N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
10/08/22	WM	62	M
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Divorced	Non-specified Environmental - Rash
Code Status	**Height**	**Weight**	
DNR (No CPR)	5’9”	150 lbs	

Medical History (5 Points)

Past Medical History: Asthma, COPD, Atrial fibrillation, Hypertension

Past Surgical History: Bilateral wrist fusion

Family History: Parents are deceased

Social History: Smokes 0.5 packs of cigarettes per day for the past 40 years. Drinks 12 cans of beer daily.

Assistive Devices: Glasses

Living Situation: Nursing home

Education Level: High school

Admission Assessment

Chief Complaint (2 points): Fever, hemoptysis, cough, hematemesis, melena, generalized weakness.

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

The symptoms began on 10/6 when the patient developed a fever. On 10/7, he began having bloody stools, and on 10/8, he arrived by ambulance at the OSF emergency department. By 10/8, he had developed an upper GI bleed with coffee ground emesis and epigastric abdominal pain.

On the way to the hospital, he became hypoglycemic with a blood glucose level of 47. The patient denies a history of ulcers or cirrhosis of the liver.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute liver failure due to alcohol cirrhosis

Secondary Diagnosis (if applicable): Spontaneous bacterial peritonitis

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

Alcoholic liver disease affects more than 2 million people in the United States (Capriotti, 2020). Although there is no known genetic predisposition for alcoholic liver disease, alcohol abuse does run in families (Capriotti, 2020). The damage to the liver from alcoholic cirrhosis causes severe functional impairment and the prognosis has a mortality rate of about 60% within 4 years of diagnosis (Capriotti, 2020). A beer equals about 12 grams of alcohol, and my patient has a history of drinking twelve cans of beer per day. Men who drink 60-80 grams a day over 10 years, or women who drink 20-40 grams a day over 10 years, will develop alcoholic liver disease with fatty liver (Capriotti, 2020). There are three different stages of alcoholic liver disease, beginning with fatty liver disease, which is reversible, alcoholic hepatitis, stage II which is sometimes reversible with cessation of alcohol, and cirrhosis being the final and irreversible stage (Hinkle & Cheever, 2018). Approximately 50% of people with alcoholic liver disease will progress to cirrhosis (Capriotti, 2020). Cirrhosis is the 3rd most common cause of death among people 45-65 years old, with alcohol cirrhosis having the worst prognosis (Capriotti, 2020). Some of the symptoms of cirrhosis that present in the later stages include nutritional deficiency, hepatocellular jaundice, which results from an abnormal amount of bilirubin in the blood and portal hypertension (Hinkle & Cheever, 2018). Dead liver cells are replaced by scar tissue

which eventually leads to portal hypertension and liver failure (Hinkle & Cheever, 2018). The blood backs up and leads to venous dilation of the esophagus and legs, and blood pressure increases in the portal venous system causing the blood to bypass the liver and preventing the hepatocytes from being able to perform essential functions (Hinkle & Cheever, 2018). When bilirubin builds up in the skin, it causes jaundice (yellowing of the skin), and sclera (Capriotti, 2020). Portal hypertension can also cause esophageal varices, where the veins in the esophagus will become distended and turn into varicose veins, which can rupture and bleed (Capriotti, 2020).

There are many lab tests run to check the function of the liver, but often won't show as abnormal until about 70% of the parenchyma of the liver is damaged (Hinkle & Cheever, 2018). Some liver tests include albumin, AST, ALT, bilirubin, alkaline phosphate, CBCs, and electrolytes (Hinkle & Cheever, 2018). Damage to the liver from alcohol abuse causes an abundance of problems and is shown in looking at the lab values. My patient came into the hospital on 10/08 with a primary diagnosis of acute liver failure due to alcoholic cirrhosis and a secondary diagnosis of spontaneous bacterial peritonitis and a gastrointestinal bleed. According to Tholey (2022), spontaneous bacterial peritonitis is the infection of the ascitic fluid which can be life-threatening; this patient is being treated with cefepime. The bilirubin, ALT, AST and alkaline phosphate, PT, and INR are all elevated due to the liver's inability to do its job effectively (Pagana et al., 2022). His electrolytes are low because the liver damage has caused malnutrition and malabsorption (Hinkle & Cheever, 2018). His RBC, Hct, Hgb are low due to excess fluid, which causes the blood to be diluted, and decreased platelets are due to cirrhosis and the liver not producing the hormone thrombopoietin needed to make the platelets (Pagana et al., 2022). My patient will be transitioning to a comfort care status sometime during the week.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

