N431 Care Plan #2

Lakeview College of Nursing

Kati Davis

Demographics (3 points)

Date of Admission	**Client Initials**	**Age**	**Gender**
10.17.2022	D. N.	70yo	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasion/Non-Hispanic or Latino	Retired	Divorced	Lemon Flavor Reaction→ Unknown Strawberry Reaction → Unknown
Code Status	**Height**	**Weight**	
FULL	6’	150lb	

Medical History (5 Points)

Past Medical History: The patient has a past medical history of acute pyelonephritis (4.16.2018), benign prostatic hyperplasia, COPD (04.16.2018), erectile dysfunction, hematuria, hypertension, sepsis (04.16.2018), kidney stones, and urinary tract infection.

Past Surgical History: The patient has a past surgical history that includes neck surgery, ureteral stent placement (Right, 04.25.2019), Lithotripsy (04.30.2019), and a diagnostic endoscopy.

Family History: Family history includes diabetes in his mother and sister. Emphysema in his father and heart disease in brother.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient has a history of smoking cigarettes. The patient has smoked about one pack per day for the past 20+ years. The patient has never used smokeless tobacco. The patient reports he is not an alcohol user and has never used drugs.

Assistive Devices: Wheelchair

Living Situation: The patient resides in a nursing home. The chart states he lives in Garden view Manor, but when speaking to the patient, he says he lives at Arcadia care of Danville on Bowman Ave.

Education Level: Highest level of education not on file

Admission Assessment

Chief Complaint (2 points): Fall

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

The patient is a 70-year-old male who presented to the hospital from the nursing home with complaints of low temperature and a fall (10.17.2022). The patient had a witnessed fall at the nursing home in the late morning, around 1100, where he fell forward while sitting in a wheelchair, striking his forehead. The fall was intense enough that he had a wound above his (L) eyebrow. Upon admission, the patient was not complaining of any headaches or pain. The patient was negative for vision changes, chest pain & shortness of breath, abdominal pain, constipation & diarrhea, arthralgias, and myalgias. The patient was vigilant and oriented on presentation to the hospital. On presentation, the patient was hypotensive but responded to fluid boluses and a temperature of 88°. He was placed on Bair Hugger and was given 1 dose of meropenem due to an ongoing UTI. The patient did not take any over-the-counter (OTC) medication for pain from the fall before admission, but he was on Bactrim at the nursing home for his UTI.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Hypothermia

Secondary Diagnosis (if applicable): Sepsis secondary to UTI

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

An uncontrollable decline in body temperature below 35 degrees Celcius is what is referred to as hypothermia (Capriotti & Frizzell, 2020). When in a state of hypothermia, the body can no longer produce enough heat to maintain homeostasis and healthy bodily function; this is a medical emergency (Duong & Patel, 2022). Your heart, neurological system, and other organs cannot function normally when your body temperature decreases.

The patient had a body temperature of 88 degrees Fahrenheit (31.1 degrees Celsius). This is considered “moderate” hypothermia because it falls between 28 to 32 C (Duong & Patel, 2022). During this state, the patient may experience cognitive impairment and fatigue. Pupils that are less sensitive and dilated due to hyporeflexia could result from increased central nervous system (CNS) depression (Duong & Patel, 2022). Some expected findings may be bradycardia, bradypnea, and hypotension (Duong & Patel, 2022). Given that shivering is your body’s natural response to low temperatures, it is likely that one would experience it initially as the temperature drops. However, shivering may cease between 30-32 degrees Celsius.

Taking a core temperature is necessary to correctly identify and treat hypothermia. Taking an oral temperature is not ideal to see the level of severity considering most commercial thermometers cannot read temperatures below 35 degrees Celsius (Duong & Patel, 2022). Esophageal temperature measurement is most precise when carried out properly; however, this should only be done for patients who have a well-developed airway. Knowing the clinical symptoms linked to the stages of hypothermia is essential so that the proper therapy can start right away given the challenge of taking an immediate accurate temperature in a pre-hospital scenario.

