

N441 Care Plan

Lakeview College of Nursing

Jillian Kurtz

Demographics (3 points)

Date of Admission 04/11/2022	Client Initials R.H.	Age 48 years old	Gender Male
Race/Ethnicity White/Caucasian	Occupation Assistant Supervisor at Hydro-Gear	Marital Status Single	Allergies NKA
Code Status Full Code	Height 193 cm	Weight 120 kg	

Medical History (5 Points)

Past Medical History: Patient has a past medical history of Bell's Palsy, hypertension, hypothyroidism, hypercholesteremia, and shingles (herpes zoster).

Past Surgical History: Patient has a past surgical history of an umbilical hernia repair on 05/15/20 and a cardiac catheterization in 09/2020.

Family History: Patient has a past family history of colon cancer, congestive heart failure, esophageal varices, liver disease, heart attacks, hypertension, and strokes on the paternal side. Patient has a past family history of multiple sclerosis and Parkinson's disease on the maternal side.

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

Patient states he drank alcohol in the past around a fifth of vodka every week, but he quit about 15 years ago. Patient denies drug use. Patient currently uses a vape. Patient states he goes through one vape about every 2-3 days and he has been using tobacco products since he was 20 years old.

Assistive Devices: Patient wears glasses.

Living Situation: Patient lives in a trailer park with his brother in Windsor, Illinois.

Education Level: This patient attended some years of college and has no learning barriers.

Admission Assessment

Chief Complaint (2 points): Patient complains of high blood pressure readings all weekend paired with accompanying headache, blurred vision, and numbness in the hands and feet.

History of Present Illness – OLD CARTS (10 points): Patient is a 48-year-old male who presented to the Sarah Bush Lincoln hospital emergency room on 04/11/2022 complaining of high blood pressure readings all weekend with blurry vision, numbness in the hands and feet, and a headache. Patient states that occasionally he will get high blood pressure readings, but it has never been this high before. When the patient arrived at the emergency department his blood pressure was in the 220's. Patient states that it could be due to a lot of stress in his life right now including a relapse of multiple sclerosis, problems with a friend, having several teeth removed, and recently switching from Solu-Medrol to Prednisone. Patient states a 5/10 for pain on a numeric scale, which he correlated to getting his teeth pulled. He has been taking Ibuprofen up to 800 mg 3x a day for that. Patient also states that he began taking Amlodipine 5 mg 5 days ago, but it hasn't been working. Patient will be admitted to 2 East for further treatment and observation.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Hypertensive Crisis- Urgency

Secondary Diagnosis (if applicable): N/A

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

A hypertensive crisis is an acute and life-threatening condition that requires an immediate reduction in blood pressure. A hypertensive crisis is a severe increase in blood pressure that can lead to stroke. Hypertensive crisis is an extremely high blood pressure with a higher systolic pressure of 180 millimeters of mercury (mmHg) and a diastolic pressure of 120 millimeters of

mercy (mmHg) (Silvestri & Silvestri, 2020). Extremely high blood pressure for a prolonged period can damage the blood vessels. The blood vessels become inflamed and may leak fluid or blood, and because of this, the heart may not be able to pump blood effectively. An individual with a hypertensive crisis may present with an extreme blood pressure of systolic over 180 mmHg and diastolic over 120 mmHg, headache, drowsiness and confusion, blurred vision, changes in neurological status, tachycardia and tachypnea, dyspnea, cyanosis, and seizures (Silvestri & Silvestri, 2020). My patient currently is not experiencing any of these symptoms. Still, upon admission, this patient was experiencing systolic blood pressure in the 220s, headache, blurry vision, and numbness in the hands and feet. Expected findings related to a hypertensive crisis include the highly elevated blood pressure shown in the patient's vital signs. Typical diagnostic tests for hypertensive emergencies include an electrocardiogram (EKG), urinalysis, and serum BUN and creatinine (Silvestri & Silvestri, 2020). If a patient presents with neurologic findings, ordering a head CT will be necessary to diagnose intracranial bleeding, edema, or infarction (Silvestri & Silvestri, 2020). If the patient presents with chest pain or dyspnea, a chest x-ray may be required. This patient had an electrocardiogram performed to rule out any heart conditions or electrical abnormalities. The results of the EKG showed normal sinus rhythm with 84 beats per minute. Also, the patient's urinalysis, BUN, and creatinine were all within normal limits. The patient had a CT of the head performed because he presented to the emergency department with a headache and vision changes, but it did not show any abnormalities. The patient also had an echocardiogram performed, but it did not result, and the chest x-ray showed no acute cardiopulmonary abnormalities. Treatment for hypertensive crisis includes administering IV and oral antihypertensives (Holman et al., 2019). Emergency treatment is required because target organ damage such as the brain, heart, kidneys, and retina of the eyes