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

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). *Mosby's Manual of Diagnostic and Laboratory tests.* Elsevier

Tholey, D. (2022, September 26). *Spontaneous bacterial peritonitis (SBP) - hepatic and biliary disorders*. Merck Manuals Professional Edition. Retrieved October 13, 2022, from https://www.merckmanuals.com/professional/hepatic-and-biliary-disorders/approach-to-the-patient-with-liver-disease/spontaneous-bacterial-peritonitis-sbp

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	4.5-5.8	**3.43**	**3.38**	This patient has acute liver failure from alcoholic cirrhosis and an acute GI bleed which can cause iron-deficiency anemia (Hinkle & Cheever, 2018). He also has acute kidney injury, which decreases the production of erythropoietin which in turn causes a decrease in RBC production Hinkle & Cheever, 2018). Cirrhosis of the liver causes a breakdown of RBCs (Capriotti, 2020).

Hgb	13-16.5	**12.5**	**11.6**	Iron deficiency anemia impacts the production of RBCs which in turn results in a decrease of hemoglobin (Hinkle & Cheever, 2018). Cirrhosis of the liver causes a breakdown of RBCs (Capriotti, 2020)
Hct	38-50	39.4	**34.2**	Low RBCs from decreased production of erythropoietin also means a lower hematocrit, as the amount of RBCs in the blood is what makes up hematocrit (Capriotti, 2020). Cirrhosis of the liver causes a breakdown of RBCs (Capriotti, 2020)
Platelets	140-440	**118**	**42**	Decreased due to cirrhosis and the liver not producing the hormone thrombopoietin needed to make the platelets (Capriotti, 2020). Cirrhosis causes the spleen to be enlarged, which destroys platelets (Capriotti, 2020).
WBC	4-12	10.6	4.5	
Neutrophils	40-68%	**82.7%**	**79.6%**	Neutrophils are first on the scene when there is infection or inflammation (Capriotti, 2020). This patient has a GI bleed, spontaneous bacterial peritonitis, and sepsis secondary to acute liver failure/alcohol cirrhosis.
Lymphocytes	19-49	**7**	**7.7**	Lymphocytes are increased when there is infection or inflammation (Capriotti, 2020). This patient has a GI bleed, spontaneous bacterial peritonitis, and sepsis secondary to acute liver failure/ alcohol cirrhosis.
Monocytes	3-13	9.7	12.5	
Eosinophils	0-8%	0.2	0	
Bands	0-0.5	0	0	

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	**123**	**131**	Decreased sodium levels are associated with fluid retention due to the dilution of sodium in the blood (Hinkle & Cheever, 2018). My patient has fluid overload and 2+ pitting edema. Vomiting also causes electrolyte imbalance due to the loss of sodium, potassium, and chloride through fluids lost with emesis (Hinkle & Cheever, 2018).
K+	3.5-5.1	**5.3**	**3.1**	Acid base imbalance cause potassium to move into the cells from the blood (Hinkle & Cheever, 2018). Low magnesium levels also will cause the kidneys to excrete potassium in the urine (Hinkle & Cheever, 2018). Chronic alcoholic cirrhosis causes malnutrition which also is a reason for low potassium (Hinkle & Cheever, 2018). Vomiting also causes electrolyte imbalance due to the loss of sodium, potassium, and chloride through fluids lost with emesis (Hinkle & Cheever, 2018).
Cl-	98-107	**84**	**93**	Vomiting can cause an electrolyte imbalance due to the loss of sodium, potassium, and chloride through fluids lost with emesis (Hinkle & Cheever, 2018).
CO2	21-31	**12**	**27**	Decreased in my patient. AKI can impact the kidney's ability to correct acid-base imbalance (Hinkle & Cheever, 2018). A low CO2 with low potassium indicates respiratory acidosis (Hinkle & Cheever, 2018).
Glucose	70-99	**151**	**129**	Glucose is metabolized and regulated through the liver. Alcohol cirrhosis impairs the liver function (Hinkle & Cheever, 2018). This patient is also on Protonix which can cause elevated glucose levels (Jones & Bartlett, 2020).
BUN	7-25	25	**39**	BUN is related to the metabolic function of the liver and the excretory

