N431 Care Plan #1

Lakeview College of Nursing

Levi Hahne

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
9/08/2022	CG	53	M
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	UPS driver	Married	None on file
Code Status	**Height**	**Weight**	
Full	6’	220 lbs	

Medical History (5 Points)

Past Medical History: Has not been reviewed by care team

Past Surgical History: Has not been renewed by care team

Family History: No family history on file

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

None on file

Assistive Devices: None at home

Living Situation: Lives with his wife at home

Education Level: College

Admission Assessment

Chief Complaint (2 points): MVC accident

History of Present Illness – OLD CARTS (10 points): CG, a 53 year old male, reported to Carle Foundation hospital by ambulance after suffering a motor vehicle accident. He came from Kankakee on 9/08/2022. Patient works for UPS and hit a parked car. Upon arrival he was hypotensive and unresponsive. During his ambulance ride he was given 5 packs of RBC and 3L crystalloids and 150mcg morphine. X-ray images showed subarachnoid

hemorrhage, IVH, trace subdural hematoma and facial lacerations. Patient history was taken from the chart as he was unresponsive and cannot provide information.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Intracranial hemorrhage

Secondary Diagnosis (if applicable): Traumatic pneumothorax

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

Intracranial hemorrhage is a condition that can result from a stroke or traumatic accident. A rupture in the arteriosclerotic artery in the brain results in bleeding of one of the four surfaces; epidural, subdural, subarachnoid, and intraparenchymal. In the subarachnoid, there is bleeding caused by either trauma or non-traumatic incidents. Non-aneurysm subarachnoid is a condition that develops due to blunt head trauma. In this area of the brain, cortical surface vessels are injured. During an incident when a patient presents with this intracranial hemorrhage, initial evaluations, such as your ABCs, airway, breathing, and circulation, need to be performed. There is a quick decline in patients with this disorder; usually, intubating them is one of the first steps in primary care. Providers will need to order CT scans of the head and other extremities, which are often done without contrast to avoid blocking the images of arteries. Additional CT scans may be ordered throughout care to examine the progress in the head. In this patient's condition, he was injured all over the body, so the doctor ordered x-rays of the extremities, MRIs, and a CT lumbar reconstruction. Labs will need to be ordered as well to monitor bleeding times, and you may see PT and INR labs ordered to be drawn. This patient did have a high PT, WBC,

glucose, creatine, phosphate, and AST count. Other labs pertinent to the hemorrhage include all other CMB and electrolyte labs.

Patients that come into the ER are usually experiencing an altered level of consciousness and may present with specific signs and symptoms. They may display weakness or paralysis, difficulty speaking, confusion or disorientation to their environment, and swallowing difficulties.

Surgery is commonly used to stop bleeding when treating patients in the hospital. However, they may also have blood transfusions and be put on medications. When patients are recovering on the floor or unit, rehabilitation is strongly advised in their care plan. Patients may struggle with activities of daily living, self-hygiene, and eating disabilities, as sometimes permanent damage may have occurred in the brain. They may be required to make alternative life changes like smoking cessation, monitoring blood pressure regularly, or in some cases, be discharged with plans to wear helmets for cranial protection if they are doing specific exercises or activities. This particular client was on the CCU floor, and his treatment was targeted more with medications as he was already four days into care. He was taking opioids, insulins like Novolog, anticonvulsants, and blood pressure medications during the day of care.

Pathophysiology References (2) (APA):

Hinkle, J.L. & Cheever, K.H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia: Wolters Kluwer.

Quiñones-Ossa, G. A., Durango-Espinosa, Y., Padilla-Zambrano, H., Moscote-Salazar, L. R., Keni, R., Deora, H., & Agrawal, A. (2020). The puzzle of spontaneous versus traumatic intracranial hemorrhages. *Egyptian Journal of Neurosurgery*, *35*(1), 1-9.

