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N311 Care Plan #5

Lakeview College of Nursing

Beatriz Amaya

Demographics (5 points)

Date of Admission 12/8/18	Client Initials D.G.	Age 78	Gender F
Race/Ethnicity Caucasian	Occupation Seamstress	Marital Status Divorced	Allergies Azithromycin
Code Status DNR	Height 5'3	Weight 173.8 lb.	

Medical History (5 Points)

Past Medical History: Hypertensive crisis, Chronic diastolic heart failure, weakness, difficulty walking, dysphagia following cerebral infarction, COVID-19,Athersclerotic heart disease of native coronary artery with angina pectoris, primary hypertension, major depressive disorder, anemia, myoclonus, dependence on renal diagnosis, diabetes mellitus with complications, respiratory failure unspecified with hypoxic or hyperlipidemia, Transient ischemic attack, cerebral infarction with residual deficits

Past Surgical History: Cardiac catheterization, Cholecystectomy, Cystocele, Urethrocele, Rectocele

Family History: Dad passed away from a heart attack.

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

Admission Assessment

Chief Complaint (2 points): Lower Back Pain

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

Patient states the pain has been going on for several years but is unable to recall when it specifically started. When asked location of pain patient stated, "My lower back is where I feel the most pain". Her pain lasts for a few minutes to hours, and it starts to hurt once she starts to

get up out of bed. Pain is sharp, tight, and constant. Aggravating factors are moving around too much and transferring to and from bed to wheelchair. Alleviating factors patient stated “padding on my wheelchair” as it would relieve pressure from her back. Reliving factors patient stated, “laying on side with pillow to support my back”. Treatment patient takes Tylenol every four hours for her back pain. Her severity is chronic due to back pain lasting over six months patient rated her pain at an 8 out of 10 at eight in the morning on 3/24/2022.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): End of stage renal disease

Secondary Diagnosis (if applicable): N/A

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

The end of stage renal disease is the last stage in a chronic kidney disease. “The kidney maintains GFR, despite progressive destruction of nephrons, because the remaining normal nephrons develop hyperfiltration and compensatory hypertrophy” (Capriotti, 2020, p.539). Ultimately, the kidney can no longer function enough to filter out urine and nitrogenous waste as the “GFR falls to less than 5% of normal” (Capprotti,2020, p.540). Nitrogenous waste is left in the blood stream due to kidneys not being able to filter it out. Due to these complications’ signs and symptoms seen are, “fatigue, drowsiness, decrease in urination or inability to urinate, dry skin, itchy skin, headache, weight loss, nausea, bone pain, skin and nail changes and easy bruising” (*End Stage Renal Disease*, para.2). My patient also has diabetes which in the long run can play a factor in affecting the kidneys. High blood glucose affects blood vessels as my patients reading was 130 mg/dL upon admission which is on the high-range causing damage to the vessels. Now my patient also has Hypertension crisis another factor damaging the kidneys

blood vessels. So many factors damaging the vessels came to kidneys not being able to profuse and work properly.

Further continuation some diagnostics to be able to identify kidney damage are, “A CBC with differential, serum electrolytes, serum creatinine, total albumin, BUN, and urinalysis will demonstrate abnormalities of renal failure” (Caprotti,2020, p.541). Some other diagnostics can be renal ultrasound, and non-contrast abdominopelvic CT scan, and a plain abdominal x-ray. My patient has labs done with CBC, Uranalysis, and a CT of her abdomen. Treatments used is “Hemodialysis is necessary if the disease progresses to ESRD. Patients are usually eligible for kidney transplant” (Caprotti,2020, p.537). This patient goes to dialysis Monday, Wednesday, and Fridays to treat her renal disease.

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. VitalSource Bookshelf Online. Retrieved March 2, 2022, from https://fadavisreader.vitalsource.com/reader/books/9781719641470/epubcfi/6/56 [%3Bvnd.vst.idref%3Dc12]! /4/2/2/44/2

“End Stage Renal Disease (ESRD).” *Johns Hopkins Medicine*, https://www.hopkinsmedicine.org/health/conditions-and-diseases/end-stage-renal-failure.

