

N431 Care Plan #2

Lakeview College of Nursing

Chelsea Grubb

Demographics (3 points)

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|--|----------------------------------|--------------------------------------|--|
| Date of Admission 11/04/2022 | Client Initials K.D. | Age 53 | Gender Female |
| Race/Ethnicity White | Occupation Unemployed | Marital Status Married | Allergies Aspirin (acetylsalicylic acid) |
| Code Status Full code | Height 157.2 cm (5'2") | Weight 146.5 kg (322 lbs.) | |

Medical History (5 Points)

Past Medical History: Osteomyelitis (2020), cervical cancer (2019), anxiety (2019), chronic pain (2018), anemia (2016), type II diabetes (2013), and NASH cirrhosis (2001).

Past Surgical History: Hysterectomy (2019), and a lumbar laminectomy (2019).

Family History: No family history on file, the patient is a transport patient from St. Anthony's Hospital.

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

K.D. smokes 0.50 packs per day and has smoked for 33 years. The patient does not drink alcohol. The patient has a positive screen for marijuana upon drug screen, unable to assess the amount used per day due to being intubated and the patient being alone at bedside. No other drug use known at this time.

Assistive Devices: The patient does not have any assistive devices.

Living Situation: The patient lives at home with her husband and no pets.

Education Level: The husband stated her highest level of education is 6th grade.

Admission Assessment

Chief Complaint (2 points): Upper GI bleed

History of Present Illness – OLD CARTS (10 points): The patient is unable to provide an adequate H&P due to being sedated and intubated. The given information was taken from the

patient's husband. The patient's husband found the patient lying in the chair when he was carrying in the groceries. The patient's husband explains he was gone for more than 6 hours that day running errands. The patient is unable to provide the last time he has seen her at her normal baseline. This event happened on 11/04/22 in the afternoon. The patient was seen in her recliner unresponsive and gurgling. The patient's husband could not wake her up and described her in a state he has never seen her in before. Some characteristics that her husband described seeing her do was gurgling and drooling. The husband immediately called 911 instead of trying different medical treatments at home. This event lasted until the patient was transferred to St. Anthony's Hospital where then she was intubated due to inability to breath on her own. The patient has never had an episode like this happen before, and she has never been treated for this in the past. The patient was flown over via helicopter to Carle ICU to provide the proper care she needs. The providers then diagnosed her with internal bleeding, and she was given three bags of RBC and two bags of platelets. The patient is now currently still intubated with no plans of being extubated anytime soon. Her status is improving although she came to the hospital in such a bad state.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Upper GI bleed

Secondary Diagnosis (if applicable): MRSA bacteremia in the blood

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

According to hospital estimates, acute GI bleeding accounts for 300,000 hospital admissions annually in the United States. Compared to lower GI bleeding, which has an annual frequency of 20–27 episodes per 100,000 people and a mortality rate of 4%–10%, upper GI bleeding has a range of 40–150 episodes per 100,000 people each year and a mortality rate of

6%–10% (Oakland, 2019). Men have acute GI bleeding more frequently than women, and it becomes more common as people age. The esophagus, stomach, and duodenum are three possible sites for acute upper GI bleeding. Based on anatomical and pathophysiologic variables, upper GI bleeding can be divided into six categories: ulcerative, vascular, traumatic, iatrogenic, tumors, and portal hypertension. Peptic ulcer disease, including aspirin and other non-steroidal anti-inflammatory medicines (NSAIDs), variceal hemorrhage, Mallory-Weiss rupture, and neoplasms, including stomach malignancies, are the most frequent causes of acute upper GI bleeding (Oakland, 2019). Quick assessment and resuscitation should come first in unstable individuals with acute severe bleeding. Once hemodynamic stability has been established, patients should be assessed for the immediate risk of rebleeding and consequences, as well as the underlying cause of bleeding. Risk assessments, like the Glasgow Blatchford Score (GBS) and Rockall Score, have been created and validated for acute upper GI bleeding (Capriotti & Frizzell, 2020).

