N431 Care Plan #1

Lakeview College of Nursing

Corinne Monte De Oca

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
6/2/22	L.M.	93 years old	Female
Race/Ethnicity White	**Occupation** Retired	**Marital Status** Widowed	**Allergies** Codeine (nausea), penicillins (hives), ciprofloxacin (tendon rupture)
Code Status DNR	**Height** 162.0 cm	**Weight** 70.8 kg	

Medical History (5 Points)

Past Medical History: Abnormal nuclear stress test, coronary artery disease, DVT, hypercholesteremia, hypertensive CVD, hypothyroidism, diabetes mellitus type 2, osteoporosis

Past Surgical History: Total hysterectomy (1972), cholecystectomy (1957), resection of liver (1957), right mastectomy, appendectomy (1971), cardiac catheterization – left heart (2017)

Family History: CVD (sister)

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient denies tobacco, alcohol, or drug use other than secondhand tobacco smoke from husband.

Assistive Devices: Wheelchair, walker

Living Situation: Patient arrived from her assisted living facility

Education Level: High school

Admission Assessment

Chief Complaint (2 points): Left shoulder pain

History of Present Illness – OLD CARTS (10 points): The patient is a 93-year-old woman who presented to the ED on 6/1/22 with complaints of left shoulder pain after sustaining a fall. Patient stated she tripped over her feet and fell on her left side. Patient stated she hit her head but did not lose consciousness. Patient reported neck pain and left shoulder pain that she rated an

8/10. Patient stated the pain was worse with movement. The patient was brought to the ED via EMS and was given 60 mcg of fentanyl and 4 mg of Zofran by EMS personnel. EMS also tried immobilizing the affected area but patient stated this did not help the pain. Patient was administered 4 mg of morphine in the ED, which alleviated the pain. After morphine, patient rated the pain 4/10.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Reverse left total shoulder replacement

Secondary Diagnosis (if applicable): N/A

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

A reverse total shoulder replacement surgery consists of replacing parts of the shoulder with artificial parts. In a reverse total shoulder replacement, the rounded head on the upper arm bone, also called the humerus, is removed, and the surgeon screws a plastic socket into place. Part of the shoulder blade socket is also removed and replaced with a metal ball (Johns Hopkins Medicine, n.d.). These then function as a typical ball and socket joint but are reversed from normal human anatomy.

Signs and symptoms a patient may be experiencing prior to surgery could include severe shoulder pain or weakness that hinders activities of daily living, decreased or diminished range of motion in the affected extremity, or insomnia (Cleveland Clinic, 2021). These signs and symptoms may indicate that a client would be an appropriate candidate for a shoulder replacement. Signs and symptoms post-surgery may include swelling, redness, and pain (Capriotti, 2020).

A few possible expected findings may include decreased RBCs, hemoglobin, and hematocrit. An increased WBC may also be evident due to the increase in inflammation (Capriotti, 2020).

Before surgery, diagnostic testing may include an x-ray, a CT scan, or an MRI (Johns Hopkins Medicine, n.d.). These will allow for visualization of the bones and surrounding soft tissues to see the extent of the injury. This patient received CT scans and pre-operative and post-operative x-rays.

Treatment after surgery involves managing pain and rehabilitation. This patient was currently taking acetaminophen for pain. The patient was planning on going to a nursing home for rehabilitation after discharge. She was also taking ferrous sulfate supplements to increase her hemoglobin since she had low levels following surgery.

Pathophysiology References (2) (APA):

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

Cleveland Clinic (2021, January 4). *Shoulder replacement*. https://my.clevelandclinic.org/health/treatments/8290-shoulder-replacement

Johns Hopkins Medicine. (n.d.). *Reverse total shoulder replacement.* https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/reverse-total-shoulder-replacement#:~:text=In%20a%20reverse%20total%20shoulder,replaced%20with%20a%20metal%20ball.