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	**4.1-5.7**	**5.58**	**4.5**	
Hgb	**12-18**	**15.7**	**12**	
Hct	**37-51**	**49**	**39.2**	
Platelets	**140-400**	**131**	**158**	When a patient has a traumatic head injury coagulopathy can develop, resulting in thrombocytopenia (Hinkle, 2018)
WBC	**4-11**	**18**	**14.09**	A release of immature cells develop and marrow increases with neutrophil margination (Hinkle, 2018)
Neutrophils	**%40-68**	n/a	n/a	
Lymphocytes	**%19-49**	**6**	**9**	
Monocytes	**%3-13**	**3.3**	**6**	
Eosinophils	**%0-0.8**	**0.1**	**3**	
Bands	**%n/a**	n/a	n/a	

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**136-145**	**138**	**139**	
K+	**3.5-5.1**	**6.1**	**4.4**	There was a destruction of red blood cells from injury resulting in higher potassium levels (Hinkle, 2018)
Cl-	**98-107**	**105**	**107**	

CO2	**22-29**	**22**	**22**	
Glucose	**74-100**	**242**	**170**	The patient's body can not produce enough insulin, predisposed to diabetes (Hinkle, 2018)
BUN	**8-26**	**18**	**20**	
Creatinine	**0.55-1.3**	**1.7**	**1.48**	Patient needed packed red blood cells due to blood loss from his accident, resulting in dehydration or shock which increases creatinine levels(Hinkle, 2018)
Albumin	**3.5-5**	n/a	**2.3**	During a severe injury albumin may decrease due to inflammation in the body (Hinkle, 2018)
Calcium	**8.9-10.6**	n/a	**8.9**	
Mag	**1.6-2.6**	n/a	**2.2**	
Phosphate	2.5-4.5	n/a	n/a	
Bilirubin	**0.2-1.2**	n/a	**1.2**	(Hinkle, 2018)
Alk Phos	**40-150**	n/a	**165**	lack of blood flow to the liver can elevated liver enzymes (Hinkle, 2018)
AST	**5-34**	n/a	**36**	AST levels have increased due to heart releasing more blood to areas in the body from injury (Hinkle, 2018)
ALT	**0-55**	n/a	**31**	
Amylase	23-85	n/a	n/a	
Lipase	0-160	n/a	n/a	
Lactic Acid	4.5-19.8	n/a	n/a	
Troponin	**0-0.03**	**0.05**	n/a	Due to injury all over the body and bleeding, the heart releases troponin into the blood (Hinkle, 2018)
CK-MB	3.5-5	n/a	n/a	
Total CK	24-204	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**	**1.1**	n/a	
PT	**11.7-13.8**	**14.4**	n/a	Patient may have suspected low vitamin K levels resulting in longer clotting times (Hinkle, 2018)
PTT	25-36	n/a	n/a	
D-Dimer	0.5	n/a	n/a	
BNP	<100	n/a	n/a	
HDL	60	n/a	n/a	
LDL	60-130	n/a	n/a	
Cholesterol	<200	n/a	n/a	
Triglycerides	<150	n/a	n/a	
Hgb A1c	4-5.9	n/a	n/a	
TSH	0.45-4.5	n/a	n/a	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	pale/yellow	n/a	n/a	
pH	4.5-7.8	n/a	n/a	
Specific Gravity	1.016-1.025	n/a	n/a	
Glucose	>0.5	n/a	n/a	

Protein	negative	n/a	n/a	
Ketones	negative	n/a	n/a	
WBC	<4	n/a	n/a	
RBC	<3	n/a	n/a	
Leukoesterase	4-11	n/a	n/a	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35-7.45**	n/a	**7.45**	
PaO2	**80-100**	n/a	**124.5**	With oxygen therapy and high tissue demand for oxygen the body works harder to compensate for demands (Hinkle, 2018)
PaCO2	**35-45**	n/a	**33**	This is due to hyperventilation from injury in the lungs, the patient suffered a pneumothorax (Hinkle, 2018)
HCO3	**22-26**	n/a	**22.2**	
SaO2	**92-100**	n/a	**98.3**	

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	negative	n/a	
Blood Culture	negative	negative	n/a	
Sputum Culture	negative	positive	n/a	**The patient had few squamous epithelial cells, rare gram positive cocci (Hinkle, 2018)**
Stool Culture	negative	negative	n/a	

Lab Correlations Reference (1) (APA):

Ellis, C. S. (2018). *Brunner & Suddarth's Handbook of Laboratory and Diagnostic tests*. Wolters Kluwer.