can occur. The goal is to lower the blood pressure by 20% to 25% in the first hour but not drop the blood pressure to less than 140/90 mm Hg (Holman et al., 2019). This patient is receiving Spironolactone, Carvedilol, Amlodipine, and Hydralazine for treatment. If the patient's blood pressure is not under control with these oral medications and their blood pressure is >180 / >110, the patient will receive Labetalol intravenous push.

Pathophysiology References (2) (APA):

Holman, H. C., Williams, D., Johnson, J., Ball, B. S., Wheless, L. K., Leehy, P., & Lemon, T. (2019). *Rn Adult Medical Surgical Nursing: Review module* (11th ed.). Assessment Technologies Institute, LLC.

Silvestri, L. A., & Silvestri, A. E. (2020). *Saunders Comprehensive Review for the Nclex-Rn examination* (8th ed.). Elsevier.

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	3.8 – 5.4 x 10 ⁶ /mcL	5.36	5.14	
Hgb	11.3 – 15.2 g/dL	16.9	16.5	The patient is on a steroid for his recent Bell's Palsy relapse which can cause an increase in hemoglobin (Capriotti, 2020).
Hct	33.2 – 45.3 %	49.0 %	47.1 %	The patient is on a steroid for his recent Bell's Palsy relapse which can cause an increase in hemotocrit (Capriotti, 2020).
Platelets	149 – 393 kg/mcL	233	193	
WBC	4.0 – 11.7 kg/mcL	16.0	12.3	The patient is on a steroid for his recent Bell's Palsy relapse which can

				cause an increase in WBC count (Capriotti, 2020).
Neutrophils	45.3 – 79.0 %	78.3 %	69.3 %	
Lymphocytes	11.8 – 45.9 %	6.9 %	18.4 %	The patient is on a steroid for his recent Bell's Palsy relapse which can cause an increase in lymphocytes (Capriotti, 2020).
Monocytes	4.4 – 12.0 %	11.4 %	11.9 %	
Eosinophils	0.0 – 6.3 %	N/A	0.2 %	
Bands	0.0 – 6.0 %	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 mmol/L	137	N/A	
K+	3.5 – 5.1 mmol/L	3.8	N/A	
Cl-	98 – 107 mmol/L	103	N/A	
CO2	21 – 31 mmol/L	29	N/A	
Glucose	74 – 109 mg/dL	108	N/A	
BUN	7 – 25 mg/dL	23	N/A	
Creatinine	0.60 – 1.20 mg/dL	1.18	N/A	
Albumin	3.5 – 5.2 g/dL	4.1	N/A	
Calcium	8.6 -10.3 mg/dL	9.5	N/A	
Mag	1.6 – 3.6 mg/dL	N/A	N/A	
Phosphate	2.5 – 4.5 mg/dL	N/A	N/A	
Bilirubin	0.3 – 1.0 mg/dL	0.5	N/A	

Alk Phos	34 – 104 unit//L	77	N/A	
AST	13 – 39 unit/ L	13	N/A	
ALT	7 – 52 unit/ L	22	N/A	
Amylase	60 – 120 U/ L	N/A	N/A	
Lipase	0 – 160 U/L	N/A	N/A	
Lactic Acid	0.5 – 2.2 mEq/L	N/A	N/A	
Troponin	0.0 – 0.03 ng/mL	<0.010	N/A	
CK-MB	3 – 5 %	N/A	N/A	
Total CK	22 – 198 U/ 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 seconds	N/A	N/A	
PT	10.1 – 13.1 seconds	N/A	N/A	
PTT	25 – 36 seconds	N/A	N/A	
D-Dimer	0.00 – 0.62 mcg/mL	N/A	N/A	
BNP	>100 pg/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	<5.7 %	N/A	N/A	