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	3.61	N/A	Due to the patient's recent surgery, she experienced an EBL of 700 mL. This caused post-operative anemia, which accounts for her decreased RBC value (Capriotti, 2020).
Hgb	11.3-15.2 g/dL	7.6	8.1	Due to the patient's recent surgery, she experienced an EBL of 700 mL. This caused post-operative anemia, which accounts for her decreased hemoglobin value (Capriotti, 2020).
Hct	33.2-45.3%	23.6%	24.2%	Due to the patient's recent surgery, she experienced an EBL of 700 mL. This caused post-operative anemia, which accounts for her decreased hematocrit value (Capriotti, 2020).
Platelets	149-393 K/mcL	249	306	N/A
WBC	4.0-11.7 K/mcL	15.3	12.5	The patient likely had an increased WBC count in her urine due to having a UTI (Capriotti, 2020). Older adults are prone to UTIs related to urinary retention.
Neutrophils	45-79%	81.6%	N/A	An elevated neutrophil count often indicates infection since neutrophils are the first responders to an infection, stressful event, or inflammatory response (Capriotti, 2020). The patient's neutrophil levels were only slightly above expected levels. However, she did have a UTI.
Lymphocytes	11-45%	11.3%	N/A	N/A
Monocytes	4.4-12%	6.5%	N/A	N/A
Eosinophils	< 7%	0.2%	N/A	N/A
Bands	0-10%	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-	135-145 mmol/L	135	N/A	N/A
K+	3.5-5.0 mmol/L	3.7	N/A	N/A
Cl-	98-107 mmol/L	98	N/A	N/A
CO2	23-29 mEq/L	30	N/A	N/A
Glucose	70-100 mg/dL	174	N/A	The patient had type 2 diabetes and may not have it well-controlled (Capriotti, 2020). She could have also just eaten prior to testing.
BUN	8-25 mg/dL	21	N/A	N/A
Creatinine	0.6-1.3 mg/dL	0.67	N/A	N/A
Albumin	3.5-5.2 mg/dL	N/A	N/A	N/A
Calcium	8.6-10 mg/dL	8.6	N/A	N/A
Mag	1.8-2.6 mg/dL	N/A	N/A	N/A
Phosphate	2.7-4.5 mg/dL	N/A	N/A	N/A
Bilirubin	0.1-1.4 mg/dL	N/A	N/A	N/A
Alk Phos	35-105 U/L	N/A	N/A	N/A
AST	10-30 U/L	N/A	N/A	N/A
ALT	10-40 U/L	N/A	N/A	N/A
Amylase	40-140 U/L	N/A	N/A	N/A
Lipase	0-160 U/L	N/A	N/A	N/A

Lactic Acid	0.5-2.2 mmol/L	N/A	N/A	N/A
Troponin	0-0.04 ng/mL	N/A	N/A	N/A
CK-MB	5-25 IU/L	N/A	N/A	N/A
Total CK	25-200 U/L	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	0.8-1.2	N/A	N/A	N/A
PT	11-13 sec	N/A	N/A	N/A
PTT	30-40 sec	N/A	N/A	N/A
D-Dimer	< 250 ng/mL	N/A	N/A	N/A
BNP	< 100 pg/mL	N/A	N/A	N/A
HDL	> 60 mg/dL	N/A	N/A	N/A
LDL	< 130 mg/dL	N/A	N/A	N/A
Cholesterol	< 200 mg/dL	N/A	N/A	N/A
Triglycerides	< 150 mg/dL	N/A	N/A	N/A
Hgb A1c	4-5.6%	N/A	N/A	N/A
TSH	0.5-5.0 mIU/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	Straw-dark yellow, clear-slightly	Yellow	N/A	N/A

	hazy			
pH	4.5-8	7.5	N/A	N/A
Specific Gravity	1.005-1.035	1.031	N/A	N/A
Glucose	Negative	Negative	N/A	N/A
Protein	Negative-trace	Trace	N/A	N/A
Ketones	Negative	Negative	N/A	N/A
WBC	Negative	> 100	N/A	The patient likely had an increased WBC count in her urine due to having a UTI (Capriotti, 2020).
RBC	Negative	7	N/A	The patient likely had an increased RBC count in her urine due to having a UTI (Capriotti, 2020).
Leukoesterase	Negative	4+	N/A	The patient likely tested positive for leukocyte esterase due to having a UTI (Capriotti, 2020).

