N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
09/07/2022	RW	87	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Married	Lisinopril (Facial/lip swelling/Angioedema)
Code Status	**Height**	**Weight**	
Full	6’8” (203.2cm)	116.1kg (255lbs)	

Medical History (5 Points)

Past Medical History: Bell’s Palsy / Cataracts / Hypertension / BPH

Past Surgical History: Exploratory Laparotomy / Lysis of adhesions / Subtotal colectomy / Creation of ileostomy

Family History: Father (Brain Cancer/Hypertension)

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

Client reports no tobacco, alcohol, or drug use.

Assistive Devices: None

Living Situation: Lives at home with wife

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): Shortness of breath / Back pain / Shaking

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

On 9/7/22, the client woke up at two in the morning with shortness of breath and back pain. The client's wife called EMS, who assessed the ECG and advised the client that he was okay. The client went back to sleep and woke up again at seven in the morning with worsening shortness of breath, severe back pain, uncontrolled shaking, weakness, and vomiting. The client went to the emergency department and determined he had atrial fibrillation. After assessing the client, the

providers found he also had a ridged abdomen and was sent to surgery, where they removed part of the bowel that was ischemic. The client is currently recovering from surgery in the intensive care unit with a nasogastric tube in place and an ileostomy. Client presently states back pain is 9 out of 10 on a numeric scale. The client's wife stated that he has never had any symptoms of shortness of breath or severe back pain before the recent events.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Atrial Fibrillation

Secondary Diagnosis (if applicable): Ischemic colitis

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

Atrial fibrillation, a heart arrhythmia, occurs when the right and left atrium beat irregularly (Capriotti & Frizzell, 2020). The irregular heartbeat and lack of coordination cause cardiac output reduction (Capriotti & Frizzell, 2020). The inability to pump out sufficient cardiac output affects oxygen delivery and perfusion, ultimately increasing the workload on the heart (Capriotti & Frizzell, 2020). Blood is more likely to clot in the heart because blood stasis causes clot formation, which travels from the heart to the brain and other parts of the body (Capriotti & Frizzell, 2020). Atrial fibrillation increases the risk of developing severe complications such as heart failure and stroke (Capriotti & Frizzell, 2020).

Signs and symptoms of atrial fibrillation include heart palpitations, weakness, fatigue, and shortness of breath (Center for Disease Control and Prevention, 2022). The client's respiratory rate elevates due to shortness of breath, and the body compensates for reduced oxygen delivery. Heart rate description of irregularly irregular demonstrates the atria and ventricles not coordinating with each other and the atria is quivering (Hinkle & Cheever, 2018). An ECG reports absent p-wave and narrow QRS complexes to diagnose atrial fibrillation (Hinkle &

Cheever, 2018). Providers draw CBC and CMP labs to determine a cause for atrial fibrillation, such as infection, potassium imbalance, or other contributing factors (Hinkle & Cheever, 2018). Individuals at an increased risk for atrial fibrillation include advanced age, male gender, obesity, and hypertension (Center for Disease Control and Prevention, 2022).

In treating atrial fibrillation, preventing complications and restoring the heart's function are priorities. Anticoagulant prescription reduces the risk of stroke due to the development of clots in the heart (Hinkle & Cheever, 2018). Beta-blockers prescription slows the heart rate and lower blood pressure (Hinkle & Cheever, 2018). Cardioversion, not always used in treatment, helps to restore normal sinus rhythm (Hinkle & Cheever, 2018). The client presented today had no prescriptions to treat atrial fibrillation.

Ischemic colitis occurs due to a lack of blood flow to a portion of the large intestine resulting in a deficient oxygen supply to that organ (Hinkle & Cheever, 2018). The obstruction of blood flow to the colon results from chronic constipation, bowel obstruction, blood clots, or atherosclerosis (Hinkle & Cheever, 2018). Clients with ischemic colitis experience abdominal pain, an urgency to defecate, blood in the stool, diarrhea, and nausea (Hinkle & Cheever, 2018). An abdominal CT scan and fecal occult blood test help to diagnose ischemic colitis. Removal and resection of the bowel are treatments used when chronic ischemia results in cell death of a portion of the bowel (Hinkle & Cheever, 2018). The client underwent a colectomy and had an ileostomy placed due to colon necrosis.

Pathophysiology References (2) (APA):

Capriotti, T. & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed.). F.A. Davis Company.