Hinkle, J.L. & Cheever, K.H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia: Wolters Kluwer.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT brain w/o contrast, XR chest AP, XR right forearm, XR right hand, CT right ankle w/o contrast, MRI cervical spine w/o contrast, CT right knee w/o contrast, MRI brain w/o contrast, CT lumbar reconstruction, CT facial bones, CT carotid, XR right pelvis

Diagnostic Test Correlation (5 points): A CT of the brain will allow for visual effects of brain bleed and where it is traveling through the head, no contrast was used to avoid allergic reactions. The patient needs to be cautiously examined before attempting to use contrast in the head, especially for head trauma. The chest XR was ordered for the patient

to rule out a pneumothorax, in his instance it came back positive for a collapsed lung. An XR was also used to examine any fractures in the patient's extremities after the accident. The provider ordered an MRI on the lumbar spine to examine soft tissue damage and any fractures in that area. A CT reconstruction of the lumbar was also ordered to look at all angles of the spine. A CT of the carotid was used to monitor blood flow to the head to view the status of oxygenated blood. These are all important tests in order to get appropriate diagnoses for the right treatment. Some tests were ordered repeatedly to monitor progress in certain locations.

Diagnostic Test Reference (1) (APA):

Ellis, C. S. (2018). *Brunner & Suddarth's Handbook of Laboratory and Diagnostic tests*. Wolters Kluwer.

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

——— Patient did not have a home med list so I added 5 current meds I chose———-

Home Medications (5 required)

Brand/Generic	**Aspirin / aspri-low**	**Oxycodone/ roxicodone**	**Zofran/ odenestron**	**Labetalol/ normodyne**	**Moi-stir/ mucosal spray**
Dose	**325mg**	**5mg**	**4mg**	**10mg**	**1 spray**
Frequency	**q6hr**	**Q3hr prn**	**Daily prn**	**Q10mins**	**Once**

				prn	**daily prn**
Route	**oral**	**Gastric tube**	**Injection/IV push**	**IV push**	**Oral**
Classification	**Antipyretic**	narcotic	**antiemetic**	beta blocker	mouth throat product
Mechanism of Action	**Produce analgesia to reduce inflammation**	inhibits adenylyl-cyclase of neurons, and decreases excitability	**Reduce nausea vomiting by blocking those receptors**	beta blocker used to treat hypertension	**Avoid mucosal dryness**
Reason Client Taking	for pain and inflammation	to reduce any pain the patient may have	prevent vomiting episodes	high blood pressure	relieve dry mouth
Contraindications (2)	bleeding disorders and allergies to nsaids	severe asthma, or intestinal blockage	do not use apomorhine with zofran, liver disease	cardiogenic shock and bradycardia	liver failure and hypertension
Side Effects/Adverse Reactions (2)	**Tinnitus, GI bleed**	hives, slow heart rate	bloating, agitation	ortho hypotension, and blurred vision	excessive absorption of electrolytes and renal failure
Nursing Considerations (2)	monitor skin color and temperature, and assess alergies	monitor for cool clammy skin, monitor confusion or changes in LOC	monitor for dizziness, and do oral assessments	asthma and low blood pressure	no more than 2 sprays at once and
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Pain scale, assess blood pressure**	monitor respirations, and nurses should monitor for confusion	monitor bowels, and heart rhythms	assess fluid intake and lung sounds	potassium and sodium labs need monitored
Client Teaching	call doctor if	avoid	Take as	May cause	do not

Needs (2)	signs of allergic reaction, can be taken with or without food	alcohol, avoid driving or operating machinery	prescribed by provider, do not take medication in smaller or larger amounts	drowsiness and sweating may occur so call provider	swallow the medication, and oral powder needs mixed with water

Hospital Medications (5 required)

