144	N/A
K+	3.5-5.1	3.5	3.7	N/A
Cl-	98-107	106	110	The client's high levels could be related to her history of congestive heart failure (Pagana et al, 2021).
CO2	21-31	29	25	N/A
Glucose	74-109	121	98	The clients increased levels could be due to acute stress syndrome from being in the hospital with a GI bleed (Pagana et al, 2021).
BUN	7-25	39	42	The increased levels could have resulted from the client's GI bleed (Pagana et al, 2021).

Creatinine	0.84-1.21	1.11	1.26	Increased levels could be due to the client's history of congestive heart failure as it can cause an increase in creatinine (Pagana et al, 2021).
Albumin	3.5-5.2	3.5	N/A	N/A
Calcium	8.6-10.3	8.3	7.9	The client is taking vitamin D to prevent deficiency, this can cause low levels if the client is deficient in vitamin D (Pagana et al, 2021).
Mag	1.6-2.1	N/A	2.0	N/A
Phosphate	45-117	N/A	N/A	N/A
Bilirubin	0.3-1.0	0.5	N/A	N/A
Alk Phos	30-120	48	N/A	N/A
AST	13-39	23	N/A	N/A
ALT	13-39	13	N/A	N/A
Amylase	30-110	N/A	N/A	N/A
Lipase	11-82	40	N/A	N/A
Lactic Acid	0.5-1.0	0.9	N/A	N/A
Troponin	0.0-0.030	0.02	N/A	N/A
CK-MB	0.60-6.30	N/A	N/A	N/A
Total CK	30-223	N/A	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	1.74	N/A	N/A

	2-3			
PT	10-12 seconds	21.1	N/A	The client had a blood transfusion which can increase PT. The transfusion was given due to the GI hemorrhage and losing a lot of blood (Pagana et al, 2021).
PTT	30-45 seconds	40.3	N/A	N/A
D-Dimer	<200	N/A	N/A	N/A
BNP	0-100	367	N/A	N/A
HDL	23-92	N/A	N/A	N/A
LDL	<100	N/A	N/A	N/A
Cholesterol	<199	N/A	N/A	N/A
Triglycerides	0-149	N/A	N/A	N/A
Hgb A1c	<6.4	N/A	N/A	N/A
TSH	0.45-5.33	N/A	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	Pale yellow/clear	N/A	N/A	N/A
pH	5-8	N/A	N/A	N/A
Specific Gravity	1.005-1.030	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	0-5	N/A	N/A	N/A
RBC	0-6	N/A	N/A	N/A
Leukoesterase	Negative	N/A	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	N/A
PaO2	40-50	N/A	N/A	N/A
PaCO2	40-50	N/A	N/A	N/A
HCO3	22-26	N/A	N/A	N/A
SaO2	92-100%	N/A	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	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	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):

The client had an endoscopy, which revealed an ulcer in the stomach. The physician took a biopsy of the ulcer to test for helicobacter pylori while performing the endoscopy. The client had a chest x-ray done, which revealed pulmonary vascular congestion. The client had a CT scan of the head done which showed no abnormalities of the intracranial process.

Diagnostic Test Correlation (5 points):

An endoscopy is an insertion of a tube directly into the body to observe an organ for bleeding, inflammation, or cancers (Pagana et al., 2021). The client had an endoscopy to look inside the gastrointestinal system to look for ulcers that caused the GI bleeding and a biopsy. A chest x-ray can identify tumors, inflammation, fluid accumulation, air accumulation, fractures and show the heart size (Pagana et al., 2021). The client had a chest x-ray done due to her history of congestive heart failure. Computerized tomography of the head shows a 3D view of cranial contents, variation, and density of each tissue and shows anatomical pictures of brain sections (Pagana et al., 2021). The client had this done due to her recent fall to ensure there was no damage to the head.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	Losartan / Cozaar	Pantoprazole / Protonix	Rivaroxaban / Xarelto	Isosorbide Mononitrate / Monoket	Simvastatin / Zocor
Dose	50 mg	40 mg	20 mg	30 mg	10 mg
Frequency	Daily	BID	QPM	QAM	QAM
Route	PO	PO	PO	PO	PO
Classification	Angiotensin II receptor; Antihypertensive	Proton pump inhibitor; Antiulcer	Factor Xa inhibitor; Anticoagulant	Nitrate; Antianginal	HMG-CoA reductase inhibitor; Antilipemic
Mechanism of Action	Blocks binding of angiotensin II receptors and reduces blood pressure (Jones, 2021)	Block gastric acid production to prevent more stomach acid from forming.	Blocks the active site of factor Xa causing blood clotting to be impaired.	Increases formation of cGMP level which may relax vascular smooth muscle causing vasodilation. Improves cardiac output by reducing preload and afterload	Reduces the formation of mevalonic acid causing LDLs to be consumed and cholesterol levels decrease.
Reason Client Taking	To manage hypertension	Prevention for GI ulcer	To reduce the risk of stroke and systemic embolism in clients with nonvalvular atrial	To prevent angina	To reduce risk of cardiovascular events

