N431 Care Plan # 1

Lakeview College of Nursing

Name: Shivani Patel

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
8/25/22	JJB	63	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Not employed	Married	Cephalexin, Lisinopril
Code Status	**Height**	**Weight**	
Full code	5'9" (175.3 cm)	205 lbs (93 kg)	

Medical History (5 Points)

Past Medical History: Actinic keratosis, basal cell carcinoma, BPH, depression with anxiety, history of alcoholism, hypertension, tubular adenoma of colon

Past Surgical History: Ankle surgery, colonoscopy, Lasik, mouth surgery, rotator cuff repair

Family History: Pacemaker (heart condition)- mother, COPD- father

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): No tobacco use, alcohol, and drug use- not currently (frequency, quantity, and duration not specified)

Assistive Devices: N/A

Living Situation: Lives at home with wife

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points):The patient came into the emergency department with complaints of headache and neck pain

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

The patient was admitted into the emergency department due to having a severe headache. The patient was diagnosed with cerebellar hemorrhage upon admission. The patient stated

they started experiencing symptoms on 8/25. He experienced a severe headache while eating at home. The pain is located on the anterior and posterior surface of his head. The patient states that he has been experiencing a headache for about 3 weeks. The patient is currently in the ICU getting treated. The pain radiates to the patient's neck. The pain is constant, and he describes it as "something exploding at the back of the head". When the patient gets up or walks around, he experiences an increase in pain. The patient initially took Tylenol for his pain, but later he was prescribed Zofran. The patient had a pain level of 10 on a scale of 1 to 10 in that moment. The patient also experienced nausea, vomiting, and dizziness alongside his headache. At this moment, the patient is not able to verbalize his pain level, and there are no non-verbal indicators either.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cerebral hemorrhage

Secondary Diagnosis (if applicable): Acute respiratory failure with hypoxia

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

Cerebral hemorrhage is type of intracranial hemorrhage that occurs where bleeding is in the posterior fossa or cerebellum. Long-standing hypertension with degenerative changes in the vessel walls and rupture are believed to be the most common cause of cerebellar hemorrhage. Cerebellar hemorrhage is usually spontaneous and occurs most frequently in middle-aged or older adults (Capriotti, 2020). Other factors like tumors, blood disorders, trauma, or stimulant drug abuse may lead to cerebellar hemorrhage. Cerebellar hemorrhage mainly affects the brain along with other parts of the body. For instance, the patient can experience weakness and fatigue throughout their entire part of the body. Signs

and symptoms of cerebellar hemorrhage include headache, nausea, vomiting, dizziness, nuchal pain, and double vision. Cerebellar hemorrhage causes an increase in the patient's blood pressure. Along with that, patients can also see a decrease in their platelet count. They see an increase in intracranial pressure when a blood clot or hematoma forms as blood collects. A D-dimer is performed to assess if there is any blood-clotting. Cerebellar hemorrhage is usually diagnosed with a CT scan with no contrast or magnetic resonance imaging (Capriotti, 2020). An arterial blood gas test is done to measure the oxygen and carbon dioxide levels in the blood knowing patients can experience severe breathing and lung problems with cerebellar hemorrhage. An EVD or an external ventricular drain is placed on a patient to help drain the cerebrospinal fluid. The patient had an EVD placed to help reduce the intracranial pressure (Harary et al., 2018). The main goal is to measure and control the intracranial pressure to reduce the pressure on the brain from any blood clotting.

Pathophysiology References (2) (APA):

Capriotti, Theresa. (2020). ***Davis Advantage for Pathophysiology. Introductory Concepts and Clinical Perspectives (second edition)*****. FA. Davis**

Harary, M., Dolmans, R. G., & Gormley, W. B. (2018). Intracranial pressure monitoring-review and avenues for development. ***Sensors*****,** ***18*****(2), 465.**

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	4.10-5.70	4.20	3.36	Low levels of RBCs can be due to anemia (Pagana et al., 2019).
Hgb	12.0-18.0	13.2	10.6	The patient has low iron (Pagana et al., 2019).
Hct	37.0%-51.0%	37.0	31.6	Low levels of hematocrit can be due to nutritional problems like low iron (Pagana et al., 2019).
Platelets	140-400	161	162	
WBC	4.00-11.00	8.39	10.05	
Neutrophils	47.0%-73.0%	N/A	N/A	
Lymphocytes	18.0%-42.0%	N/A	9.8	Low levels indicate the blood doesn't have enough white blood cells. It can also indicate infections (Pagana et al., 2019).
Monocytes	4.0%-12.0%	N/A	9.1	
Eosinophils	0.0%-5.0%	N/A	1.6	
Bands	Less than or equal to 10%	N/A	N/A	