In order to make better use of the limited hospital in-patient resources, patients with minimal or intermittent bleeding who are classified as low risk can be assessed in an outpatient setting. There are multiple ways of recognizing an active bleed. Some symptoms that may be seen in an internal GI bleed are hypotension, little to no urination (oliguria), bounding/rapid pulse, and the patient may become unconscious (Oakland, 2019). However, there are treatment options for an internal GI bleed. These may include taking appropriate medication and surgery (Capriotti & Frizzell, 2020). An internal bleed is a medical emergency, no matter the extent of the internal bleed. Some patients can even pass away due to an internal GI bleed. Following up with your provider is essential in getting back to a healthy lifestyle.

Pathophysiology References (2) (APA):

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

Oakland, K. (2019). Risk stratification in upper and upper and lower GI bleeding: Which scores should we use? *Best practice & research clinical gastroenterology*, 42, 101613.

Laboratory Data (15 points)

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

| Lab | Normal Range | Admission Value | Today's Value | Reason for Abnormal Value |
|-------------|---------------------|-----------------|---------------|--|
| RBC | 3.50 m/uL-5.20 m/uL | 2.53 m/uL | 3.00 m/uL | Decreased RBC are common in patients with internal bleeding (Kee, 2018). |
| Hgb | 11.0 g/dL-16.0 g/dL | 7.1 g/dL | 8.8 g/dL | Decreased Hgb are common in patients with anemia and internal bleeding (Kee, 2018). |
| Hct | 34%-47% | 22.4% | 27.9% | Decreased Hct levels are common in patients with anemia and internal bleeding (Kee, 2018). |
| Platelets | 140,000-400,000 | 81,000 | 90,000 | Decreased platelet counts are due to internal hemorrhage (Kee, 2018). |
| WBC | 4.00 uL-11.00 uL | 6.05 | 8.68 | Within normal range. |
| Neutrophils | 55 uL-70 uL | N/A | N/A | Not completed on this admission. |
| Lymphocytes | 20 uL-40 uL | N/A | N/A | Not completed on this admission. |
| Monocytes | 2 uL-8 uL | N/A | N/A | Not completed on this admission. |
| Eosinophils | 1 uL-4 uL | N/A | N/A | Not completed on this admission. |
| Bands | 50%-65% | N/A | N/A | Not completed on this admission. |

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

| Lab | Normal Range | Admission Value | Today's Value | Reason For Abnormal |
|-----|---------------|-----------------|---------------|----------------------|
| Na- | 135-145 mEq/L | 138 mEq/L | 145 mEq/L | Within normal range. |

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|--------------------|------------------------------|-------------|----------------|---|
| K+ | 3.5 mEq/L- 5.1 mEq/L | 3.7 mEq/L | 3.7 mEq/L | Within normal range. |
| Cl- | 98 mEq/L- 105 mEq/L | 105 mEq/L | 102 mEq/L | Within normal range. |
| CO2 | 22 mEq/L- 29 mEq/L | 23 mEq/L | 25 mEq/ L | Within normal range. |
| Glucose | 70 mg/dL- 110 mg/dL | 304 mEq/L | 122 mEq/L | Increased glucose levels due to the patient having diabetes mellitus (Kee, 2018). |
| BUN | 5 mg/dL-25 mg/dL | 18 mg/dL | 19 mg/dL | Within normal range. |
| Creatinine | 0.5 mg/dL- 1.2 mg/dL | 0.7 mg/dL | 0.8 mg/ dL | Within normal range. |
| Albumin | 3.5 g/dL-5.0 g/dL | 3.6 g/dL | 4.3 g/dL | Within normal range. |
| Calcium | 8.9 mEq/L- 10.6 mEq/L | N/A | 9.4 mEq/L | Within normal range. |
| Mag | 1.5 mEq/L- 2.6 mEq/L | N/A | 2.2 mEq/L | Within normal range. |
| Phosphate | 1.7 mEq/L- 2.6 mEq/L | N/A | N/A | Not completed on this admission. |
| Bilirubin | 0.1 mg/dL- 1.2 mg/dL | 0.5 mg/dL | 0.8 mg/ dL | Within normal range. |
| Alk Phos | 40 units/dL- 150 units/dL | 74 units/dL | 83 units/dL | Within normal range. |
| AST | 0-35 units/L | 26 units/L | 30 units/L | Within normal range. |
| ALT | 0-55 units/L | 18 units/L | 19 units/L | Within normal range. |
| Amylase | 60 units/L- 120 units/L | N/A | N/A | Not completed on this admission. |
| Lipase | 0-160 units/ L | N/A | N/A | Not completed on this admission. |
| Lactic Acid | 5 mg/dL-20 mg/dL | 5.5 mg/dL | N/A | Within normal range. |
| Troponin | < 0.1 ng/dL | N/A | N/A | Not completed on this admission. |
| CK-MB | < 5.0 ng/mL | N/A | N/A | Not completed on this admission. |
| Total CK | 5 IU/L-25 IU/L | N/A | N/A | Not completed on this admission. |

