N431 Care Plan #1

Lakeview College of Nursing

Marianna Craighead

Demographics (3 points)

Date of Admission 9/12/22	**Client Initials** A.H.	**Age** 70	**Gender** Male
Race/Ethnicity White	**Occupation** NA	**Marital Status** Single	**Allergies** NKA
Code Status Full	**Height** 5’9”	**Weight** 191	

Medical History (5 Points)

Past Medical History: Diabetic type 2, Hypertension, Hyperlipidemia, Prostatic hypertrophy, Depression, Autistic

Past Surgical History: Hernia repair

Family History: NA

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

Assistive Devices: NA

Living Situation: Lives at home with mom

Education Level: High School

Admission Assessment

Chief Complaint (2 points): Abdominal Pain

History of Present Illness – OLD CARTS (10 points): Patient came into ER due to the complaints of black tarry stool that were diarrhea. He had also lost consciousness and hit his head in a bathroom stall. States That he has had nausea and some vomiting that started today with the diarrhea and has gotten worse as the day went on. Patient hadn’t tried any previous treatment. Came in due to loss of consciousness.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute Pancolitis

Secondary Diagnosis (if applicable): Syncope

Pathophysiology of the Disease, APA format (20 points): Acute Pancolitis see 4 page

Pathophysiology References (2) (APA):

MediLexicon International. (2022, February). *Pancolitis: Symptoms, causes, and treatment*. Medical News Today. Retrieved September 17, 2022, from https://www.medicalnewstoday.com/articles/320064

Shin, D. S., Cheon, J. H., Park, Y. E., Park, Y., Park, S. J., Kim, T. I., & Kim, W. H. (2018). Extensive disease subtypes in adult patients with ulcerative colitis: non-pancolitis versus pancolitis. *Digestive diseases and sciences*, *63*(11), 3097-3104.

Pancolitis is a form of ulcerative colitis that affects the entire large intestine or bowel; is a type of inflammatory bowel disease (Shin et al., 2018). Pancolitis is a chronic condition with no known cure. Pancolitis is a type of ulcerative colitis, which is an autoimmune disease that affects the colon (Medilexicon International, 2022). An estimated that around 20% of people who have ulcerative colitis will have pancolitis (Medilexicon International, 2022).

Pancolitis and ulcerative colitis main symptoms very. Pancolitis symptoms are recurring diarrhea, which can contain blood mucus or pus, abdominal pain, urgent need to empty bowels, tenesmus, fatigue, weight loss, loss of appetite, fever, and night sweats (Medilexicon International, 2022). Patient A.H. presented to the emergency room on 9/12/22 with the following symptoms: complaints of black tarry stool that were diarrhea. He had also lost consciousness and hit his head in a bathroom stall. States That he has had nausea and some vomiting that started today with diarrhea and has gotten worse as the day went on. Also complains of increased tiredness. A.H.'s symptoms collaborate with diarrhea by the patient having black tarry stools. He also complained of having abdominal, feeling tired, and having a loss of appetite. These are symptoms that coordinate with the diagnosis of pancolitis.

Labs and diagnostic testing are used to help diagnose the disease. Some of the blood tests performed if the disease is present is ESR, CRP, and PV (Medilexicon International, 2022). A CT scan of the abdomen is also performed to be able to see detailed images of the abdomen (Medilexicon International, 2022). A.H. had a CT of the abdomen and it showed cholelithiasis with mild diverticulosis. Another diagnostic test that can be performed is a colonoscopy; this allows the physician to be able to see the inside of the colon and take a biopsy of the colon. A.H. is scheduled to have a colonoscopy with his primary care provider in October.

Some treatment methods are antiulcer medications, anti-inflammatory medications, and corticosteroids (Medilexicon International, 2022). Surgical removal of the bowel may be performed if it is affecting the person's quality of life and they will have an ileostomy (Medilexicon International, 2022). A.H. is taking antiulcer medications which are helping to elevate his symptoms. There is no cure for pancolitis just management of symptoms. A.H. is able to manage the symptoms and causing them to decrease with his treatments that he is currently taking.