Laboratory Data (20 points)
If laboratory data is unavailable, values will be assigned by the clinical instructor

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.0-5.8x10^6/ mcL	3.33 mcL	**N/A**	Patient has low red blood cells due to her medical history of anemia, “Lack of RBCs causes anemia”

				(Caprotti,2020, p.248).
Hgb	12.0-15.8g/dL	**9/dL**	**10.9/dL**	My patient has low hemoglobin due to her anemia, “A lack of iron results in small amounts of Hgb in each RBC and a resulting low amount of oxygen carriage in the blood” (Caprotti,2020, p.273).
Hct	36.0-47.0%	**28.2%**	**N/A**	My patient’s low hematocrit is due to her anemia, “Anemia is the major pathophysiological condition affecting RBCs. It can be defined as a decreased RBC mass that becomes clinically apparent when levels of Hgb and hematocrit (Hct) are less than normal” (Caprotti,2020, p.277).
Platelets	140-440K/ mcL	**317**/mcL	**N/A**	N/A
WBC	4.0-12.0K/ mcL	**8.7**/mcL	**N/A**	N/A
Neutrophils	40-60%	**79.8%**	**N/A**	My patients’ neutrophils were high due to stress events simply because of her admission to the hospital causes stress and her constant back pain “the first responders to an infection, stressful event, or inflammatory reaction” (Caprrotii,2020, p.246).
Lymphocytes	19-49%	**11.8%**	**N/A**	**My patents lymphocytes was low due to possible infection, “Lymphocytosis is a sign of infection, particularly viral infection” (Caprotti,2020,p.248).**
Monocytes	3.0-13.0%	**N/A**	**N/A**	**N/A**
Eosinophils	0.0-8.0%	**2.6%**	**N/A**	**N/A**
Bands	0.0-10.0%	**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-	134-144mmol/L	**143** mmol/L	**N/A**	**N/A**
K+	3.5-5.1mmol/L	4 mmol/L	**5.3** mmol/L	**N/A**
Cl-	98-107mmol/L	**105** mmol/L	**N/A**	**N/A**
CO2	21-31mmol/L	**27** mmol/L	**N/A**	**N/A**
Glucose	70-99mg/dL	**130** mg/dL	**123**	My patient's diabetes is high due to history of having disabilities mellitus and patient probably is not taking care of her diet to keep her glucose stable. "In uncontrolled diabetes, high blood glucose levels chemically injure the membranes of endothelial cells" (Capprotti,2020, p.18).
BUN	7-25 mg/dL	**61** mg/dL	**N/A**	My patient has end of stage renal disease causing her elevated BUN as her glomerular filtration rate is not working properly and as efficient. "An elevated BUN can occur when there is a decrease in the GFR, which leads to accumulation of nitrogenous waste products in the blood" (Capriotti, 2020, p.528).
Creatinine	**0.** .50-1.20 mg/dL	**2.08** mg/dL	**N/A**	My patient has elevated Creatinine due to her end of stage renal disease as her glomerular filtration rate is not working properly and as efficient. "Accumulation of serum creatinine indicates decreased filtering of creatinine at the glomerulus" (Caprotti,2020, p.528).

Albumin	3.5-5.7 g/dL	**N/A**	**N/A**	N/A
Calcium	8.6-10.3 mg/dL	**8.3** mg/dL	**N/A**	My patient has high calcium due to her chronic heart failure and renal disease. (Capriotti,2020, table 7-4).
Mag	1.6-2.6 mg/dL	**N/A**	**N/A**	**N/A**
Phosphate	2.4-4.5 units/L	**N/A**	**N/A**	**N/A**
Bilirubin	0.3-1.0 mg/dL	**N/A**	**N/A**	**N/A**
Alk Phos	34-104 units/L	**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	Yellow, Clear	**Yellow, Turbid**	**Yellow, Turbid**	My patient has abnormal urine clarity due to her kidneys not functioning and fileting out nitrogenous waste as they should, not getting enough fluids, and because of presence of red blood cells, "The urine is dark because it contains RBC" (Capriotti, 2020, p.530).
pH	5.0-9.0	**7.5**	**7.5**	
Specific Gravity	1.003-1.013	**1.014**	**1.015**	Specific gravity is high due to urine being "highly concentrated" due to her end of stage renal disease and dehydration. (Caprotti,2020, p.527).
Glucose	Normal	**Normal**	**Normal**	N/A
Protein	Normal	**2+**	**2+**	Abnormal due to patient having a kidney disease, "Excess protein in the urine is abnormal and is usually an indication of glomerular injury"

