N431 Care Plan #2

Lakeview College of Nursing

Levi Hahne

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
11/05/22	AB	25	M
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	N/a	Not Married	None on file
Code Status	**Height**	**Weight**	
Full	5'9	79.1 kg	

Medical History (5 Points)

Past Medical History: Has not been reviewed by care team

Past Surgical History: Has not been renewed by care team

Family History: No family history on file

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

None on file

Assistive Devices: Not needed

Living Situation: Lives with his mother

Education Level: College

Admission Assessment

Chief Complaint (2 points): MVC with ejection

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

AB, a 25 year old male, has an unknown PMH and presents to St. Anthony's ED by ambulance with an MVC. Patient arrived with a glasgow coma scale of 3 and is intubated. Patient has a chest tube in place with a confirmed right right pneumothorax, and pelvic fracture. A CT scan showed a subdural hemorrhage and compressions on the c7 and T3 endplates.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): MVC accident with subdural hemorrhage

Secondary Diagnosis (if applicable): pneumothorax

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

Pneumothorax is a condition where too much pressure from the air gets into the pleural space of the lungs, causing a collapse. This may be due to traumatic injury or spontaneous conditions. Spontaneous may be primary or secondary, resulting from a disease process. In this patient's case, he developed a traumatic pneumothorax from an MVC accident. Normal lung pressure is negative due to the inner walls tightening and expanding upon exertion. When outside air enters the lungs, the intrapleural pressure changes, causing it to rise while lung volume decreases. Patients may develop chest pain and dyspnea as signs and symptoms of lung damage. Chest pain may radiate to other organs and cause cardiac issues.

When diagnosing a pneumothorax, doctors may order chest x rays to examine the lungs and other organs. They may see a tracheal deviation in severe cases or deflated lungs through imaging. Doctors will order AGB tests also to monitor the values of carbon dioxide, oxygen, and bicarb in the blood. Patients suspected of pneumothorax should be put on supplemental oxygen if this condition is suspected in order to avoid further respiratory complications. Treatment for a pneumothorax includes thoracotomies, chest tubes, or other surgical procedures depending on the cause and severity of the lung damage. As always, complications may develop from procedures and treatment. Difficulties to look for with instances of chest tubes in place can be air leaks from the hose, obstructions in the passageways, and or chest tube misplacement.

Patient education with pneumothorax is essential to regain proper respiratory function. Doctors may prescribe specific medications as well. In this patient's situation, he was prescribed Dilaudid through IV to manage his lung damage pain. There are concerns with Dilaudid as it may cause respiration reduction. This patient was in the setting of trying to wean off the Dilaudid and put on oxycodone to help avoid respiratory complications and to help wean off the sedation. The doctors were trying to regain his consciousness in doing so by switching the medications.

A healthy diet and plenty of rest is recommended for patients recovering from a pneumothorax. Providers may give the patient a list of medications to take upon discharge. Patients should follow the dosage and frequency of medication use as directed, and doctors may order daily wound cleaning and bandage changing if there is a wound from the condition. Discharge education also includes refraining from smoking and drinking plenty of fluids. Smoking can decrease the lungs and cause a collapse again. Staying hydrated will help keep urine regular as well. Patients should always follow up with their provider if they notice signs of anxiety, trouble breathing, chest pain, chills, confusion, and coughing up blood, as these may be signs of infection, allergies to medications, or unresolved lung problems.

Pathophysiology References (2) (APA):

Hinkle, J.L. & Cheever, K.H. (2018). Brunner & Suddarth's Textbook of Medical-Surgical Nursing (14th ed.). Philadelphia: Wolters Kluwer.