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 | 1.3 | 1.4 | The patient's INR was increased due to her massive blood transfusion (Kee, 2018). |
| PT | 11-13.5 | 16.3 | 17.3 | The patient's PT was increased due to her massive blood transfusion (Kee, 2018). |
| PTT | 25 seconds-35 seconds | N/A | N/A | Not completed on this admission. |
| D-Dimer | < 0.50 ng/mL | N/A | N/A | Not completed on this admission. |
| BNP | 6 mg/dL-20 mg/dL | N/A | N/A | Not completed on this admission. |
| HDL | < 40 ng/dL | N/A | N/A | Not completed on this admission. |
| LDL | < 100 mg/dL | N/A | N/A | Not completed on this admission. |
| Cholesterol | < 200 mg/dL | N/A | N/A | Not completed on this admission. |
| Triglycerides | < 150 mg/dL | N/A | N/A | Not completed on this admission. |
| Hgb A1c | < 5.7% | N/A | N/A | Not completed on this admission. |
| TSH | 0.5 mIU/L-5.0 mIU/L | N/A | N/A | Not completed on this admission. |

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 | Light straw-amber | N/A | N/A | Not completed on this admission. |
| pH | 4.5-8.0 | N/A | N/A | Not completed on this admission. |
| Specific Gravity | 1.005-1.030 | N/A | N/A | Not completed on this admission. |
| Glucose | Negative | N/A | N/A | Not completed on this admission. |
| Protein | 2 mg/dL-8 mg/dL | N/A | N/A | Not completed on this admission. |

| | | | | |
|----------------------|----------|-----|-----|----------------------------------|
| Ketones | Negative | N/A | N/A | Not completed on this admission. |
| WBC | Negative | N/A | N/A | Not completed on this admission. |
| RBC | Negative | N/A | N/A | Not completed on this admission. |
| Leukoesterase | Negative | N/A | N/A | Not completed on this admission. |

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 | 7.35 | N/A | Within normal range. |
| PaO2 | 80-100 mmHg | 147.7 mmHg | N/A | Increased PaO2 levels due to the patient hyperventilating before being intubated (Kee, 2018). |
| PaCO2 | 35-45 mmHg | 43 mmHg | N/A | Within normal range. |
| HCO3 | 22-26 mEq/ L | 23 mEq/L | N/A | Within normal range. |
| SaO2 | 95%-100% | 98% | N/A | Within normal range. |

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 | Not completed on this admission. |
| Blood Culture | Negative/No growth | No growth in 5 days. | N/A | Within normal range. |
| Sputum Culture | Normal URT | Mixed bacterial flora with caused by methicillin-resistant | N/A | The patient's sputum culture came back with mixed growth due to MRSA in her blood and sputum (Kee, 2018). |

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|----------------------|-------------------------|-------------------------------|-----|----------------------------------|
| | | Staphylococcus aureus. | | |
| Stool Culture | Normal intestinal flora | N/A | N/A | Not completed on this admission. |

Lab Correlations Reference (1) (APA):

Kee, J. L. F. (2018). *Pearson handbook of laboratory & diagnostic tests with nursing implications* (8th Ed.). Pearson.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The patient got a chest x-ray on 11/04/22. The patient has never gotten a chest x-ray before for this problem. The provided ordered a chest x-ray to determine what part of the lungs is affected by *Staphylococcus aureus*.

Diagnostic Test Correlation (5 points): The chest x-ray will allow the providers a more detailed image of the lungs and the space around the lungs (Pagana et al., 2018). The chest x-ray showed right pleural effusion. The impression and images were sent to the provider for further review.

Diagnostic Test Reference (1) (APA):

Pagana, K.D., & Pagana, T. J., Pagana, T. N. (2018). *Mosby’s manual of diagnostic and laboratory test reference* (14th Ed.). Mosby.