Preventing more heat loss and starting rewarming are the main goals of managing and treating unintentional hypothermia. The patient was treated with Bair hugger warming blankets. To aid in boosting blood flow, these blankets provide heat near to the patient's body.

Pathophysiology References (2) (APA):

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

Duong, H., & Patel, G. (2022). *Hypothermia - StatPearls - NCBI Bookshelf*. National Library of Medicine. Retrieved October 23, 2022, from https://www.ncbi.nlm.nih.gov/books/NBK545239/

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	2.63 (L)	2.61 (L)	A lowered red blood cell count could indicate that illness or infection is present (Pagana et al., 2018). Based upon an x-ray the patient received, there is sign of pneumonia.
Hgb	13.0-16.5 g/dL	8.6 (L)	8.6 (L)	The HGB is low because the RBCs are low. RBC carries the HGB which carries O2 throughout the body.
Hct	38.0-50.0%	25.4 (L)	25.1 (L)	HCT reflects the percentage of blood volume that makes up the RBC. As stated above, the potential infection (pneumonia) could be restricting the RBC causing slight anemia.

Platelets	140-440 10(3) mcL	124 (L)	140	During a state of hypothermia, the platelet count drops (Pagana et al., 2018). This number was only low during admission when the patient was in a hypothermic state.
WBC	4.00-12.00 10(3) mcL	2.80 (L)	4.10	Hypothermia slows down the ability to fight infection (Pagana et al., 2018). This would indicate why his WBC count was low upon admission.
Neutrophils	40.0-68.0%	81.1 (H)	62.8	Higher neutrophil levels can indicate stress (Pagana et al., 2018). This level was elevated upon admission. The patient could have been experiencing stress from his recent fall and head wound.
Lymphocytes	19.0-49.0%	13.4 (L)	26.5	Lymphocytes are associated with the white blood cell count. As stated above, hypothermia slows down the ability and drive to fight infection (Pagana et al., 2018). This level was only low at time of admission.
Monocytes	3.0-13.0%	5.2	8.5	
Eosinophils	0.0-8.0	0.2	1.8	
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	135	139	
K+	3.5-5.1 mmol/L	4.0	4.0	

Cl-	98-107 mmol/L	104	107	
CO2	21-31 mmol/L	21	23	
Glucose	70-99 mg/dL	126 (H)	77	This is a slight elevation. These levels are not necessarily concerning. Like neutrophils, glucose levels can elevate in moments of stress. The patient had just fallen out of his wheelchair and struck his head.
BUN	7-25 mg/dL	47 (H)	31 (H)	An elevated BUN reading may indicate the presence of renal damage or illness (Pagana et al., 2018). The patient has a history of hypertension - this could be causing said damage.
Creatinine	0.50-1.20 mg/dL	1.67 (H)	1.61 (H)	High blood pressures can harm the kidney's blood vessels, impairing kidney function and resulting in high creatinine levels (Pagana et al., 2018). The patient has a medical history of hypertension.
Albumin	3.5-5.7 g/dL	3.5	N/A	
Calcium	8.8-10.2 mg/dL	8.8	9.1	
Mag	1.6-2.6 mg/dL	1.9	N/A	
Phosphate	34-104	N/A	N/A	
Bilirubin	0.2-0.8 mg/dL	0.3	N/A	
Alk Phos	34-104 U/L	135	N/A	The patient's value was not flagged on OSF database, considering it to be within their normal range.
AST	13-39 U/L	15	N/A	
ALT	7-52 U/L	18	N/A	
Amylase	23-85	N/A	N/A	

