N431 Care Plan # 1

Lakeview College of Nursing

Kati Davis

Demographics (3 points)

Date of Admission	**Client Initials**	**Age**	**Gender**
9/7/22	R. W	87	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian/Not Hispanic or Latino	Self-employed (lawyer)	Married	Lisinopril Reaction: Swelling Severity: High
Code Status	**Height**	**Weight**	
Full Code	6’ 8”	255lb	

Medical History (5 Points)

Past Medical History: The patient has a past medical history of urinary tract infections, gross hematuria hypothyroidism, hypertension, and atrial fibrillation.

Past Surgical History: The patient has a past surgical history including a left foot debridement, cataract surgery, and a tonsillectomy.

Family History: Family history was obtained from the wife. Per the wife, the patient’s father had a brain tumor and his sister passed away from ovarian cancer.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): The patient has never smoked tobacco. The patient has never used smokeless tobacco. The patient has never used illicit drugs. The patient reports being an alcohol user; he has, on average, one beer every 2 weeks with dinner. He has done this for the past 20 years.

Assistive Devices: The patient was given a cane after his foot debridement. This is in the home and used as needed.

Living Situation: The patient lives with his wife.

Education Level: The patient has a Juris Doctor (JD) degree. He is currently still a practicing lawyer.

Admission Assessment

Chief Complaint (2 points): Shortness of breath and back pain

History of Present Illness – OLD CARTS (10 points): The patient is an 87-year-old male who presented to the emergency department (ED) on 9/6/22 with lower back pain. His wife was present and stated the pain started around 2:00 am (9/6/22). The pain was severe enough to wake him out of his sleep. The discomfort lasted for about half an hour and then would subside. The patient was able to lie back down comfortably and get some rest. The pain resumed once he got up that morning and positioned himself in his recliner. Changing positions triggered the discomfort. The pain was stabbing and caused the patient's breathing to become heavy. The patient did not take any over-the-counters prior to presenting to the ED.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Atrial fibrillation

Secondary Diagnosis (if applicable):

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

Atrial fibrillation, also known as A-fib, is a cardiac rhythm disorder that may cause blood clots in the heart because it is erratic and frequently very rapid (Mayo Clinic, 2021). Atrial fibrillation is the most common cardiac arrhythmia. The atria experience chaotic electrical activity during atrial fibrillation—the atria quiver instead of contracting as a unit (Hinkle et al., 2022). If someone is experiencing a-fib, the SA node is not controlling the heart's electrical rhythm. Instead, the atria endure this fast, erratic beat because of several impulses firing swiftly and simultaneously. The atria can then not efficiently contract or pump blood into the ventricles. This rapid, uneven heartbeat is the direct result of abnormal ventricular contraction.
Some individuals who have a-fib are asymptomatic. But, if the ventricles start to beat quicker, one can notice signs and symptoms such as irregular heartbeat, chest tightness, shortness of breath, dizziness, palpitations, and extreme fatigue (Cleveland Clinic, 2022).

If a-fib is suspected, the physician will probably order an EKG or echocardiogram to make the diagnosis after the initial assessment. Blood draws show some imbalances that can cause a-fib, but laboratory blood tests are mainly used to help decide the best medicine to prescribe based on the individual kidney and liver functions. When treating a-fib, controlling the heart rate and regaining a normal rhythm is a priority. Rate control medications may be prescribed for treatment. The patient is prescribed metoprolol to prevent ventricles from beating too fast. Blood thinners may also be prescribed; the patient is on apixaban, an anticoagulant. When a-fib cannot be controlled with medication, a procedure may be necessary. Electrical cardioversion or a permanent pacemaker may be considered (Cleveland Clinic, 2022).

If one is concerned with developing a-fib, there are modifiable risk factors. An individual can follow a heart-healthy diet with many fruits, vegetables, and whole grains. Smoking

cessation can be implanted as well as limiting alcohol intake. Tracking these healthy lifestyle choices can factor into other benefits such as weight loss and more nutritional cholesterol levels (Cleveland Clinic, 2022). If someone is concerned about heart health, they can reach out to their PCP for guidance and questions.