**Current Medications (10 points, 1 point per completed med)
*10 different medications must be completed***

Home Medications (5 required)

| | | | | | |
|----------------------------------|--|---|---|---------|-----|
| Brand/Generic | oxycodone (Xtampza ER) | lorazepam (Ativan) | ferrous gluconate (Fertinic) | N/ A | N/A |
| Dose | 20 mg. | 1 mg. | 324 mg. | N/ A | N/A |
| Frequency | Q4 hours | 3 x daily | 1 x daily | N/ A | N/A |
| Route | PO | PO | PO | N/ A | N/A |
| Classification | Pharmacologic class: Opioid Therapeutic class: Opioid analgesic (Jones & Bartlett Learning, 2020). | Pharmacologic class: Benzodiazepine Therapeutic class: Anxiolytic (Jones & Bartlett Learning, 2020). | Pharmacologic class: Hematinic Therapeutic class: Antianemic, nutritional supplement (Jones & Bartlett Learning, 2020). | N/ A | N/A |
| Mechanism of Action | Alters perception of emotional response to pain at the spinal cord (Jones & Bartlett Learning, 2020). | GABA and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in cortical and limbic areas of CNS (Jones & Bartlett Learning, 2020). | Acts to normalize the RBC production by binding to the hemoglobin and oxidize the reticuloendothelial cells of the bone marrow (Jones & Bartlett Learning, 2020). | N/ A | N/A |
| Reason Client Taking | Pain management | Anxiety | Anemia | N/ A | N/A |
| Contraindications (2) | Hypersensitivity to oxycodone and significant respiratory depression (Jones & | Hypersensitivity to lorazepam and being mechanically ventilated (Jones & Bartlett | Hypersensitivity to iron salts or actively bleeding internally (Jones & Bartlett Learning, 2020). | N/ A | N/A |

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|---|--|--|--|-----|-----|
| | Bartlett Learning, 2020). | Learning, 2020). | | | |
| Side Effects/Adverse Reactions (2) | Oliguria and respiratory depression (Jones & Bartlett Learning, 2020). | Constipation and abdominal pain (Jones & Bartlett Learning, 2020). | Nausea and constipation (Jones & Bartlett Learning, 2020). | N/A | N/A |
| Nursing Considerations (2) | Monitor the patient's respiratory status before and after giving the drug. Assess the patients vitals (Jones & Bartlett Learning, 2020). | Ask the patient if she is having suicidal thoughts and ask about drug use (Jones & Bartlett Learning, 2020). | Monitor the patient for signs of iron overdose and check for occult blood in the stool (Jones & Bartlett Learning, 2020). | N/A | N/A |
| Key Nursing Assessment(s)/Lab(s) Prior to Administration | Assess the patient for stomach issues prior to administering. Assess the patient's pain level (Jones & Bartlett Learning, 2020). | Assess the patient's anxiety level and ask about drug usage (Jones & Bartlett Learning, 2020). | Give iron tablets with a full glass of water and give one hour before eating or two hours after eating (Jones & Bartlett Learning, 2020). | N/A | N/A |
| Client Teaching Needs (2) | Educate the patient to push fluids to decrease constipation and only take the prescribed dosage. | Educate the patient that when taking lorazepam and opioids together the duration of the opioid will be limited and to only take the prescribed dosage. | Educate the patient to drink orange juice with the iron tablets to increase absorption and avoid dairy products because this decreases absorption. | N/A | N/A |

Hospital Medications (5 required)