Sahota, J., & E, S. (2020). *Tension Pneumothorax*. Europe PMC. Retrieved November 10, 2022, from https://europepmc.org/article/NBK/nbk559090

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	**4.1-5.7**	6.2 ^	4.5	Patient had low oxygen levels from lung trauma, causing an increase in the RBC levels (Hinkle, 2018)
Hgb	**12-18**	18.5 ^	13.2	There is a compensation of hgb levels increasing due to the oxygen level demand (Hinkle, 2018)
Hct	**37-51**	60 ^	39	Hct levels rise when there is severe blood loss, in his case he has lost blood in the cranium, and other parts of the body (Hinkle, 2018)
Platelets	**140-400**	364	173	
WBC	**4-11**	32.9 ^	13	THis increased due to severe inflammation and injury throughout the body (Hinkle, 2018)
Neutrophils	**%40-68**	28 (L)	n/a	severe trauma can affect neutrophil count due to inadequate blood circulation (Hinkle, 2018)
Lymphocytes	**%19-49**	19		
Monocytes	**%3-13**	4		
Eosinophils	**%0-0.8**	0.6		
Bands	**%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-	**136-145**	145	141	
K+	**3.5-5.1**	2.6 (L)	5.0	Changes with potassium levels is common in severe head damage due to cellular shift in the blood flow when damaged (Hinkle, 2018)
Cl-	**98-107**	105	107	
CO2	**22-29**	23	23	
Glucose	**74-100**	156 ^	123 ^	Due to hypermetabolic stress after an accident, glucose rises (Hinkle, 2018)
BUN	**8-26**	8	8	
Creatinine	**0.55-1.3**	1.2	1.28	
Albumin	**3.5-5**	3.8	n/a	
Calcium	**8.9-10.6**	8.9	7.8 (L)	Due to blood transfusions, calcium can see a decline after administered (Hinkle, 2018)
Mag	**1.6-2.6**	1.9	n/a	
Phosphate	2.5-4.5	2.8	n/a	
Bilirubin	**0.2-1.2**	0.3	n/a	
Alk Phos	**40-150**	78	n/a	
AST	**5-34**	128 ^	n/a	This is usually an indicator of acute life threatening complications from organ damages throughout the body (Hinkle, 2018)
ALT	**0-55**	145 ^	n/a	This is usually an indicator of acute life threatening complications from organ damages throughout the body (Hinkle, 2018) May also be from medications not processed through the liver appropriately

Amylase	23-85	n/a	n/a	
Lipase	0-160	n/a	n/a	
Lactic Acid	4.5-19.8	n/a	n/a	
Troponin	**0-0.03**	n/a	n/a	
CK-MB	3.5-5	n/a	n/a	
Total CK	24-204	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	**0.9-1.1**	**1.1**	n/a	
PT	**11.7-13.8**	**14.4 ^**	n/a	The patient's clotting levels are taking too long to clot due to multiple injuries causing blood loss (Hinkle, 2018)
PTT	25-36	24.9 (L)	n/a	The patient's clotting levels are taking too long to clot due to multiple injuries causing blood loss (Hinkle, 2018)
D-Dimer	0.5	n/a	n/a	
BNP	<100	n/a	n/a	
HDL	60	n/a	n/a	
LDL	60-130	n/a	n/a	
Cholesterol	<200	n/a	n/a	
Triglycerides	<150	288 ^	n/a	Patient may have elevated levels from liver damage causing a release of triglycerides (Hinkle, 2018)
Hgb A1c	4-5.9	n/a	n/a	
TSH	0.45-4.5	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	pale/yellow	n/a	n/a	
pH	4.5-7.8	n/a	n/a	
Specific Gravity	1.016-1.025	n/a	n/a	
Glucose	>0.5	n/a	n/a	
Protein	negative	n/a	n/a	
Ketones	negative	n/a	n/a	
WBC	<4	n/a	n/a	
RBC	<3	n/a	n/a	
Leukoesterase	4-11	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**	7.23 (L)	**7.45**	Lactic acid rapidly accumulates with poor tissue perfusion (hinkle, 2018)
PaO2	**80-100**	67.4 (L)	**149 ^**	Patient had damage to the respiratory system and decreased

				oxygen perfusion throughout the body (Hinkle, 2018)
PaCO2	**35-45**	38.6	**40**	
HCO3	**22-26**	22	**22.2**	
SaO2	**92-100**	90.6 (L)	**98.3**	This is a result of anemia in patients (Hinkle, 2018)

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	negative	n/a	
Blood Culture	negative	negative	n/a	
Sputum Culture	negative	negative	n/a	
Stool Culture	negative	negative	n/a	

Lab Correlations Reference (1) (APA):

Ellis, C. S. (2018). *Brunner & Suddarth's Handbook of Laboratory and Diagnostic tests*. Wolters Kluwer.