Pathophysiology References (2) (APA):

Cleveland Clinic. (2022). *Atrial fibrillation (AFIB): Causes, symptoms and treatment*. Cleveland Clinic. Retrieved September 24, 2022, from https://my.clevelandclinic.org/health/diseases/16765-atrial-fibrillation-afib

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

Mayo Clinic. (2021, October 19). *Atrial fibrillation*. Mayo Clinic. Retrieved September 24, 2022, from https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624

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	4.40-5.80 10(6) mcL	3.87	2.85	Low RBC can be caused by malnutrition. The patient recently got an ileostomy bag and just returned to a general diet on 9/21. The lack of nutrition can trigger anemia (Sonora Quest Laboratories, 2022).
Hgb	13.0-16.5	12.5	9.2	The HGB is low because the RBCs

	g/dL			are low. RBC carries the HGB which carries O2 throughout the body.
Hct	38.0-50.0%	36.5	26.7	HCT reflects the percentage of blood volume that makes up the RBC. Just as above, the lack of nutrition due to the new ileostomy bag could be triggering slight anemia (Sonora Quest Laboratories, 2022).
Platelets	140-440 10(3) mcL	212	427	
WBC	4.00-12.00 10(3) mcL	11.00	7.50	
Neutrophils	40.0-68.0%	*N/A*	69.3 ^	This is a slight elevation. Higher neutrophil level can indicate stress. The patient could be stressed from being in the hospital for two weeks (Morris, 2018).
Lymphocytes	19.0-49.0%	*N/A*	13.8	
Monocytes	3.0-13.0%	*N/A*	14.8 ^	An elevated monocyte count could be an indication of the body trying to fight infection. The patient's CT showed a thickened bowel wall... this thickening could be a sign of a possible infection (Yazdi, 2021).
Eosinophils	0.0-8.0	*N/A*	0.8	
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-	133-144 mmol/L	138	145 ^	The patient is on hydrochlorothiazide. This is a diuretic. Although this level is not concerningly high, hypernatremia can be a result of diuretics.
K+	3.5-5.1 mmol/L	3.5	3.8	

Cl-	98-107 mmol/L	103	117 ^	Hyperchloremia can result from high sodium levels in the blood. Although the patient's sodium level was only slightly elevated... it is still considered not "in range" and could be the cause of this elevation (Carlos, 2021).
CO2	21-31 mmol/L	24	19	The patient had moments of rapid breaths. During these moments of elevated respirations, the patient was exhaling more than he could inhale Because of this breathing pattern, CO2 may become lower.
Glucose	70-99 mg/dL	100 ^	109 ^	This is a slight elevation. These levels are not necessarily concerning. Like neutrophils, glucose levels can elevate in moments of stress. The patient has been in the hospital for 2 weeks.
BUN	7-25 mg/dL	22	36 ^	An elevated BUN reading may indicate the presence of renal damage or illness (Healthwise Staff, 2022). This damage could be cause by the hypertension the patient has.
Creatinine	0.50 – 1.20 mg/dL	1.47 ^	0.94	High blood pressures can harm the kidney's blood vessels, impairing kidney function and resulting in high creatinine levels (Sherrell, 2021). The patient has a previous medical history of hypertension.
Albumin	3.5-5.7 g/dL	3.7	3.5	
Calcium	8.8-10.2 mg/ dL	8.2	7.8	I am unable to identify why this lab value is abnormal. I thought this was in relation to the patient's hypothyroidism, but I believe calcium levels are more affected by the diagnosis of hypoparathyroidism.
Mag	1.6-2.6 mg/dL	*N/A*	2.0	
Phosphate	*N/A*	*N/A*	*N/A*	
Bilirubin	0.2-0.8 mg/dL	0.8	0.8	