Lipase	0-160	22.7	N/A	
Lactic Acid	0.7-2.0 mmol/L	0.8	N/A	
Troponin	0.000-0.040 ng/mL	< 0.030	N/A	
CK-MB	26-192	N/A	N/A	
Total CK	39-308	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	1.1	N/A	
PT	10.1-13.1 seconds	11.9	N/A	
PTT	25-36 seconds	43 (H)	N/A	I am unable to identify why this level was high upon admission. Typically, if a PTT test is elevated it indicates a bleeding disorder (Pagana et al., 2018). The patient does have a history of hematuria but that would not affect current results. The elevated PTT would explain the patient's extreme ecchymosis on his upper extremities.
D-Dimer	0-622 ng/mL	N/A	N/A	
BNP	0-100 pg/mL	N/A	N/A	
HDL	> 40	N/A	N/A	
LDL	< 130	N/A	N/A	
Cholesterol	< 200	N/A	N/A	
Triglycerides	< 150	N/A	N/A	
Hgb A1c	4-6%	N/A	N/A	
TSH	0.00-5.000	2.976	N/A	

	ml U/L			

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	Yellow & turbid	N/A	
pH	5.0-9.0	5.5	N/A	
Specific Gravity	1.003-1.030	1.015	N/A	
Glucose	Negative	(-)	N/A	
Protein	Negative	2+!	N/A	UTI's are commonly associated with (+) results of proteinuria (Pagana et al., 2018). The patient has a UTI.
Ketones	Negative	Trace!	N/A	UTIs can lead to high ketone levels (Pagana et al., 2018). The patient has a UTI.
WBC	0-5	Packed!	N/A	WBC in urine may indicate a present UTI (Pagana et al., 2018). The patient has a UTI.
RBC	0-2/hpf	3-5!	N/A	A potential cause of RBC in the urine includes UTIs, kidney or bladder infections (Pagana et al., 2018). The patient has a UTI
Leukoesterase	Negative	3+ !	N/A	This indicates WBC in the urine. WBC in urine may indicate a present UTI (or other infection) (Pagana et al., 2018). The patient has a UTI

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

Test	Normal	Value on	Today's	Explanation of Findings

	Range	Admission	Value	
pH	7.35-7.45	7.25 (L)		As a result of hypothermia, metabolic acidosis may occur because the liver is unable to process this excess (Pagana et al., 2018). < 7.35 is acidic.
PaO2	80-100 mmHg	87		
PaCO2	35-45 mmHg	45		
HCO3	22-26 mmol/ L	22.2		
SaO2	94-100%	89 (L)		A pulse oximeter may be inaccurate if place on the fingers due to peripheral vasoconstriction during hypothermia (Duong & Patel, 2022). This low value may be inaccurate

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***	Collected 10.18.2022 1249 - pending results	Collected 10.18.2022 1249 - pending results	
Blood Culture	No growth	No growth within one day	N/A	
Sputum Culture	No growth	N/A	N/A	

Stool Culture	No growth	N/A	N/A	

Lab Correlations Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

(1) CT CHEST, ABDOMEN, PELVIS WITHOUT CONTRAST – (10.18.2022)

(2) CT HEAD OR BRAIN WO CONTRAST (10.18.2022)

Diagnostic Test Correlation (5 points):

(1) The patient had this diagnostic test done because of his age (70yo) and presenting abdominal pain and distention. To diagnose conditions like appendicitis, pyelonephritis, or infected fluid collections, often called abscesses, CT scans of the abdomen are performed (John Hopkins, 2021). The following findings were noted: Minimal infiltration in the right lower lobe, thickening of the wall of the lower esophagus, mild distention of the stomach, thickening of the wall of the urinary bladder, and signification thickening of the wall of the urinary bladder.

(2) The patient had this diagnostic test done because he fell and hit his head causing an abrasion above the left eye. This diagnostic test was performed to rule out hemorrhage, bleeding in the brain, and swelling of the brain during the first moments after the injury. The CT found no acute intracranial bleeding, no scalp soft tissue swelling, and no depressed skill fracture was seen.