				function of the kidneys. Elevated BUN levels occur due to AKI (Hinkle & Cheever, 2018).
Creatinine	0.5-1.2	**2.04**	1.19	Creatinine is related to the metabolic function of the liver and the excretory function of the kidneys. Elevated levels occur due to AKI (Hinkle & Cheever, 2018).
Albumin	3.5-5.7	**3.1**	**3.1**	Decreased in my patient due to cirrhosis which affects the liver's ability to synthesize albumin, therefore having poor protein and liver function (Pagana et al., 2022).
Calcium	8.6-10.3	**8.5**	**8**	Decreased because calcium binds to albumin; therefore, if albumin is low, calcium and magnesium will be low (Hinkle & Cheever, 2018). Chronic alcoholic cirrhosis causes malnutrition which also is a reason for low calcium (Hinkle & Cheever, 2018). AKI can also cause low calcium (Hinkle & Cheever, 2018).
Mag	1.6-2.6	2.3	2.1	
Phosphate	2.4-4.5	n/a	n/a	
Bilirubin	0.2-0.8	**7**	**8**	When the liver is damaged, the hepatocytes do not remove bilirubin from the blood, which is why this is elevated (Pagana et al., 2022).
Alk Phos	34-104	**150**	**122**	ALP is found in the liver and excreted into the bile. Damaged liver causes elevated ALP (Hinkle & Cheever, 2018).
AST	13-39	**219**	**260**	AST is made by hepatocytes, so when the liver is damaged, it leaks into the blood, which makes it high (Hinkle & Cheever, 2018).
ALT	7-52	**807**	**1367**	This enzyme is made by the liver, and when the liver is damaged, it leaks into the blood, making it elevated (Hinkle & Cheever, 2018).

Amylase	29-103	71	n/a	
Lipase	11-82	43	n/a	
Lactic Acid	0.5-2	**> 13.4**	1.7	Severe liver disease or shock can cause an increase in lactic acid levels (Pagana et al., 2022). This patient has cirrhosis of the liver and septic shock.
Troponin	0-0.04	**0.68**	**151**	Atrial fibrillation or sepsis can result in elevated troponin levels (Pagana et al., 2022). This patient has Afib and is also septic.
CK-MB	5-25	n/a	n/a	
Total CK	30-223	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	**12.8**	**6.4**	Increased bleeding time is caused by a damaged liver unable to effectively produce the clotting factors (Capriotti, 2020). This patient has acute liver failure/alcohol cirrhosis.
PT	25-36	**< 134**	**76.5**	Increased bleeding time is caused by a damaged liver unable to effectively produce the clotting factors (Capriotti, 2020). This patient has acute liver failure/alcohol cirrhosis.
PTT	10.1-13.1	**44**	n/a	Increased bleeding time is caused by a damaged liver unable to effectively produce the clotting factors (Capriotti, 2020). This patient has acute liver failure/alcohol cirrhosis.
D-Dimer	<250	n/a	n/a	
BNP	<100	n/a	n/a	