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	7.35-7.45	N/A	N/A	N/A
PaO2	75-100 mmHg	N/A	N/A	N/A
PaCO2	35-45 mmHg	N/A	N/A	N/A
HCO3	22-26 mEq/L	N/A	N/A	N/A

SaO2	95-100%	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	Positive – proteus mirabilis	N/A	The patient likely had a urinary tract infection, as this is a common causative pathogen (Capriotti, 2020).
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* (2nd ed.). F. A. Davis Company.

Hinkle, J. L., Cheever, K. H., & Overbaugh, K. (2022). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Diagnostic Test Correlation (5 points):

Diagnostic Test Reference (1) (APA):

1. CT of the brain/head and cervical spine without contrast

   a. A CT scan is a non-invasive imaging tool that produces two-dimensional images of organs, bones, or tissues (Capriotti, 2020). It helps providers detect vascular irregularities, brain damage from an injury, and other conditions (Capriotti, 2020).
   b. The patient stated she hit her head when she fell, so a CT was done to rule out any possible head or back injury that she may have sustained.

2. EKG
   a. An electrocardiogram (ECG), or an EKG, records the heart's electrical activity through electrodes placed on different points of the body (Capriotti, 2020).
   b. The patient has a history of CAD, so this could help check for any cardiac abnormalities or cardiac events.
3. X-ray – left shoulder
   a. An x-ray is a diagnostic test that is able to portray bone structures and soft tissues (Capriotti, 2020). It can be used to identify fractures, dislocations, tissue derangement, or bony abnormalities (Capriotti, 2020).
   b. An x-ray was done upon arrival to see the location and severity of the injury. This was also done to evaluate the shoulder post-operatively.

Capriotti, T. M. (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 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Calan/ verapamil	Synthroid/ levothyroxine	Pravachol/ pravastatin sodium	Eliquis/ apixaban	Evista/ raloxifene
Dose	240 mg	0.1 mg	10 mg	5 mg	60 mg
Frequency	Daily	Daily	Daily	BID	Daily
Route	PO	PO	PO	PO	PO
Classification	Pharmacologic: calcium channel blocker Therapeutic: Antianginal, antiarrhythmic, antihypertensive	Pharmacologic: Synthetic thyroxine (T_4) Therapeutic: Thyroid hormone replacement	Pharmacologic: HMG-CoA reductase Therapeutic: Antilipemic	Pharmacologic: Factor Xa inhibitor Therapeutic: Anticoagulant	Pharmacologic: Selective estrogen receptor modulator (ISERM) Therapeutic: Antiosteoporotic
Mechanism of Action	Inhibits calcium movement into coronary and vascular smooth muscle cells by blocking slow calcium channels in cell membranes.	Levothyroxine replaces endogenous thyroid hormone, which may exert its physiologic effects by controlling DNA transcription and protein synthesis.	Inhibits cholesterol synthesis in liver by blocking the enzyme needed to convert hydroxyl-methylglutaryl-CoA to mevalonate, a cholesterol precursor. When cholesterol synthesis is blocked, the liver also increases breakdown of LDL cholesterol.	Inhibits free and clot-bound factor Xa and prothrombinase activity. Indirectly inhibits platelet aggregation induced by thrombin. By inhibiting factor Xa, apixaban decreases thrombin generation and thrombus development.	Prevents osteoporosis by binding to estrogen receptors, which decreases bone resorption and increases bone mineral density in postmenopausal women.
Reason Client Taking	Hypertension	Hypothyroidism	Hypercholesteremia	History of DVT	Osteoporosis
Contraindications (2)	- Cardiogenic shock - Hypotension	-Hyper sensitivity to levothyroxine - Uncorrected adrenal insufficiency	- Active hepatic disease - Pregnancy	- Active pathological bleeding - Severe hypersensitivity to apixaban or its	- Active or past history of thromboembolic disease - Pregnancy