TSH	0.45 – 5.33 mIU/mL	23.75	N/A	The patient has hypothyroidism which means the thyroid is not making enough hormones (Capriotti, 2020).
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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	N/A	Light yellow, clear	
pH	5.0 – 9.0	N/A	7.5	
Specific Gravity	1.003 – 1.035	N/A	1.014	
Glucose	Negative	N/A	Negative	
Protein	Negative	N/A	Negative	
Ketones	Negative	N/A	Negative	
WBC	< 5 /mCL	N/A	<1	
RBC	0 – 3	N/A	0	
Leukoesterase	Negative	N/A	Negative	

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. NO LABS PERFORMED.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35 – 7.45	N/A	N/A	
PaO2	10.3 – 23.3	N/A	N/A	
PaCO2	35.0 – 45.0	N/A	N/A	
HCO3	22.0 – 26.0	N/A	N/A	
SaO2	92 – 100 %	N/A	N/A	

Cultures **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format. **NO LABS PERFORMED.**

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

Lab Correlations Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

Sarah Bush Lincoln Health Center. (2021). *Cerner*. <https://www.sarahbush.org/>

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

04/11 Electrocardiogram (EKG): shows normal sinus rhythm, heart rate: 84 beats per minute

04/11 Chest X-ray 1 view: shows no acute cardiopulmonary, no pneumothorax, no effusion, no definite acute abnormality

04/11 CT Brain/Head without contrast: No acute intracranial abnormality

04/12 Echocardiogram: Results pending

Diagnostic Test Correlation (5 points):

The electrocardiogram (EKG) was performed routinely in the emergency room to discover baseline heart rate and ensure no electrical abnormalities associated with the patient's hypertensive state. An EKG is used to visualize the electrical activity of the heart. An x-ray is used to visualize the cardiac shadow and pulmonary fields along with bone structure. The x-ray

of the chest was performed because of the patient’s elevated blood pressures to show if there was any targeted organ damage. The CT of the brain and head without contrast was performed due to the patient presenting to the emergency room with pain, headache, and vision changes. The CT of the head helps assess head injuries, severe headaches, dizziness, and other symptoms of aneurysm, bleeding, stroke, or brain tumors. The echocardiogram was performed due to the patient going into periods of sinus tachycardia and also to ensure no organ damage due to extreme blood pressures. Echocardiograms are noninvasive sonograms that can show the activity and structures of the heart. They are commonly used to look at the size of and function of the ventricles, valve structure, and valve function.

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

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

Home Medications (5 required)

Brand/Generic	Spironolactone/ Aldactone, Carospir	Sildenafil / Viagra	Gabapentin/ Neurontin	Aspirin/ Bayer	Carvedilol/ Coreg
Dose	25 mg	20 mg	300 mg	81 mg	25 mg
Frequency	Daily	Daily	BID	PRN Daily	BID
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharmacological: Potassium-sparing diuretic Therapeutic: Diuretic	Pharmacological: Phosphodiesterase 5 inhibitor Therapeutic: Antihypertensive, erectile dysfunction	Pharmacological: 1- amino-methyl cyclohexane acetic- acid Therapeutic: Anticonvulsant	Pharmacological: Salicylate Therapeutic: NSAID	Pharmacological: Nonselective beta blocker and alpha- 1 blocker Therapeutic: Antihypertensive
Mechanism of Action	Competes with aldosterone for these receptors, thereby preventing sodium and water reabsorption and causing their excretion through the distal	Enhances the effect of nitric acid released in the penis by stimulation. Nitric oxide increased cGMP level, relaxes smooth muscle, and	Prevent exaggerated responses to painful stimuli and pain-related responses to a normally innocuous stimulus	Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis	Reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance, which