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.5-5.2	3.53	3.58	NA
Hgb	12-18	10.9	10.2	This lab value can be abnormal on the patient related to diarrhea which cause an imbalance within the body (Hinkle & Cheever, 2022).
Hct	37-51%	32%	34%	This lab value can be abnormal on the patient related to diarrhea which cause an imbalance within the body (Hinkle & Cheever, 2022).
Platelets	140-400	218	238	This value is within normal limits
WBC	4-11	8.76	5.9	This value is within normal limits
Neutrophils	1.6-7.7	7.59	4.18	This value is within normal limits
Lymphocytes	1.0-4.90	1.61	1.23	This value is within normal limits
Monocytes	0-1.0	0.49	0.46	This value is within normal limits
Eosinophils	0-0.50	0.02	0.01	This value is within normal limits
Bands	0.01-0.20	0.02	0.01	This value is within normal limits

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145	131	138	This lab value can be abnormal on the patient related to diarrhea which cause an imbalance within the body (Hinkle & Cheever, 2022).
K+	3.5-5.1	4.7	4.0	This value is within normal limits
Cl-	98-107	102	106	This value is within normal limits

CO2	22-29	22	23	This value is within normal limits
Glucose	74-100	145	76	This lab value can be abnormal on the patient related to diarrhea which cause an imbalance within the body (Hinkle & Cheever, 2022).
BUN	0.2-1.2	0.4	1.3	This value is within normal limits
Creatinine	0.55-1.30	1.30	1.05	This value is within normal limits
Albumin	3.5-5.5	4.1	NA	This value is within normal limits
Calcium	8.9-10.6	9.9	9.1	This value is within normal limits
Mag	1.6-2.6	1.9	2.0	This value is within normal limits
Phosphate	2.5	2.6	NA	This value is within normal limits
Bilirubin	0.2-1.6	0.4	NA	This value is within normal limits
Alk Phos	40-150	56	NA	This value is within normal limits
AST	5-34	21	NA	This value is within normal limits
ALT	0-55	19	NA	This value is within normal limits
Amylase	22-1125	NA	NA	There was no lab value on this patient
Lipase	<140	NA	NA	There was no lab value on this patient
Lactic Acid	Venous:0.5-1.7	NA	NA	There was no lab value on this patient
Troponin	0.001-0.12	NA	NA	There was no lab value on this patient
CK-MB	5-25 IU/L	NA	NA	There was no lab value on this patient
Total CK	22-198	NA	NA	There was no lab value on this patient

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.8-1.2	NA	NA	There was no lab value on this patient
PT	11-13 seconds	NA	NA	There was no lab value on this patient
PTT	21-35 seconds	NA	NA	There was no lab value on this patient
D-Dimer	<250	NA	NA	There was no lab value on this patient
BNP	<100	NA	NA	There was no lab value on this patient
HDL	35-65	NA	NA	There was no lab value on this patient
LDL	<160	NA	NA	There was no lab value on this patient
Cholesterol	<205	NA	NA	There was no lab value on this patient
Triglycerides	44-180	NA	NA	There was no lab value on this patient
Hgb A1c	4.4-6.4%	5.6%	NA	This lab value is normal
TSH	0-15	NA	NA	There was no lab value on this patient

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow to amber Clear	Yellow and clear	NA	This lab value is normal
pH	5.0-9.0	5.5	NA	This lab value is normal
Specific Gravity	1.003-1.030	1.015	NA	This lab value is normal
Glucose	Negative	Negative	NA	This lab value is normal
Protein	Negative	Negative	NA	This lab value is normal
Ketones	Negative	Negative	NA	This lab value is normal

WBC	0-5	4	NA	This lab value is normal
RBC	0-2	0	NA	This lab value is normal
Leukoesterase	Negative	Negative	NA	This lab value is normal