Hinkle, J.L. & Cheever, K.H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia: Wolters Kluwer.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): XR chest AP, XR pelvis, CT brain w/o contrast, CT spine w/o contrast, CT facial w/o contrast, CT lumbar reconstruction, XR KUB, XR right humerus, MRI brain w/o contrast, MRI cervical/thoracic w/o contrast

Diagnostic Test Correlation (5 points): A CT of the brain will allow for visual effects of brain bleed and show where it is traveling through the head, no contrast was used to avoid allergic reactions when they dont get an updated allergy history on patients. The patient needs to be cautiously examined before attempting to use contrast in the head, especially for head trauma. The chest XR was ordered for the patient to rule out a pneumothorax, in his instance it came back positive for a collapsed lung. An XR was also used to examine any fractures in the patient's extremities after the accident and he also had a facial CT which displayed images of his fractured jaw. The provider ordered an MRI on the lumbar spine to examine soft tissue damage and any fractures in that area. A CT reconstruction of the lumbar was also ordered to look at all angles of the spine for damages. And he had a KUB XR to show functioning, or damages, in the kidneys and urinary region. These are all important tests in order to get appropriate diagnoses for the right treatment.

Diagnostic Test Reference (1) (APA):

Ellis, C. S. (2018). *Brunner & Suddarth's Handbook of Laboratory and Diagnostic tests*. Wolters Kluwer.

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

Home Medications (5 required)

Brand/Generic	Aspirin	Oxycodone/roxicodone	Zofran/ondansetron	**Propranolol / Inderal LA**	Lispro insulin
Dose	325mg	5mg	4mg	20 mg	0.6 kg day
Frequency	q6hr	Q3hr prn	Daily prn	3 x daily	15 minutes before meals
Route	oral	Gastric tube	Injection/IV push	tablet oral	injection
Classification	**Antipyretic**	narcotic	**antiemetic**	beta blocker	insulins
Mechanism of Action	**Produce analgesia to reduce inflammation**	binding receptor that inhibits adenylyl-cyclase	**Reduce nausea**	blocks B1 and B2 receptors	replaces insulin that is stored in body
Reason Client Taking	Taken to help with patient's blood flow	Pain management	eliminate nausted feelings	prevent migraine headaches	diabetes
Contraindications (2)	asthma and allergies to nsaids	asthma, and respiratory depression	low magnesium and hypotension	heart blocks and depression	hypokalemia and diarrhea
Side Effects/Adverse Reactions (2)	**Tinnitus, GI bleed**	hallucinations and shivering	dizziness and constipation	difficulty sleeping, and dizziness	weight gain and low blood sugar
Nursing Considerations (2)	May reduce sodium and potassium levels, and be aware of bleeding time	monitor respirations and caution with ICP	caution liver dizziness and assess balance/gait	monitor vasoconstriction and signs of coldness	rotate vial before giving and rotate injection sites

Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Pain scale, assess blood pressure**	neuro checks and monitor respirations that are below 12	assess irregular heartbeat and any swelling	assess vitals and monitor blood pressure	assess pulses, and check glucose labs before administering
Client Teaching Needs (2)	swallow with full glass of water, do take as directed by doctor	Do not take in large amounts and may result in ortho hypotension	take with or without food, and tell provider before hand if you have intestinal problems	Take at same time of day and do not exceed dosage amount	rotate sites if giving by yourself and give this medication before meals if glucose levels are high

Hospital Medications (5 required)

Brand/Generic	Atropine /Isopto	**Dilaudid** / Hydromorphone	**pepcid/famotidine**	NaCl 0.9%	**Keppra/ Levetiracetem**
Dose	0.4 mg/kg	10 ml	**20mg**	100 ml/hr	**1000mg**
Frequency	Q 5 mins	Q 3 hours	**BID**	prn	**BID**
Route	injection	IV	**Gastric tube**	IV	**Gastric tube**
Classification	anticholinergic	controlled substance	**Histamine H2 receptor**	crystalloid fluid replacement	**Anticonvulsants**