| | | | | | |
|----------------------------|--|--|--|--|---|
| Brand/Generic | insulin lispro (Humalog) | ertapenem (Invanz) | bisacodyl (Dulcolax) | insulin glargine (Lantus) | pantoprazole (Protonix) |
| Dose | Sliding scale | 1 g. | 10 mg. | 225 units | 40 mg. |
| Frequency | Q4 hours | Q24 hours | 1 x daily/PRN | PRN | Q12 hours |
| Route | Subcutaneous | IV | Rectal | Subcutaneous | IV push over 2 minutes |
| Classification | Pharmacologic class: Human insulin Therapeutic class: Antidiabetic (Jones & Bartlett Learning, 2020). | Pharmacologic class: Carbapenem Therapeutic class: Antibiotic (Jones & Bartlett Learning, 2020). | Pharmacologic class: Therapeutic class: (Jones & Bartlett Learning, 2020). | Pharmacologic class: Human insulin Therapeutic class: Antidiabetic (Jones & Bartlett Learning, 2020). | Pharmacologic class: Proton pump inhibitor Therapeutic class: Antiulcer (Jones & Bartlett Learning, 2020). |
| Mechanism of Action | Lowers blood glucose levels by stimulating peripheral glucose uptake by fat and skeletal muscle, and by inhibiting hepatic glucose production (Jones & Bartlett Learning, 2020). | Inhibits bacterial cell wall synthesis by binding to specific penicillin-binding proteins (Jones & Bartlett Learning, 2020). | Bisacodyl directly stimulates parasympathetic nerves in the colon, stimulating contraction of longitudinal smooth muscle but not circular smooth muscle (Jones & Bartlett Learning, 2020). | Insulin glargine binds to the insulin receptor (IR), a heterotetrameric protein consisting of two extracellular alpha units and two transmembrane beta units. The binding of insulin to the alpha subunit of | Inhibits the hydrogen-potassium-adenosine triphosphatase enzyme system, or proton pump, in gastric parietal cells, which inhibit stomach acid output (Jones & Bartlett Learning, 2020). |

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| | | | | IR stimulates the tyrosine kinase activity intrinsic to the beta subunit of the receptors (Jones & Bartlett Learning, 2020). | |
| Reason Client Taking | Type II diabetes mellitus | MRSA | Constipation | Type II diabetes mellitus | GI discomfort |
| Contraindications (2) | Hypersensitivity to human insulin and respiratory status decline (Jones & Bartlett Learning, 2020). | Hypersensitivity to beta-lactams and its components and hypersensitivity to this drug class (Jones & Bartlett Learning, 2020). | Hypersensitivity to bisacodyl and its components and having an active GI bleed (Jones & Bartlett Learning, 2020). | Hypersensitivity to human insulin or components inside of eggs (Jones & Bartlett Learning, 2020). | Hypersensitivity to pamidronate, other bisphosphonates, or their components (Jones & Bartlett Learning, 2020). |
| Side Effects/Adverse Reactions (2) | Diarrhea and hypoglycemia (Jones & Bartlett Learning, 2020). | Hyperglycemia and small bowel obstruction (Jones & Bartlett Learning, 2020). | Abdomen pain and nausea (Jones & Bartlett Learning, 2020). | Headache and difficulty concentrating (Jones & Bartlett Learning, 2020). | Nausea and constipation (Jones & Bartlett Learning, 2020). |
| Nursing Considerations (2) | Monitor the patient's blood sugar levels closely and watch for signs of hypoglycemia (Jones & | Shake the medication well before reconstituting it and use within six hours if stored at room | When the patient is allowed to eat and drink again pushing fluids and listening to the patient's | Keep a close eye on the patient's blood sugar and monitor the patient's vital signs (Jones & Bartlett | As directed, obtain a serum creatinine level before each treatment. Notify the provider if |

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| | Bartlett Learning, 2020). | temperature (Jones & Bartlett Learning, 2020). | bowel sounds (Jones & Bartlett Learning, 2020). | Learning, 2020). | the results are abnormal, as the drug may need to be withheld or the dosage adjusted until the creatinine level returns to normal (Jones & Bartlett Learning, 2020). |
| Key Nursing Assessment(s)/Lab(s) Prior to Administration | Check potassium levels and check the patient's blood sugar levels (Jones & Bartlett Learning, 2020). | Obtain a blood culture before administering this medication and inspect the drug for discoloration (Jones & Bartlett Learning, 2020). | Inspecting the patient's abdomen for masses and palpating the abdomen for masses (Jones & Bartlett Learning, 2020). | Checking the patient's blood glucose levels (Jones & Bartlett Learning, 2020). | Assess the patient's bowel sounds and assess the patient's blood pressure (Jones & Bartlett Learning, 2020). |
| Client Teaching Needs (2) | Educate the patient on smoking cessation and refraining from high sugar foods. | Educate the patient to report any changes in skin because a rash is common when taking this antibiotic and advise the patient that diarrhea is normal when taking this drug. | Add high fiber and drink 1500 mL of water daily. | Educate the patient on signs and symptoms of hypoglycemia and the signs and symptoms of hyperglycemia. | Educate the patient on taking pantoprazole at the same time everyday and advising them to swallow whole and never chew the medication. |

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse’s drug handbook* (19th Ed.). Jones & Bartlett Learning.