HDL	>60	n/a	n/a	
LDL	<130	n/a	n/a	
Cholesterol	<200	n/a	n/a	
Triglycerides	<150	n/a	n/a	
Hgb A1c	4-5.6% Diabetic <7%	n/a	n/a	
TSH	0.27-4.2	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	Yellow and clear	n/a	n/a	
pH	5.0-7.0	n/a	n/a	
Specific Gravity	1.003-1.005	n/a	n/a	
Glucose	Negative	n/a	n/a	
Protein	Negative	n/a	n/a	
Ketones	Negative	n/a	n/a	
WBC	0-25	n/a	n/a	
RBC	0-20	n/a	n/a	
Leukoesterase	Negative	n/a	n/a	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	n/a	7.4	
PaO2	80-100		**62**	The PaO2 measures the oxygen dissolved in plasma and determines the force of oxygen across the alveoli (Pagana et al., 2022). This patient has bilateral lower lobe partial atelectasis with small pleural effusions. This patient also has fluid overload.
PaCO2	35-45		**48**	A C02 greater than 45 indicates acidosis (Hinkle & Cheever, 2018). This patient is experiencing acute kidney injury and alcoholic liver cirrhosis, resulting in metabolic alkalosis.
HCO3	22-26		n/a	
SaO2	95-100%	**88**		Some of the reasons for decreased O2 in my patient include has bilateral lower lobe partial atelectasis with small pleural effusions. This patient also has fluid overload.

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	n/a	n/a	
Blood Culture	Negative	n/a	n/a	

Sputum Culture	Negative	n/a	n/a	
Stool Culture	Negative	n/a	n/a	

Lab Correlations Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

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

Jones & Bartlett Learning. (2020). 2020 *Nurse's Drug Handbook.*

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). *Mosby's Manual of Diagnostic and Laboratory tests.* Elsevier

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Computerized tomography (CT) of the abdominal pelvis without contrast was done on 10/8, which revealed bilateral lower lobe partial atelectasis and small bilateral pleural effusions. The stomach was moderately distended with fluid, slight ascites were present in the intraperitoneal space, and small bowel obstruction and liver cirrhosis were noted.

Diagnostic Test Correlation (5 points): The CT scan was the imaging tool used to evaluate the abdominal pelvis area of this patient. The CT provides different views of the area of concern, shows abnormalities, and assists with diagnosing the problem (Capriotti, 2020).

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

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

Home Medications (5 required)

Brand/Generic	metoprolol succinate/ Toprol - XL	acetylsalicylic acid/ASA Aspirin (chewable)	furosemide/ Lasix	potassium chloride/ Klor-con	atorvastatin calcium/Lipitor
Dose	25 mg	81 mg	40 mg	20 mEq	80 mg
Frequency	Daily	Daily	Daily	Daily	Nightly
Route	PO	PO	PO	PO	PO
Classification	Beta blocker/ Antianginal, antihypertensive	Salicylate NSAID	Loop diuretic Antihypertensive, Diuretic	Electrolyte cation Electrolyte replacement	HMG-CoA reductase Antihyperlipidemic
Mechanism of Action	Inhibits stimulation of beta receptor sites in the heart and decreases output and myocardial oxygen demand.	Blocks activity of cyclooxygenase	Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation	Acts as the major cation in intracellular fluid. It helps maintain normal renal function and acid-base balance	Reduces cholesterol levels by inhibiting HMG-CoA reductase
Reason Client Taking	Management of hypertension	Reduce the severity of or prevent acute MI	To reduce edema caused by alcoholic cirrhosis	To treat hypokalemia	To maintain control over hypercholesterolemia
Contraindications (2)	Cardiogenic shock Pulse less than 45 bpm	Active bleeding or coagulation disorders,	Anuria Hypersensitivity to furosemide	Acute dehydration Renal impairment	Hepatic disease Hypersensitiv