Diagnostic Test Reference (1) (APA):

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	**ferrous sulfate (Fer-In-Sol)**	**baclofen (LIORESAL)**	**amitriptyline (ELAVIL)**	**bisacodyl (DULCOLAX)**	**docusate sodium (COLACE)**
Dose	325mg	40mg	25mg	10mg	100mg
Frequency	Daily	BID	Daily (At night)	PRN - if no BM X 4 days	Daily
Route	oral	Oral	Oral	Rectal	Oral
Classification	<u>Pharmacologic class:</u> Hematinic <u>Therapeutic class:</u> Antianemic	<u>Pharmacologic class:</u> skeletal muscle relaxants <u>Therapeutic class:</u> antispasticity agent	<u>Pharmacologic class:</u> Tricyclic antidepressant <u>Therapeutic class:</u> Antidepressant	<u>Pharmacologic class:</u> Organic compound <u>Therapeutic class:</u> Stimulant laxative	<u>Pharmacologic class:</u> Surfactant <u>Therapeutic class:</u> Laxative

Mechanism of Action	Acts to normalize RBC production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendothelial cells of the bone marrow, liver, and spleen.	Reduces the release of excitatory neurotransmitters in the pre-synaptic neurons and stimulates inhibitory neuronal signals in the post-synaptic neurons with resultant relief of spasticity.	Blocks serotonin and norepinephrine reuptake by adrenergic nerves.	Stimulates enteric neurons to cause peristalsis, or colon contraction.	Acts as a surfactant that softens stool by decreasing surface tension between oil and water in feces
Reason Client Taking	Patient's RBC, HGB and HCT counts are low.	To help relax his muscles	To relieve depression, especially when accompanied by anxiety and insomnia	To treat constipation	To treat constipation
Contraindications (2)	1. hemochromatosis 2. hemolytic anemias	1. hypersensitivity to baclofen or any component of its formula 2. hydrocodone	1. acute recovery phase after MI 2. hypersensitivity to amitriptyline or its components	1. Hypersensitivity 2. obstruction or severe impaction	1. Fecal impaction 2. concomitant use with mineral oil
Side Effects/Adverse Reactions (2)	1. Dizziness 2. Stool discoloration	1. Dizziness 2. Vision changes	1. suicidal ideation 2. arrhythmias	1. nausea 2. Diarrhea	1. Abdominal cramps & distention 2. dizziness
Nursing Considerations (2)	1. Give iron tablets and capsules with a full glass of juice or water 2. Do not crush enteric coated tablets	1. Monitor patient closely during initial doses 2. Monitor sudden changes in	1. Use caution if patient has a history of seizures, urine retention or angle-closure	1. Assess for abdominal distention and bowel function 2. Instruct patient to drink 1500-	1. Expect excessive or long-term use of docusate to cause dependence on

	or open capsules	spasticity, muscle strength, or CNS symptoms	glaucoma 2. Do not give an MAO inhibitor within 14 days of amitriptyline because of the risk of seizures and death.	2000 mL/day during therapy	laxatives for BMs 2. Assess for laxative abuse syndrome.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1. check RBC, HGB, and HCT levels 2. Be sure to monitor patient's BP as this can cause hypotension	1. Check blood sugar levels 2. Assess patient's spasticity, range of motion, functional ability and posture prior to administering baclofen.	1. Monitor BP for hypotension or hypertension 2. Stay alert for behavioral changes.	1. Want to ensure there is no stomach pain or blockage 2. want to ensure no prior history of ulcerative colitis or other bowel disease.	1. check for edema (after administration) 2. Keep an eye on BP as this could increase
Client Teaching Needs (2)	1. Do not chew any solid form of iron except for chewable tablets 2. Urge patient to eat chicken, fish, lean red meat, and turkey, as well as foods rich in vitamin C to improve iron absorption.	1. Do not drive while taking baclofen 2. Do not drink alcohol	1. Instruct patient to avoid using alcohol. 2. Urge family or caregiver to watch patient closely for suicidal tendencies.	1. Do not take rectal suppository or enema by mouth. 2. Wash your hands before and after using rectal bisacodyl.	1. Tell patient not to use docusate when she has abdominal pain, nausea, or vomiting 2. advise patient to take docusate with a full glass of milk or water

Hospital Medications (5 required)