	convoluted tubules	increases blood flow to the corpus cavernosum, producing an erection			reduced blood pressure and cardiac workload
Reason Client Taking	Hypertension	Erectile dysfunction	Manage nerve pain for Bell's Palsy	Acute pain	Hypertension
Contraindications (2)	Acute renal insufficiency, hyperkalemia	Concomitant guanylate cyclase stimulator therapy, hypersensitivity to sildenafil or its components	Chronic kidney disease, hypersensitivity to gabapentin or its components	Active bleeding or anticoagulation disorders, hypersensitivity to aspirin	Asthma or related bronchospastic conditions, angioedema
Side Effects/Adverse Reactions (2)	Hypotension, Gastric bleeding	Hypotension, seizures	Intracranial hemorrhage, suicidal ideation	GI bleeding, thrombocytopenia	Bradycardia, renal insufficiency
Nursing Considerations (2)	Stop drug several days before undergoing adrenal vein catheterization. Monitor patients with renal impairment more closely due to increased risk of hyperkalemia	Use cautiously in elderly patients with hepatic or renal dysfunction, monitor vision especially in individuals over 50	May be opened and mixed with applesauce/pudding for administration, give drug at least 2 hours after an antacid	Don't crush timed-release or controlled-release aspirin tablets, ask about tinnitus	Use cautiously in patients with peripheral vascular disease, be aware Carvedilol is not withheld prior to major surgery
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess patient's blood pressure prior to administration. Monitor patient's potassium levels during beginning of therapy and dosage changes.	Monitor patients blood pressure before and often during therapy, monitor patients heart rate and rhythm during therapy	Monitor kidney function labs, monitor the patient for suicidal thinking or behavior especially when starting therapy or changing doses	Monitor coagulation labs, assess pain before and after taking the medication	Monitor patient's blood glucose levels, daily weights should be a priority to assess fluid overload
Client Teaching needs (2)	Instruct patient to take with meals or milk, teach patient how to measure their blood pressure	May be taken up to 4 hours before sexual activity, instruct patient to stop taking if they experience vision difficulties in one or both eyes	Caution the patient not to stop drug abruptly, instruct the patient to perform good oral hygiene to prevent gingivitis	Caution patient not to consume aspirin 2 hours before or 1 hour after consuming alcohol, tell patient not to use aspirin if it has a strong vinegar-like odor	Warn patient the drug can cause dizziness, and light-headedness, alert patients with diabetes to monitor glycemic control closely because the drug may increase blood glucose or mask symptoms of hypoglycemia

Hospital Medications (5 required)

Brand/Generic	Amlodipine/ Norvasc	Atorvastatin/ Lipitor	Hydralazine/ Apresoline	Labetalol/ Trandate	Levothyroxine/ Eltroxin
Dose	10 mg	80 mg	100 mg	10 mg = 2 mL	25 mcg
Frequency	Daily	Daily	BID	PRN	Daily
Route	Oral	Oral	Oral	IV push	Oral
Classification	Pharmacological: Calcium-channel blocker	Pharmacological: HMG-CoA reductase inhibitor	Pharmacological : Vasodilator	Pharmacological : Noncardioselectiv	Pharmacological : Synthetic

	Therapeutic: Antianginal, Antihypertensive	Therapeutic: Antihyperlipidemi c	Therapeutic: Antihypertensive	e beta-blocker/alph a 1 blocker Therapeutic: Antihypertensive	thyroxine Therapeutic: Thyroid hormone replacement
Mechanism of Action	Binds of dihydropyridine and nondihydropyridine cell membrane receptor sites on myocardial and vascular smooth-muscle cells and inhibits influx of extracellular calcium ions across slow calcium channels	Reduced 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	Dilates arteries, not veins, which minimizes orthostatic hypotension and increases cardiac output and cerebral blood flow	Blocks alpha 1 and beta 2 receptors in vascular smooth muscle and beta 1 receptors in heart to reduce blood pressure and peripheral vascular resistance	Replace endogenous thyroid hormone which may exert its physiologic effects by controlling DNA transcription and protein synthesis
Reason Client Taking	Hypertension	Hypercholesteremi a	Hypertension	SBP: >180 DBP: >110	Hypothyroidism
Contraindications (2)	Hypersensitivity to its components, patients with heart failure	Active hepatic disease, hypersensitivity to atorvastatin or its components	Coronary artery disease, hypersensitivity to hydralazine	Asthma, hypersensitivity to labetalol or its components	Acute MI, hypersensitivity to levothyroxine or its components
Side Effects/Adverse Reactions (2)	Arrhythmias, pancreatitis	Hypoglycemia, anaphylaxis	Palpitations, Anorexia	Heart block, hypotension	Myxedema coma, angioedema
Nursing Considerations (2)	Use cautiously in patients with heart block, assess patient frequently for chest pain	Use cautiously in patients who consume substantial quantities of alcohol, atorvastatin should not be used in patients taking cyclosporine	Monitor ANA titer, CBC, and lupus erythematosus cell preparation before therapy, give tablets with food to increase bioavailability	Keep supine position for 3 hours after I.V. administration, be aware that stopping labetalol tablets abruptly could result in angina, MI, or arrhythmias	Cannot be used for treatment of obesity or fat weight loss, administer tablets as a single dose 30 to 60 minutes before breakfast
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor blood pressure before and during, monitor hepatic labs in patients with impaired function	Monitor diabetes blood glucose levels, monitor liver function levels before starting therapy	Monitor blood pressure and pulse rate regularly, weight patient daily during therapy	Monitor blood pressure every 5 minutes for the first 30 minutes, monitor glucose levels in diabetic patients	Monitor PT for patient who is receiving anticoagulant, monitor blood glucose levels of diabetic patient
Client Teaching needs (2)	Suggest taking with food to reduce GI upset, tell patient to take missed dose as soon as remembered	Emphasize that atorvastatin is an adjunct to-not a substitute for- a low cholesterol diet, tell patient to take the drug at the same time each day to maintain its effects	Advise patient to change positions slowly, urge patient to report numbness and tingling in limbs	Urge patient to avoid alcohol during therapy, suggest patient minimize effects of orthostatic hypotension by avoiding sudden position changes	Instruct patient to separate antacids and calcium or iron supplements by at least 4 hours from levothyroxine dose, emphasize the need to take levothyroxine with a full glass of water to avoid choking