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145	142	152	High levels of sodium can be caused by kidney problem or dehydration (Pagana et al., 2019).
K+	3.5-5.1	2.9	3.6	Low potassium levels can be due to frequent vomiting (Pagana et al., 2019).
Cl-	98-107	108	118	High levels can indicate dehydration. Low levels can indicate metabolic alkalosis. Low levels can be due to kidney and vomiting (Pagana et al., 2019).

CO2	**22.0-29.0**	**20.0**	**25.0**	**It can indicate an electrolyte imbalance, or that there is a problem removing carbon dioxide through your lungs (Pagana et al., 2019).**
Glucose	**74-100**	**152**	**125**	**The cause of high blood sugar can be caused by dehydration and a lack of exercise. Low blood sugar is caused by not eating enough food (Pagana et al., 2019).**
BUN	**8-26**	**16**	**30**	
Creatinine	**0.55-1.30**	**0.77**	**0.70**	
Albumin	**3.4-4.8**	**3.8**	**N/A**	
Calcium	**8.9-10.6**	**8.9**	**7.8**	**Low levels of calcium can be due to a disorder that interferes with the body's ability to absorb calcium (Pagana et al., 2019).**
Mag	**1.6-2.6**	**1.8**	**N/A**	
Phosphate	**2.5-4.5**	**N/A**	**N/A**	
Bilirubin	**0.2-1.2**	**0.8**	**N/A**	
Alk Phos	**40-150**	**71**	**N/A**	
AST	**5-34**	**12**	**N/A**	
ALT	**0-55**	**13**	**N/A**	
Amylase	**40-140**	**N/A**	**N/A**	
Lipase	**8-78**	**N/A**	**N/A**	
Lactic Acid	**0.50-2.20**	**N/A**	**N/A**	
Troponin	**0-0.4**	**N/A**	**N/A**	

CK-MB	**3%-5%**	**N/A**	**N/A**	
Total CK	**22-198**	**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**	**1.0**	**N/A**	
PT	**11.7-13.8**	**13.4**	**N/A**	
PTT	**22.4-35.9**	**20.6**	**N/A**	**Low levels of PTT indicate it can take a longer time for a clot to form (Pagana et al., 2019).**
D-Dimer	**Less than 0.5**	**N/A**	**N/A**	
BNP	**Less than 100**	**N/A**	**N/A**	
HDL	**45-70**	**N/A**	**N/A**	
LDL	**Less than 100**	**N/A**	**N/A**	
Cholesterol	**Less than 200**	**N/A**	**N/A**	
Triglycerides	**Less than 150**	**N/A**	**N/A**	
Hgb A1c	**Less than 5.7%**	**N/A**	**N/A**	
TSH	**0.5-5.0**	**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	**Clear-yellow**	**Clear-yellow**	**N/A**	
pH	**4.6-8.0**	**8.0**	**N/A**	
Specific Gravity	**1.000-1.030**	**1.015**	**N/A**	

Glucose	**Negative**	**Negative**	**N/A**	
Protein	**Negative**	**Negative**	**N/A**	
Ketones	**Negative**	**Trace**	**N/A**	**There is ketone buildup. Ketone buildup indicates the body is too acidic (Pagana et al., 2019).**
WBC	**0-25**	**5**	**N/A**	
RBC	**0-20**	**0**	**N/A**	
Leukoesterase	**Negative**	**Negative**	**N/A**	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35-7.45**	**N/A**	**7.5**	**Patient is experiencing alkalosis. There is an increase in alkaline (Pagana et al., 2019).**
PaO2	**80-100**	**N/A**	**94.6**	
PaCO2	**35-45**	**N/A**	**37.6**	
HCO3	**22.0-26.0**	**N/A**	**28.4**	**Patient is experiencing metabolic alkalosis. The patient is having trouble maintaining acid-base balance. This can be caused by digestive issues like vomiting (Pagana et al., 2019).**
SaO2	**92%-100%**	**N/A**	**92%**	

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**	
Blood Culture	**No growth**	**N/A**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana T. N. (2019). ***Mosby's diagnostic and laboratory desk reference*** **(14th ed.). Elsevier.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The patient's head was examined through a CT scan without contrast. A CT of the head uses a special x-ray tool to help assess head injuries, headaches, dizziness, aneurysms, brain tumors, bleeding, and stroke. Overall, a CT scan can provide crucial information about the brain to establish a diagnosis.