Assessment

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

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|---|---|
| <p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p> | <p>The patient is sedated and intubated. The patient isn’t in any known distress. The patient is disheveled and ungroomed.</p> |
| <p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: 11 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p> | <p>The patient’s skin color is pale with a yellow tint to it. Her skin is dry yet warm and clammy to the touch. The patient’s skin turgor is normal. There are no rashes or bruises present. The patient does have three wounds present. The first wound is on her right foot, the second wound is on her coccyx and the third wound is on her posterior left thigh. All of the wounds seem to be caused from pressure that she had prior to coming in on 11/04/22. Her Braden score is an 11. She has no drains present.</p> |
| <p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p> | <p>Patient has normal head shape and size; the neck is supple. Patient has symmetrical, no tracheal deviations, non-palpable thyroid, non-palpable lymph nodes. Pallor, TM bilateral. External ears and nose atraumatic. Bilateral, symmetrical pinas, no lesions, bulges, keloids present. No drainage, purulent from the canals. Septum is midline, turbinates are moist and pink bilaterally and no visible bleeding or polyps present. The patient has poor dentition.</p> |
| <p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p> | <p>Clear S1 and S2 sounds without any murmurs, gallops, or rubs. S3 and S4 were clear as well. Normal sinus rhythm. Peripheral pulses were 2+. Capillary refills were less than 3. The patient has +3 pitting edema bilaterally in lower extremities up to mid-thigh.</p> |

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| <p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p> | <p>There was no usage of the accessory muscles. The left lobes were clear with equal air entry. Rhonchi noted in the right lower and middle lobe.</p> |
| <p>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 <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p> | <p>The patient eats a normal diet at home. The patient is NPO here at the hospital. The patient is 157.2 cm (5'2") and weights 146.5 kg (322 lbs.). There are normoactive, audible bowel sounds in all four quadrants. The patient's last bowel movement was on 11/12/22. There was no pain or masses upon palpation. There is an umbilical hernia noted upon inspection and palpitation. No abdominal distention, incisions, or drains present. There are three nickel size scars present from her hysterectomy that was done in 2019. There are no abdominal wounds present. The patient does not have an ostomy, nasogastric/feeding/PEG tube.</p> |
| <p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: Size:</p> | <p>The patient's urine is yellow and very concentrated. The patient has oliguria. No pain present with urination. The patient is not on dialysis. The inspection of the patient's genitals is normal for a female. The patient does have a 16G foley catheter present that was placed on 11/04/22.</p> |
| <p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 17 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input checked="" type="checkbox"/> Needs support to stand and walk <input checked="" type="checkbox"/></p> | <p>The patient's neurovascular status is decline due to patient's status. The patient has significant mobility impairment. Unable to assess patient's ROM, the patient cannot follow commands. The patient has a 25cm endotracheal tube in her airway helping her breathe. The patient's husband helps her with her daily living tasks. The patient is a fall risk and has a fall score of 17. The patient is not mobile due to being on bed rest. The patient needs assistance with getting out of bed and walking prior to this admission.</p> |

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|---|---|
| <p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p> | <p>The patient is unoriented to person, place, and time. The patient’s mental status is incoherent. PERLA is noted. Unable to assess the patient’s speech due to being sedated and intubated. The patient does not react to sensory tests. Level of consciousness is intubated and sedated.</p> |
| <p>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):</p> | <p>Unable to assess the patient’s coping method due to the patient’s status. The patient is alone with no one at her bedside. The husband did note on 11/04/22 her highest level of education is a 6th grade level. She does have slight development impairment. No religion noted in her chart. The husband notes that they are all each other have, seems to have adequate and appropriate family support.</p> |

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

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|------|-------|--------|-----------|----------------------|--------|
| 0823 | 51 | 107/58 | 14 | 97.6 F (axillary) | 94% |
| 1045 | 53 | 109/55 | 17 | 97.2 F (axillary) | 95% |

Vital Sign Trends: The patient’s vital sends are stable and trending positive. The patient’s vitals are more stable than they ever have been throughout this patient’s admission. Continuous vitals are needed on this patient to ensure positive vital trends.