			fibrillation		
Contraindications (2)	Concurrent aliskiren therapy and hypersensitivity to losartan or its components.	Concurrent therapy with rilpivirine containing products, or hypersensitivity to pantoprazole	Active pathological bleeding or hypersensitivity to rivaroxaban or its components.	Concurrent use of phosphodiesterase inhibitors or hypersensitivity to isosorbide, other nitrates, or their components.	Active hepatic disease or concurrent use with cyclosporine, danazol, or gemfibrozil.
Side Effects/Adverse Reactions (2)	Hypotension and dizziness	Hepatotoxicity and leukopenia	GI bleeding and excessive bleeding	Hemolytic anemia and orthostatic hypotension	Atrial fibrillation and hepatic failure
Nursing Considerations (2)	Monitor client for muscle pain and renal function studies and monitor serum potassium	Don't give within 4 weeks of testing Helicobacter pylori because antibiotics suppress H. pylori and may lead to false negative results. Administer 30 minutes before a meal.	Should not be given to acutely ill medical patients at a high risk of bleeding. Be aware if rivaroxaban is discontinued and an alternative anticoagulation is not started, the risk for thrombosis increases.	Give drug 1 hour before or 2 hours after meals. Isosorbide should be used cautiously in patients with hypovolemia or mild hypotension. It may cause increased hypotension and reduced cardiac output.	Monitor clients for muscle pain, tenderness, or weakness. Use cautiously in elderly patients and those with hepatic or renal impairment.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor blood pressure	Monitor PT or INR in a client taking an oral anticoagulant	Monitor PT and INR levels	Monitor blood pressure and cardiac output	Monitor cholesterol and liver enzymes
Client Teaching	Instruct	Teach the	Teach the	Teach	Teach

Needs (2)	client to notify provider if prolonged diarrhea, nausea or vomiting occurs. Teach the client to avoid potassium-containing salt substitutes because they may increase risk of hyperkalemia.	client to not crush or chew the drug and to swallow the medication whole. If there is severe diarrhea for a prolonged period, they should notify the provider.	importance of taking the rivaroxaban exactly as prescribed. Instruct a client with atrial fibrillation to take the drug with the evening meal.	clients and family to recognize signs and symptoms of angina, including chest pain, fullness, or pressure. Teach client to reduce the effects of orthostatic hypotension by changing position slowly	clients to take simvastatin in the evening. Instruct clients to follow a low-fat, cholesterol lowering diet.

Hospital Medications (5 required)

Brand/Generic	Furosemide / Lasix	Carvedilol / Coreg	Hydralazine / Apresoline	Gabapentin / Neurontin	Sertraline / Zoloft
Dose	80 mg	12.5 mg	50 mg	200 mg	50 mg
Frequency	Daily	BID	BID	BID	Daily
Route	PO	PO	PO	PO	PO
Classification	Thiazide diuretic; Diuretic	Nonselective beta blocker and alpha-1 blocker; Antihyperte	Vasodilator; Antihypertensive	1-amino-methyl cyclohexane acetic acid; Anticonvulsant	Selective serotonin reuptake inhibitor (SSRI); Anxiolytic