Diagnostic Test Correlation (5 points): The CT scan indicated a cerebellar hemorrhage. There was a hemorrhage within the cerebellar veins and right cerebellar hemisphere. Along with that, the CT scan indicated that there is blood along the left and right teritorium. There was a paranasal sinus mucosal thickening with dependent hyperdense fluid in the maxillary sinuses. The CT scan also indicated that there was an increase in intracranial pressure.

Diagnostic Test Reference (1) (APA):

Flanders, A. E., Prevedello, L. M., Shih, G., Halabi, S. S., Kalpathy-Cramer, J., & Ball, R. (2020). Construction of a machine learning dataset through collaboration: The RSNA 2019 brain CT hemorrhage challenge. ***Radiology: Artificial Intelligence****,* ***2*****(3), e19021.**

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

Home Medications (5 required)

Brand/ Generic	**Aspirin/ Acetylsalicylic acid**	**Doxazosin/ Cardura**	**Spironolactone/ Aldactone**	**Ciclopirox/ Loprox**	**Fluocinonide/Vanos**
Dose	**81 mg**	**8 mg**	**25 mg**	**8%-6.6 mL**	**0.05%-60 mL**
Frequency	**Daily**	**Daily**	**Daily-every morning**	**Daily-bedtime**	**BID as needed**
Route	**Oral**	**Oral**	**Oral**	**Topical solution**	**Topical solution**
Classification	**Pharmacological class: Salicylate Therapeutic class: NSAID**	**Pharmacological class: Alpha blocker Therapeutic class: Antihypertensive, benign prostatic hyperplasia therapeutic agent**	**Pharmacological class: Potassium-sparing diuretic Therapeutic class: Diuretic**	**Pharmacological class: Antifungal Therapeutic class: Antifungal**	**Pharmacological class: Corticosteroid Therapeutic class: Corticosteroid**
Mechanism of Action	**It blocks the activity of**	**It inhibits alpha1-**	**Aldosterone attaches to**	**It chelates polyvalent**	**Fluocinonide is a potent**

	cyclooxygenase, the enzyme needed for prostaglandin synthesis. Prostaglandins cause local vasodilation with swelling and pain. With blocking of cyclooxygenase and inhibition of prostaglandins, inflammatory symptoms subside.	**adrenergic receptors in the sympathetic nervous system, causing peripheral vasodilation and reduced peripheral vascular resistance. This action decreases blood pressure.**	**receptors on the walls of distal convoluted tubule cells, causing sodium and water reabsorption in the blood. Spironolactone competes with aldosterone for these receptors, thereby preventing sodium and water reabsorption.**	**cations (aluminum, iron) that result in the inhibition of metal-dependent enzymes that are responsible for degrading peroxides inside fungal cells.**	**glucocorticoid steroid used topically as anti-inflammatory agent for the treatment of skin disorders such as eczema. Fluocinonide binds to the cytosolic glucocorticoid receptor. After binding the receptor, the receptor-ligand complex translocate itself into the nucleus. It binds to many glucocorticoid response elements.**
Reason Client Taking	**It helps to relieve mild pain and fever**	**Manages hypertension**	**Helps to treat hypertension**	**Prevents fungal infections on fingernails**	**Helps to treat eczema**
Contraindications (2)	**-Active bleeding or coagulation disorders -Hypersensitiv**	**-Hypersensitivity to doxazosin -Hypersensit**	**-Addison's disease -Hypersensitivity to spironolactone**	**-Hypersensitivity -Effects of drug abuse**	**-Corticosteroid hypersensitivity -Cushing's**