Centers for Disease Control and Prevention. (2022). *Atrial fibrillation*. Centers for Disease Control and Prevention. https://www.cdc.gov/heartdisease/atrial_fibrillation.htm

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

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	4.4 – 5.8mL	3.71	3.69	Decreased RBC are due to post-operative inflammation or blood loss during surgery (Pagana et al., 2019)
Hgb	13-16.5g/dL	11.9	11.6	Decreased Hgb due to surgery causing reduction of erythropoiesis and blood loss (Pagana et al., 2019). The reduction of red blood cells contributes to low Hgb (Pagana et al., 2019).
Hct	38 – 50%	35.1	34.9	Decreased Hct due to a decrease in Hgb levels (Pagana et al., 2019).
Platelets	140 – 440mcl	193	195	N/A
WBC	4 -12mcl	12.70	16.8	Increased WBC due to response to surgical procedure caused inflammation or infection in the body (Pagana et al., 2019).
Neutrophils	40 – 68%	87.5	92.8	Increased neutrophils are an indication of bacterial infection (Pagana et al., 2019).
Lymphocytes	19 – 49%	3.8	2.8	Decreased lymphocytes due to client not consuming enough calories and protein from NPO status and leaving the client at risk for infection (Pagana et al., 2019).
Monocytes	3 – 13%	7.5	4.1	N/A
Eosinophils	0 – 8%	0.4	0.2	N/A
Bands	3.0-6.0%	N/A	N/A	N/A

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	133 – 144mmol/L	133	138	N/A
K+	3.5 – 5.1mmol/L	3.2	4.0	Lack of potassium in diet and related to the cause of atrial fibrillation diagnosis (Pagana et al., 2019).
Cl-	98 – 107mmol/L	100	107	N/A
CO2	21 – 31mmol/L	24	22	N/A
Glucose	70 – 99mg/dL	87	99	N/A
BUN	7 – 25mg/dL	28	43	The client is NPO and cannot replenish thirst by mouth (Pagana et al., 2019). Gastrointestinal bleeding during surgery causes increased BUN (Pagana et al., 2019).
Creatinine	0.5 – 1.0mg/dL	1.32	1.24	Renal function impairment contributed to urinalysis results (Pagana et al., 2019).
Albumin	3.5 – 5.7g/dL	3.4	2.5	Poor nutrition, infection, post-surgical inflammation, dehydration, renal impairment, or hepatic impairment contribute to low albumin levels relating to the current client (Pagana et al., 2019).
Calcium	8.8 – 10.2mg/dL	7.7	7.5	The client has felt fatigued and in a fog, potentially from low calcium levels (Pagana et al., 2019). Low albumin levels and malnutrition cause hypocalcemia (Pagana et al., 2019).
Mag	1.6 – 2.6mg/dL	1.8	2.2	N/A
Phosphate	2.5 – 4.5mg/dL	N/A	2.7	N/A
Bilirubin	0.2 – 0.8mg/dL	0.9	1.9	Hemolysis causes bilirubin levels to increase (Pagana et al., 2019). Stress

				from surgery and pain, dehydration, and infection cause bilirubin levels to elevate (Pagana et al., 2019).
Alk Phos	30 – 120 U/L	70	69	N/A
AST	13 – 39U/L	16	26	N/A
ALT	7 – 52U/L	8	15	N/A
Amylase	30-220 U/L	N/A	N/A	N/A
Lipase	0-160 U/L	N/A	N/A	N/A
Lactic Acid	0.5 – 2.0mmol/L	N/A	N/A	N/A
Troponin	0 – 0.040	0.062	N/A	Hypertension and atrial fibrillation cause stress on the heart elevating troponin levels (Pagana et al., 2019).
CK-MB	2.5 – 4.5mg/dL	N/A	N/A	N/A
Total CK	0.2 – 0.8mg/dL	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 – 1.1	N/A	1.3	The client was administered enoxaparin in the hospital to prevent DVTs causing an increase in INR (Pagana et al., 2019).
PT	9.5 – 11.3 seconds	N/A	14.7	Anticoagulation medication increases the clotting time (Pagana et al., 2019).
PTT	30 – 40 seconds	27	N/A	N/A
D-Dimer	<250ng/mL	14,103	N/A	Test used to detect venous thrombosis and the results show the client had a thromboembolic event (Pagana et al., 2019).
BNP	0 – 100pg/mL	165	N/A	Test used to distinguish heart failure by measuring a protein produced by