		nsive, heart failure treatment adjunct			, antidepressant
Mechanism of Action	Inhibits the ascending limb of the loop of Henle, by binding to the chloride transport channel leading to urination.	Reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance which reduces blood pressure and cardiac workload	Vasodilates smooth muscle	Inhibits the rapid firing of neurons associated with seizures. Prevents exaggerated responses to painful stimuli and pain related responses	Stops the reuptake of serotonin which increases the amount of serotonin in the nerve synaptic cleft which helps the mood.
Reason Client Taking	Congestive Heart Failure	To control hypertension	To control hypertension	To relieve nerve pain	To treat depression
Contraindications (2)	Anuria and sulfa allergy	Bronchial asthma or related bronchospastic conditions and hypersensitivity to carvedilol or its components	Coronary artery disease and mitral valvular rheumatic heart disease	Hypersensitivity to gabapentin or hypersensitivity to its components	Concurrent use of disulfiram or pimozide. Use of an MAO within 14 days.
Side Effects/Adverse Reactions (2)	Dry mouth increased urination	Heart failure and aplastic anemia	Orthostatic hypotension and Edema	Hypotension and Melena	Atrial arrhythmias and hemorrhage.
Nursing Considerations (2)	Be aware elderly clients are more susceptible	Know that if a client has heart failure, expect to	Weigh the client daily during therapy. Orthostatic	Give at least two hours after an antacid. Be aware that	Do not give this medication to a person

	to hypotensive and electrolyte altering effects. Notify the provider if the client experiences hearing loss, vertigo or ringing in her ears.	give digoxin, a diuretic, and an ACE inhibitor. Use cautiously in clients with peripheral vascular disease because it may aggravate symptoms of arterial insufficiency.	hypotension is common with this medication	various brands of gabapentin are not interchangeable.	with a low heart rate. Monitor closely for serotonin syndrome.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain daily weight and monitor potassium levels.	Monitor blood glucose level	Monitor heart rate and blood pressure	Monitor blood pressure and renal function labs.	Check clients heart rate
Client Teaching Needs (2)	Take in the morning or early evening if 2 doses are needed. Educate on signs of low electrolytes	Warn patients that the drug may cause dizziness, light-headedness, and orthostatic hypotension. If a client has heart failure, notify the provider if she gains 5 lbs or more in 2 days or if shortness of breath increases.	Teach the client to change positions slowly to prevent falls. Ensure client's safety to reduce fall risks.	Teach clients to not stop drugs abruptly. Inform clients about possible ataxia, dizziness, drowsiness, and nystagmus.	Teach the client to take their own heart rate. This drug can cause the pupils to be more dilated.

Medications Reference (1) (APA):

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

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented to time, place, situation, and person. A & O x4 The client was not in distress and was calm. The client's overall appearance was well-groomed.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 17** **Drains present: Y☐ N X** **Type: N/A**	 Pink Dry with no moisture present Warm on the anterior and posterior side of trunk and extremities +3 turgor/elastic She had a bruise on her right hand and right side of the trunk. No rashes or wounds present. Braden score of 17.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The client's head and neck were symmetrical. Her trachea was without deviation and midline. Her thyroid was non-palpable. The client's ears were without drainage and non-tender. She denied hearing deficits and any changes in visual acuity. Her eyes PERRLA bilaterally. Sclera white and conjunctiva were pink. No symmetrical with no nasal drainage. The client had no missing teeth.

CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N X** **Edema Y X N ☐** **Location of Edema:** lower legs	Heart sounds S1 and S2 heard along with a systolic murmur. No gallops or friction rubs present when auscultating at the aortic, pulmonic, Erb's point, tricuspid, and mitral locations. Cardiac rhythm N/A. Pulses were 3+ and were palpated at the carotid, radial, popliteal, and dorsalis pedis sites bilaterally. Unable to palpate posterior tibial due to edema. The clients capillary refill was less than 3 seconds in all extremities. No neck vein distention present. Trace edema present in lower legs.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The client's breath sounds were even and unlabored bilaterally. No crackles, wheezes or rhonchi noted in both upper and lower lobes. The client was maintaining oxygen saturation of 93-94% on room air.
GASTROINTESTINAL: **Diet at home:** Regular **Current Diet:** Soft Diet **Height:** 157 cm **Weight:** 83.8 kg **Auscultation Bowel sounds:** Normoactive in all 4 quadrants **Last BM:** 02/14/22 **Palpation: Pain, Mass etc.:** Patient denies any pain or tenderness in the abdomen. No masses present. **Inspection:** **Distention:** None **Incisions:** None **Scars:** Small scar on right side of the abdomen. **Drains:** None **Wounds:** None **Ostomy: Y ☐ N x** **Nasogastric: Y ☐ N x** **Size: N/A** **Feeding tubes/PEG tube Y ☐ N x** **Type: N/A**	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N X**	Yellow Clear, not cloudy Urine output was approximately 1250 mL during this shift. The client denies pain with urination