				components	
Side Effects/Adverse Reactions (2)	- Abnormal EKG - CVA	- Arrhythmias - Cardiac arrest	- Rhabdomyolysis - Angioedema	- Hemorrhage - Hypotension	- CVA - Pulmonary embolism
Nursing Considerations (2)	- Assess for bradycardia and hypotension, and notify prescriber if blood pressure or heart rate declines significantly - Institute measures to prevent constipation, including a high-fiber diet and a stool softener, as prescribed.	- Use levothyroxine cautiously in the elderly and patients with underlying cardiovascular disease. Know that levothyroxine should be started at a lower dose in these patients because overtreatment can increase cardiac contractility, cardiac wall thickness, and heart rate, which can precipitate angina or arrhythmias. - Administer levothyroxine capsules or tablets as a single daily dose 30 to 60 minutes before breakfast.	- Use cautiously in patient with hepatic or renal impairment and in elderly patients. - Monitor blood lipoprotein level, as indicated, to evaluate response to therapy.	- Expect apixaban to be discontinued 48 hours before an invasive procedure or surgery if patient has a moderate or high risk of hemorrhage and 24 hours before an invasive procedure or surgery if patient has a mild risk of hemorrhage. - Monitor patient closely for bleeding, as apixaban may cause life-threatening bleeding.	- Be aware that raloxifene should not be used in premenopausal women. - Use cautiously in patients who smoke or have a history of atrial fibrillation, hypertension stroke, or TIA because raloxifene may increase the risk of stroke.
Key Nursing Assessment(s)/Lab (s) Prior to Administration	- Heart rate - Blood pressure	- Glucose levels - Arrhythmias	- Liver enzymes - Lipid levels	- Coag studies - Liver function	- Kidney function - Physical exam
Client Teaching Needs (2)	- Instruct patient not to chew or crush capsules or tablets. - Inform patient that adverse skin reactions may subside with continued	- Instruct patient to separate antacids and calcium or iron supplements by at least 4 hours from levothyroxine doses.	- Instruct patient to take drug at bedtime, without regard to meals. - Urge women of childbearing age to use a reliable method of contraception during pravastatin therapy and to	- Advise patient to report any unusual bleeding or bruising to the prescriber. - Instruct patient to take bleeding precautions.	- Instruct patient to report adverse reactions to prescriber, especially coughing up blood, leg pain or swelling, shortness of breath, sudden

	verapamil use. Advise them to notify prescriber if rash persists.	- Inform patient that levothyroxine replaces a hormone that is normally produced by the thyroid gland and that they will probably need to take the drug for life.	notify prescriber if she becomes pregnant or thinks she may be pregnant.		change in vision, or sudden chest pain. - Advise patient that postmenopausal women require an average of 1500 mg of elemental calcium and 400 to 800 international units of vitamin D daily.

Hospital Medications (5 required)

Brand/Generic	Tylenol/ acetaminophen	Lovenox/ enoxaparin	Benadryl/ diphenhydramine	Toprol/ metoprolol succinate ER	Novolog/ insulin aspart
Dose	1000 mg	40 mg/0.4 mL	50 mg	100 mg	Per sliding scale
Frequency	Q6H, PRN	Daily	Q6H, PRN	Daily	ACHS
Route	PO	Subcutaneous	PO	PO	Subcutaneous
Classification	Pharmacologic: Nonsalicylate, paraminophenol derivative, Therapeutic: Antipyretic, nonopioid analgesic	Pharmacologic: Low-molecular weight heparin Therapeutic: Anticoagulant	Pharmacologic: Antihistamine Therapeutic: Antianaphylactic adjunct	Pharmacologic: Beta$_1$-adrenergic blocker Therapeutic: Antianginal, antihypertensive	Pharmacologic: Recombinant human insulin analog Therapeutic: Antidiabetic
Mechanism of Action	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse	Potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III,	Binds to central and peripheral H_1 receptors, competing with histamine for these sites and preventing it from reaching its site of	Inhibits stimulation of beta$_1$-receptor sites, located mainly in the heart, resulting in decreased cardiac excitability,	Lowers blood glucose levels by binding to the insulin receptors on muscle and fat cells and facilitates the cellular uptake

	generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E_2.	enoxaparin rapidly binds with and inactivates clotting factors (primarily factor Xa and thrombin). Without thrombin, fibrinogen can't convert to fibrin and clots can't form.	action. By blocking histamine, diphenhydramine produces antihistamine effects, inhibiting GI, respiratory, and vascular smooth muscle contraction; decreasing capillary permeability, which reduces flares, itching, and wheals.	cardiac output, and myocardial oxygen demand. These effects help relieve angina, minimize cardiac tissue damage from a myocardial infarction, and help relieve symptoms of heart failure. Metoprolol also helps reduce blood pressure by decreasing renal release of renin.	of glucose and inhibits hepatic glucose production.
Reason Client Taking	Pain	DVT prophylaxis	Itching	Hypertension	Type 2 diabetes
Contraindications (2)	-Severe hepatic impairment -Severe active liver disease	- Active major bleeding - Hyper -sensitivity to benzyl alcohol (if only multidose vial available), enoxaparin, heparin, pork products or their components.	- Breastfeeding - Use in newborns or premature infants	- Sinus bradycardia - Heart block greater than first degree	- Hypoglycemic episode - Hypersensitivity to human insulin or any of its components
Side Effects/Adverse Reactions (2)	-Hypotension - Hepatotoxicity	- Atrial fibrillation - Pulmonary edema	- Drowsiness - Arrhythmias	- Shortness of breath - Pruritus	- Hypoglycemia - Pruritis
Nursing Considerations (2)	-Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition,	- Watch closely for bleeding. Notify prescriber if platelet count falls below 100,000/mm^3. - Check serum potassium	- Expect to give parenteral form only when oral ingestion isn't possible. - Expect to discontinue drug at least 72 hours before skin tests for allergies	- Know that if dosage exceeds 400 mg daily, patient should be monitored for bronchospasm and dyspnea because drug competitively	- Monitor patient closely for signs and symptoms of hypoglycemia, which could become severe. - Monitor patient's blood glucose levels

	severe hypovolemia, or severe renal impairment -Store suppositories under 26.6 degrees C (80 degrees F).	level for elevation, especially in patients with renal impairment or who are currently using potassium-sparing diuretics.	because drug may inhibit cutaneous histamine response, thus producing false-negative results.	blocks beta$_2$-adrenergic receptors in bronchial and vascular smooth muscles. - Expect to taper dosage over 1 to 2 weeks when drug is discontinued; stopping abruptly can cause MI, severe hypertension, or ventricular arrhythmias.	closely to detect need for dosage adjustment, as ordered.
Key Nursing Assessment(s)/Lab (s) Prior to Administration	- Pain - Liver function	- Platelet count - Blood pressure	- Heart rate - I&Os	- Heart rate - Blood pressure	- Blood glucose - Potassium
Client Teaching Needs (2)	- Tell patient that tablets may be crushed or swallowed whole. -Teach patient to recognize signs of hepatotoxicity, such as bleeding, easy bruising, and malaise, which commonly occurs with chronic overdose.	- Inform patient that taking aspirin or other NSAIDs may increase risk for bleeding - Inform patient that they may bruise and/or bleed more easily and that it may take longer than usual to stop bleeding while taking enoxaparin. Review bleeding precautions with patient.	- Advise patient to take drug with food to minimize GI distress. - Urge patient to avoid alcohol while taking diphenhydramine.	- Instruct patient to take metoprolol with food at the same time each day – once daily for E.R. tablets. - Advise diabetic patients to check blood glucose levels often during therapy.	- Teach patient signs and symptoms of hypoglycemia and how to treat them. - Tell patient to avoid performing hazardous activities such as driving until the effects of insulin on their nervous system are known.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *Nurse's Drug Handbook* (20th ed.).

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient was alert to person, place, time, situation (A&O x4). Patient showed no signs of distress. Overall appearance was clean and appropriate for age.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient's skin color was appropriate for ethnicity. Skin was dry, intact, warm, pink, and loose. Patient had no rashes present. Patient's left upper extremity was edematous and ecchymosis present on the upper portion of the extremity. Patient's Braden score was 20. Patient had no drains present.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head appeared normocephalic. Neck was supple. Patient exhibited normal hearing to voice. Eyes exhibited PERRLA. Extraocular movements were intact. Nose was midline. No signs of deviated septum or sinus tenderness were present. Oral mucosa was moist and pink. .
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:**	S1 and S2 sounds were auscultated. Normal rate and rhythm were present. Dorsalis pedis pulses and radial were palpable at 3+ bilaterally. Capillary refill was less than 3 seconds in all 4 extremities. Edema was present in the left upper extremity.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒**	Anterior and posterior lung sounds were auscultated. Breath sounds were clear and equal