	ity to aspirin	**ivity to quinazolines such as prazosin or terazosin, or their components**	**or its components**		**syndrome**
Side Effects/ Adverse Reactions (2)	**-Confusion -Bronchospasms**	**-Dizziness -Dyspnea**	**-Ataxia -Increased intraocular pressure**	**-Severe itching -Hair loss**	**-Blistering -Redness and scaling around mouth**
Nursing Considerations (2)	**-Don't crush timed-release or controlled-release aspirin tablets unless directed -Ask about tinnitus. Reactions can occur when blood aspirin reaches or exceeds maximum dosage**	**-Know that drug should not be given to hypotensive patients -Monitor patients with renal disease for exaggerated effects, such as first-dose orthostatic hypotension**	**-Do not interchange oral suspension for tablet form as the two formulations are not therapeutically equivalent -Evaluate spironolactone's effectiveness by assessing blood pressure and presence and degree of edema**	**-Educate the patient on avoiding the medication from getting into the patient's eyes - Monitor for itching, burning, and swelling**	**-Monitor for itching, burning, and swelling -Educate patient not to exceed the prescribed dose**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**-Check BUN and creatinine levels for kidney problems -Assess the patient for tartrazine allergy**	**-Examine prostate gland -Do a prostate specific antigen test**	**-Check for potassium and creatinine levels**	**-Check for additional skin issues**	**-Check for any allergies to corticosteroids**
Client Teaching Needs (2)	**-Advise adult patient taking low-dose aspirin not to take**	**-Inform patient that he may take doxazosin in the**	**-Instruct patient to take spironolactone with meals or milk**	**-Use medication for prescribed time even**	**-Avoid prolonged use on the face -Avoid use**

	ibuprofen or naproxen because these drugs may reduce the cardioprotective and stroke preventive effects of aspirin. -Instruct patient to take aspirin with food or after meals because it may cause GI upset if taken on an empty stomach	**morning or evening and with food, if desired -Instruct patient to change position slowly to minimize orthostatic hypotension**	**-Tell patient who can't swallow tablets that drug is available as a suspension**	**though symptoms improve -Avoid on open or draining areas**	**around the eyes**

Hospital Medications (5 required)

Brand/ Generic	**Clonazepam /Xanax**	**Famotidine/ Pepcid**	**Hydralazine/ Apresoline**	**Furosemide/Lasix**	**Heparin/ Hep-Lock**
Dose	**1 mg**	**20 mg**	**25 mg**	**20 mg**	**5000 u**
Frequency	**Every 12 hours**	**BID**	**Every 6 hours**	**Every 8 hours**	**Every 8 hours**
Route	**Oral**	**Oral**	**Oral**	**IV**	**Sub-Q**
Classification	**Pharmacologic class: Benzodiazepine Therapeutic class:**	**Pharmacological class: Histamine-2 blocker Therapeutic class:**	**Pharmacological class: Vasodilator Therapeutic class: Antihypertensi**	**Pharmacologic class: Loop diuretic Therapeutic class:**	**Pharmacological class: Anticoagulant Therapeuti**

	Anticonvulsant, antipanic	**Antiulcer agent**	**ve**	**Antihypertensive, diuretic**	**c class: Anticoagulant**
Mechanism of Action	**It is thought to prevent panic and seizures by potentiating the effects of gamma-aminobutyric acid (GABA), which is an inhibitory neurotransmitter.**	**Famotidine is an H2-receptor antagonist, reduces HCl formation by preventing histamine from binding with H2 receptors on the surface of parietal cells**	**It exerts a direct vasodilating effect on vascular smooth muscle. It interferes with calcium movement in vascular smooth muscle by altering cellular calcium metabolism**	**It Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation. Also, by reducing intracellular and extracellular fluid volume, the drug reduces blood pressure and decreases cardiac output**	**Heparin binds with antithrombin III, enhancing antithrombin III's inactivation of the coagulation enzymes thrombin. At high doses, heparin inactivates thrombin, and prevents fibrin formation and existing clot extension**
Reason Client Taking	**It is used to control seizures**	**It is used to precent duodenal ulcers**	**Manages hypertension**	**Manages hypertension**	**It prevents blood clotting**
Contraindications (2)	**-Acute-narrow-angle glaucoma -Hepatic disease**	**- Hypersensitivity to famotidine - Hypersensitivity to other H2-receptor antagonists, or their**	**-Coronary artery disease - Hypersensitivity to hydralazine or its components**	**-Anuria - Hypersensitivity to furosemide or its components**	**-Heparin-induced thrombocytopenia - Hypersensitivity to heparin**