Alk Phos	34-104 U/L	*N/A*	91	
AST	13-39 U/L	16	24	
ALT	7-52 U/L	8	16	
Amylase	*N/A*	*N/A*	*N/A*	
Lipase	*N/A*	*N/A*	*N/A*	
Lactic Acid	*N/A*	*N/A*	*N/A*	
Troponin	0.000-0.040 ng/mL	0.079 ^	*N/A*	Like BNP, elevated troponin levels are going to show when there is damage to the heart muscle. This damage does not necessarily have to mean heart failure but could indicate some damage that occurred during the episode of dysrhythmia (A fib) when the heart was beating chaotically (Georgilis & Byfield, 2022).
CK-MB	*N/A*	*N/A*	*N/A*	
Total CK	*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*	1.8 ^	The patient is on an anticoagulant. This can elevate the PT/INR values.
PT	10.1-13.1 seconds	*N/A*	19.8 ^	The patient is on an anticoagulant. This can elevate the PT/INR values.
PTT	25-36 seconds	27	*N/A*	
D-Dimer	0-622 ng/mL	14,103 ^	*N/A*	D-dimer levels can be elevated after recent surgery. The patient recently underwent surgery to place an ileostomy (Medline Plus, 2020).
BNP	0-100 pg/mL	165 ^	*N/A*	There is not a specific lab to watch

				for that determines A Fib. But, if a patient has atrial fibrillation, it could weaken their heart if it persists. An elevated BNP could detect heart muscle damage that transpired from the episode of A-fib when the heart was not pumping in the way it needed to (Georgilis & Byfield, 2022).
HDL	*N/A*	*N/A*	*N/A*	
LDL	*N/A*	*N/A*	*N/A*	
Cholesterol	*N/A*	*N/A*	*N/A*	
Triglycerides	*N/A*	*N/A*	*N/A*	
Hgb A1c	*N/A*	*N/A*	*N/A*	
TSH	*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	Colorless-yellow	Dark yellow/clear	*N/A*	
pH	5.0-9.0	5.0	*N/A*	
Specific Gravity	1.003- 1.030	> 1.030 ^	*N/A*	This could be an indication that the patient is dehydrated (Johnson, 2022).
Glucose	Negative	Negative	*N/A*	
Protein	Negative	Trace!	*N/A*	A trace of protein is not necessarily concerning right away. If it starts to be excreted in excess, this could be a sign of a kidney disease.
Ketones	Negative	Trace!	*N/A*	Having some ketones in urine is not abnormal. This trace could be from the patient's dehydration and elevated blood sugar levels.
WBC	0-5	0-5	*N/A*	

RBC	0-2/ hpf	0-2	*N/A*	
Leukoesterase	Negative	1 +	*N/A*	This is a potential sign of a urinary tract infection (UTI).

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	7.41	*N/A*	
PaO2	30-40 nmmHg	20	*N/A*	The patient has been noted and observed to have labored and frequent breathing. These impaired breaths could cause the PaO2 to decrease
PaCO2	41-51	51	*N/A*	
HCO3	22-26 mmol/L	26.0	*N/A*	
SaO2	94-100%	94	*N/A*	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	*No growth*	*N/A*	*N/A*	
Blood Culture	*No growth*	*N/A*	*N/A*	
Sputum Culture	*No growth*	*N/A*	*N/A*	
Stool Culture	*No growth*	*N/A*	*N/A*	

Lab Correlations Reference (1) (APA):

Carlos, T. (2021, January 13). *High chloride levels (Hyperchloremia) Symptoms & Causes*. SelfDecode Labs. Retrieved September 24, 2022, from https://labs.selfdecode.com/blog/high-chloride-levels-hyperchloremia/

Georgilis, S., & Byfield, C. (2022). Atrial fibrillation: What nurses need to know. *Nursing made Incredibly Easy*, *20*(5), 24-31.

Healthwise Staff. (2022, July 13). *Blood urea nitrogen (BUN) test*. Interventional Cardiology Associates. Retrieved September 24, 2022, from https://icacardiology.com/health-library/healthwise/?DOCHWID=aa36271#:~:text=A%20high%20BUN%20value%20can,may%20cause%20a%20high%20BUN.