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse’s drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

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

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>Alert and responsive Oriented to person, place, time, and situation. Shows no signs of distress or discomfort. Appears to be clean and well groomed, appropriate.</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Usual for ethnicity. Dry and intact. Warm to the touch. Elastic skin turgor. No rashes. No bruises. No wounds. 19 No drains present.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Symmetrical appearance of face and neck, no deviation. No hearing difficulties, ears clean, free of discharge, tympanic membrane pearly gray. PERRLA; follows 6 cardinal fields, white sclera. Patent; no drainage or sputum deviation. No dental caries present, teeth have yellow tint.</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema: N/A</p>	<p>S1 and S2 heart sounds. Normal sinus rhythm. 3+ pulse of the left and right radial artery, 3+ of the left and right popliteal artery, 3+ pulse of the left and right dorsalis pedis. Capillary refill < 3 seconds bilaterally in both the upper and lower extremities.</p>

<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character ET Tube: N/A Size of tube: N/A Placement (cm to lip): N/A Respiration rate: N/A FiO2: N/A Total volume (TV): N/A PEEP: N/A VAP prevention measures:</p>	<p>. No accessory muscle use. Regular, unlabored respirations. Vesicular breath sounds present Clear, equal breath sounds of the right upper lobe, right middle lobe, right lower lobe, left upper lobe, and left lower lobe anteriorly and posteriorly VAP prevention measures: Provide oral care, subglottic suctioning, early mobility, adequate nurse staffing</p>
<p>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 <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: N/A Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: N/A</p>	<p>Regular diet, 3 meals per day Heart Healthy diet 193 cm 120 kg Active in all four quadrants; RLQ, RUQ, LUQ, LLQ 04/08/22 No pain or masses upon palpation in all four quadrants No distention No incisions No scars No drains No wounds</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size: CAUTI prevention measures:</p>	<p>Light Yellow Clear 200 mL No pain with urination No dialysis No swelling or redness, genitals clean No catheter CAUTI prevention measures: Limiting the use and duration of catheter, using aseptic technique, proper catheter care</p>
<p>MUSCULOSKELETAL:</p>	<p>.</p>

<p>Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 45 Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Nail beds pink; capillary refill is < 3 seconds in the upper and lower extremities. Extremities are warm and have sensation to touch. Active ROM present, moves extremities well No supportive devices 5/5 strength bilaterally in upper and lower extremities No ADL assistance Moderate fall risk Independent (up and lib)</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>. Equal strength bilaterally in upper and lower extremities Oriented to person, place, time, and situation Normal cognition, no delays noticed Clear, non-impaired speech Sensitive to touch, sound, hearing, and light Alert</p>
<p>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):</p>	<p>. Patient states that he relies on his girlfriend and brother for support. Can read and write, forms structured sentences, and has the capability of making a fully informed decision. Patient is Christian and attends services when he can on Sundays. Patient lives in a trailer with his brother and nearby to his girlfriend.</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	70 BPM	183/116 Automatic Left arm Patient lying in bed	20 Respirations/minute	36.2 C (Oral)	97% on room air
1030	73 BPM	130/77	18	36.3 C	98 % on