Dialysis: Y ☐ N X **Inspection of genitals:** **Catheter: Y X N ☐** **Type: Purewick** **Size: N/A**	and is not on dialysis. Pink, clean and dry Client had a purewick catheter.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y X N☐** **Fall Score: 85** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment X** **Needs support to stand and walk☐**	Strength and reflexes within normal limits. PROM done while she was in bed. Strength 5/5 bilaterally in all extremities. Client's skin is warm with pulses present in all extremities. Client stated she uses a cane at home, but is using a walker and gait belt in the hospital. The client's fall risk score is 85.
NEUROLOGICAL: **MAEW: Y X N☐** **PERLA: Y X N☐** **Strength Equal: Y X N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The client was oriented to person, place, time, and situation. She moves all extremities well. Her eyes PERRLA. Her strength is equal in upper and lower extremities. Client was A & O times 4. Fully intact thinking Speech- Clear and understandable. Sensory- Sensation on both sides of the body both upper and lower extremities equal LOC- The client is alert and oriented.
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's coping methods include watching TV and visiting with her husband when he comes to visit. Client is fully informed and able to make decisions on her own. The client is Baptist and states this is important to her. She has a good support system including her husband and son. She also has a housekeeper that comes and helps her around the house.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0755	76 bpm	183/89	20 rpm	37.2 C	94% on room

		mmHg			air
1110	70 bpm	96/48 mmHg	20 rpm	37.1 C	93% on room air

Vital Sign Trends: The client's blood pressure was high until taking her antihypertensive medications, then her blood pressure decreased significantly. The client had positive orthostatic blood pressure upon assessment. All other vital signs were stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0755	Numeric	N/A	0 out of 10	N/A	N/A
1110	Numeric	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 Right antecubital fossa vein 02/11/22 IV is patent and flushes well. No erythema, drainage, phlebitis or infiltration. Dressing was dry, clean, and intact. Saline locked during my care.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Water- 740 mL	Urine voided- 1250 mL

Nursing Care

Summary of Care (2 points)

Overview of care: During my shift, I was able to administer medications, helped her order her food, and do my head to toe assessment.

Procedures/testing done: There were no tests or procedures performed during my shift.

Complaints/Issues: The client complained about her soft diet and her ears were irritating her. The doctor was able to check them when he was in the room and said everything looked fine.

Vital signs (stable/unstable): The client's blood pressure was high until she was given her antihypertensive medications. All of her other vital signs were stable.

Tolerating diet, activity, etc.: The client is on a soft diet and is tolerating it. The client was in bed most of the day due to being very tired.

Physician notifications: The physician was lowering her carvedilol dose to 12.5 mg instead of 18.75 mg. He was discontinuing the furosemide.

Future plans for client: The client will be staying another day because she was not comfortable with leaving. The physician wanted to monitor her medications with the changes he made for another day.

Discharge Planning (2 points)

Discharge location: The client is planning to be discharged home with her husband.

Home health needs (if applicable): N/A

Equipment needs (if applicable): The client may need a walker instead of just her cane to use at home.

Follow up plan: The client should follow up with her primary care provider within a week.

Education needs: The client should be educated on preventing GI bleeds and ways to manage orthostatic hypotension.