Medline Plus. (2020). *D-dimer test: Medlineplus medical test*. MedlinePlus. Retrieved September 24, 2022, from https://medlineplus.gov/lab-tests/d-dimer-test/#:~:text=Also%2C%20high%20D%2Ddimer%20levels,tests%20to%20make%20a%20diagnosis.

Morris, S. Y. (2018, September 29). *Neutrophils: Definition, counts, and more*. Healthline. Retrieved September 24, 2022, from https://www.healthline.com/health/neutrophils

Sonora Quest Laboratories. (2022). *Understanding the complete blood count (CBC)*. Sonora Quest. Retrieved September 24, 2022, from https://www.sonoraquest.com/patient/knowledge-center/understanding-the-complete-blood-count-cbc/#:~:text=Low%20RBC%20counts%2C%20hemoglobin%20and,can%20also%20cause%20low%20levels.

Yazdi, P. (2021, March 2). *Monocytes: Normal, High & Low Levels*. SelfDecode Labs. Retrieved September 24, 2022, from https://labs.selfdecode.com/blog/monocytes/

Zia, S. (2021). *High creatinine levels: Causes, symptoms, and when to seek help*. Medical News Today. Retrieved September 24, 2022, from https://www.medicalnewstoday.com/articles/when-to-worry-about-creatinine-levels

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

(1) Xray chest single view (9/15/22)

(2) CT abdomen pelvis w/o contrast (9/14/22)

Diagnostic Test Correlation (5 points):

(1) The patient had this diagnostic test done because of a presenting cough. Chest x-rays can detect infection or air in the space surrounding the lung. A chest X-ray may be done to rule out pneumonia or asthma (Cleveland Clinic, 2022). The patient's chest X-ray determined pulmonary congestion and free air beneath the right hemidiaphragm.

(2) The patient had this diagnostic test done because of suspected perforation. To diagnose conditions like appendicitis, pyelonephritis, or infected fluid collections, often called abscesses, CT scans of the abdomen are performed (John Hopkins, 2021). With this CT scan, the medical team was able to visualize a perforated viscus and a thickened bowel wall.

Diagnostic Test Reference (1) (APA):

Cleveland Clinic. (2022). *Chest X-ray: What to expect, diagnosis, safety, results*. Cleveland Clinic. Retrieved September 24, 2022, from https://my.clevelandclinic.org/health/diagnostics/10228-chest-x-ray

John Hopkins. (2021, August 8). *Computed Tomography (CT or cat) scan of the abdomen*. Johns Hopkins Medicine. Retrieved September 24, 2022, from https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/computed-tomography-ct-or-cat-scan-of-the-abdomen

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

Home Medications (5 required)

Brand/ Generic	hydroCHLOROthiazide/ Microzide, Oretc, Urozide	levothyroxine/ Synthroid	tamsulosin/ FLOMAX	triamcinolone/ KENALOG
Dose	25 mg	25mcg	0.4mg	0.1%
Frequency	Daily	Daily	Daily	Daily
Route	Oral	Oral	Oral	Topical
Classification	<u>Pharmacologic class</u>: Thiazide diuretic <u>Therapeutic class:</u> Diuretic	<u>Pharmacologic class:</u> Synthetic thyroxine (T4) <u>Therapeutic class:</u> Thyroid hormone replacement	<u>Pharmacologic class:</u> Alpha adrenergic antagonist <u>Therapeutic class:</u> Benign prostatic hyperplasia (BPH) agent	<u>Pharmacologic class:</u> Glucocorticoid <u>Therapeutic class:</u> Corticosteroid
Mechanism of Action	This is a diuretic that promotes the movement of sodium, chloride and water from the blood into the distal convoluted tubule. The goal is to reduce blood pressure and to stabilize cardiac output.	This replaces the endogenous thyroid hormone	Inhibits smooth-muscle contraction in the bladder neck and prostate, prostatic capsule, and prostatic urethra, which enhances the rate of urine flow and reduces symptoms of	Activates natural substances in the skin to reduce edema, redness, and pruritus