Breath Sounds: Location, character	bilaterally. No wheezing or crackles present. No accessory muscles were used.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y** ☐ **N** ☒ **Nasogastric: Y** ☐ **N** ☒ **Size:** **Feeding tubes/PEG tube Y** ☐ **N** ☒ **Type:**	Patient is on a regular diet. The patient is 162 cm and weighs 70.8 kg. Bowel sounds were active in all 4 quadrants. Patient's last bowel movement was 6/7/22. Abdomen was soft and non-tender. No masses were palpated. Patient's incision site on the left extremity was covered with a Mepilex dressing. Dressing was dry and intact. Incision showed no signs of infection.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y** ☐ **N** ☒ **Dialysis: Y** ☐ **N** ☒ **Inspection of genitals:** **Catheter: Y** ☒ **N** ☐ **Type:** **Size:**	Patient voided 500 mL of clear, yellow urine during the clinical shift. Patient denied pain with urination. Patient had an external catheter in place.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y**☒ **N** ☐ **Fall Risk: Y** ☒ **N**☐ **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	All cranial nerves intact. Patient displayed full ROM in both lower extremities and the right upper extremity. Patient had limited passive ROM in the left extremity. Patient uses a walker and requires a 2 assist. Patient's fall score was 110. Patient requires assistance with a walker and gait belt to stand and ambulate.
NEUROLOGICAL:	Patient moves all extremities well except the left

MAEW: Y ☐ N☒ **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☒ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	upper extremity. Patient was A&O x4. Patient was responsive. Senses were intact.
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):**	Patient's coping method was socializing. Patient's religious affiliation is Lutheran. Patient's main support is her daughter.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	90	117/82	18	37.0 C	96% 2 L nasal cannula
1345	92	130/70	18	36.4 C	94% RA

Vital Sign Trends:

All vitals remained stable throughout the shift, with the exception of blood pressure which fluctuated. Patient's oxygen levels were doing well, so the nasal cannula was removed to see how she would do on room air. Monitoring was continued.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	1-10	Left arm	4	NA	Acetaminophen

1330	1-10	Left arm	0	NA	NA

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:**	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL orange juice 120 mL water	500 mL urine

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was very friendly and cooperative throughout the shift. She had a med sitter on continuous monitoring. Her left extremity was kept elevated across her chest to reduce swelling. Patient's vitals were monitored Q4H. Patient was ambulating QID, which she tolerated well. Patient was using the Plexi Pulse intermittently since she has a history of DVT. Patient was on 2 L nasal cannula at the beginning of the clinical shift but was taken off to see how she would tolerate on room air. Patient remained on room air for the remainder of the shift.

Procedures/testing done: Patient was going to receive a Hgb draw at 1500 to see if her levels had increased with the ferrous sulfate supplementation.

Complaints/Issues: None

Vital signs (stable/unstable): Vitals remained stable throughout the shift.

Tolerating diet, activity, etc.: Patient was tolerating both diet and activity well.

Physician notifications: N/A

Future plans for client: Client will live in a nursing home following discharge. She will work with PT/OT for rehab.

Discharge Planning (2 points)

Discharge location: Nursing home

Home health needs (if applicable): N/A

Equipment needs (if applicable): Wheelchair, walker

Follow up plan: Patient will need to follow up with orthopedics.

Education needs: Patient should receive education on how to reduce falls. Patient should also be educated on signs of infection related to her extremity and when to contact her provider.