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	NA	NA	There was no lab value on this patient
PaO2	80-100	NA	NA	There was no lab value on this patient
PaCO2	35-45	NA	NA	There was no lab value on this patient
HCO3	22-26	NA	NA	There was no lab value on this patient
SaO2	92-100%	NA	NA	There was no lab value on this patient

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	NA	NA	There was no lab value on this patient
Blood Culture	Negative	NA	NA	There was no lab value on this patient
Sputum Culture	Negative	NA	NA	There was no lab value on this

				patient
Stool Culture	Negative	Pending results	NA	Pending results

Lab Correlations Reference (1) (APA):

Carle Database (2022)

Hinkle, J.L., & Cheever, K. H. (2022). *Brunner suddarth's textbook of medical-surgical nursing* (15 th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT of the Brain- Normal, CT of the abdomen- Cholelithiasis with mild diverticulosis

Diagnostic Test Correlation (5 points): A CT scan is that can be done using dye or without dye that takes a series of detailed pictures of the area inside the body (Hinkle & Cheever, 2022). The patient had a CT of the brain due to episode of syncope. The patient had a CT of the abdomen related to the abdominal pain.

Diagnostic Test Reference (1) (APA):

Hinkle, J.L., & Cheever, K. H. (2022). *Brunner suddarth's textbook of medical-surgical nursing* (15 th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

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

Home Medications (5 required)

Brand/Generic	Oxybutynin Oxytrol	Tamsulosin Flomax	Quinapril Accupril	Atorvastatin Lipitor	Finasteride Proscar
Dose	5mg	0.4mg	10mg	20mg	5mg
Frequency	BID	Daily	Daily	Daily qhs	Daily qhs
Route	PO	PO	PO	PO	PO
Classification	Anticholinergic	Alpha Adrenergic antagonist	Ace inhibitor	HMG-CoA Reductase inhibitor	Reductase inhibitor
Mechanism of Action	Antispasmodic (urinary)	Benign prostatic hyperplasia agent	Antihypertension	Antihyperlipidemic	Benign prostatic hyperplasia agent
Reason Client Taking	Prostate hypertrophy	Prostate hypertrophy	Hypertension	Hyperlipidemia	Prostate hypertrophy
Contraindications (2)	Angle-closure glaucoma Gastric retention	Hypersensitivity to tamsulosin or its components NA	Aliskiern therapy Hypersensitivity to quinapril	Hepatic disease Hypersensitivity to atorvastatin	Hypersensitivity to finasteride Female
Side Effects/Adverse Reactions (2)	Abnormal behaviors Arrhythmias	Arrhythmia Constipation	CVA Arrhythmias	Abnormal dreams Hypoglycemia	Asthenia Depression
Nursing Considerations (2)	Use cautiously in pt. with diarrhea may signal an incomplete GI Obstruction Do not crush	Prostate cancer should be ruled out before treatment Give medication 30	Use cautiously in patients with diabetes Use cautiously in renal impairment patients	Avoid the use in renal failure patients Use cautiously in diabetic patients	Urologic evaluation before starting medication Digital rectal

	tab or open capsule	minutes after the same meal each day			examination periodically of the prostate
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Watch for changes in CNS Assess urinary symptoms before an after-medication administration	Orthostatic hypotension Assess urinary symptoms	Potassium level Blood pressure before administration of medication	Liver function panel Cholesterol levels 2-4 weeks	Monitor PSA levels Assess prostate frequently
Client Teaching Needs (2)	Instruct patient to nut break chew or crush tabs must be swallowed whole Avoid drinking alcohol	Take30 minutes after the same meal each day Change positions slowly to prevent dizziness	If a procedure is being done inform the physician of the medication Consult the prescriber before using potassium supplements or salt substitutes that contain potassium	Not a substrate for a low-cholesterol diet Take in the evening at the same every day	Can cause sexual dysfunction Women should avoid handling medication

Hospital Medications (5 required)

Brand/Generic	Famotidine Pepcid	Sertraline Zoloft	Alum-Mag-Senath	Insulin asparts Novolog	Fentanyl Abstral
Dose	20mg	50mg	30mL	Blood sugar 181-230=1 unit 231-280= 2 units	25mcg