			BPH.	
Reason Client Taking	To manage his hypertension.	The patient has a previous medical history of hypothyroidism.	To treat BPH	To reduce inflammation on a spot the patient has on his back.
Contraindications (2)	1. Anuria 2. Hypersensitivity to hydrochlorothiazide	1. Hypersensitivity to lebothyroxine or its components 2. Uncorrected adrenal insufficiency	1. Hypersensitiivity to tamsulosin 2. Hypersensitivity to quinazolines, or their components.	1. Acute status asthmaticus 2. Hypersensitivity to triamcinolone or its components.
Side Effects/Adverse Reactions (2)	1. Hypotension 2. Elevated cholesterol and triglyceride levels	1. Arrhythmias 2. Palpitations	1. Arrhythmia 2. Chest pain	1. Increased intracranial pressure 2. Anaphylaxis
Nursing Considerations (2)	1. Give in the am and early evening to avoid nocturia 2. Monitor BP, daily weight, I&Os, and electrolyte levels, especially potassium.	1. Be aware that this drug is not prescribed for weight loss 2. Levothyroxine should be started at a low dose	1. Nurses should be aware that prostate cancer should be ruled out before prescribing tamsulosin 2. Drug should be given around 30 mins after the same meal every day.	1. Nurses should be aware that high doses of this drug are not recommended for patients with cranial trauma. 2. Use cautiously in patients with active or latent peptic ulcer, diverticulitis, and ulcerative colitis as there is an increased risk of a perforation for patients with these conditions.
Key Nursing Assessment(s) /Lab(s) Prior to Administration	Check BP prior to administration	Before administering levothyroxine, a patient would have a blood test done including T4, TSH, and T3 levels	Before being prescribed tamsulosin, a core needle biopsy may be done to rule out prostate cancer.	Before administration the respiratory status and lung sounds should be monitored.

Client Teaching Needs (2)	1. Advise patient to take in the am and early evening to avoid awakening throughout the night to use the restroom 2. Instruct patient to take with food or milk if stomach upset occurs.	1. Take in the morning on an empty stomach, 45 mins before eating breakfast. 2. Take medicine with a full glass of water	1. Patient should not chew, crush, or open capsules. 2. The nurse should instruct the patient to take the drug about 30 mins after the same meal each day.	1. Educate patient that the benefit of the drug may not occur for up to 2 weeks. 2. Teach patient how to administer topical cream.	

Hospital Medications (5 required)

Brand/Generic	**ertapenem (INVanz)**	**metoprolol (Lopressor)**	**apixaban (Eliquis)**	**pantoprazole (Protonix)**	**LORazepam (Ativan)**
Dose	1g	25mg	5mg	40mg	1mg
Frequency	Daily	BID	BID	Daily	Every 6 hours PRN
Route	Intravenous	Oral	Oral	Oral	Intravenous
Classification	Pharmacologic class: Carbapenem Therapeutic class: Antibiotic	Pharmacologic class: Beta Blocker Therapeutic class: Antianginal, antihypertensive	Pharmacologic class: Factor Xa inhibitor Therapeutic class: Anticoagulant	Pharmacologic class: Proton pump inhibitor Therapeutic class: antiulcer	Pharmacologic class: Benzodiazepine Therapeutic class: Anxiolytic
Mechanism of Action	This works by killing bacteria and inhibiting their growth.	This is a beta blocker. This changes the way the body reacts to some nerve impulses. It helps the heart pump blood easier, and slows heart rate.	This stops the clotting factor.	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphatase enzyme system, or proton pump, n gastric	Increases your calming chemical, (GABA), in the brain.