		hypersensitivity to aspirin			ity to atorvastatin
Side Effects/Adverse Reactions (2)	Anxiety Hepatitis	Confusion decreased blood iron level	Thrombocytopenia Hypomagnesemia	GI bleeding Dyspnea	Arrhythmias Hypoglycemia
Nursing Considerations (2)	Assess for signs of poor glucose control. Before taking this medication for heart failure, give an ACE inhibitor, digoxin, and a diuretic to stabilize the patient.	Do not administer to patients with tartrazine allergy. Monitor for tinnitus which is a reaction that can occur when the max dose has been taken.	Use cautiously in patients with advanced hepatic cirrhosis, especially if there is a history of electrolyte imbalance. Give in the morning to avoid interrupting patients' sleep	Administer with meals. Monitor for abdominal pain, distention, or GI bleeding	This medication should not be taken by patients who are taking cyclosporine. This medication should be used cautiously in patients who consume an excessive amount of alcohol or have liver disease.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Monitor daily dosage, more than 400 mg. The patient needs to be monitored for dyspnea. ECG due to the risk of AV block	Monitor for signs of allergic reaction. Monitor for signs of GI bleed	Weigh the patient daily before and during therapy to monitor for fluid loss Monitor BUN, creatinine, and electrolytes.	Monitor electrolyte levels. Review medical history for conditions that may predispose the patient to develop hyperkalemia	Liver function tests should be done before beginning this medication. Lipid levels should be measured two to four weeks after the start of the medication.
Client Teaching needs (2)	Take this medication at the same time each day. Taper the medication rather than stop it abruptly.	Stop taking if there are any signs of a GI bleed. Patients should talk with providers before taking this medication if they are taking medications for diabetes or gout.	Take at the same time every day to maintain therapeutic effects. Change positions slowly to minimize the effects of orthostatic hypotension.	Do not crush or chew. Monitor stools and notify the provider of black, tarry, or red stools.	This medication should be taken at the same time to maintain the intended effects. Take a missed dose immediately unless it is

					close to the time for the next dose.

Hospital Medications (5 required)

Brand/Generic	pantoprazole sodium/Protonix	cefepime hydrochloride/ Maxipime	diltiazem hydrochloride/ Cardizem	Octreotide acetate/ Sandostatin	potassium chloride
Dose	40 mg	1 g	5-15 mg/hr	75 mcg	20 mEq
Frequency	BID	TID	Once daily	BID	Q2 hr
Route	IV	IV	IV	IV	IV
Classification	Proton pump inhibitor/antiulcer	Cephalosporin antibiotic	Calcium channel blocker Antiarrhythmic	Octapeptide Somatropic hormone	Electrolyte cation Electrolyte replacement
Mechanism of Action	Inhibits the hydrogen-potassium-adenosine triphosphatase system in gastric cells reducing gastric acid production.	Interferes with bacterial cell wall synthesis to rupture and kill bacteria.	Inhibits calcium movement into the coronary and vascular smooth muscle, blocking calcium channels in cell membranes.	Controls diarrhea secretions by inhibiting the secretion of GI, pituitary, and serotonin hormones.	Acts as the major cation in intracellular fluid. Helps maintain normal renal function and acid-base balance.
Reason Client Taking	Treatment of GI bleed	Treatment of spontaneous bacterial peritonitis	Treatment of atrial fibrillation with ventricular tachycardia	Diarrhea and hypokalemia	Treatment of hypokalemia
Contraindications (2)	Concurrent therapy with products containing rilpivirine. Hypersensitivity to pantoprazole	Hypersensitivity to cephalosporins, penicillins, or other beta-lactam antibiotics. Drug interaction with potent diuretics results in an	Cardiogenic shock. Systolic blood pressure below 90 mmHg, ventricular tachycardia	Hypersensitivity to octreotide. Drug interactions include diuretics due to increased risk of fluid and electrolyte imbalances.	Acute dehydration Renal impairment