				281-330= 3 units 331-380=4 units 381> 5 units	
Frequency	Q12hrs	Daily	PRN q 6hrs	Q6hrs	PRN q3hrs
Route	IVP	PO	PO	Sub-Q	IVP
Classification	Histamine-2 blocker	SSRI	Aluminum salt	Antidiabetic	Opioid
Mechanism of Action	Antiulcer agent	Antidepressant	Antacid	Artificial insulin	Analgesic
Reason Client Taking	Chronic Diarrhea	Depression	Nausea/vomiting	Diabetes	Abdominal p
Contraindications (2)	Hypersensitivity to famotidine or other h2-receptor NA	Avoid given to bradycardia patient Increased risk of prolonged QT interval	Hypersensitivity to alum-mag-senath NA	Renal impairment patients Hypersensitivity to Novolog	Hypersensiti to fentanyl Upper airwa obstruction
Side Effects/Adverse Reactions (2)	Anxiety Abdominal pain	Abnormal dreams AV block	Encephalopathy Constipation	Hypoglycemia	Respiratory depression Asystole
Nursing Considerations (2)	Shake vigorously for 5-10 seconds before administration Dangerous for patients who have phenylketonuria	Monitor for hypo-osmolarity Monitor for GI bleed	Avoid giving 2 hrs before or after other medications Monitor CMP	Rotate injection sites Give 15-20 minutes prior to meal	Use in cauti with COPD patients Use with caution in patients with head injury
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess patients for abdominal pain Assess GI system	Assess for depression Monitor potassium levels	CMP (sodium and phosphate) Abdominal pain	Blood glucose level Monitor A1c	Respiratory assessment Pain assessm prior and aft administrati
Client Teaching Needs (2)	Wait to take antacids 30-60 minutes after taking famotidine Avoid alcohol	Avoid hazardous activities Don't stop abruptly	Avoid maximum dose for longer than 2 weeks Drink 2-3L of fluid a day	Rotate injection sites and avoid bruised sites Monitor blood sugar before injection of	Avoid grapefruit increases lev of fentanyl Do not take medication

	and smoking during famotidine therapy			medication	longer than needed

Medications Reference (1) (APA):

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

Assessment

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

GENERAL: **Alertness:** Yes **Orientation:** x4 **Distress:** No acute distress **Overall appearance:** Groomed and awake	Mr. A is a 70-year-old male. The client is groomed and awake. The client weighs 191 lbs and is 5'9" in height. The client is pleasant when speaking and is in no acute distress.
INTEGUMENTARY: **Skin color:** pink **Character:** dry **Temperature:** warm **Turgor:** less than two seconds **Rashes:** none **Bruises:** none **Wounds:** none **Braden Score:** 23 **Drains present: Y☐ N ☒** **Type:**	Skin is warm and dry upon palpation. Skin turgor is less than two seconds, normal mobility. Nails are without clubbing. There are no rashes or bruises upon inspection. The client's capillary refill is less than 3 seconds between fingers and toes bilaterally. Braden score of 23, indicating no risk. A 20g IV is in place in the right forearm.
HEENT: **Head/Neck:** Skull is normocephalic, neck is midline with body **Ears:** WNL **Eyes:** WNL **Nose:** WNL **Teeth:** Poor dentition	The client's head and neck are symmetrical and there are non-palpable lymph nodes and lobes. There is no visible abnormality of ears or palpable deformities. The sclera is white bilaterally. The client's cornea is clear b/l. Their conjunctiva is pink b/l with no mucus. Their EOMs are intact b/l and PERRLA b/l. The client's septum is midline. The client has poor dentition. The client does not have dentures. .
CARDIOVASCULAR: **Heart sounds:** Clear S1 and S2 without murmur **S1, S2, S3, S4, murmur etc.**	. Upon auscultation, there are clear S1 and S2 without murmurs. The client's PMI is palpable at the 5th intercostal space at the MCL. There is a normal rate and rhythm. Mr. A extremities are