				the heart when damaged (Pagana et al., 2019). These results show the heart suffered some trauma.
HDL	>60mg/dL	N/A	N/A	N/A
LDL	<130mg/dL	N/A	N/A	N/A
Cholesterol	<200mg/dL	N/A	N/A	N/A
Triglycerides	<150mg/dL	N/A	N/A	N/A
Hgb A1c	<7%	N/A	N/A	N/A
TSH	2 – 10mU/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	Clear and Yellow	Dark yellow / clear	N/A	Client is NPO status and NG tube suction cause fluid volume deficit (Pagana et al., 2019). The urinalysis results from today were not available to compare.
pH	4.5 - 8	5.0	N/A	N/A
Specific Gravity	1.005-1.025	>1.030	N/A	Client has an NG tube in place and on NPO dietary status causing dehydration and elevated specific gravity (Pagana et al., 2019).
Glucose	Negative	Negative	N/A	N/A
Protein	Negative	Trace	N/A	UTI and kidney disfunction cause elevated protein in urine (Pagana et al., 2019).
Ketones	Negative	Trace	N/A	Client is NPO and unable to consume caloric intake causing buildup of ketones (Pagana et al., 2019).
WBC	Negative 0-5	0 - 5	N/A	N/A
RBC	Negative 0-2	0 - 2	N/A	N/A
Leukoesterase	Negative	1+	N/A	UTI is a cause of elevated leukoesterase in the urine (Pagana

				et al., 2019).

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	7.42	7.42	N/A
PaO2	90 – 100mmHg	55	92	Lungs are unable to oxygenate the blood from low Hgb and RBC (Hinkle & Cheever, 2018).
PaCO2	35 – 45mmHg	28	32	Compensated respiratory alkalosis (Pompey & Abraham-Settles, 2019). Client has shortness of breath and using accessory muscles to breath.
HCO3	22 – 26mEq	18.3	20.5	Compensated respiratory alkalosis, renal system compensates for the respiratory problem (Pompey & Abraham-Settles, 2019). NG tube with suction causes reduction of HCO3 (Pagana et al., 2019).
SaO2	95% - 100%	88	96	Low perfusion of oxygen to the rest of the body from low RBC and hemoglobin (Hinkle & Cheever, 2018). Client presented to the hospital with shortness of breath.

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

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

	10,000 Positive > 100,000			
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Normal URT	N/A	N/A	N/A
Stool Culture	Normal Intestinal flora	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

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

Pompey, J., & Abraham-Settles, B. (2019). Clarifying the confusion of arterial blood gas analysis: Is it compensation or combination? *AJN The American Journal of Nursing*, *119*(3), 52-56. https://nursing.ceconnection.com/ovidfiles/00000446-201903000-00030.pdf

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-ray

Diagnostic Test Correlation (5 points): Client is at risk for pneumonia in the hospital after surgery (Pagana et al., 2019). Upon assessment of the client's lung sounds and breathing, the lungs sounded diminished, the client was coughing, and breathing was becoming labored.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	Ondansetron / Zofran	Acetaminophen / Tylenol	Hydrochlorothiazide / Microzide	Tamsulosin hydrochloride/ Flomax	Levothyroxine sodium / Synthroid
Dose	4mg	650mg	25mg	0.4mg	25mcg
Frequency	PRN every 6hrs	Q 6hrs PRN	Once per day	Once per day	Once per day
Route	PO	PO	PO	PO	PO
Classification	Pharm: Opioid Therapeutic: Opioid analgesic (Jones & Bartlett, 2020)	Pharm: No salicylate Therapeutic: Antipyretic, nonopioid analgesic (Jones & Bartlett, 2020)	Pharm: Thiazide diuretic Therapeutic: Diuretic (Jones & Bartlett, 2020)	Pharm: Alpha adrenergic antagonist Therapeutic: Benign Prostatic hyperplasia agent (Jones & Bartlett, 2020)	Pharm: Synthetic thyroxine Therapeutic: Thyroid hormone replacement (Jones & Bartlett, 2020)
Mechanism of Action	Bind to opioid receptor sites in the CNS altering the perception of pain (Jones & Bartlett, 2020).	Blocks prostaglandin production and interferes with pain impulses generated from the peripheral nervous system (Jones & Bartlett, 2020)	Reduces blood pressure by moving sodium, chloride, and water from blood in peritubular capillaries into nephron tubule (Jones & Bartlett, 2020).	Inhibits smooth muscle contraction in the bladder neck and prostate to improve voiding and reduce BPH symptoms (Jones & Bartlett, 2020).	Replace endogenous thyroid hormone, which may exert its physiologic effect by controlling DNA transcription and protein synthesis (Jones & Bartlett, 2020).
Reason Client	To manage	To treat	To manage	To treat	To treat