		components			
Side Effects/ Adverse Reactions (2)	**-Dysarthria -Bronchitis**	**-Agitation - Anaphylaxis**	**-Anorexia -Headache**	**-Dizziness - Hyperglycemia**	**-Chest pain -Epistaxis**
Nursing Considerations (2)	**- Monitor blood drug level, CBC, and liver enzymes during long-term or high-dose therapy, as ordered - Monitor patient closely for signs of loss of effectiveness of anticonvulsant activity**	**- Shake famotidine oral suspension vigorously for 5 to 10 seconds before administration - Know that adult patients who have a suboptimal response or an early symptomatic relapse should be evaluated for gastric malignancy**	**-Be aware that hydralazine may change color when exposed to a metal filter -Give tablets with food to increase bioavailability**	**-Be aware that patients who are allergic to sulfonamides may also be allergic to furosemide -Obtain patient's weight before and periodically during furosemide therapy to monitor fluid loss**	**-Use heparin cautiously in alcoholics; menstruating women; patients over age 60 and patients with conditions that increase risk of hemorrhage -Read heparin label carefully. Revision has been made to state the strength of the entire container of heparin**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**-Check the patient for any respiratory problems**	**-Assess heart rate, ECG, and heart sounds**	**-Monitor for allergic reactions to hydralazine before prescribing -Assess the patient's blood pressure**	**-Monitor blood pressure and pulse before administration -Assess the patient's**	**-Assess the patient's hemoglobin, hematocrit, platelet count, aPTT, and PT levels**

				fluid status	
Client Teaching Needs (2)	**- Teach patient to take drug exactly as prescribed. Also, explain that stopping abruptly can cause seizures and withdrawal symptoms -Urge patient to carry medical identification of his seizure disorder and drug therapy**	**-Instruct patient to carefully chew chewable tablets thoroughly before swallowing. -Instruct patient who also takes antacids to wait 30 to 60 minutes after taking famotidine, before taking antacid**	**-Instruct patient to take hydralazine tablets with food. -Advise patient to change position slowly, especially in the morning. Also, caution that hot showers may increase hypotension**	**-Instruct patient to take furosemide at the same time each day to maintain therapeutic effects -Advise patient to change position slowly to minimize effects of orthostatic hypotension, and take furosemide with food or milk to reduce GI distress**	**-Advise patient to avoid drugs that interact with heparin, such as aspirin and ibuprofen -Inform patient about increased risk of bleeding; urge her to avoid injuries and use a soft-bristled toothbrush and an electric razor**

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2021). 2021 *Nurse's drug handbook* (twentieth).

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient is not alert and oriented to person, place, and time** **There is no visible acute distress** **Pt well dressed in clean gown** **Pt's skin, hair, nails clean and well maintained**

INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type:**	**Skin color: White** **Character: Skin is warm and dry upon palpation** **Temperature: Taken orally and was 99.5 F** **Turgor: Skin has normal turgor** **Pt has no visible bruising** **Normal quantity, distribution, and texture of hair** **Braden score: 12** **The patient has an external ventricular drain (EVD)**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head/Neck: Head and neck are symmetrical. Normocephalic and atraumatic** **Ears: Left/right external ear normal** **Eyes: Visible drainage from eyes, the bilateral sclera is yellow, the bilateral cornea is clear, bilateral conjunctiva is pink. Bilateral lids are red with some discharge** **Extraocular movements: extraocular movements are not intact** **Conjunctiva/sclera: conjunctivae/sclera are abnormal** **Pupils: pupils are equal, round, and are reactive to light** **The patient is experiencing double vision and blurred vision in both eyes** **Nose: Septum is midline and no visible bleeding from nose** **Teeth: Did not notice plaque or tartar. Teeth are white and somewhat aligned with gums. The mucous membrane is moist** .
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 ☐**	. **Normal heart rate and rhythm. Clear S1 and S2 without any murmurs** **Peripheral pulses: 3+** **Capillary refill: 2 seconds** **The patient has neck vein distention** **There is edema on both legs**