		Automatic Right arm Patient lying in bed	Respirations/minute	(Oral)	room air
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Vital Sign Trends/Correlation:

The patient’s vital signs are all within normal limits except for his blood pressures at 0700. The patient received amlodipine, hydralazine, and atenolol for his high pressure. After receiving medications, the patient’s vitals at 1030 were all within normal limits and were not a level of concern at this time. The patient remains stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numerical	N/A	0/10	N/A	Continued to monitor
1030	Numerical	N/A	0/10	N/A	Continued to monitor

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge Location of IV: Left AC Date on IV: 04/11/22 Patency of IV: Patent, flushes w/o difficulty Signs of erythema, drainage, etc.: No signs of erythema, infiltration, or drainage IV dressing assessment: Dry, intact, transparent	Saline Lock
Other Lines (PICC, Port, central line, etc.)	
Type: N/A	No other lines in place.

Size: N/A Location: N/A Date of insertion: N/A Patency: N/A Signs of erythema, drainage, etc.: N/A Dressing assessment: N/A Date on dressing: N/A CUROS caps in place: Y <input type="checkbox"/> N <input type="checkbox"/> CLABSI prevention measures:	CLABSI prevention measures: Hand hygiene, appropriate skin antiseptic, ensure that skin prep has completely dried, use 5 maximal sterile barrier precautions
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Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL of orange juice	200 mL of urine

Nursing Care

Summary of Care (2 points)

During the clinical day from 0630-1200, the nursing student and the registered nurse provided the patient with basic health needs. The patient’s morning medications were administered at 0800. An echocardiogram was performed at 1000, the results were still pending at the end of the clinical day. There are no complaints or issues. The patient’s vital signs were unstable at 0700 due to a blood pressure reading of 183/116 but were all within normal limits at 1030 once the patient had received his morning blood pressure medications. The patient ate breakfast and tolerated it well. The patient also ambulated in the hallway with the nursing student and tolerated it well. The physician was notified of the elevated blood pressure this morning but instructed the registered nurse and nursing student to hold the Labetalol unless the blood pressure was not improved within the hour. Future plans for the client include continuing his blood pressure medication, monitoring is blood pressure every 30 minutes, and neurological checks every 6 hours. Discharge preparation will be initiated upon control of blood pressure and symptom free from hypertensive crisis.

Discharge Planning (2 points)

The patient will be discharging home in Windsor, Illinois with his brother once his blood pressure is controlled. The patient will not need any new home health or equipment needs. However, he will need to continue to self-monitor his blood pressure at home as he was previously. Patient will need to follow up with Dr. Katsamakidis in the cardiac center in 4-8 weeks regarding hypertensive crisis and the risk of organ injury. Patient will also need to follow up with an Endocrinologist in 3-4 weeks in regard to his blood pressure and going into hypertensive urgency. The patient is not going to be discharged on any new medications at this time, but he will need to be educated on compliance with blood pressure medications, monitoring his blood pressure, and stroke prevention.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • 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 	<p>Rationale</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Interventions (2 per dx)</p>	<p>Outcome Goal (1 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the client/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for decreased cardiac output related to increased peripheral vascular resistance</p>	<p>This nursing diagnosis was chosen as priority because the patient is at risk for organ failure and stroke</p>	<p>1. Assess blood pressure every hour until the patient meets the appropriate parameters (Phelps, 2020). 2. Monitor response</p>	<p>1. The patient will maintain an appropriate blood pressure within individually acceptable</p>	<p>The patient responded positively to the assessment actions by the nurse. The patient understood the purpose of the</p>