				parietal cells.	
Reason Client Taking	To prevent an infection following his colon surgery.	This is a rate control medication. This medication prevents the ventricles from being to quickly.	Blood thinners are often prescribed when a patient has a-fib.	To treat GERD short-term	To treat hospital acquired anxiety.
Contraindications (2)	1. Hypersensitivity to ertapenem, beta-lactams, and other drugs in the same clas 2. Hypersensitivity to local anesthetics of the amide type	1. Hypersensitivity to other beta blockers. 2. Cardiogenic shock	1. Active pathological bleeding 2. Severe hypersensitivity to apixaban or its components.	1) concurrent therapy with rilpivirine – containing products 2) hypersensitivity to pantoprazole	1. Hypersensitivity to benzodiazepines or to any of the components. 2. contraindicated in individuals with myasthenia gravis, COPS, sleep apnea, and bronchitis.
Side Effects/Adverse Reactions (2)	1. hypotension 2. Seizures	1. arrhythmias 2. Heart failure	1. Hypotension 2. Hemorrhagic stroke	1. Hepatic failure 2. Hepatoxicity	1. Suicidal ideations 2. Seizures
Nursing Considerations (2)	1. Do not mix with other drugs 2. Do not dilute this with solutions containing dextrose (sugar).	1. Use cautiously in patients with angina or hypertension who have CHF because beta blockers can depress the way the heart contracts which can worsen heart failure. 2. The nurse should be aware that the	1. Nurses should be aware that this should be administered to a patient with severe hepatic dysfunction 2. Crush tablet and mix with juice or water or mix with a soft food such as applesauce.	1. Nurses should inform the patient to inform the prescriber if they have a history of liver disease. 2. Nurses should inform patient to tell their physician if they are allergic to any kind of	1. Nurse should instruct the patient to avoid alcohol while taking this drug. 2. Nurses should reiterate that this drug does not treat anxiety disorder but just treats the symptoms.

		dose for this is highly individualized.		proton pump inhibitor.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check blood sugar as this can cause hyperglycemia	Checking heart rate is important before administering .	Patient should be monitored closely for bleeding .	Assess the patient for signs and symptoms of stomach pain, heart burn, stomach upset, and N/V	Monitor the patient's respiratory status because this drug can cause reparatory depression.
Client Teaching Needs (2)	1. Instruct patient to immediately report any sign of an allergic reaction. 2. Instruct patient to let their provider know if they have diarrhea that is severe and lasts longer than 3 days.	1. Instruct patient to take with food at the same time every day. 2. If patient is unable to swallow pill, the capsule may be opened and sprinkled over a soft food.	1. Instruct the patient to take this exactly how it is prescribed. 2. If patient is unable to swallow pill, the capsule may be opened and mixed with water, apple juice, or a soft food.	1. Advise patient to take before meals 2. Advise patient to not crush	1. Instruct patient to take drug exactly how it is prescribed. 2. Instruct patient to report excessive drowsiness and nausea

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *Nurse's Drug Handbook 2021.* Jones & Bartlett Learning. (Original work published 2021)

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and oriented to person, place, and time (A&Ox3). He is ill-appearing but not in acute distress. The patient is cooperative and pleasant.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 14** **Drains present: Y☐ N ☒** **Type:**	Skin is white, intact, and dry without jaundice. At the time of assessment fingers were cool to the touch. At this time I instructed the patient to take big breaths in through his nose and out of his mouth → this improved circulation and the fingertips began to warm up. Turgor is < 2 seconds. (-) for rashes. (+) for medial coccyx pressure injury. There is an incision midline abdomen.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Normocephalic, white sclera, moist mucous membranes, no oral lesions. The head and neck are symmetrical. Trachea is midline without deviation. Oral cavity pink moist and clear. Auricles are bilateral no visible deformities. The septum is midline no visible bleeding. Teeth are natural and missing several.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	(-) for chest pain at the time of assessment. Rate and rhythm S1, S2 are normal without murmur, click, rub, or gallops. Capillary refill < 2 seconds. No neck vein distension. No edema present.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breath sounds quick and labored in supine position. Lung expansion is symmetrical. Anterior and posterior chest walls have no tenderness, masses, or crepitus upon palpation.