Location of Edema:	
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	. **The lung sounds are clear to auscultation bilaterally** **Breath sounds: normal breath sounds** **Depth and pattern regular, breathing is unlabored** **Expansion is symmetric, no retractions** **Supported on mechanical ventilation, no wheezing** **No accessory muscle use** **Effort: pulmonary effort is normal. No respiratory distress because patient is on ventilator**
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:**	. **Diet at home: regular** **Current diet: NPO** **Height: 5'9"** **Weight: 205 lbs** **Bowel sounds: audible and normoactive** **Last BM: 9/5/22** **Upon palpation there is pain and an abdominal mass present. The abdomen is soft** **Tenderness: There is abdominal tenderness. There is no guarding or rebound** **Distention: none** **Incisions: none** **Scars: none** **Drains: none** **Wounds: none** **No ostomy** **Patient has a nasogastric that is 12 Fr in size** **Patient has a feeding tube called a PEG tube**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐**	**Clear, yellow** **The urine output was 1675 mL** **There is no pain with urination** **The patient has no dialysis** **Genitals appear normal upon examination.** **The patient has an indwelling catheter that is 14 Fr**

Type: **Size:**	
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☐**	. **Neurovascular status: abnormal** **No swelling. No range of motion** **Cervical back- no range of motion** **Strength: Patient noticeably weak** **Patient unable to move the body as instructed** **Supportive devices: none** **ADL assistance: yes (bathing and dressing)** **Fall risk: yes** **The patient is currently on bed rest** **Fall risk score: 19** **Mobility status: patient not able to move freely** **The patient is dependent** **Needs assistance with equipment** **Will need support to stand and walk when patient gets downgraded** **Does not need assistance when standing or walking.** **One part of the body is weaker than the other**
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	. **MAEW: no** **PERLA: no (pupils somewhat reactive to light)** **Strength is not equal** **There is no movement in arms or fingers** **There is subtle movement only with toes on right leg** **Handgrip, dorsiflexion, and plantarflexion absent** **Orientation: pt is not oriented** **Mental status: pt is not alert and oriented to person, place, and time** **Speech: unable to speak** **Sensory: abnormal sensation. Patient not responsive to stimuli besides light** **LOC: pt not awake and alert. Currently sedated**
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):**	**Coping method: resting** **Developmental level: developmental status appropriate for age** **Patient is calm. The patient is also accepting and behaves appropriately during care. Behavior is appropriate to the situation. The patient does not state that they are religious. The patient's personal family data is undetermined.** **Care explained, choices provided, emotional support provided, reassurance provided, thoughts/feelings of family acknowledged**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
8:00	**93**	**154/80**	**16**	**99.5F(rectal)**	**97%**
10:00	**106**	**148/76**	**14**	**100.2F(rectal)**	**96%**

Vital Sign Trends: The vital signs remain somewhat unstable. The pulse rate and temperature have increased and are above normal range. The patient's blood pressure remains high.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8:00	**0-10**	**N/A**	**N/A**	**N/A**	**N/A**
10:00	**0-10**	**N/A**	**N/A**	**N/A**	**N/A**

The patient is unable to verbalize their pain level.

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:**	**Size of IV: 18 G** **Location of IV: Right upper arm** **Date on IV: 8/25/22** **Patency of IV: open** **Signs of erythema, drainage, etc.: no signs** **IV dressing assessment: dry and intact**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Ampicillin- 100 mL **Hydromorphone- 20 mL** **Propofol- 34 mL** **154 mL**	**Urine- 1675 mL** **EVD- 25 mL** **1700 mL**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient is diagnosed with cerebellar hemorrhage. Patient is currently sedated. Labs are monitored daily and an EVD is placed to reduce intracranial pressure in the brain.

Procedures/testing done: CT scan without contrast

Complaints/Issues: There are no complaints or issues

Vital signs (stable/unstable): Unstable

Tolerating diet, activity, etc.: Patient tolerating activity. Currently sedated

Physician notifications: Notify if patient's intracranial pressure goes above normal range

Future plans for client: Admit the client to rehab or long-term care facility

Discharge Planning (2 points)

Discharge location: Undetermined

Home health needs (if applicable): Patient may need oxygen therapy

Equipment needs (if applicable): Patient may need a wheelchair

Follow up plan: No surgical intervention planned. The patient will need to follow-up with outpatient

Education needs: The patient will be educated on how to use oxygen at home. Provide information on ways to manage hypertension