Pain Assessment, 2 sets (2 points)

| Time | Scale | Location | Severity | Characteristics | Interventions |
|-------------|--|-----------------|-----------------|------------------------|----------------------|
| 0823 | CPOT Non-verbal indicators are absent | N/A | N/A | N/A | N/A |
| 1045 | CPOT Non-verbal indicators are absent | N/A | N/A | N/A | N/A |

IV Assessment (2 Points)

| IV Assessment | Fluid Type/Rate or Saline Lock |
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| Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment: | The patient has a CVC non-tunneled triple lumen that was placed on 11/04/22. The patency is open with no signs of erythema or drainage. The dressing is intact and dry and was last changed on 11/13/22. There were no current medications running IV at the time of assessment. The patient has a 25 cm endotracheal tube in her airway that was placed on 11/07/22. The placement of her endotracheal tube is appropriate. |

Intake and Output (2 points)

| Intake (in mL) | Output (in mL) |
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| No intake due to NPO status | 80 mL of urine out of the patients 16G foley catheter. The patient did not have a bowel movement during this assessment. |

Nursing Care

Summary of Care (2 points)

Overview of care: The patient arrived via EMS from St. Anthony’s Hospital. The patient was then sedated and intubated. The client will remain on bedrest and intubated. There are no

current plans to extubate the patient and remove the sedation due to the patient's condition. The patient's vital signs are improving, and we will continue to monitor them at this time. The patient is tolerating being NPO and on bedrest. Watch for signs of internal bleeding and manage proper hygiene in order to eliminate infection.

Procedures/testing done: Colonoscopy done on 11/9/22, EGD/DHC/hemoclip done on 11/05/22.

Complaints/Issues: The husband found her unresponsive and incoherent upon stimulation. No complaints by patient due to the patient being intubated.

Vital signs (stable/unstable): The patient's vital signs are stable.

Tolerating diet, activity, etc.: The patient is tolerating her diet and bed rest within reason.

Physician notifications: The provider was not notified during this nursing student's day in ICU.

Future plans for client: The patient does not have a discharge date placed currently due to her status.

Discharge Planning (2 points)

Discharge location: If and when the patient is allowed to go home, she will be discharged to her house with her husband.

Home health needs (if applicable): The patient is advised to get proper wound care supplies to change dressings at home. The patient is advised to get 4% chlorhexidine to decolonize MRSA.

Equipment needs (if applicable): Obtaining sterile wound care supplies and 4% chlorhexidine.

Follow up plan: The patient is to follow up with her primary care provider within seven days of future discharge date. The patient is to follow up with the provided pulmonologist within two weeks from discharge date. The patient is to follow up with dermatology and infection control within three months of discharge.

Education needs: Educate the patient on healthy diet choices and making healthy lifestyle choices. Encourage smoking and marijuana cessation. Manage proper medication regimen and educate further about type II diabetes mellitus. Educate the patient’s husband so that everyone is on the same page. Educate the patient on the importance of following up with her provider.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

| <p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • 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 | <p>Rationale</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis is was chosen | <p>Interventions (2 per dx)</p> | <p>Outcome Goal (1 per dx)</p> | <p>Evaluation</p> <ul style="list-style-type: none"> • How did the client/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan. |
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| <p>1. Fluid volume deficit relate to blood volume loss secondary to GI bleed as evidence by hematochezia.</p> | <p>The patient is at a greater risk of losing fluid faster due to an internal bleed.</p> | <p>1. Take the patient’s vitals Q2 hours. 2.Educate the patient on the signs and symptoms of recurrent GI</p> | <p>1. The patient’s vitals remain stable, and the patient does not decline. 2. The patient will understand the signs and symptoms of</p> | <ul style="list-style-type: none"> • The patient understood why vitals are so important when you lose so much blood. • The patient was able to |