<p>secondary to hypertension as evidenced by BP 183/116</p>	<p>when blood pressure remains that high.</p>	<p>to medications to control blood pressure (Phelps, 2020).</p>	<p>range.</p>	<p>assessment and did not have any concerns regarding the plan of care.</p>
<p>2. Risk for falls related to hypertensive crisis as evidenced by blood pressure in the 220s, blurry vision, and numbness in the hands and feet.</p>	<p>This nursing diagnosis was chosen because the patient suffers from dizziness, blurred vision, and numbness which increases the risk for falling.</p>	<p>1. Place items the patient frequently uses within reach (Phelps, 2020). 2. Implement fall precautions interventions (Phelps, 2020).</p>	<p>1. The patient will use the call light and other safety measures to prevent any falls during his stay at the hospital.</p>	<p>The patient responded positively to the teaching about the risk for falls and how to prevent them. The patient understands how to use the call light when needing to get up.</p>
<p>3. Deficient knowledge related to lack of knowledge as evidenced by request for more information.</p>	<p>This nursing diagnosis was chosen because the patient has experienced high blood pressure but has never been in hypertensive crisis.</p>	<p>1. Assist the patient in identifying modifiable risk factors (Phelps, 2020). 2 Define and state the limits of desired BP and explain hypertension and its effects on the heart, blood vessels, kidneys, and brain (Phelps, 2020).</p>	<p>1. The patient will understand the causes of hypertension and identify ways to avoid hypertensive crisis.</p>	<p>The patient responded positively to the teaching about hypertensive crisis. The patient understands the risk factors and will implement changes to maintain his blood pressure.</p>
<p>4. Decreased activity tolerance related to sedentary lifestyle as evidenced by abnormal BP response</p>	<p>This nursing diagnosis was chosen because the patients BP increased while walking out in the</p>	<p>1. Instruct the patient in energy-conserving techniques (Phelps, 2020). 2. Encourage progressive activity and self-care when</p>	<p>1. The patient will participate in desired activities and identify techniques to enhance activity</p>	<p>The patient responded positively to participating in self-care. The patient understands the importance of using</p>

to activity	hallway.	tolerated (Phelps, 2020).	tolerance.	energy-conserving techniques during care.
5. Acute pain related to increased cerebral vascular pressure as evidenced by reported headache and blurred vision.	This nursing diagnosis was chosen because the patient presented to the emergency department with pain related to being in hypertensive crisis.	1. Provide nonpharmacological measures to relieve headache (Phelps, 2020). 2. Eliminate vasoconstricting activities that may aggravate headache (Phelps, 2020).	1. The patient will report relief of pain and properly demonstrate the use of relaxation skills and activities.	The patient responded positively to the use of nonpharmacological pain techniques. The patient understands the importance of eliminating straining activities to alleviate headaches.

Other References (APA):

Phelps, L. L. (2020). *Nursing diagnosis: Reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points)

Subjective Data

Nursing Diagnosis/Outcomes

- Risk for decreased cardiac output related to increased peripheral vascular resistance secondary to hypertension as evidenced by BP 183/116
 - o The patient will maintain an appropriate blood pressure within individually acceptable range.
- Risk for falls related to hypertensive crisis as evidenced by blood pressure reading and numbness in the hands and feet.
 - o The patient will use the call light and other safety measures to prevent any falls during his stay at the hospital.
- Deficient knowledge related to lack of knowledge as evidenced by request for more information.
 - o The patient will understand the causes of hypertension and identify ways to avoid hypertensive crisis.
- Decreased activity tolerance related to sedentary lifestyle as evidenced by abnormal BP response to activity.
 - o The patient will participate in desired activities and identify techniques to enhance activity tolerance.
- Acute pain related to increased cerebral vascular pressure as evidenced by reported headache and blurred vision.
 - o The patient will report relief of pain and properly demonstrate the use of relaxation skills and activities.

Patient came in with hypertensive crisis. The patient presented with a blood pressure in the 220s; headache, blurry vision, and numbness in the hands and feet. Patient appears to be in no distress and is alert and oriented. Patient states he has a lot of stress in his life which believes lead up to this crisis.

Objective Data

Client Information

Nursing Interventions

- Assess blood pressure every hour until the patient meets appropriate parameters
- Monitor vital signs
- Implement fall precautions
- Administer medications as ordered
- Encourage patient to rest
- Provide patient education
- Eliminate vasoconstricting activities that many aggravate headache

Patient had an EKG performed upon admission that showed normal sinus rhythm and a heart rate of 84 beats per minute. Patient also had a normal echocardiogram. CT of the brain/head and neck showed no evidence of hemorrhage. Chest x-ray which showed normal findings. Patient had increased hematocrit, hemoglobin, WBC and self-reported headache. R.H. has no current tobacco use. R.H. has no lymph nodes and TSH levels upon admission. No abnormal assessment findings as this time.