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 decreased cardiac output related to cerebellar hemorrhage ad evidenced by a blood pressure	**The patient's blood pressure levels remained high throughout the hospitalization which can affect the patient's cardiac output**	**1. Auscultate the patient's heart tones and breath sounds** **2. Monitor the patient's vital signs every hour to assess if treatment is working to**	**1. Continue to give the patient their blood pressure medications in the correct dose and frequency**	**The patient was aware of all the blood pressure medications he was given. Family agreed to do continuous monitoring of the patient's blood pressure at home. They were**

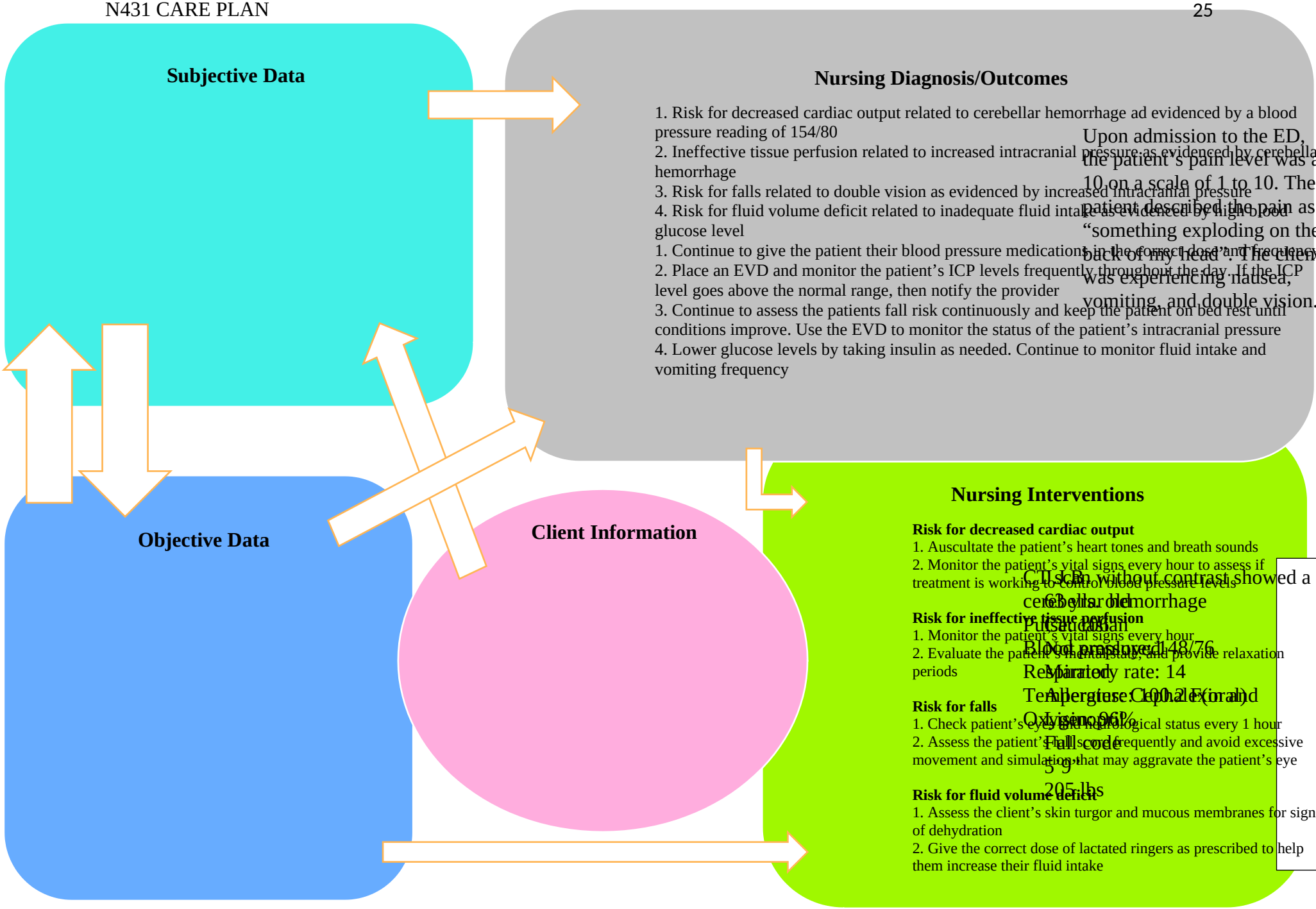
reading of 154/80		**control blood pressure levels**		**instructed to give the patient medications in a timely manner and notify the provider if there is a drastic increase in blood pressure.**
2. Risk for ineffective tissue perfusion related to increased intracranial pressure as evidenced by cerebellar hemorrhage	**The patient's intracranial pressure went above 30 which led to an increase in the pressure around the brain. A possible perfusion may occur if ICP levels remain high**	**1. Monitor the patient's vital signs every hour** **2. Evaluate the patient's mental state, and provide relaxation periods**	**1. Place an EVD and monitor the patient's ICP levels frequently throughout the day. If the ICP level goes above the normal range, then notify the provider**	**The patient remained calm throughout the education regarding ICP monitoring and EVD. The family was explained what a normal ICP level is. They were also educated on how the EVD drain works to reduce the ICP levels. The family was accepting of the continuous monitoring of the patient's ICP levels.**
3. Risk for falls related to double vision as evidenced by increased intracranial pressure	**The patient's intracranial pressure was above 30 at a point. Increased intracranial pressure caused the patient to have blurred and double vision**	**1. Check patient's eyes and neurological status every 1 hour** **2. Assess the patient's fall score frequently and avoid excessive movement and simulation that may aggravate the patient's**	**1. Continue to assess the patients fall risk continuously and keep the patient on bed rest until conditions improve. Use the EVD to monitor the status of the patient's**	**The client was calm throughout the teaching. Family understood that bedrest is important until the patient's condition improves, and he no longer is at risk for falls. The family was educated on how to read the EVD monitor.**