Cardiac rhythm (if applicable): Normal sinus rhythm **Peripheral Pulses:** + 2 **Capillary refill:** Less than 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	pink, warm, and dry. There is no edema, palpated in all extremities. The epitrochlear lymph nodes are nonpalpable b/l. The client's pulses are 2+ b/l. Their capillary refill is less than 3 seconds between fingers and toes b/l.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	. Upon auscultation, the client's lungs are Resonant and clear b/l throughout posterior and anterior. Respirations are unlabored and no history of illicit drug use
GASTROINTESTINAL: **Diet at home:** Regular **Current Diet** Diabetic diet **Height:** 5'9" **Weight:** 191lbs **Auscultation Bowel sounds:** active in all quadrants **Last BM:** 9/13/22 **Palpation: Pain, Mass etc.:** No palpable mass or pain **Inspection:** **Distention:** None **Incisions:** None **Scars:** None **Drains:** None **Wounds:** None **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	. Upon inspection, the client's abdomen flat. There are active and normal bowel sounds and no tenderness after palpation of all four quadrants. The clients last BM was 9/13/22. The client does not follow a diabetic diet at home and his currently on a diabetic diet. The client denies nausea, pain, and vomiting. There is no pain with defecation. There is no distention, incisions, scars, or wounds visible on the abdomen.
GENITOURINARY: **Color:** Yellow **Character:** Clear **Quantity of urine:** 460 **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** No abnormalities **Catheter: Y ☐ N ☒** **Type:** **Size:**	The client urinal had 460mL of urine that was yellow and clear. The client has no complaints of urinary system. The clients genitals have no abnormalities.
MUSCULOSKELETAL:	. The client shows no signs of muscular atrophy

Neurovascular status: Normal **ROM:** Active **Supportive devices:** **Strength:** 5/5 b/L throughout **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** 30 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	in limbs. The client's arm muscle strength is rated at a 5/5 and their hip muscle strength is rated at a 5/5. The client is a standby due to the episode of syncope. Fall score of 30. Client also has a shuffle to his gait. Client does not use assistive devices to get around.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** yes **Mental Status:** Alert but is intellectually delayed **Speech:** disorganized **Sensory:** intact **LOC:** None	. The patient is alert and restless. The client-oriented x4; to person, place, time, and situation. The client's speech is disorganized in thought. Upon assessment, PERRLA b/l. The client's strength is equal throughout. The client performed pedal pushes and hand grips with ease.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** Medication and Support frothe m mother **Developmental level:** Intellectually delayed **Religion & what it means to pt.:** Is Christian but doesn't actively practice **Personal/Family Data (Think about home environment, family structure, and available family support):** Has support from family	. The client is alert and oriented x4 (to person, place, time, and situation). Thought processes are disorganized and memory is intact. The client is developmentally delayed due to an autistic diagnosis. The patient lives at home with his mother but has adequate support from family.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	60	151/72	18	97.1	100 % on room air
1030	65	128/72	18	97.8	98% on room air

Vital Sign Trends: Stable

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	1-10	NA	0	NA	NA
1030	1-10	NA	0	NA	NA

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g **Location of IV:** RFA **Date on IV:** 9/12/22 **Patency of IV:** excellent **Signs of erythema, drainage, etc.:** No **IV dressing assessment:** dry clean intact	Saline Lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
560mL (water)	460 (urine)

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was calm and cooperative during assessments. Client was discharged home with mother.

Procedures/testing done: The client had few labs drawn at 0515 without complications

Complaints/Issues: Currently has no complaints or concerns

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Client is being compliant with the diabetic diet, the client is compliant with stand by assistance

Physician notifications: Any abnormalities related to the patient

Future plans for client: Has scheduled colonoscopy in October

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): NA

Equipment needs (if applicable):NA

Follow up plan: Follow up with PCP when back from vacation or if symptoms come back go to