Brand/Generic	**enoxaparin (Lovenox)**	**pantoprazole (Protonix)**	**linezolid (Zyvox)**	**acetaminophen (tylenol)**	**Melatonin (Circadin)**
Dose	40mg	40mg	600mg	650mg	6mg
Frequency	Every 24 hours	Daily	Every 12 hours	Every 6 hours PRN	Nightly PRN
Route	subcutaneous	Oral	IV	Oral	oral
Classification	Pharmacologic class: Low-molecular-weight heparin Therapeutic class: Anticoagulant	Pharmacologic class: Proton pump inhibitor Therapeutic class: antiulcer	Pharmacologic class: Oxazolidinine Therapeutic class: antibiotic	Pharmacologic class: Nonsalicylate, para-aminophenol derivative Therapeutic class: Antipyretic, nonopioid analgesic	Pharmacologic class: Was unable to find Therapeutic class: Sedative/hypnotic
Mechanism of Action	Potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors.	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphatase enzyme system, or proton pump, n gastric parietal cells.	Inhibits bacterial protein synthesis by interfering with translation of ribonucleic acid (RNA) to protein.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Regulates the sleep-wake cycle by chemically causing drowsiness and lowering the body temperature
Reason Client Taking	To prevent DVT since patient is on bed rest	To treat GERD short-term	To treat an infection (MRSA of the nares)	To relieve mild to moderate pain	To help sleep at night.
Contraindications (2)	1. Active-major bleeding 2. History of immune-mediated heparin-induced thrombocytopenia within past 100 days or in the	1. concurrent therapy with rilpivirine – containing products 2. hypersensitivity to pantoprazole	1. hypersensitivity to linezolid or its components 2. Use within 14	1. Hypersensitivity to acetaminophen or its components 2. severe hepatic impairment	1. bleeding disorders 2. depression

	presence of circulating antibodies, which may persist for several years.		days of an MAO inhibitor		
Side Effects/Adverse Reactions (2)	1) pulmonary edema 2) A fib	1. Hepatic failure 2. Hepatoxicity	1. Seizures 2. Stevens-Johnson syndrome	1) Agitation/anxiety 2) Hepatotoxicity	1. Dizziness 2. Nausea
Nursing Considerations (2)	1) Keep protamine sulfate nearby in case of accidental overdose 2) Expect to give drug with aspirin to patient with unstable angina, STEMI, and non-Q-wave MI	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 proton pump inhibitor.	1. Monitor CBC weekly 2. Assess bowel pattern daily.	1) Use cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment 2) Monitor renal function in patient on long-term therapy.	1. Instruct patient to take at bedtime as directed. 2. Instruct patient to avoid driving and other activates requiring alertness until response to supplement is known
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	1. Watch closely for bleeding 2. check serum potassium level for elevation	Assess the patient for signs and symptoms of stomach pain, heart burn, stomach upset, and N/V	1. assess heart rate 2. monitor signs of confusion, lethargy, shallow rapid breaths, tachycardia, hypotension, N/V	1. Liver function tests – ALT, AST 2. Check pain level before administering.	1. monitor blood glucose 2. Monitor coagulation panel
Client Teaching Needs (2)	1. Advise patient to notify provider of any adverse reactions, especially bleeding 2. Inform patient that taking Aspirin may	1. Advise patient to take before meals 2. Advise patient to not crush	1. Advise patient not to take OTC cold remedies without consulting prescriber because	1. Take exactly as directed on the package label 2. Do not take more Tylenol or take it more often than directed even if	1. Avoid alcohol use. 2. Avoid other CNS depressants

	increase risk for bleeding.		medications that contain propanolamine or pseudoephedrine may cause or worsen hypertension 2. Instruct patient to avoid beverages and foods that contain large amounts of tyramine, including aged cheese, air-dried or fermented meats.	fever and pain are still present.	