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| | | bleed. | an internal bleed. | understand the signs and symptoms of an internal bleed. No modification to these current plans are needed at this time. |
| <p>2. Ineffective tissue perfusion related to lower GI bleed as evidence by bright red blood coming out of the rectum upon inspection.</p> | <p>The patient's internal bleed leaves the other organs at risk for inadequate perfusion.</p> | <p>1. The patient will get a EGD every three months for follow up care.</p> <p>2.The patient will stick to a medication regimen by taking her proton pump inhibitors as prescribed.</p> | <p>1. The patient followed up with her gastrointestinal provider and got her EGD every three months as advised.</p> <p>2. The patient showed proof of getting her Protonix filled at her local pharmacy and stuck to her medication regimen.</p> | <ul style="list-style-type: none"> • The patient understood the reason behind getting an EGD. The patient attended all EGD appointments. • The patient understood why her Protonix was prescribed to her and maintained the medication regimen as prescribed by her provider. There are no modifications needed at this time. The patient understood all the |

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| | | | | education given and asked questions when appropriate. |
| <p>3. Impaired skin integrity related to immobility as evidence by multiple skin wounds.</p> | <p>The patient is immobile here at the hospital and was immobile at home.</p> | <p>1. Assess the skin integrity and condition every two hours.</p> <p>2. Rotate and turn every two hours in order to maintain skin integrity.</p> | <p>1. The patient's skin condition maintained stable with no decline in integrity. There were no new skin infections.</p> <p>2. The patient turned every two hours and maintained proper positioning to decrease the chances of skin breakdown.</p> | <ul style="list-style-type: none"> • The patient's skin integrity improved. The patient understood being more conscious about her skin integrity. • The patient was able to position herself adequately and independently in order to improve skin conditions. There are no modifications needed at this time. |
| <p>4. Risk for infection related to compromised immune system as evidence by positive MRSA gram stain.</p> | <p>The patient is at a higher risk of getting MRSA in the future due to being exposed to MRSA currently.</p> | <p>1. Sterile technique when changing wound dressings.</p> <p>2. Proper hand hygiene using antibacterial</p> | <p>1. The patient used all sterile dressings and techniques during independent wound changing.</p> <p>2. The patient used proper</p> | <ul style="list-style-type: none"> • The patient worked independently when changing her wounds. The patient maintained proper sterility. • The patient showed this |

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| | | <p>soap and using 4% chlorhexidine.</p> | <p>hand washing technique in order to eliminate further infection control. The patient obtained 4% chlorhexidine to decolonize MRSA.</p> | <p>nursing student the proper way to wash her hands. The patient understood why 4% chlorhexidine is used to decolonize MRSA. The patient plans to meet with dermatology and infection control after discharge date.</p> |
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Other References (APA):

Phelps, L.L. (2020). *Sparks and Taylor’s nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points):

Fluid volume deficit relate to blood volume loss secondary to GI bleed as evidence by hematochezia. The patient's vitals remain stable, and the patient does not decline. The patient will understand the signs and symptoms of an internal bleed.

Subjective Data

Infection related to lower GI bleed as evidence by bright red blood coming out of the rectum upon inspection. The patient followed up with her gastrointestinal provider and got her EGD every three months as advised. The patient showed proof of getting her Protonix filled at her local pharmacy and stuck to her medication regimen.

Impaired skin integrity related to immobility as evidence by multiple skin wounds. The patients skin condition maintained stable with no decline in integrity. There were no new skin infections. The patient turned every two hours and maintained proper positioning to decrease the chances of skin breakdown.

Risk for infection related to compromised immune system as evidence by positive MRSA gram stain. The patient used all sterile dressings and techniques during independent wound changing. The patient used proper hand washing technique in order to eliminate further infection control. The patient obtained 4% chlorhexidine to decolonize MRSA.

Nursing Diagnosis/Outcomes

Take the patient's vitals Q2 hours. Educate the patient on the signs and symptoms of recurrent GI bleed. The patient followed up with her gastrointestinal provider and got her EGD every three months as advised.

Client Information

The patient showed proof of getting her Protonix filled at her local pharmacy and stuck to her medication regimen. The patients skin condition maintained stable with no decline in integrity. There were no new skin infections. The patient turned every two hours and maintained proper positioning to decrease the chances of skin breakdown. The patient used all sterile dressings and techniques during independent wound changing. The patient used proper hand washing technique in order to eliminate further infection control. The patient obtained 4% chlorhexidine to decolonize MRSA.

Nursing Interventions

Objective Data

Female
53 years old
Married
Unemployed