		increased risk of nephrotoxicity.			
Side Effects/Adverse Reactions (2)	Hepatic failure thrombocytopenia	Hepatic failure Renal failure	Ventricular tachycardia Acute renal failure	Arrhythmias hypotension	Bloody stools GI bleeding
Nursing Considerations (2)	Flush IV with normal saline before and after administration of this medication. For IV push over 2 minutes, reconstitute with 10 mL of normal saline.	Use cautiously in patients with impaired renal function or a history of GI disease. Assess bowel pattern daily for diarrhea.	Use cautiously in patients with hepatic or renal impairment. Assess for signs and symptoms of heart failure.	Dilute in 50 to 200 ml of normal saline and infuse over 15 to 30 minutes. Use immediately after reconstituting.	Dilute potassium with an adequate volume of solution before IV administration. Infuse slowly at a controlled rate to avoid phlebitis and decrease the risk of cardiac reactions
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor PT and INR. Monitor for hypomagnesemia, especially if administering this medication long-term.	Obtain culture and sensitivity before administering this medication. Monitor BUN and creatinine levels for signs of nephrotoxicity.	Monitor blood pressure, heart rate, and rhythm by continuous ECG. Keep emergency medications and equipment nearby.	Monitor bowel sounds and stool consistency. Monitor for signs of dehydration and electrolyte imbalances.	Monitor serum potassium levels before and during administration. Monitor creatinine level and urine output.
Client Teaching needs (2)	Notify the provider of a decrease in urine output or hematuria. Notify the provider of prolonged diarrhea.	Report episodes of severe diarrhea to the provider. Seek emergency treatment for mental status changes, slurred speech, or seizures.	Abruptly stopping the medication may have life-threatening effects. Monitor blood pressure and pulse rate regularly and report changes to the provider.	Instruct the patient to change positions slowly to minimize orthostatic hypotension. Notify the provider of adverse reactions such as abdominal pain.	Notify the provider of significant changes in heart rate or rhythm. Monitor stools for changes in color and consistency and notify the provider of black, tarry stools.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). 2020 *Nurse's Drug Handbook*.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Confused and lethargic Acute distress, restless, unclear, and garbled speech. A&O x 0 Aroused to voice.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 13** **Drains present: Y☐ N ☒** **Type:**	Pale skin, slightly jaundiced with patchy ecchymosis on the right and left arms Dry, cool skin, Skin turgor is poor, slow to recoil Edematous with 2+ pitting edema Wounds on arms and legs, weeping wound on left forearm. Braden score: 13 – He is bedridden and immobile due to declining health, confusion, and generalized weakness; he is incontinent of stool and, has a condom catheter, requires q2 turns.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck symmetrical. The trachea is midline without deviation. No lymphadenopathy was inspected or palpated. Thyroid is nonpalpable. Bilateral auricles are without drainage and free of lesions. Sclera is yellow and clear drainage is noted. Nose is dry and free of discharge and lesions. No teeth, no dentures present. .
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** 2+ **Capillary refill:** > 3 **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:** All four extremities	Irregular rhythm, tachycardic Clear S1, and S2. No murmur, gallops, or rubs were noted. Pulses 1+ throughout bilaterally. Capillary refill greater than 3 seconds. 2+ pitting edema inspected and palpated in extremities

RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** No **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	Breath sounds even, regular and nonlabored bilaterally. Coarse, wet crackles auscultated. HOB was maintained at 30 degrees; suctioning was implemented as needed. Patient is on 2L nasal cannula
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:**	Regular Ice chips/Clear liquids 5'9" 150lbs Normoactive bowel sounds Black, tarry melena stool (10/11) Abdomen is firm, patient grimacing upon palpation, no masses palpated, no distention, incisions, scars, drains, or wounds present.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	Yellow Clear 1700 mL Scrotal edema noted Condom catheter in place
MUSCULOSKELETAL: **Neurovascular status:**	Generalized weakness, bedrest, mobility impaired, requires Q2 repositioning. The patient

ROM: **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	is too disoriented and weak to be out of bed, but if he was to be moved to the chair, he would require a Hoyer due to weakness and impaired mobility. The patient is arousable to voice but not able to follow commands. Therefore, I was not able to determine the movement of extremities.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Confused, lethargic, weak and no strength, alert, and oriented x 0 Arousable to voice, spontaneous eye movement. The patient is arousable to voice but not able to follow commands. Therefore, I was not able to determine the movement of extremities. Speech is unclear and garbled.
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):**	No spiritual, cultural, or religious beliefs POA is his twin brother

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	**117**	113/74	20	98.5 - Temporal	97% - 2L nasal cannula
1100	**110**	**97/66**	20	97.8 - Temporal	97% - 2L nasal cannula

Vital Sign Trends/Correlation: The patient's vital signs remained stable during the shift. He has atrial fibrillation with ventricular tachycardia, which is why he has increased pulse rates. His blood pressure fluctuated throughout the shift due to the fluid overload and administration of diuretics.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	CPOT	Abdomen, arms, and legs	Unable to confirm	Patient grimaced and groaned when palpating the abdomen. His extremities are bruised and edematous, causing discomfort.	Repositioned to provide comfort and utilized pillows for elevation and support of upper and lower extremities. Monitored vital signs for indications of increasing discomfort.
1100	CPOT	Abdomen, arms, and legs	Unable to confirm	Patient grimaced and groaned when palpating the abdomen. His extremities are bruised and edematous, causing	Repositioned to provide comfort and utilized pillows for elevation and support of upper and lower extremities.

				discomfort.	Monitored vital signs for indications of increasing discomfort.