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 infection related to implantation of foreign objects as evidenced by inflammation of the left extremity.	This nursing diagnosis was chosen because the patient just recently had surgery and has a large incision site on her arm.	**1.**Minimize patient's risk of infection by performing hand hygiene before and after care and wearing gloves to maintain asepsis when providing direct care. **2.**Monitor WBC count, as ordered and report any elevations or depressions in levels.	**1.** Patient will remain free from signs and symptoms of infection.	The client responded well to the care. Her incision site was monitored frequently and no indications of infection were noted throughout the shift.
2. Impaired physical mobility related to alteration in bone structure integrity as evidenced by arm in sling.	This nursing diagnosis was chosen because the patient has a significantly decreased range of motion with her left extremity.	**1.** Place joints in functional position and perform range of motion exercises to joints, unless contraindicated, at least once every shift. **2.**Place items within reach of the unaffected arm if patient has one-sided weakness or paralysis to promote patient's independence.	**1.** Patient or family member will make plans to use resources to help maintain or increase level of functioning.	The client responded well. She was very compliant when the extremity was repositioned to reduce swelling. The patient's daughter was also supportive of this intervention. They were also in concurrence with rehab with PT/OT.
3. Acute pain related to post-operative healing as	This nursing diagnosis was chosen because the patient was in	**1.** Assess patient's signs and symptoms of pain behavioral cues	**1.** Patient will express relief from pain within a reasonable	The patient responded well to the pain medication. She rated her pain a 0

evidenced by patient rating pain 4/10.	pain at the beginning of the clinical shift.	and administer pain medication as prescribed. **2** Use a pain scale when assessing pain and monitor and record the medication's effectiveness and adverse effects.	time after interventions.	by the end of the clinical shift after interventions.
4. Deficient knowledge related to fall precautions as evidenced by insufficient knowledge.	This nursing diagnosis was chosen because the patient was unsure how the fall occurred and will be likely to experience another fall if no changes are made.	**1.** Assess patient's level of knowledge to determine whether patient requires the basic information or reinforcement of previous learning. **2.** Select teaching strategies appropriate for patient's individual learning style.	**1.** Patient will state or demonstrate understanding of what has been taught.	The patient and her daughter responded well to the education provided on ways to reduce the risk of falling in the home.

Other References (APA):

Concept Map (20 Points):

Subjective Data

Patient rated pain a 4 on a numerical (1-10) scale at 0900.
Patient rated pain a 0 on a numerical (1-10) scale at 1330.

Nursing Diagnosis/Outcomes

1. Risk for infection related to implantation of foreign objects as evidenced by inflammation of the left extremity.
   a. Patient will remain free from signs and symptoms of infection.
2. Impaired physical mobility related to alteration in bone structure integrity as evidenced by arm in sling.
   a. Patient or family member will make plans to use resources to help maintain or increase level of functioning.
3. Acute pain related to post-operative healing as evidenced by patient rating pain 4/10.
   a. Patient will express relief from pain within a reasonable time after interventions.
4. Deficient knowledge related to fall precautions as evidenced by insufficient knowledge.
   a. Patient will state or demonstrate understanding of what has been taught.

Objective Data

Vitals (0800): P- 90, BP- 117/82, R- 18, T- 37.0 C, O2- 96% 2 L nasal cannula
Vitals (1345): P- 92, BP- 130/70, R- 20, 36.4 C, O2- 94% RA

Incision site showed no signs of infection.

Client Information

Patient is a 93 year old female who presented to the ED via EMS after falling. Patient fell on her left side. Patient underwent reverse total left shoulder replacement. Patient has a history of abnormal nuclear stress test, coronary artery disease, DVT, hypercholesteremia, hypertensive CVD, hypothyroidism, diabetes mellitus type 2, and osteoporosis.

Nursing Interventions

1.Minimize patient's risk of infection by performing hand hygiene before and after care and wearing gloves to maintain asepsis when providing direct care.
2.Monitor WBC count, as ordered and report any elevations or depressions in levels.
3. Place joints in functional position and perform range of motion exercises to joints, unless contraindicated, at least once every shift.
4.Place items within reach of the unaffected arm if patient has one-sided weakness or paralysis to promote patient's independence.
5. Assess patient's signs and symptoms of pain behavioral cues and administer pain medication as prescribed.
6 Use a pain scale when assessing pain and monitor and record the medication's effectiveness and adverse effects.
Assess patient's level of knowledge to determine whether patient requires the basic information or reinforcement of previous learning.
2. Select teaching strategies appropriate for patient's individual learning style.