Mechanism of Action	inhibits muscarinic actions	binds to opioid receptors	**Inhibits gastric secretions**	cation of extracellular fluid for controlling water distribution	binds to vesicle protein SV2A in the brain
Reason Client Taking	Treat bradycardia like symptoms	pain management	help with patients GERD	treat dehydration and hypovolemia	**Patient has developed neuro issues, prescribed to reduce the possibility of seizure**
Contraindications (2)	fever and urinary tract obstruction	sulfite allergies and status asthmaticus	stomach cancer and kidney disease	salt retention and heart disease	alcohol and barbiturates
Side Effects/Adverse Reactions (2)	fatigue and flushing	nausea and constipation	**Diarrhea, headache**	sleepiness and febrile reactions	**Confusion and rashes on the skin**
Nursing Considerations (2)	monitor for blurry vision and tachycardia	notify physician if feeling of unconscious and monitor for euphoric symptoms	Give with water for patient and do not exceed two pills a day	check for fluid overload and document baseline data	monitor fluid balance and document any seizure like activity
Key Nursing Assessment(s)/Lab(s) Prior to Administration	check apical pulse and look for dry mouth concerns	assess heart rate and respiratory depression	monitor respirations and any skin rashes that may develop	electrolyte labs and heart rhythms	monitor rbcs and monitor neutrophils
Client Teaching Needs (2)	avoid driving and stay hydrated on this medication	Take strictly as directed, and being a controlled substance	Take at bedtime and take around same time with antacid	Taken by IV and this is used to help flush lines	can be taken with or without food and caffeine

		this medication can cause addiction		with medications	can trigger the medication

Medications Reference (1) (APA):

How to use Davis's drug guide for nurses: Davis's Drug Guide. How to Use Davis's Drug Guide For Nurses | Davis's Drug Guide. (n.d.). Retrieved September 13, 2022, from https://www.drugguide.com/ddo/view/Davis-Drug-Guide/110089/all/How_to_Use_Davis's_Drug_Guide_For_Nurses

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient showed signs of no responses, the patient does not open eyes when aroused or spoken to, the patient cannot speak or signal needs or desires, the patient is not alert or oriented. Minimal distress due to inactivity of ROMs, patient overall stable with vitals**

INTEGUMENTARY: **Skin color: dry, bruising** **Character:** **Temperature: 98.6** **Turgor:normal mobility** **Rashes: forearms, chest, head, jaw, top of skull** **Bruises: arms legs and head** **Wounds: Skull, and jawline** **Braden Score: 10** **Drains present: Y☐ ** N ☐** **Type: Nasogastric tube, chest tube, urine Cath, feeding tube**	**Patient appeared warm and dry with visible rashes on extremities and head, no signs of clubbing in the nail beds, rashes and lacerations pink and scabbed over with bigger lacerations on head and wrapped with bandages, drainage systems all appear to be functioning properly**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head and neck symmetrical, no palpable thyroid, bilateral carotid and pedal pulses +2, PERRLA bilateral, teeth white and symmetrical , nose midline, jaw adjusted back into place with slight deviation to the left**
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: +2** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐**** **Edema Y ☐** N ☐** **Location of Edema: Bilateral ankles, bilateral arms, and face**	**Heartbeat slightly tachycardic, S1 and 2 present, no gallop noted, and capillary refill less than 3, no murmur present upon auscultation**
RESPIRATORY: **Accessory muscle use: Y☐ N ☐**** **Breath Sounds: Location, character**	**breath sounds diminished upon auscultation in all lobes of the lungs**