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:**	20 g Left wrist 10/8 Patent, flushed easily No signs of drainage or erythema noted Clean, dry, and intact 20g Right wrist 10/8 Patent, flushed easily No signs of drainage or erythema noted Clean, dry, and intact
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:**	4 Fr Single lumen catheter in the right basilic vein – Saline locked 10/10 Patent flushed easily No drainage or erythema noted Clean, dry, and intact Needless connector was cleaned with alcohol, CUROS cap was applied. Dressing assessed.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
475 mL IV medications	1700 – patient received Lasix early in the morning.

Nursing Care

Summary of Care (2 points)

Overview of care: The patient is bedridden with generalized weakness, confusion, and lethargy. Medications were administered. He was given a bed bath and oral care, and his linens were changed. He was repositioned every two hours, passive range of motion exercise of the extremities was provided, dorsiflexion of the feet was provided, pillows were used to elevate the extremities, and incontinence care was provided as needed.

Procedures/testing done: No procedures or tests were done on this shift

Complaints/Issues: The patient could not verbalize complaints or issues, and his POA was not present.

Vital signs (stable/unstable): Vital signs remained stable. The blood pressure was monitored automatically every 10 minutes due to the fluctuation of pressures from poor perfusion, as well as the diuretics to treat the fluid overload.

Tolerating diet, activity, etc.: The patient is on a clear liquid diet, he is bedridden, he had Lasix early in the morning, and had a large volume of urine output through the condom catheter. He had two episodes of incontinence of black tarry stools; he tolerated his bed bath and the repositioning well.

Physician notifications: No physician notifications during this shift

Future plans for client: The plan is to keep monitoring his condition, and if his health continues to deteriorate as it has been, the POA will complete the paperwork to transition him to hospice/comfort care**.**

Discharge Planning (2 points)

Discharge location: The patient is currently a DNR. He will not be discharged as his health is rapidly declining, and he will likely be transferred to a medical-surgical floor for comfort care once the POA has decided to make that change.

Home health needs (if applicable): n/a

Equipment needs (if applicable): n/a

Follow up plan: The only follow-up plan at the time is to follow up with the POA regarding the paperwork and consent to transition him to comfort care.

Education needs: As the patient's health continues to deteriorate quickly, the POA will need education about transitioning to hospice/comfort care, the details of comfort care, and the paperwork for consent to make that change. If the patient were to recover, he would need to receive information on community/support to help him with decreasing his intake of alcohol, and he would need to be educated on smoking cessation and healthy food choices.

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. Impaired perfusion	Perfusion is necessary for	1. Administer fluids to maintain	1. Within one hour of interventions, the	Goal was not met. The nurse will need