Education needs: Compliance with diabetic diet

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.
Abdominal pain is related to inflammation of the colon as evidenced by diarrhea.	This diagnosis was chosen due to the chief complaint and diagnosis.	Fentanyl 25 mcg q 3hrs prn for pain Famotidine 20 mg q 12 hrs. for inflammation/diarrhea	Patient will have a pain score of less than 2 after the administration of medications.	The client was compliant with the medication orders and tolerated it well. The client was able to achieve to goal and had a pain score of 0.
At risk for fluid and electrolyte imbalance related to diarrhea as evidenced by abnormal lab values.	This diagnosis was chosen due to abnormal labs.	Monitor vital signs q 4hrs. Monitor intake and output. Monitor CMP q daily	Patient will have no abnormal labs prior to discharge.	The client was compliant with interventions. The client still had an abnormal HGB/HCT prior to discharge.
Risk for fall related to fall score of 30 as evidenced by syncope	This diagnosis was chosen due to the client loss of	The patient will be a standby assist. There will be mats and a bed alarm on	The patient will not have a fall prior to discharge.	The patient understood the safety reason behind having a standby assist. The

episode.	consciousness and falling and hitting his head.	the patient's bed.		patient did not sustain a fall prior to discharge.
Knowledge deficit related to intellectual delay as evidenced by disorganized thoughts.	This diagnosis was chosen due to the client's diagnosis of intellectual delay.	The medical staff will speak in lames term to the patient and make sure he understands what was said. The medical staff will also explain medications to family and make sure they understand as well.	The patient will be able to understand medical staff during interactions and ask question if he doesn't understand during his hospital stay.	The patient was able to understand medical staff and if he did not understand he asked staff to explain in another way. The patient and family were able to meet the goal.

Other References (APA):

Phelps, L.L. (2020). Sparks and Taylor's Nursing Diagnosis Reference Manual (11th ed.). Wolters Kluwer.

Concept Map (20 Points) See page 21

Subjective Data

Chief complaint abdominal pain
On 9/12/22 complaints of black tarry stool that were diarrhea. He had also lost consciousness and hit his head in a bathroom stall. States That he has had nausea and some vomiting that started today with the diarrhea and has gotten worse as the day went on. Patient hadn't tried any previous treatment. Came in due to loss of consciousness. Patient currently denies any pain. Doesn't have any questions or concerns currently.

Nursing Diagnosis/Outcomes

ominal pain is related to inflammation of the colon as evidenced by diarrhea.
Patient will have a pain score of less than 2 after the administration of medications.
At risk for fluid and electrolyte imbalance related to diarrhea as evidenced by abnormal lab values.
Patient will have no abnormal labs prior to discharge.
Risk for fall related to fall score of 30 as evidenced by syncope episode.
The patient will not have a fall prior to discharge.
Knowledge deficit related to intellectual delay as evidenced by disorganized thoughts.
The patient will be able to understand medical staff during interactions and ask question if he doesn't understand during his hospital stay.

Objective Data

Vitals: BP 128/68, P 65, RR 18, temp 97.1, O2 96% on room air
Weight: 191lbs
Height: 5'9"
Abnormal findings from the assessment:
The client has poor dentition. The client does not have dentures. Fall score of 30. The client also has a shuffle to his gait. The client's speech is disorganized in thought the thought process is disorganized. The client is developmentally delayed due to an autistic diagnosis.

Client Information

A.H. is a 70-year-old male who is a full-code.
PMH: Diabetes, Autism, Depression, Hypertension, prostatic hypertrophy, Intellectual disability, hyperlipidemia
PSH: Hernia repair
Family history: Unable to obtain
Lives at home with mom
Admitted on 9/12/22
Discharged 9/14/22

Nursing Interventions

Fentanyl 25 mcg q 3hrs prn for pain
Famotidine 20 mg q 12 hrs. for inflammation/diarrhea
Monitor vital signs q 4hrs.
Monitor intake and output.
Monitor CMP q daily
The patient will be a standby assist
There will be mats and a bed alarm on the patient's bed.
The medical staff will speak in lames term to the patient and make sure he understands what was said.
The medical staff will also explain medications to family and make sure they understand as well.