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 and place, but not time (A&Ox2). He is tired but not in acute distress. The patient is cooperative and pleasant.
INTEGUMENTARY: **Skin color:** **Character:**	Skin is white, intact, and dry without jaundice. At the time of assessment, there was slight edema in the lower extremities bilaterally. Turgor is <2

Temperature: **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 15** **Drains present: Y☐ N ☐** **Type:**	seconds. (-) for rashes. (+) for ecchymosis on upper and lower extremeties bilaterally. (+) for wounds, listed below Wounds: (1) Medial sacral spine pressure injury. This was present on admission (2) R Lateral foot pressure injury (3) Left heel pressure injury
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 almost all missing. .
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. (+) for edema in lower extremities.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Breath sounds are unlabored and regular in high fowler's 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:**	Home diet is considered normal adult diet. Current diet in hospital setting is general. Does need assistance feeding. Height: 6' Weight: 150lb Last BM: 10/19/22 X's 2 Bowel sounds normoactive in all four quadrants. The abdomen is soft, flat, and non-tender. The patient is incontinent and wearing depends. He had 3 voids during my clinical hours and 2

Ostomy: Y ☐ N ☐ **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	bowel movements.
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 incontinent x 3 during my clinical shift.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score: 40** **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 turkey lunch before taking a bite and expressed it smelled “decent.” Decreased active range of motion. Weakness associated with using upper extremities (such as eating). Strength 2/5. I fed the patient his lunch and provided help with each drink he desired. The patient is bedfast in the hospital. He states he always uses a wheelchair.
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. 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**	Appropriate affect, and a normal speech pattern. For coping, the patient enjoys watching HGTV as he used to flip houses for work and as a hobby. No specific religion is practiced. His developmental level would be categorized as normal adult.

available family support):	

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1545	62	124/70	14	96.8	95
1700	71	120/75	18	96.8	96

Vital Sign Trends: Vital signs remained stable during my clinical rotation. Prior to me arriving, the nurse stated the patient's BP got down to 80/40 but, improved and stabilized after a bolus of IV fluids.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1415	Numeric Scale	No pain present	0/10	No pain present	No pain present
1600	Numeric Scale	Stomach	7/10	The patient said he thinks his stomach hurt because he was hungry.	His food was delivered shortly after, and there were no more complaints of pain

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.:**	The patient has a midline single lumen Size: 18 Right Basilic vein Placed 10.18.2022 0009 No redness, tenderness, or swelling. The

IV dressing assessment:	access is clean, dry, and intact. The patient also has a peripheral IV Size 18G Left forearm Placed 10.17.2022 2350 No redness, tenderness, or swelling. The access is clean, dry, and intact. Saline locks

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
1 cup of diet Pepsi: 240 mL ½ cup of large water: 480 mL	Heavily continent x 3 void

Nursing Care

Summary of Care (2 points)

Overview of care: During this clinical time, I was able to assist my patient with feeding and providing company. Although my patient slept quite a bit, he was responsive and extremely pleasant. During lunch time, we watched HGTV together and bonded over the show, “Farmhouse Fixer.”

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

Complaints/Issues: The only complaint my patient had was his stomach hurting but he expressed this was probably due to hunger because he had been NPO since midnight the night prior.

Vital signs (stable/unstable): The patient’s vital signs remained stable the entire clinical time.

Tolerating diet, activity, etc.: The patient is tolerating his general diet well. He does need assistance feeding but he does just fine with it without needing any restrictions. There is not much activity required of the patient, he is on bedrest and typically has a wheelchair. He does get turned in bed Q2 hours and tolerates this change in position just fine.

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

Future plans for client: Future plans for the patient include getting moved out of CCU to the medical/surgical floor. The patient originally was moved to CCU due to a low BP (80/40) but with a bolus of fluids his BP returned stable, and no other complications arose.

Discharge Planning (2 points)

Discharge location: Back to the nursing home. Per the patient, this is Arcadia care of Danville.

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.