	related to decreased blood flow as evidenced by capillary refill greater than 3 seconds, pulses of 1+, and blood pressure of 97/66.	the function of the brain and other vital organs. His body is not receiving the necessary oxygenated blood (Swearingen & Wright, 2019).	adequate blood pressure. 2. Monitor blood pressure, skin color, and temperature.	patient will have a cap refill of less than 3 seconds, pulses greater than 2+, and blood pressures within 20 mmHg of baseline.	to continue with interventions and re-evaluate
2.	Excess fluid volume related to liver failure as evidenced by 2+ pitting edema and ascites as shown on CT scan.	My patient is on bed rest with generalized weakness and lethargy. He has 2+ pitting edema.	1. Extremities elevated, and positions changed every two hours. 2. Medications administered to remove excess fluid.	1. The ascites and edema will improve during the remainder of his hospital stay.	Goal met. The patient was repositioned every two hours, extremities were elevated and assessed, medications were administered, and his output during the shift was 1700 mL.
3.	Impaired skin integrity related to excess fluid as evidenced by pitting edema of the extremities.	This patient has a lot of swelling in his extremities.	Frequent position changes Monitor for pain, redness, and irritation**.**	**1.** The patient will be repositioned every two hours and will not show any signs of skin breakdown during the shift.	Goal met- Each time I rounded on him, I inspected his skin for redness ad irritation and monitored the edema. I adjusted the pillows and repositioned him every two hours and as needed.
4.	Acute confusion related to liver failure as evidenced by garbled speech and A&O x 0.	The patient is confused, lethargic, and has garbled speech.	**1.** Frequent neurological assessments and reorient as needed (Swearingen & Wright, 2019**).** **2.** Maintain bed in a low position, rails up, and bed alarm on.	**1.** During hospitalization, the patient will remain free from injury.	Goal partially met. The patient was reoriented, and neuro checks were completed twice during this shift.
5.	Risk for deep vein thrombosis (DVT), related to impaired venous flow as evidenced by prolonged immobility.	Deep vein thrombosis can lead to a life-threatening pulmonary embolism (Swearingen & Wright, 2019).	**1.** Perform passive range of motion and dorsiflexion and reposition every two hours (Swearingen & Wright, 2019**).** **2.** Monitor and assess the lower extremities for	**1.** During hospitalization, the patient will remain free from a DVT.	Goal partially met. Range of motion, dorsiflexion, and repositioning was done every two hours. The nurse will need to continue with interventions and re-evaluate.

		signs of a DVT, including warmth, redness, and pain.		

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Concept Map (20 Points):

Subjective Data

Patient-reported a fever and bloody stools, abdominal pain and coughing up blood
Patient-reported that he “smokes half of a pack of cigarettes every day for the past 40 years”
“Drinks 12 cans of beer every day”
Patient has become more confused since arriving to the emergency room on 10/8

Nursing Diagnosis/Outcomes

Impaired perfusion related to decreased blood flow as evidenced by capillary refill greater than 3 seconds, pulses of 1+, blood pressure of 97/66
Within one hour of interventions, the patient will have a cap refill of less than 2 seconds, pulses greater than 2+ and blood pressures within 20 mmHg of baseline

Excess fluid volume related to liver failure as evidenced by 2+ pitting edema and ascites as shown on CT scan
The ascites and edema will improve during the remainder of his hospital stay

Impaired skin integrity related to excess fluid as evidenced by pitting edema of the extremities
The patient will be repositioned every two hours and will not show any signs of skin breakdown during the shift

Acute confusion related to liver failure as evidenced by garbled speech and A&O x 0
During hospitalization, the patient will remain free from injury

Risk for deep vein thrombosis (DVT), related to impaired venous flow as evidenced by prolonged immobility
During hospitalization, the patient will remain free from a DVT

Objective Data

Na- 131, K+ 3.1, BUN 39, Creatinine 2.04, Bilirubin 8, AST 2625, ALT 1367
CT abdominal pelvis- bilateral lower lobe partial atelectasis and small bilateral pleural effusions, cirrhosis noted.
Patient demonstrates a decreased loc, lethargy and is on bed rest. He has 2+ pitting edema and 1+ pulses, irregular heart rate and rhythm

Client Information

WM is a 62-year- old Caucasian male who has a history of COPD, atrial fibrillation, and hypertension. He presented to OSF emergency department by ambulance on 10/8 and was diagnosed with acute liver failure secondary to alcohol cirrhosis

Nursing Interventions

2. Monitor blood pressure, and skin color and temperature

1. Extremities elevated, and positions changed every two hours

2.Medications administered to remove excess fluid

1.Frequent position changes

2.Monitor for pain, redness, and irritation

1. Frequent neurological assessments and reorient as needed (Swearingen & Wright, 2019)

2. Maintain bed in low position, rails up and bed alarm on

1. Perform passive range of motion and dorsiflexion and reposition every two hours (Swearingen & Wright, 2019)

2. Monitor and assess the lower extremities for signs of a DVT, including warmth, redness, and pain