Taking	postoperative pain	pain	hypertension	BPH	hypothyroidism
Contraindications (2)	Intermittent pain / hypersensitivity to fentanyl (Jones & Bartlett, 2020)	Hypersensitivity to acetaminophen or its components / severe hepatic impairment (Jones & Bartlett, 2020)	Anuria / Hypersensitivity to hydrochlorothiazide (Jones & Bartlett, 2020)	Hypersensitivity to tamsulosin, quinazolines, and their components (Jones & Bartlett, 2020)	Uncorrected adrenal insufficiency / Hypersensitivity to levothyroxine (Jones & Bartlett, 2020).
Side Effects/Adverse Reactions (2)	Respiratory depression / asystole (Jones & Bartlett, 2020)	Hepatotoxicity / hypokalemia (Jones & Bartlett, 2020)	Hypotension / renal failure (Jones & Bartlett, 2020)	Atrial fibrillation / respiratory impairment (Jones & Bartlett, 2020)	Seizures / hyperthyroidism (Jones & Bartlett, 2020)
Nursing Considerations (2)	Monitor the patient for signs and symptoms of hypersensitivity to ondansetron because anaphylaxis can occur. Place the disintegrating tablets or oral soluble on the client's tongue immediately after opening (Jones & Bartlett, 2020).	Use cautiously in patients with hepatic impairment or alcoholism / Monitor renal function (Jones & Bartlett, 2020)	Give in the mornings / Check blood glucose often (Jones & Bartlett, 2020)	Prostate cancer should be ruled out before administration / Give at the same time every day after a meal (Jones & Bartlett, 2020)	Start a lower dose for elderly clients with underlying cardiovascular disease / Give medication at least 4 hours before antacids (Jones & Bartlett, 2020)
Key Nursing	PERRLA /	Assess	Potassium	Blood	Medication

Assessment(s)/Lab(s) Prior to Administration	Respiratory assessment (Jones & Bartlett, 2020)	AST, ALT, bilirubin, and creatinine lab results / monitor I & O (Jones & Bartlett, 2020)	levels / blood pressure (Jones & Bartlett, 2020)	pressure / heart rate and rhythm auscultation or ECG (Jones & Bartlett, 2020)	recalls to determine any drug interaction before starting Levothyroxine / Assess client for signs of hyperthyroidism (Jones & Bartlett, 2020)
Client Teaching needs (2)	Report decreased libido to provider / Inform all other prescribers of fentanyl use (Jones & Bartlett, 2020)	Call provider if you experience severe and unusual abdominal pain. Take medication with meal or snack (Jones & Bartlett, 2020)	Take medication with food or milk / Change positions slowly to avoid orthostatic hypotension (Jones & Bartlett, 2020).	Do not open or chew the capsules / Change positions slowly after the initial dose to prevent orthostatic hypotension (Jones & Bartlett, 2020)	Take medication 30 minutes before breakfast for better absorption / Take medication with a full glass of water (Jones & Bartlett, 2020)

Hospital Medications (5 required)

Brand/Generic	fentanyl / Sublimaze	morphine / Roxanol	lorazepam / Ativan	pantoprazole / Protonix	enoxaparin sodium / Lovenox
Dose	25mcg	2mg	1mg	40mg	30mg
Frequency	PRN every 4hrs	PRN every 4hrs	PRN every 6hrs	Once per day	Q 12hrs
Route	Intravenous	Intravenou	Intravenous	Intravenous	Subcutaneou