		eye	**intracranial pressure**	
4. Risk for fluid volume deficit related to inadequate fluid intake as evidenced by high blood glucose level	**After admission, the patient's lab indicated a blood glucose level of 152**	**1. Assess the client's skin turgor and mucous membranes for signs of dehydration** **2. Give the correct dose of lactated ringers as prescribed to help them increase their fluid intake**	**1. Lower glucose levels by taking insulin as needed. Continue to monitor fluid intake and vomiting frequency**	**The patient's family understood that the patient will be given Iv medications while the patient remains on NPO. Since the patient is not able to verbalize any needs, the family was told to monitor any signs of dehydration in the patient.**

Other References (APA):

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

Concept Map (20 Points):


Subjective Data
Upon admission to the ED, the patient's pain level was a 10 on a scale of 1 to 10. The patient described the pain as "something exploding on the back of my head". The client was experiencing nausea, vomiting, and double vision.
Nursing Diagnosis/Outcomes
1. Risk for decreased cardiac output related to cerebellar hemorrhage ad evidenced by a blood pressure reading of 154/80
2. Ineffective tissue perfusion related to increased intracranial pressure as evidenced by cerebellar hemorrhage
3. Risk for falls related to double vision as evidenced by increased intracranial pressure
4. Risk for fluid volume deficit related to inadequate fluid intake as evidenced by high blood glucose level
1. Continue to give the patient their blood pressure medications in the correct dose and frequency
2. Place an EVD and monitor the patient's ICP levels frequently throughout the day. If the ICP level goes above the normal range, then notify the provider
3. Continue to assess the patients fall risk continuously and keep the patient on bed rest until conditions improve. Use the EVD to monitor the status of the patient's intracranial pressure
4. Lower glucose levels by taking insulin as needed. Continue to monitor fluid intake and vomiting frequency
Objective Data
Client Information
CT scan without contrast showed a cerebellar hemorrhage
63 years old
Pulse: 88
Blood pressure: 148/76
Respiratory rate: 14
Temperature: 100.2 F (oral)
Oxygen: 96%
5' 9"
205 lbs
Married
Allergies: Cephalexin and Penicillin
Full code
Nursing Interventions
Risk for decreased cardiac output
1. Auscultate the patient's heart tones and breath sounds
2. Monitor the patient's vital signs every hour to assess if treatment is working to control blood pressure levels
Risk for ineffective tissue perfusion
1. Monitor the patient's vital signs every hour
2. Evaluate the patient's mental state, and provide relaxation periods
Risk for falls
1. Check patient's eyes and neurological status every 1 hour
2. Assess the patient's vitals frequently and avoid excessive movement and simulation that may aggravate the patient's eye
Risk for fluid volume deficit
1. Assess the client's skin turgor and mucous membranes for signs of dehydration
2. Give the correct dose of lactated ringers as prescribed to help them increase their fluid intake