Brand/Generic	**Amantadine HCL/ Gocovri**	**Chlorhexidine gluconate/ Betasept**	**pepcid/ famotidine**	**Novolog insulin/ aspart**	**Keppra/ Levetiracetam**
Dose	**100mg**	**15 ml**	**20mg**	**4 units**	**1000mg**
Frequency	**BID**	**Q12 hr**	**BID**	**Q4 hr**	**BID**
Route	**Gastric tube**	**oral**	**Gastric tube**	**Sub q**	**Gastric tube**
Classification	**Antiparkinsons**	**Dental aids**	**Histamine H2 receptor**	**insulins**	**Anticonvulsants**
Mechanism of Action	**Interferes with viral nucleic acid**	**Binds to mouth tissue killing bacteria**	**Inhibits gastric secretions**	regulate glucose metabolism	induces seizure protection
Reason Client Taking	**Reduce dyskinesia**	**Prevent dental plaque**	prevent ulceration in the stomach	high glucose levels	**Reduce dyskinesia**
Contraindications (2)	psychotic disorders and drug	**Lumbar puncture, dental work**	hypersensitivity to H2 receptors	allergies and abnormal potassium	anaphylaxis shock and

	abuse		and renal impairment	levels	allergic reactions to med
Side Effects/Adverse Reactions (2)	**Dry mouth, nausea**	mouth irritation and teeth staining	**Diarrhea, headache**	low blood sugar and seizures	**Confusion , skin rash**
Nursing Considerations (2)	Be alert for anxiety, also monitor gait as may effect ability to walk	do not rinse patient mouth after use, do not ingest	check for allergies and normal urine output	do not give if hypoglycemic and its not used to treat type 2 diabetes	risk for hypoventilation and may decrease serum levels
Key Nursing Assessment(s)/Lab(s) Prior to Administration	WBC and Neutrophils	assess mouth for signs of abnormality and assess respiratory depression	decrease dose with renal failure and arrange for concurrent antacid therapy	glucose level and potassium	monitor seizure activity and monitor behavior changes
Client Teaching Needs (2)	Do not take with heart medications and may be taken with or without food	can last up to 24 hours after use, and daily bathing helps prevent infections with use of medication	take at bedtime and may experience constipation	take as directed and teach that novolog is a fast acting insulin	tell doctor if ever had kidney disease and do not take with depression

Medications Reference (1) (APA):

How to use Davis's drug guide for nurses: Davis's Drug Guide. How to Use Davis's Drug Guide For Nurses | Davis's Drug Guide. (n.d.). Retrieved September 13, 2022, from https://www.drugguide.com/ddo/view/Davis-Drug-Guide/110089/all/How_to_Use_Davis's_Drug_Guide_For_Nurses

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient showed signs of lethargy and minimal disorientation, opens eyes when aroused or spoken to, patient cannot speak or signal needs or desires, patient is A&O x2. Minimal distress due to inactivity of ROMs, patient overall stable with vitals**
INTEGUMENTARY: **Skin color: dry, rashes throughout, lacerations on head** **Character:** **Temperature: 99.1** **Turgor:normal mobility** **Rashes: forearms, chest, head** **Bruises: arms legs and head** **Wounds:** no major wounds at time of care **Braden Score: 10** **Drains present: Y☐ ** N ☐** **Type: Nasogastro tube, chest tube, urine Cath**	**Patient appeared warm and dry with visible rashes on extremities and chest, no signs of clubbing in the nail beds, rashes and lacerations pink and scabbed over with bigger lacerations on head, drainage systems all appear to be functioning properly**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head and neck symmetrical, no palpable thyroid, bilateral carotid and pedal pulses +2, PERRLA bilateral, teeth white and symmetrical , nose midline**

CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: +2** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐**** **Edema Y ☐** N ☐** **Location of Edema: Bilateral ankles, bilateral arms, and face**	**Heartbeat regular, S1 and 2 present, no gallop noted, and capillary refill less than 3, no murmur present upon auscultation**
RESPIRATORY: **Accessory muscle use: Y☐ N ☐**** **Breath Sounds: Location, character**	Non labored breathing, respirations 18, breath sounds heard front and posterior free of wheezing, rhonchi, stridor
GASTROINTESTINAL: **Diet at home: vegetables (greens), meats such as chicken and beef, clear fluids mostly** **Current Diet: NG tube** **Height: 6'1** **Weight: 220 lbs** **Auscultation Bowel sounds:** **Last BM: not noted in charts or had a BM day of care** **Palpation: Pain, Mass etc.: pain around stomach from bruising or impact from accident** **Inspection: minimal bruising** **Distention: none** **Incisions: no incisions noted** **Scars: none** **Drains: no drains in gastrointestinal area** **Wounds: head, arms, legs, minimal on chest** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐** N ☐** **Size:42-50** **Feeding tubes/PEG tube Y ☐ N ☐**** **Type:**	.no CVA tenderness, renal function working properly, bowels heard in all four quadrants, no ostomy on client

GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐*** **Dialysis: Y ☐ N ☐**** **Inspection of genitals: dry and no abnormal coloring or wounds** **Catheter: Y ☐** N ☐** **Type: foley** **Size: 20Fr**	urine yellow in color with no foul odor, clear output, and producing at least 30ml/hr, urine catheter in place
MUSCULOSKELETAL: **Neurovascular status: alert and can understand where he is at** **ROM: unable to perform on own** **Supportive devices: pillows** **Strength: minimal, cannot move by himself** **ADL Assistance: Y☐** N ☐** **Fall Risk: Y ☐** N☐** **Fall Score: 40** **Activity/Mobility Status: n/a** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	.Patient cannot move on their own, he needs support from nurse to rotate or move, patient has not been up and walking, bed rails are up to avoid fall risks in the bed
NEUROLOGICAL: **MAEW: Y ☐** N☐** **PERLA: Y ☐** N☐** **Strength Equal: Y ☐ N ☐** if no - Legs ☐ Arms ☐ Both ☐**** **Orientation: eye movements only** **Mental Status: coherent to voices** **Speech: unable to verbalize** **Sensory: sight, hearing, and touch** **LOC: unable to speak but opens eyes when spoken to**	.
PSYCHOSOCIAL/CULTURAL: **Coping method(s): reading** **Developmental level: appropriate to patient's age** **Religion & what it means to pt.: n/a** **Personal/Family Data (Think about home environment, family structure, and available family support): Family**	.Patient enjoys reading and traveling

support and spouse support	

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:00 am	73	130/60	18	98 axillary site	100% mechanical vent
9:00 am	74	127/61	18	99.1 axillary site	100% mechanical vent

Vital Sign Trends: Vitals are stable and have been similar throughout the morning care of the patient. The mechanical vent is helping with the patient's PaO2.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
7:00 am	4/10	arms and head	minimal-moderate	achy feeling	pain meds prn and restricting ROM
9:00 am	4/10	arms and head	minimal-moderate	achy feeling	pain meds prn and restricting ROM

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock

Size of IV: 18 G **Location of IV: Right upper arm** **Date on IV: 9/10/2022** **Patency of IV: placed and not locked** **Signs of erythema, drainage, etc.: none present** **IV dressing assessment: clean and no redness at site**	D5W 0.6g/kg/hr

Intake and Output (2 points)

Intake (in mL) **recorded on 9/10-9/11**	**Output (in mL)** **recorded on 9/10-9/11**
2256 ml fluids no bowel movement	3001 ml fluids no bowel movement

Nursing Care

Summary of Care (2 points)

Overview of care: Body assessment on CG, administered eye medication and turned patient to help avoid skin breakdown

Procedures/testing done: No tests or procedures done during care that morning

Complaints/Issues: No complaints, patient did look a little agitated due to not being able to talk or move

Vital signs (stable/unstable): vitals stable both rounds in the morning

Tolerating diet, activity, etc.: Plan was to tube feed around lunch, has been tolerating over the passed couple days

Physician notifications:

Future plans for client: Plan to discharge patient in 3 days, if goes well he will be headed home

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): Wife is available to help with ADL's