		s			s
Classification	Pharm: Opioid Therapeutic: Opioid analgesic	Pharm: Opioid Therapeutic: Opioid analgesic	Pharm: Benzodiazepine Therapeutic: Anxiolytic	Pharm: Proton pump inhibitor Therapeutic: Antiulcer	Pharm: Low-molecular-weight heparin Therapeutic: Anticoagulant
Mechanism of Action	Binds to opioid receptor sites in the CNS altering the perception of pain by inhibiting ascending pathways (Jones & Bartlett, 2020)	Produces analgesic euphoria by activating opioid receptors in the CNS (Jones & Bartlett, 2020)	Inhibits excitatory stimulation to reduce anxiousness (Jones & Bartlett, 2020)	Interfere with gastric acid secretions by inhibiting the hydrogen – potassium adenosine triphosphate enzyme system or proton pump in the gastric parietal cells. Reduces the production of gastric acids in the stomach (Jones & Bartlett, 2021)	Inactivated clotting factors by binding with antithrombin III preventing fibrin conversion to clots (Jones & Bartlett, 2020)
Reason Client Taking	To manage postoperative pain	To relieve severe pain not relieved by opioid combinations or nonopioid methods	To treat anxiety	To reduce gastric acid production while recovering after gastric surgery	Prevent DVTs after abdominal surgery
Contraindications (2)	Hypersensitivity to fentanyl / significant respiratory depression (Jones &	Acute or severe bronchial asthma / arrythmias (Jones & Bartlett,	Acute angle-closure glaucoma / psychosis (Jones & Bartlett, 2020)	Hypersensitivity to pantoprazole / Concurrent therapy with rilpivirine-containing	Active major bleeding / Hypersensitivity to enoxaparin (Jones & Bartlett,

	Bartlett, 2020)	2020)		products (Jones & Bartlett, 2021)	2020)
Side Effects/Adverse Reactions (2)	Bradycardia / respiratory depression (Jones & Bartlett, 2020)	Increased intercranial pressure / Bradycardia (Jones & Bartlett, 2020)	Respiratory depression / Constipation (Jones & Bartlett, 2020)	C. Diff associated diarrhea / Hepatic failure (Jones & Bartlett, 2020)	Atrial fibrillation / pneumonia (Jones & Bartlett, 2020)
Nursing Considerations (2)	Use cautiously in patients at risk for opioid abuse / Older adults are more sensitive to fentanyl effects and must be titrated carefully (Jones & Bartlett, 2020)	Be aware morphine can lead to drug abuse and a risk assessment is advised / Monitor for signs of respiratory depression (Jones & Bartlett, 2020)	Use caution in elderly clients due to respiratory depression effect / Monitor client closely for signs of altered consciousness (Jones & Bartlett, 2020)	Do not give pantoprazole within 4 weeks of testing for H. Pylori / Monitor urine output because of acute interstitial nephritis risk (Jones & Bartlett, 2020)	Use cautiously in clients with uncontrolled hypertension / Keep protamine sulfate ready incase of accidental overdose (Jones & Bartlett, 2020)
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Respiratory assessment / heart rate assessment (Jones & Bartlett, 2020)	Respiratory assessment / blood pressure assessment for hypotension (Jones & Bartlett, 2020)	Respiratory assessment / Neurological assessment (Jones & Bartlett, 2020)	Assess client's bowel movements / Assess respiratory status (Jones & Bartlett, 2020)	Platelet count / assess for signs of bleeding (Jones & Bartlett, 2020)
Client Teaching needs (2)	Do not take more drugs than are prescribed / Increase fiber and fluid intake	Inform all providers of opioid to avoid adverse effects of combined	Avoid hazardous activities / Warn about fatal effects of opioid and	Do not exceed dosage or take longer than prescribed / Do not	Do not pick scabs / Alternate injection site (Jones & Bartlett, 2020)

	to prevent constipation (Jones & Bartlett, 2020)	medication / Do not discontinue abruptly (Jones & Bartlett, 2020)	lorazepam combination (Jones & Bartlett, 2020)	become pregnant while taking Protonix due to fetal harm (Jones & Bartlett, 2020)	

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** Drowsy **Orientation:** x3 **Distress:** anxious / grimacing **Overall appearance:** Weak and uncomfortable	Alert, oriented to person, place, and time. The client's orientation to his situation is not present. The client appears anxious and grimaces with pain periodically. The client is weak overall and experiencing constant pain.
INTEGUMENTARY: **Skin color:** White and gray **Character:** Dry/pale/bruised **Temperature:** Warm **Turgor:** <3seconds/elastic **Rashes:** None	Skin is pale and gray in color, warm and dry upon palpation. No rashes or lesions are present on inspection. Assessment of the skin showed several bruises on the arms and legs bilaterally. Average quantity, distribution, and texture of hair. Nails without clubbing or cyanosis. Skin