	Breath sounds clear without wheezing or crackles.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☒ N ☐** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Home diet is considered normal. Per the wife, he eats healthy. Current diet in hospital setting is general. Height: 6' 8" Weight: 255lb Last BM: 9/21/22 Bowel sounds normoactive in all four quadrants. The abdomen is soft, flat, and non-tender The patient has a midline incision. The patient is ileostomy continent. Abdominal pouch was placed 9/11/22 in the RLQ.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient is wearing depends. The urine is yellow and clear. The patient was heavily continent x 3 during my clinical shift.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒** **Fall Score: 20** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☒**	Observed the presence of cranial nerve 1. The patient smelled his milkshake before taking a sip and expressed it smelled "good." Patient has a cane at home to use as needed. The wife stated he was moved to the chair using a patient lift the day before (9/20/22). Decreased active range of motion. Pain associated with position changes, especially in supine position. Strength 3/5
NEUROLOGICAL:	

MAEW: Y ☒ N☐ **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient is alert and awake. He can use senses as they are intact. Unaided sight. The patient seemed a little hard of hearing but is responsive. Hearing is unaided.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Appropriate affect, and a normal speech pattern. For coping, patient has wife at bedside. The patient's hobbies include mowing the grass, target shooting and watching sports. No specific religion is practiced. His developmental level would be categorized as normal adult.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1545	**110**	**159/85**	**31**	**98.0**	**95**
1700	**93**	**139/63**	**23**	**97.6**	**96**

Vital Sign Trends: BP and respirations show improvement. Although not recorded on this document, the patient's O2 fluctuated throughout the day. The saturation would drop and then with deep breaths, return to an appropriate level.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1545	Numeric Scale	L & R foot	Severe 10/10	Aching	Told nurse, Rachel, his pain rating. We gave him a pain pill shortly after the assessment.

1710	Numeric Scale	No pain present	0/10	No pain present	No pain present

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:**	The patient has a PICC Triple Lumen. Length: 20 cm PICC Line located on patient's right upper arm. No redness, tenderness, or swelling. The access is clean, dry, and intact. Normal saline running at 75 ml/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Normal Saline: 375 mL Half of a McDonald's milkshake: 180 mL 2 cups of water: 480 mL	425 mL (Colostomy output) Heavily continent x 3 void

Nursing Care

Summary of Care (2 points)

Overview of care: During this clinical time, I was able to assist the nurse with ostomy care and bed bathing. Although the patient slept a lot, he was responsive with a fun/ornery sense of humor. I chatted with the wife often and we ended the day with her saying I am going to be a good nurse.

Procedures/testing done: No procedures or testing was done during my clinical hours.

Complaints/Issues: The only complaints were pain from the patient during position changes in bed.

Vital signs (stable/unstable): The vital signa were stable except for his O2 level at times. This O2 saturation would drop throughout the day but with deep breaths in through the nose and out through the mouth, this saturation level would rise.

Tolerating diet, activity, etc.: The patient is tolerating his general diet but did not tolerate the activity very well that the occupational therapist was helping with. He became very exhausted very quickly and had to lie back down.

Physician notifications: No updated physical notes during these clinical hours.

Future plans for client: Future plans include continuing and encouraging occupation therapy. The nurse notes “he has been lying in bed too long” and it is imperative to regain his range of motion. Once the patient discharges, he will need to go to an inpatient rehabilitation center.

Discharge Planning (2 points)

Discharge location: Inpatient rehabilitation facility

Home health needs (if applicable): The patient is not being discharged home. At this time, there are no home health needs.

Equipment needs (if applicable): The patient is not being discharged home. At this time, equipment is not needed.

Follow up plan: Follow up with primary care provider after discharge. It is encouraged to follow up with occupation therapy/speech therapy/physical therapy after discharge also.

Education needs: It is imperative to educate the patient and family on the importance of following up with PT/OT/ST. Reiterating the education on diet could also be helpful so the family can pass along those helpful tips to the patient’s future PT/OT team.