GASTROINTESTINAL: **Diet at home: Meats, fish, and other protein rich foods** **Current Diet: TPN** **Height: 5'9** **Weight: 79.1 kg** **Auscultation Bowel sounds: present but hypoactive** **Last BM: not noted in charts** **Palpation: Pain, Mass etc.: pain around stomach from bruising or impact from accident** **Inspection: bruising** **Distention: none** **Incisions: cranial** **Scars: none** **Drains:** **Wounds: head, arms, legs** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐** N ☐** **Size:42-50** **Feeding tubes/PEG tube Y ☐ N ☐**** **Type:**	**Bowels hypoactive in all 4 quadrants, Patient tolerating TPN, slight raise in blood pressure upon oral care and repositioning the client, wounds all over the patient's body and bandage around the head** **Chest tube right mid axillary (drain)** **Feeding tube (drain)** **EVD (Drain)** **endotracheal tube (airway)**
GENITOURINARY: **Color: yellow/brown** **Character: slightly foggy** **Quantity of urine: 50 ml during morning care** **Pain with urination: Y ☐ N *☐** **Dialysis: Y ☐ N ☐*** **Inspection of genitals: no rashes, foul odor** **Catheter: Y ☐* N ☐** **Type: Foley** **Size: 20 FR**	

MUSCULOSKELETAL: **Neurovascular status: not alert** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y ☐* N ☐** **Fall Risk: Y ☐* N☐** **Fall Score: 42** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	The patient is at risk for falls with no mobility, there are no signs of strength in all extremities, his fall risk is a 42, no assistive devices at the time as patient cannot move or get out of bed, ROM is not active as he cannot move on his own, Needs no assistance at home
NEUROLOGICAL: **MAEW: Y *☐ N☐** **PERLA: Y *☐ N☐** **Strength Equal: Y ☐ N *☐ if no -** **Legs ☐ Arms ☐ Both ☐*** **Orientation: not oriented to setting** **Mental Status: showing no signs of mental stability** **Speech: not applicable** **Sensory: not applicable** **LOC: Not present**	Patient in serious distress and unable to provide feedback on pain, needs, wants, Patient cannot move arms or legs with the nurse providing movement for him, no signs of consciousness
PSYCHOSOCIAL/CULTURAL: **Coping method(s): N/A** **Developmental level: appropriate to age** **Religion & what it means to pt.: N/A** **Personal/Family Data (Think about home environment, family structure, and available family support): Mother, girlfriend and brothers**	.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:00 am	90	134/60	18	98.7 axillary site	102% mechanical vent

11:00 am	92	142/72	18	98.6 axillary site	102% mechanical vent

Vital Sign Trends: Vitals are stable and have been similar throughout the morning care of the patient. Upon giving treatment that caused discomfort, his blood pressure rose throughout the morning. The mechanical vent is helping with the patient's PaO2 for the morning care.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
7:00 am	5/10	arms, jaw and head	moderate	N/A	pain meds prn and restricting ROM
9:00 am	5/10	arms, jaw and head	moderate	N/A	pain meds prn and restricting ROM

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 G **Location of IV: Right radial** **Date on IV: 11/6/2022** **Patency of IV: placed and not locked** **Signs of erythema, drainage, etc.: none present** **IV dressing assessment: clean and no redness at site**	normal saline 100 ml/hr

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
4316 ml fluids no bowel movement	1930 ml fluids no bowel movement

Nursing Care

Summary of Care (2 points)

Overview of care: Body assessment on AB, administered eye medication and turned patient to help avoid skin breakdown, administered TPN, feedings, drew blood for labs, drew urine for labs, pupil dilation tests, provided oral care, applied SCDs to client's legs, administered IV medications, and crushed medications. Monitor HgB levels, prevent volume overload and give lasix, and wean off Dilaudid, order a urinalysis panel, and monitor pulmonary capacity

Procedures/testing done: No tests or procedures done during care that morning

Complaints/Issues: No complaints

Vital signs (stable/unstable): vitals stable both rounds in the morning with moderate hypertension

Tolerating diet, activity, etc.: No activity in plan for few days, tolerates TPN administered

Physician notifications: Monitor neuro function next few days

Future plans for client: No plans until brain activity is restored

Discharge Planning (2 points)