Bruises: Arms/legs **Wounds:** Surgical incision in the middle abdomen / Right Lower abdomen ileostomy **Braden Score: 2** **Drains present: Y☒ N ☒** **Type:** Urinary catheter / NG tube / ileostomy / IVs	turgor is less than three seconds without tenting —Braden score of 2. IV access on the right and left forearm and left wrist. Presence of surgical incision in the middle of the abdomen above the umbilicus. No sign of infection upon assessment of incision. Lower right quadrant ileostomy. The stoma is pink without cyanosis or infection—urinary catheter and nasogastric tube functioning correctly.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Atraumatic, oral cavity is pink, and dentition is good. The oral cavity is dry related to the NPO status. Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage from eyes. Bilateral lids are pink and dry without lesions or discharge noted. PERRLA is present bilaterally but sluggish bilaterally. Red light reflex is present bilaterally. Rosenbaum 20/20, EOMs intact bilaterally. The head and neck are symmetrical; the trachea is midline without deviations, the thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and 2+. No bruit auscultated. No lymphadenopathy in the head or neck was noted. Bilateral auricles are not visible or palpable deformities, lumps, or lesions. Bilateral canals are clear with pearly grey tympanic membranes. The septum is midline, turbinate moist, and pink bilaterally, and no visible bleeding or polyps. Bilateral frontal sinuses are nontender to palpation.
CARDIOVASCULAR: **Heart sounds: Irregular** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 2+** **Capillary refill:<3seconds** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: N/A**	Irregular heart rate present upon auscultation. Telemetry shows irregularly irregular heart rhythm. PMI is palpable at the fifth intercostal space at MCL. All extremities are warm, dry, and symmetrical. Pulses 2+ throughout bilaterally. Capillary refill less than three seconds in the fingers and toes bilaterally. No edema was inspected or palpated in all extremities bilaterally. Epitrochlear lymph nodes are non-palpable bilaterally. Homan's sign is negative bilaterally. No neck vein distention.
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character** Anterior/posterior bilateral lower lobe	Auscultation of the lungs presented respiratory rate elevation and rhythm irregularity. The client uses accessory muscles to breathe. Auscultation distinguished diminished lung sounds

diminished lung sounds **ET Tube:** No ET tube in place **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	anterior/posterior bilaterally of lower lobes. The client is on 2L of nasal cannula oxygen.
GASTROINTESTINAL: **Diet at home:** Regular **Current Diet:** NPO except ice chips **Height:** 6'8" **Weight:**116.1kg **Auscultation Bowel sounds:** Hypoactive and faint **Last BM:** 9/7/22 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** Appearance of minimal distention **Incisions:** middle of abdomen above umbilicus **Scars:** No **Drains:** Ileostomy/urinary catheter/NG tube **Wounds:** Multiple bruises on arms and legs **Ostomy: Y ☒ N ☐** **Nasogastric: Y ☒ N ☐** **Size:**16Fr **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	The client consumes a regular diet at home. The client's current diet in the hospital is prescribed to NPO, but ice chips are acceptable. Inspection of the abdomen shows an incision above the umbilicus from ischemic colectomy. Bowel sound auscultation presents hypoactive with faint sounds in all four quadrants. The last bowel movement was noted on 9/7/22. The abdomen had minimal distention, and abdominal aorta bruit was not detected. The client has an ileostomy, urinary catheter, and nasogastric tube. The ileostomy stoma was inspected as pink and moist with no signs of cyanosis or infection.
GENITOURINARY: **Color:** Dark yellow **Character:** Clear **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** Foley **Size:** 16Fr **CAUTI prevention measures:**	Urinary assessment is dark yellow and clear. Quantity of urine 1,000mL. The client admits to no pain with urination. Genitals are normal with no signs of infection or injury. Foley catheter in place with routine catheter care of cleaning the catheter and ensuring it remains free of bacteria. Urinalysis on admission indicates trace amounts of protein and ketones. Leukoesterase in the urine was also detected. Dehydration is evident from a high specific gravity.