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

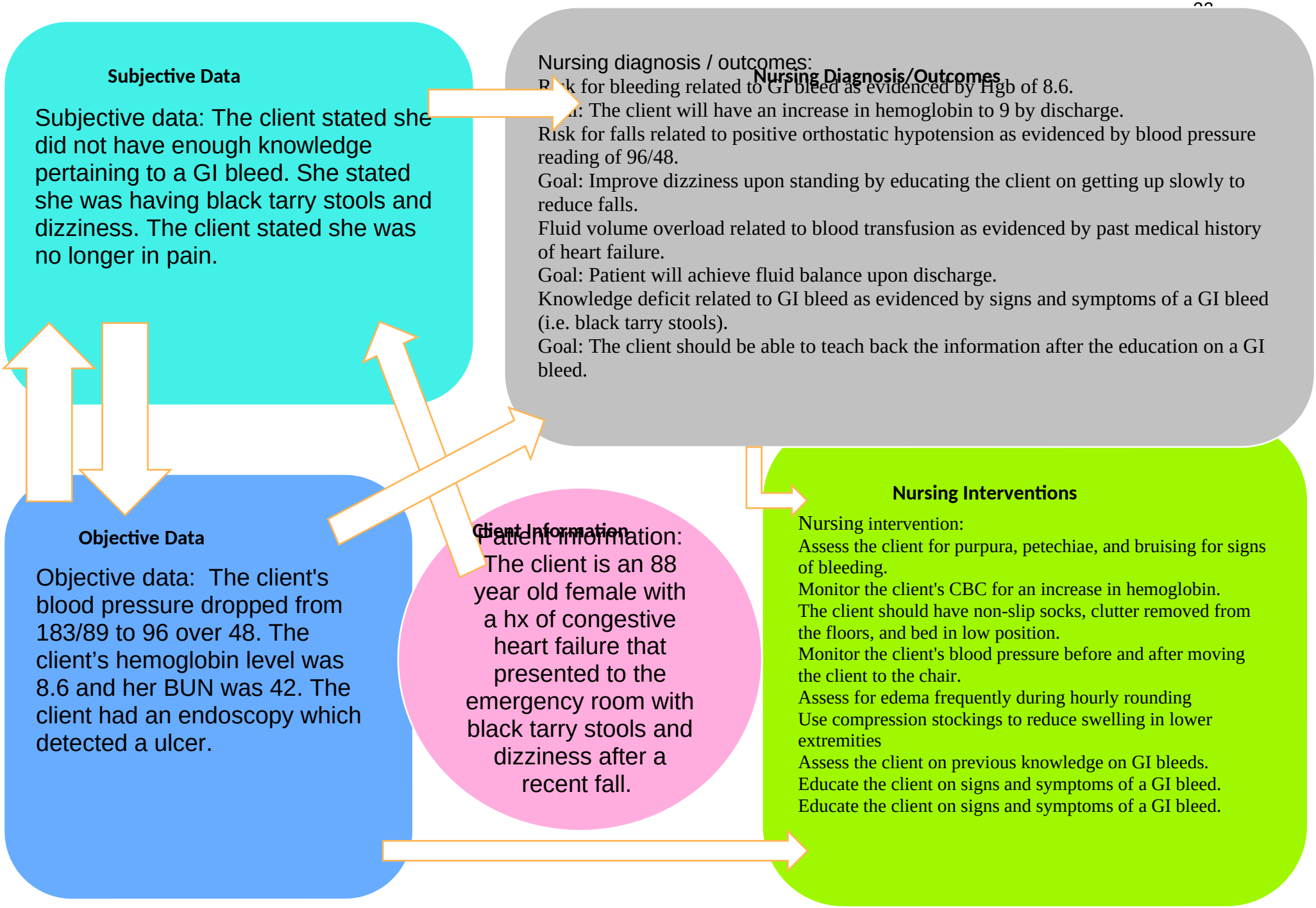
Nursing Diagnosis ● Include full nursing diagnosis with "related to" and "as evidenced by" components ● Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** ● Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 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 for bleeding related to GI bleed as evidenced by Hgb of 8.6.	The risk for bleeding was chosen because the client has an acute bleed due to a ruptured or torn peptic ulcer.	1. Assess the client for purpura, petechiae, and bruising for signs of bleeding. 2. Monitor the client's CBC for an increase	1. The client will have an increase in hemoglobin to 9 by discharge.	During my shift, I assessed the clients' skin for bruising and petechiae during my head-to-toe assessment. Unable to monitor the client's hemoglobin because she was not due for another lab draw during my shift. The client does not have plans for discharge until 02/15/2022, so I would not be able to see her