Equipment needs (if applicable): Potential walker for physical therapy, respiratory therapy may utilize oxygen for his home care

Follow up plan: Consult doctor for any abnormal feelings, falls, dizziness, follow medication regimen as ordered

Education needs: Take medications as prescribed, and report abnormal symptoms

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. Ineffective cerebral tissue perfusion	With a cerebral accident the brain may lose blood which will not allow	**1. Maintain blood pressure as ordered** **2. administer**	**1. Patient will display improved cerebral perfusion**	Patient's vitals are currently stable and within the appropriate measures ordered by provider

related to hemorrhage, as evidence by altered mental status	the patient to maintain oxygen flow and may lead to death if not treated promptly	**thrombolytics**	**through vitals ordered in the parameter**	Client is cooperative and managing professional team care accordingly
2. Risk for impaired skin integrity related to immobility as evidenced by disruption of dermal tissues	Patient is unable to move on their own, the nurse needs to continuously rotate and turn the client to avoid skin breakdown and prevent redness/sore on bony prominences	**1. Rotate patient q2hr and utilize pillow support under extremities** **2. Use adequate nutrition and hydration to help skin integrity and keep skin warm and dry**	**1. Patient will not develop pressure ulcers and maintain skin integrity**	Patient complaint with nurse ROMs and turning/use of pillows
3. Impaired verbal communication related to dysarthria as evidenced by nonverbal and extremity weakness	Patient lost ability to mobilize from head to toes and is in need of communicating to help the nurse give the best care for the patient	**1. Nurse will speak in short and direct communication methods** 2. **Encourage speech therapy**	**1. Patient will establish a form of communication to express thoughts and needs**	Patient can move eyes to show he is listening and understanding the care performed. Patient's spouse is also able to help communicate needs and explain situations
4. Patient is risk for injury related to poor motor coordination as evidenced	Patient is at risk for future injury as he cannot walk with full strength when discharged, and he cannot perform ADL's	**1. Use of bed alarms for patient** **2. Assist with feeding and fluids**	**1. Caregivers will support the patient a develop a modified environment for patient needs and ADL's**	Spouse support and occupational therapy will be available when discharged and patient is accepting of others willing to help modify his daily routine

by inability to perform self care	on his own yet so his spouse and occupational therapy may need to assist with care upon discharge			

Other References (APA):

Concept Map (20 Points):

Client information: CG, a 53 year old male, reported to Carle Foundation hospital by ambulance after suffering a motor vehicle accident. He came from Kankakee on 9/08/2022. Patient works for UPS and hit a parked car. Upon arrival he was hypotensive and unresponsive. During his ambulance ride he was given 5 packs of RBC and 3L crystalloids and 150mcg morphine. X-ray images showed subarachnoid hemorrhage, IVH, trace subdural hematoma and facial lacerations. Patient history was taken from the chart as he was unresponsive and cannot provide information.

Subjective data: Patient nervous and timid, patient pain scale is 4/10, no nauseated feelings currently

Objective data: No labored breathing, patient vitals are normal; BP 130/67, temp 99.1, respirations 18. Patient has lacerations to the head, and wounds on all 4 extremities, edema shown on face and extremities, Patient is responsive to speech and touch, patient does not express fever indications or breathing issues. patient labs that were high included; PT, wbc, glucose, creatine, phosphate, AST.

Nurse diagnosis:

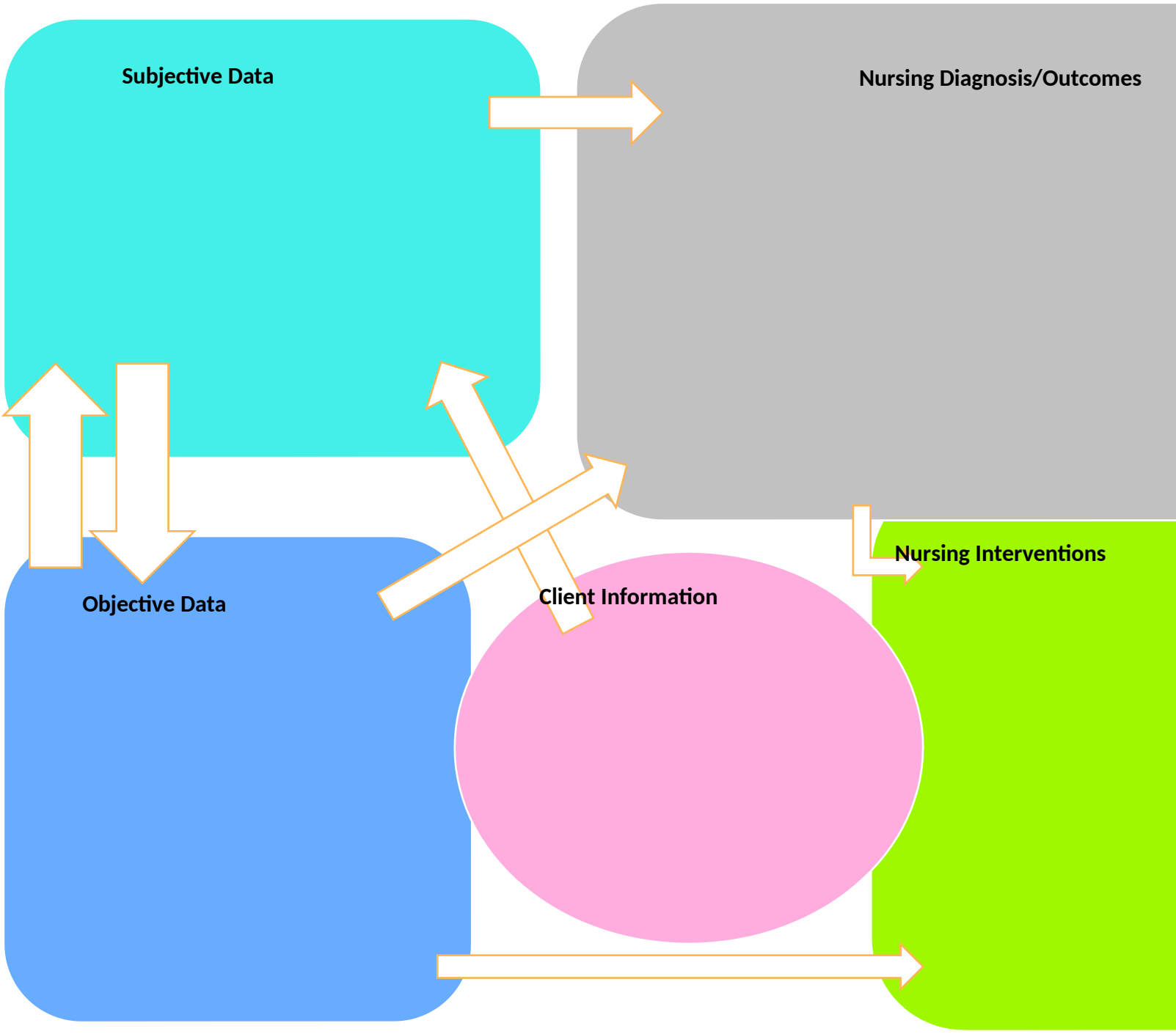
2. Ineffective cerebral tissue perfusion related to hemorrhage, as evidence by altered mental status
3. Risk for impaired skin integrity related to immobility as evidenced by disruption of dermal tissue
4. Impaired verbal communication related to dysarthria as evidenced by nonverbal and extremit
5. Patient is risk for injury related to poor motor coordination as evidenced by inability to perfor

Nurse interventions:

1. Maintain blood pressure as ordered **2. administer thrombolytics**
1. Rotate patient q2hr and utilize pillow support under extremities **2. Use adequate nutrition and hydration to help skin integrity and keep skin warm and dry**
3. Nurse will speak in short and direct communication methods 4. **Encourage speech therapy**

2. **Use of bed alarms for patient**

2. Assist with feeding and fluids


Subjective Data
Nursing Diagnosis/Outcomes
Objective Data
Client Information
Nursing Interventions