MUSCULOSKELETAL: **Neurovascular status:** Alert **ROM:** Poor **Supportive devices:** None **Strength:** Weak **ADL Assistance:** **Y☒ N ☐** **Fall Risk:** **Y ☒ N☐** **Fall Score:** 10 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	ROM of all extremities shows limitations and produces pain. Hand grips and pedal pushers/pulls demonstrate normal and equal strength. Any movement produces tremendous pain for the client, and currently unable to get up. The client is weak in all extremities bilaterally, rating a 1/5 overall. The patient is alert but fatigued. Orientation to person, place, and time. They are not oriented to situation. PERRLA is present but slow in both pupils. Cranial nerves are intact. Negative Rhombergs. Deep tendon reflexes 2+ bilaterally throughout. The client requires assistance with self-care activities. The client falls score of 10.
NEUROLOGICAL: **MAEW:** **Y ☐ N☒** **PERLA:** **Y ☒ N☐** **Strength Equal:** **Y ☐ N ☒ if no - Legs ☐ Arms ☐ Both ☒** **Orientation:** x3 **Mental Status:** Formal Operational **Speech:** Well-paced / spontaneous **Sensory:** WNL **LOC:** Altered	MAEW: No PERLA: Yes Strength equal: no, client exhibits weakness in all extremities bilaterally. Orientation: person, place, and time Mental status: formal operational Speech: clear, well-paced, and spontaneous Sensory: WNL LOC: Altered
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** Talking with wife **Developmental level:** Generativity vs. Stagnation **Religion & what it means to pt.:** Christian **Personal/Family Data (Think about home environment, family structure, and available family support):** Wife	Coping method: talks with wife Developmental Level: generativity vs. Stagnation. Religion & what it means: Christian, provides support in healing. Personal/Family Data: Wife provides company and support for the client.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0815	79 bpm	141/77mmHg	19 bpm	98.4 F	96% O2 saturation (2L of oxygen

					nasal cannula)
1200	84 bpm	140/71mmHg	20 bpm	98.1 F	96% (2L of oxygen nasal cannula)

Vital Sign Trends/Correlation:

The client's respirations are on the higher end of normal, but are stable. The client has hypertension and the blood pressure recorded provides a measurement considered as high blood pressure. The client's respiratory rate is at the high end of normal and should be watched closely for any changes.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0815	Numeric	Back	9	Constant / sharp	Pain medication provided for relief
0915	Numeric	Back	7	Constant	Repositioning

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: 20G Location of IV: Left arm, left wrist, and right arm Date on IV: Right arm (9/7/22), Left arm and wrist (9/11/22) Patency of IV: No obstruction

	Signs of erythema, drainage, etc.: No signs of redness, pain, fever, infection, or infiltration IV dressing assessment: Dry, Clean, and intact Left arm running normal saline and piggyback
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	N/A the client did not have any central line, ports, PICC, or any other lines besides IVs

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
1,500mL IV saline 200mL IV piggyback 8mL ice chips	1,000mL urine 1,400mL emesis NG tube

Nursing Care

Summary of Care (2 points)

Overview of care: Assessments of the client continuously show a struggle with pain control. The client received catheter care, continuous monitoring, and pharmacological

treatment. The client continued becoming confused about how he got to the hospital but was oriented to person, place, and time.

Procedures/testing done: Urine was collected for a urinalysis. A scheduled chest x-ray for later today.

Complaints/Issues: Back pain and dry mouth

Vital signs (stable/unstable): Stable. The client exhibited elevated blood pressure recordings in the vitals. The client's medical history shows hypertension. The client's respiratory rate is at the high end of normal and should be watched closely for any changes.

Tolerating diet, activity, etc.: NPO

Physician notifications: Switch pain medication from Fentanyl to morphine, discontinuing Fentanyl, move the client to a less intense care floor, and have a chest x-ray.

Future plans for client: The client needs to have a bowel movement to ensure appropriate bowel functioning. The client will meet with hospital staff to determine care options and education needs.

Discharge Planning (2 points)

Discharge location: Discharge to home with wife and homecare.

Home health needs (if applicable): Ostomy care, ambulation assistance, daily care, and nutrition

Equipment needs (if applicable): Ostomy bags and cleaning material

Follow up plan: Schedule a follow-up appointment with the provider to assess the healing of the abdominal incision and the client's overall well-being. Inquire about a referral to cardiology to assess the atrial fibrillation treatment plan.