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 tissue perfusion related to decreased cardiac output as evidenced by chest pain on the day patient presented to ED.	I chose this nursing diagnosis because lack of oxygenated blood flow to certain areas of the body should be priority per ABCs.	1.Monitor the client's blood pressure 2.Keep assessing mental status, LOC, speech, and behavior patterns.	1. The patient will demonstrate increased perfusion as evidenced by vital sounds being within parameters.	- The patient was cooperative to nurse visits and frequent vital sign checks. - The patient's BP and respiration rate improved and the O2 level stayed at an appropriate number.
2. Risk for impaired skin integrity related to improper hygiene as evidenced by brand new ileostomy.	I chose this nursing diagnosis because it is important to educate the patient on proper hygiene of the new stoma to prevent infection.	1. Educate the patient and family on what a healthy stoma looks like and what to look out for that could indicate infection. 2.Keep the area surrounded the stoma clean and dry and free	1. The patient will demonstrate proper sizing and application of the wafer.	- The wife displayed nonverbal understanding while watching her husband's ileostomy bag be dumped and wiped off. - I was unable to visual the goals being worked towards as the stoma pouch did not need changed

		from stool.		during the time of my clinical.
3. Disturbed body image related to loss of control over bowel movements as evidenced by involuntary gas sounds.	This nursing diagnosis was chosen to emphasize the importance of mental health in healing. It is important the patient accept this lifestyle change.	1. Take a positive approach and provide ostomy care with confidence and a positive attitude. 2. Help the patient visualize a normal life.	1. For the patient to begin to demonstrate comfort with body image by performing his own stoma care.	- The wife appreciated my kindness and patience when caring for her husband. - Since the ileostomy is brand new, I was unable to observe the client performing his own stoma care as this is still being handled by the nursing staff
4. Risk for activity intolerance related to imbalanced oxygen supply as evidenced by O2 saturation in the 70s following his occupational therapy session.	I chose this nursing diagnosis because per the wife, this patient is a rather active man. He enjoys mowing the grass as a hobby and it is important that he regains exercise capability.	1.Monitor vital signs and mental status during therapy sessions 2. Balance rest periods with activity	1. I have a goal for the patient to be able to sit up in bed without showing signs of exhaustion.	- I was unable to implement my interventions as occupational therapy was only involved once during my clinical shift. - I was unable to see this goal achieved or worked towards during this clinical time.

Other References (APA):

Linda Lee Phelps. (2020). *Sparks & Taylor's Nursing Diagnosis Reference Manual.* Wolters Kluwer Medical.

Concept Map (20 Points):

Subjective Data

Upon arriving to the ED, the patient complained of chest pain.

Per the wife, the patient had been suffering with constipation prior to being admitted.

Nursing Diagnosis/Outcomes

1. Ineffective tissue perfusion related to decreased cardiac output as evidenced by chest pain on the day patient presented to ED.
-. The patient will demonstrate increased perfusion as evidenced by vital sounds being within parameters.
2. Risk for impaired skin integrity related to improper hygiene as evidenced by brand new ileostomy.
- patient will demonstrate proper sizing and application of the wafer.
3. Disturbed body image related to loss of control over bowel movements as evidenced by involuntary gas sounds.
- For the patient to begin to demonstrate comfort with body image by performing his own stoma care.
4. Risk for activity intolerance related to imbalanced oxygen supply as evidenced by O2 saturation in the 70s following his occupational therapy session

Objective Data

Vitals when patient presented to the ER

Temperature: 97.8

Pulse: 89

BP: 112/71

O2 Sat: 93% on room air

Client Information

The patient is an 87 yo male with a pertinent history of hypertension presenting with new onset of severe back pain that was associated with shaking, shortness of breath, and chest pain.

Nursing Interventions

- Monitor the client's blood pressure
- Keep assessing mental status, LOC, speech, and behavior patterns.
- Educate the patient and family on what a healthy stoma looks like and what to look out for that could indicate infection.
- Keep the area surrounding the stoma clean and dry and free from stool.
- Take a positive approach and provide ostomy care with confidence and a positive attitude.
- Help the patient visualize a normal life.
- Monitor vital signs and mental status during therapy sessions
- Balance rest periods with activity