Discharge location: Home if applicable

Home health needs (if applicable): Not applicable at time of care

Equipment needs (if applicable): N/A

Follow up plan: N/A

Education needs: N/A

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 cerebral tissue perfusion related to hemorrhage, as evidence by altered mental status	The patient, AB, was in a state of no consciousness and has been trying to wake up over the past two days, he is at risk for inadequate oxygen to the brain without functioning because of the brain bleed. The accident he was in caused severe brain bleed throughout	**1. provide supplemental oxygen** **2. Monitor blood pressure for changes, may cause hypotension**	**1. Patient's oxygen will be stable at 100% and his blood pressure will reduce**	Patient's mother may not be fully aware of the brain damage that may be permanent, she is willing to help out in any way possible Client cannot give a form of response
2. Risk for impaired skin integrity related to immobility as evidenced by disruption of dermal tissues	The patient has not been able to move on his own since he was admitted. He runs the risk of having skin breakdown if he is not manually moved by the nurse Q2 hours. They are hoping he can regain consciousness in the next few days of inpatient care	**1. Rotate patient Q2 hours and adjust pillows where needed** **2. Monitor pressure points for redness or skin breaks**	**1. Patient will avoid any redness from sitting in a position for too long, and avoid further complications to damaged bones and skin**	Mother was pleased to have him be readjusted in bed as she described he looked uncomfortable Patient cannot give a response per care
3. Impaired verbal communication related to	Patient has been nonverbal since admitted, and there is worrisome he developed	**1. Explain what you will be doing to the patient**	**1. Receive neuro tests back and plan for brain activity to develop**	Mother is responding well to nurse-client care Patient cannot give feedback

dysarthria as evidenced by nonverbal and brain damage, and extremity weakness	severe brain damage that may affect his cognitive function	**i.e. giving medications, lifting the patient, checking vitals** 2. **Look for signs of clenching or vital changes during care to see if patient is having discomfort**	**such as eyes opening, motor movement by the patient alone, and able to speak or make noises in accordance to care**	
4. Patient is risk for injury related to poor motor coordination as evidenced by inability to perform self care	Patient cannot perform ADL's since admitted, he lacks motor function due to injury of the spine, head, and other extremities	**1. Provide daily care such as oral hydration, changing linens, moving the patient** **2. Use of bed alarms and side rails as needed**	**1. Patient will have ROM's in all four extremities and be able to signal for needs and wants**	Mother is able to assist with needs and wants and monitor for any movement she may notice if the nurse is not in the room Patient cannot give feedback per care

Other References (APA):

Concept Map (20 Points):

Client information: AB, a 25 year old male, has an unknown PMH and presents to St.

Anthony's ED by ambulance with an MVC. Patient arrived with a glasgow coma scale of 3

and is intubated. Patient has a chest tube in place with a confirmed right right pneumothorax, and pelvic fracture. A CT scan showed a subdural hemorrhage and compressions on the c7 and T3 endplates.

Subjective data: Patient is in distress, (patient cannot verbalize any signs symptoms with pain), uncomfortable body positioning (stated by mother)

objective data: pain which is seen from vitals increasing during care, skin is dry and warm to touch, no drain leaks or open wounds, no labored breathing, blood pressure is a moderate hypertension, unresponsive to touch and speech

Nurse diagnosis:

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
2. Ineffective cerebral tissue perfusion related to hemorrhage, as evidence by altered mental status
3. Risk for impaired skin integrity related to immobility as evidenced by disruption of dermal tissues
4. Impaired verbal communication related to dysarthria as evidenced by nonverbal and brain damage, and extremity weakness
5. Patient is risk for injury related to poor motor coordination as evidenced by inability to perform self care

nurse interventions:

1. provide supplemental oxygen **2. Monitor blood pressure for changes, may cause hypotension**
1. Rotate patient Q2 hours and adjust pillows where needed **2. Monitor pressure points for redness or skin breaks**
3. Explain what you will be doing to the patient i.e. giving medications, lifting the patient, checking vitals 4. **Look for signs of clenching or vital changes during care to see if patient is having discomfort**
2. Provide daily care such as oral hydration, changing linens, moving the patient **2. Use of bed alarms and side rails as needed**