Education needs: It is imperative to educate the patient on fall prevention. General prevention methods can be placing frequently used items in easy-to-reach places and always use adequate lighting. I understand it is difficult for the patient to implement these fall preventions since he depends on a wheelchair so this education would be geared more towards the nursing home staff.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis ● Include full nursing diagnosis with "related to" and "as evidenced by" components ● Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** ● Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** ● How did the client/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Risk for fall related to use of assistive devices (wheelchair) as evidenced by hx of falls.	This nursing diagnosis was chosen because the patient presented to the hospital because of a fall, and this resulted in a wound above the left eye. We want the patient to implement safety measures to avoid further injuries.	1. Provide signs or secure wristband identification for patients at risk for falls to remind healthcare professionals to implement fall precaution behaviors. 2. Place items the patient uses within easy reach, such as call light, remote, drink, and cellphone	1. The patient and caregivers (nursing home staff) will implement strategies to increase safety and prevent falls in the home (nursing home).	During my clinical shift, I was unable to implement the suggested interventions. Ideally, the client would relate the intent to use safety measures to prevent future falls and ensure education to nursing home staff.
2. Impaired physical mobility related to decreased muscle strength or control as evidenced by needing	This nursing diagnosis was chosen because feeding is a part of his ADL. This part of his life is rather important.	1. Encourage the patient to do as much as they can 2. Medicate for pain	1. The patient will remain free of contractures and decubitus ulcers from impaired mobility.	During my clinical shift, I was unable to implement the suggested interventions. Ideally, the patient would demonstrate exercises to improve physical mobility, in

total assistance with feeding.				his hands specifically.
3. Impaired skin integrity related to impaired circulation as evidenced by extreme ecchymosis on upper extremities bilaterally	This nursing diagnosis was chosen because it links into #2. The poor skin integrity and strength of the patient's hands alter his ADLs.	1. Continues assessment of skin and wounds 2. Repositioning and support of boney prominences	1. The patient will verbalize proper prevention of pressure injuries.	During my clinical shift, I was unable to implement the suggested interventions. But, ideally the patient would show non-verbal agreement of the plan to protect the skin and will maintain intact skin integrity
4. Risk for ineffective tissue perfusion related to decreased peripheral blood flow as evidenced by patient's temperatur e getting down to 88 degrees.	This nursing diagnosis was chosen because hypothermia was the primary diagnosis for the patient.	1. ensure adequate hydration 2. Assess the patient's vital signs at least every hour, or more frequently if there is a change in the,	1. The patient will be able to achieve optimal tissue perfusion as evidenced by having strong pulses, regained strength and reduced pain.	During my clinical shift, the patient's vital signs had already stabilized from the prior hypothermic episode. The patient had a stabilized temperature within the normal range the entire clinical shift.

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

- The patient complained of a stomachache resulting from hunger
- The patient complained of feeling cold upon admission.
- Per the patient, she resides at Arcadia care of Danville.

Nursing Diagnosis/Outcomes

Nursing diagnosis:
1. Risk for fall related to use of assistive devices (wheelchair) as evidenced by hx of falls.
2. Impaired physical mobility related to decreased muscle strength or control as evidenced by needing total assistance with feeding.
3. Impaired skin integrity related to impaired circulation as evidenced by extreme ecchymosis on upper extremities bilaterally
4. Risk for ineffective tissue perfusion related to decreased peripheral blood flow as evidenced by patient's temperature getting down to 88 degrees.

Outcomes:
1. The patient and caregivers (nursing home staff) will implement strategies to increase safety and prevent falls in the home (nursing home).
2. The patient will remain free of contractures and decubitus ulcers from impaired mobility.
3. The patient will verbalize proper prevention of pressure injuries.
4. The patient will be able to achieve optimal tissue perfusion as evidenced by having strong pulses, regained strength and reduced pain.

Objective Data

Vital signs from 1545:
Pulse: 62
BP: 124/70
RR: 14
Temperature: 96.8
O2: 95 on room air

Patient's temperature on admission: 88 degrees Fahrenheit

Client Information

The patient is a 70-year-old female who presented to the hospital from the nursing home with complaints of low temperature and a fall (10.17.2022).

Nursing Interventions

- Provide signs or secure wristband identification for patients at risk for falls to remind healthcare professionals to implement fall precaution behaviors.
- Place items the patient uses within easy reach, such as call light, remote, drink, and cellphone
- Encourage the patient to do as much as they can
- Medicate for pain
- Continues assessment of skin and wounds
- Repositioning and support of boney prominences
- ensure adequate hydration
- Assess the patient's vital signs at least every hour, or more frequently if there is a change in them