Education needs: The client needs additional education on post-op ostomy care, stoma care, diet, driving restrictions, medication use and effects

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 invasive procedure as evidence by elevated WBC and abdominal incision site (Phelps,	The client's WBC is 16.8, which is above the reference range indicating infection. The opening of the skin from surgery	1.Assess drainage and dressings for signs of infection 2. Use aseptic technique when performing care on areas	1. The client's incision heals appropriately without complication	The client complies appropriately to the nurses' assessments and care of the surgical site. The client's response is a full recovery from surgery and no complications

2020)	results in a portal of entry for bacteria.	of opening in the skin		from infection. No modification needed.
2. Risk for impaired skin integrity related to intestinal resection as evidence by presence of ileostomy (Phelps, 2020)	Ileostomy presents the risk of irritation to the skin surrounding the stoma.	1. Educate client on ostomy care 2.Educate client on signs to call provider such as a cyanotic stoma	1. Client teaches back ostomy care and able to perform care independently	Client understands the vitality of maintaining healthy skin around the stoma to keep it viable. The client teaches back the skills of stoma care and signs and symptoms to report for complications. No modifications needed.
3. Risk for constipation related to opioid administration and intestinal resection as evidence by faint bowel sounds, NPO status, and prescribed opioids (Phelps, 2020)	Assessment of the client's bowel sounds indicates potential constipation due to hypoactivity and faint bowel sounds.	1. Continuously monitor intake and output 2.Ambulate client when tolerable	1. Client understands and compliant to ambulate once pain is controlled	Client is compliant to ambulating once pain is controlled. Ambulation helps to activate the gastrointestinal system. No modification needed.
4. Risk for deficient fluid volume related to NG tube and healing process as evidence by elevated BUN and creatinine (Phelps, 2020)	1400mL removed by NG tube and elevated BUN of 43 and creatinine of 1.32 indicate potential dehydration.	1. Monitor electrolyte status 2. Educate client and family on causes of dehydration and potential risks	1. Electrolyte balance is maintained and family understands the potential risks with dehydration	The client and family understand and accept the information on dehydration provided by the nurse. Electrolytes are monitored for early detection of potential complications. No modification

				needed.
5. Ineffective airway clearance related to decreased energy and altered level of consciousness as evidence by use of accessory muscles and diminished lung sounds (Phelps, 2020).	The client uses accessory muscles to breath and respiratory rate of 20. Upon auscultation, lung sounds were diminished.	1. Ensure client is using incentive spirometer appropriately. 2. Elevate head of the bed to allow for optimal lung expansion	1. Client is able to use the incentive spirometer appropriately and prevent infection from anesthesia	Client understands and complies to the use of the incentive spirometer to clear the lungs. Lungs are cleared of remaining anesthesia and client recovers without complication. No modification needed.

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

Client woke up at 2am on 9/7/22 with SOB and back pain. Client went to sleep and woke up later at 7am with worsening SOB and back pain and shakiness. Client is fatigued. Client is experiencing pain of 9 for his back.

Nursing Diagnosis/Outcomes

or infection related to invasive procedure as evidence by elevated WBC and abdominal incision site (Phelps, 2020)
The client's incision heals appropriately without complication
Risk for impaired skin integrity related to intestinal resection as evidence by presence of ileostomy (Phelps, 2020)
Client teaches back ostomy care and able to perform care independently
Risk for constipation related to opioid administration and intestinal resection as evidence by faint bowel sounds, NPO status, and prescribed opioids (Phelps, 2020)
Client understands and compliant to ambulate once pain is controlled
Risk for deficient fluid volume related to NG tube and healing process as evidence by elevated BUN and creatinine (Phelps, 2020)
Electrolyte balance is maintained and family understands the potential risks with dehydration
Ineffective airway clearance related to decreased energy and altered level of consciousness as evidence by use of accessory muscles and diminished lung sounds (Phelps, 2020).
Client is able to use the incentive spirometer appropriately and prevent infection from anesthesia

Objective Data

Hgb: 11.6
RBC: 3.69
WBC: 16.8
Neutrophils: 92.8
K+: 4.0/3.2
BUN: 43/28
Creatinine: 1.24/1.32
HR:84
BP:141/77
RR:20
Temp:98.4O2: 96%

Client Information

ient is 87 years old man living at home with his wife. The client was brought to the hospital due to worsening symptoms of SOB/back pain/shaking. After assessment client was diagnosed with atrial fibrillation and received surgery for ischemic colitis.

Nursing Interventions

1.Assess drainage and dressings for signs of infection
2. Use aseptic technique when performing care on areas of opening in the skin
1. Educate client on ostomy care
2.Educate client on signs to call provider such as a cyanotic stoma
. Continuously monitor intake and output
.Ambulate client when tolerable
. Monitor electrolyte status
. Educate client and family on causes of dehydration and potential risks
1. Ensure client is using incentive spirometer appropriately.

2. Elevate head of the bed to allow for optimal lung expansion