				(Capprotti,2020, p.528).
Ketones	**Negative**	**Negative**	**Negative**	N/A
WBC	0.0-0.5	**>100 Negative**	**>100 Negative**	Abnormal value due to my patient having renal failure, “white blood cells (WBCs); a high amount (positive result) is indicative of either a bladder or kidney infection” (Capprotti,2020, p.528).
RBC	0.0-3.0	**4**	**56**	My patient is positive for red blood count due to an ongoing urinary tract infection and possible kidney stones due to her end of stage renal disease “If positive: infection, kidney stone, or bladder cancer” (Capriotti, 2020, table 22-1).
Leuko esterase	Negative	**4+**	**4+**	My patient has a positive leuko esterase due to a urinary tract infection. “If positive: urinary tract infection” (Capriotti, 2020, table 22-1).

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):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. VitalSource Bookshelf Online. Retrieved March 2, 2022, from https://fadavisreader.vitalsource.com/reader/books/9781719641470/epubcfi/6/56[%3Bvnd.vst.idref%3Dc12]! /4/2/2/44/2

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Computed tomography (CT) of abdomen and pelvis without contrast-

Patient had an X-ray related to her abdomen and back pain. “Computed tomography (CT) of the abdomen and pelvis is a diagnostic imaging test. Doctors use it to help detect diseases of the small bowel, colon, and other internal organs. It is often used to determine the cause of unexplained pain” (*Computed Tomography (CT) - Abdomen and Pelvis,*2019, p.2). This is pertinent due to her abdominal pain patient had a CT was used to look at her kidneys. The CT showed mild heart enlargement with scattered coronary artery atherosclerotic. At the time showed stable appearing kidneys as posterior aspect of lower pole right kidney measuring fluid attenuation 24 centimeters, no urolithiasis, and hydronephrosis. No free pelvic fluid.

Diagnostic Imaging Reference (1) (APA):

ACR, R. S. N. A. and. (2020, June 15). *Computed tomography (CT) - abdomen and pelvis*. Radiologyinfo.org. Retrieved March 28, 2022, from https://www.radiologyinfo.org/en/info/abdominct

Current Medications (10 points, 2 points per completed med)
5 <u>different</u> medications must be completed

Medications (5 required)

Brand/ Generic	**Tylenol**// Acetaminophen	Lipitor/ Atorvastatin	**Zofran/ Ondansetron hydrochloride**	**Acetylsalicylic acid/Aspirin**	**Coreg/ Carvedilol**
Dose	**325mg**	**20mg**	**8mg**	**81mg**	**31.5mg**

Frequency	**Q4**	**Daily**	**Q8**	**Once a day**	**TID**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	Pharmacological: Non-salicylate, par aminophenol derivative Therapeutic: Antipyretic, nonopioid analgesic	Pharmacological: HMG-CoA reductase inhibitor Therapeutic: Antihyperlipidemic	Pharmacological: Selective Serotonin Therapeutic: Animatic	Pharmacological: Salicylate Therapeutic: NSAID (anti-inflammatory, antiplatelet, antipyretic, nonopioid analgesic)	Pharmacological: Nonselective beta blocker and alpha-1 blocker Therapeutic: Antihypertensive heart failure treatment
Mechanism of Action	"Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous syndrome" (Jones,2021, p.9).	"Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown" (Jones, 2021, p.96).	"Blocks serotonin receptors centrally in the chemo receptor trigger zone and peripherally at vagal nerve terminals intestine" (Jones, 2021, p.827).	"Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis" (Jones, 2021, p.87).	"Reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance which reduces blood pressure and cardiac workload" (Jones, 2021, p.173).