		in hemoglobin.		hemoglobin value at discharge.
2. Risk for falls related to positive orthostatic hypotension as evidenced by blood pressure reading of 96/48.	Risk for falls was choses due to the clients recent fall related to her orthostatic hypotension.	1. The client should have non-slip socks, clutter removed from the floors, and bed in low position. 2. Monitor the clients blood pressure before and after moving the client to the chair.	1. Improve dizziness upon standing by educating the client on getting up slowly to reduce falls.	When evaluating the client for fall precautions, i was able to make sure she was wearing nonslpi socks, bed was in a low position with a call light next to her, and clutter was removed from the floors. During my vital signs check, I was able to monitor her blood pressure before and after her moving from the bed. Before I left, I was able to explain to the client the importance of standing up slowly when moving around.
3. Fluid volume overload related to blood transfusion as evidenced by past medical history of heart failure.	The client received a blood transfusion, which can put the client is at risk for fluid volume overload.	1. Assess for edema frequently during hourly rounding 2. Use compression stockings to reduce swelling in lower extremities	1. Patient will achieve fluid balance upon discharge.	When doing my head to toe, i was able to assess the client for edema in the lower extremities. The client was using compression socks to help with her swelling. Before the client discharges, her fluids will remain balanced. r
4. Knowledge deficit	The client has a deficit	1. Assess the client	1. The client should be	I was able to assess her previous

related to GI bleed as evidenced by signs and symptoms of a GI bleed (i.e. black tarry stools).	knowledge of a gastrointestinal bleed, so she should be educated for the future.	on previous knowledge on GI bleeds. Educate the client on signs and symptoms of a GI bleed. 2. Educate the client on signs and symptoms of a GI bleed.	able to teach back the information after the education on a GI bleed.	knowledge of a GI bleed and she did not know what puts her at risk for a bleed or the signs and symptoms. I was then able to educate the client on a gastrointestinal bleed. When I was done educating the client, she was able to teach back the information.

Other References (APA):

Concept Map (20 Points):


Subjective Data
Subjective data: The client stated she did not have enough knowledge pertaining to a GI bleed. She stated she was having black tarry stools and dizziness. The client stated she was no longer in pain.
Nursing Diagnosis/Outcomes
Nursing diagnosis / outcomes:
Risk for bleeding related to GI bleed as evidenced by Hgb of 8.6.
Goal: The client will have an increase in hemoglobin to 9 by discharge.
Risk for falls related to positive orthostatic hypotension as evidenced by blood pressure reading of 96/48.
Goal: Improve dizziness upon standing by educating the client on getting up slowly to reduce falls.
Fluid volume overload related to blood transfusion as evidenced by past medical history of heart failure.
Goal: Patient will achieve fluid balance upon discharge.
Knowledge deficit related to GI bleed as evidenced by signs and symptoms of a GI bleed (i.e. black tarry stools).
Goal: The client should be able to teach back the information after the education on a GI bleed.
Objective Data
Objective data: The client's blood pressure dropped from 183/89 to 96 over 48. The client's hemoglobin level was 8.6 and her BUN was 42. The client had an endoscopy which detected a ulcer.
Client Information
Patient information: The client is an 88 year old female with a hx of congestive heart failure that presented to the emergency room with black tarry stools and dizziness after a recent fall.
Nursing Interventions
Nursing intervention:
Assess the client for purpura, petechiae, and bruising for signs of bleeding.
Monitor the client's CBC for an increase in hemoglobin.
The client should have non-slip socks, clutter removed from the floors, and bed in low position.
Monitor the client's blood pressure before and after moving the client to the chair.
Assess for edema frequently during hourly rounding
Use compression stockings to reduce swelling in lower extremities
Assess the client on previous knowledge on GI bleeds.
Educate the client on signs and symptoms of a GI bleed.
Educate the client on signs and symptoms of a GI bleed.