Reason Client Taking	**Pain**	**Hyperlipidemia**	**Nausea**	**Coronary Artery Disease**	**Beta Blocker**
Contraindications (2)	"Hypersensitivity to acetaminophen or its components, severe hepatic impairment" (Jones, 2021, p.9).	"Hypersensitivity to atorvastatin Active hepatic disease" (Jones, 2021, p.96).	Concomitant use of apomorphine Hypersensitivity to ondansetron or its components (Jones ,2021, p.827).	Hypersensitivity to aspirin Hypersensitivity to aspirin products (Jones, 2021, p.88).	Hypersensitivity to Carvedilol, Cardiogenic Shock (Jones, 2021, p.173).
Side Effects/Adverse Reactions (2)	Hypertension, Muscle spasms (Jones, 2021, p.9).	Hyperglycemia, dysphagia (Jones, 2021, p.96).	Agitation, Hypotension, Serotonin syndrome, prolonged QT interval shock, laryngeal edema (Jones, 2021, p.827).	Nausea, decreased blood level iron (Jones, 2021, p.88).	Heart Failure, Hyperglycemia (Jones, 2021, p.173).).

Medications Reference (1) (APA):

Jones, D.W. (2021). *Nurse's drug handbook.* (A. Bartlett, Ed.) (19th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was alert and oriented to person, place, time, and situation. Alert and Oriented times four. (A&O x4) The patient showed no signs of distress. Overall physical hygiene was well maintained and cared for.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 17** **Drains present: Y☐ N ☒** **Type:**	The patient's skin color is an even tone throughout skin and a fair white color. Skin is moist and warm to touch. Skin turgor is loose with no lesions, bruises, or wounds present. Patient Braden score is 17. (Low risk) No drains present.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is normal cephalic and symmetrical. Ears are symmetrical with no serum or epistaxis. The patient's eye represented PERLA. The nose showed no polyps, nor deviated septum. The patient teeth are intact and self-care hygiene was provided during visit.
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:**	.Patients' heart sounds S1 and S2 were auscultated. No present murmurs heard. Cardiac rhythm was not assessed. Peripheral pulses slight diminished pulse demonstrating a rating of 2+. Capillary refill less than three seconds. No neck vein distention and no edema.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No accessory muscles were used. The patient's breath sounds were auscultated anterior and posterior sounding clear and diminished.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:**	The patient's diet at home is regular, with the current diet also being regular but with limitations. Limitations included avoiding salt, ham, bacon, sausage, salted chips, orange juice, baked potatoes, tomato products, and add a scoop of protein for each meal. To continue limitations

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:**	it includes avocadoes, dried fruit nuts and yogurt. Patients' height 5'3 inches and weight 173.8 lbs. Bowel sounds were active in all four quadrants. Last bowel movement 3/23/2022 (yesterday). Upon palpation of abdomen no pain or masses present. No Distension, Incision, Scars, and Drains present. Patient does not ostomy or nasogastric tube. No feeding tubes either.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☒ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patients diet is dark yellow and clear upon incontinent episode on depends. Patient did not express pain while urinating. Patient has dialysis every Monday, Wednesday, and Friday. Patient has dialysis port on left side. Genitals were free of inflammation and nodules. Patient does not have catheter.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 45** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patients' neurovascular status is intact. Active range of motion present and demonstrated. Patient uses walker and wheelchair as a support device. Patient showed 3+ strength on upper extremities. Patient showed 2+ strength on lower extremities. Patients' fall score was 45 (moderate risk). Mobility status patient requires two personal assistances for completion of activity of daily livings. Patient does need assistance with use and set up of equipment. Patient also needs additional 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:**	The patient can move all extremities well with some weakness to the legs. Eyes were examined and exhibited PERLA. The patient has equal strength of 3+ for the upper extremities. Equal strength for lower extremities 2+. The patient is alert and oriented times four (A&Ox4). Mental status is alertness. Speech is clear. Patient sensory is intact. No loss of consciousness.

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):**	Patients coping mechanism were expressed to God about life and stressful situations. Development of mental status is appropriate for age. Patients' religion is Baptist meaning "I belong to God". Patient current environment at home states she feels lonely, and family does not come visit often. Patient says she often turns to God instead of depending on family members.

Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
07:00	**61**	**144/60** (History of Hypertension)	**16**	**97.6**	**94% RA**

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
08:00	0-10	Lower Back	8	Sharp, tight, and constant	-Tylenol -Padding on wheelchair -Repositioning in bed

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
120 ml (Milk)	**x 1 incontinence void**

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

Nursing Diagnosis • Include full	Rationale • Explain	Interventions (2 per dx)	Outcome Goal	Evaluation • How did the

nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	why the nursing diagnosis was chosen		**(1 per dx)**	client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Activity intolerance related to chronic back pain as evidence by back pain over six months and patient not being able to tolerate activity of daily livings (Phelps,2020 , p.2).	This nursing diagnosis was chosen due to patient expecting activity intolerance due to back pain as demonstrate d when patient was transferring from toilet to wheelchair patient was could not tolerate standing to transfer and had to sit back down and re-try.	1. Pain management to maintain at a level of five out of ten when asked for severity of pain. 2.Physiscal Therapy to decrease activity intolerance so patient can complete activity of daily living.	**1.** Patient will work with therapy three times a week to be able to walk down the hall and back to the room without activity intolerance and back pain maintainin g below 5 out of 10.	The family was glad to see that the nurses' actions showed an improvement in the patience activity seeing her able to tolerate walking around longer periods of time completing activity of daily livings. The patient was excited to reach her goal and satisfied that she can walk without pain disrupting her activity tolerance as her pain stayed below five out of ten.
2.Risk for social isolation related to inadequate affection received as evidence by patient verbalizing "People usually do not have time to talk to me and family does not come visit often".	This rationale was chosen due to patient medical history of major depressive disorder and verbalizing	1.Work with patient daily to show more effort in socializing and eating in dining room instead of bedroom.	**1.** Patient will be able to socialize with other residents at least go out to dining room for one of the meals	Family members saw nurses' action of making quality time and they decided to make regular visits with patient as they realized to value their loved ones.

	“People usually do not have time to talk to me and family does not come visit often”. In addition to her eating in bed instead of going out to eat in the dining room.	2.Dedeicate quality time to patient. Make sure patient feels like they are being listened too.	during the day and staff dedicate more time to listen to patient to make them feel like they are cared for and listened too.	Patients’ mood improved with no complaints of feeling lonely patient goal was achieved as patient ate in lunch in dining room for three days out of the week.

Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

"My lower back is where I feel the most pain"
""laying on side with pillow to support my back"
"My pain is a five out of ten"
"I belong to god"
Alleviating factors patient stated "padding on my wheelchair"

Nursing Diagnosis/Outcomes

Diagnosis:
1: Activity intolerance related to chronic back pain as evidence by back pain over six months and patient not being able to tolerate activity of daily livings (Phelps,2020, p.2).

Outcome:
1: The family was glad to see that the nurses' actions showed an improvement in the patience activity seeing her able to tolerate walking around longer periods of time completing activity of daily livings. The patient was excited to reach her goal and satisfied that she can walk without pain disrupting her activity tolerance as her pain stayed below five out of ten.

Diagnosis: Risk for social isolation related to inadequate affection received as evidence by patient verbalizing "People usually do not have time to talk to me and family does not come visit often".

Outcome:
Family members saw nurses' action of making quality time and they decided to make regular visits with patient as they realized to value their loved ones. Patients' mood improved with no complaints of feeling lonely patient goal was achieved as patient ate in lunch in dining room for three days out of the week.

Objective Data

Vital Signs:
Temperature: 97.6°F
Blood Pressure: 144/60
Pulse:61
Oxygen:94% RA

Client Information

Patient presents to ER admitted with abdominal pain and resident from Mattoon rehab long term side for end of stage renal disease receiving dialysis Mondays, Wednesdays, and Fridays. Patient has history of hypertensive crisis, chronic diastolic heart failure, dependence on renal diagnosis, and diabetes mellitus with complications.

Nursing Interventions

1: Pain management to maintain at a level of five out of ten when asked for severity of pain.

2. Physical Therapy to decrease activity intolerance so patient can complete activity of daily living.

1: Work with patient daily to show more effort in socializing and eating in dining room instead of bedroom.

2: Dedicate quality time to patient. Make sure patient feels like they are being listened too.