

N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 1-24-2023	Client Initials K.S.	Age 49	Gender Male
Race/Ethnicity African American	Occupation Disabled	Marital Status Married	Allergies Stadol- shortness of breath
Code Status Full	Height 5'6" (167.6cm)	Weight 160 lbs (72.6 kg)	

Medical History (5 Points)

Past Medical History: chronic pain, dialysis, hypertension, GERD, Dyslipidemia, diabetes type 2, sleep apnea, congestive heart failure, asthma, renal cell carcinoma, gout, legally blind, anemia, renal failure

Past Surgical History: right below knee amputation, dialysis catheter upper chest, right femoral dialysis catheter, dialysis fistula right arm, dialysis fistula left arm, left ankle surgery.

Family History: mom- stroke, dad- healthy, maternal grandfather- healthy, maternal grandmother- healthy, paternal grandfather- healthy, paternal grandmother- healthy.

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

Tobacco: former cigarette smoker 1 pack per day. Stopped 10 years ago.

Alcohol: none

Drugs: none

Assistive Devices: Wheelchair

Living Situation: patient states he lives with his wife.

Education Level: high school

Admission Assessment

Chief Complaint (2 points): Shortness of breath

History of Present Illness – OLD CARTS (10 points): Patient presented to the emergency department on 1-24-23 for shortness of breath for 2 hours prior to calling EMS. Patients states he constantly felt short of breath and felt like he was retaining a lot of fluid. Patients states he did not have any associating factors and did not do anything at home except call 911. Upon arrival at the hospital the nurses noted his heart rate begin to brady down. They then felt for a pulse and did not feel one. The patient was then coded.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cardiac Arrest

Secondary Diagnosis (if applicable): Acute blood loss

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

Cardiac arrest is the sudden loss of heart function, breathing and consciousness. Cardiac arrest can be caused by a variety of things and in the case of this patient it was caused by the patient losing too much blood too fast. The patient is a dialysis patient and has anemia related to renal failure. Anemia is when the patient does not create enough red blood cells and has a low red blood cell count and low hemoglobin. Red blood cells are composed of a protein called hemoglobin that carries oxygen throughout the body. Not having enough red blood cells in the body means there is not enough oxygen being circulated to the vital organs causing decreased functions of the organs. For this patient, the patient had a history of anemia and was also found to have bleeding ulcers causing the patient to have a major GI bleed and therefore lose a lot of blood very quickly. This led to his body shutting down due to not having enough red blood cells to transport the oxygen needed to keep his heart going. The patient's heart stopped beating, and the patient experienced a cardiac arrest. Anemia can be diagnosed through blood test and can be

treated in many ways such as medication or blood transfusions. A GI bleed can be diagnosed by completing a hemoccult test to test for blood in the stool. A GI bleed can be treated with medications or surgery depending on the severity of the bleeding. This patient was diagnosed through a hemoccult test and was given blood and fluids during CPR. The patient regained a pulse and was treated in the ICU. The patient also had a scope done to find where he was bleeding and was treated by a GI doctor. Cardiac arrest is diagnosed when there is no pulse and no breathing. Cardiac arrest treatment includes high quality CPR and ventilation along with medications.

Pathophysiology References (2) (APA):

Andersen, L. W., Holmberg, M. J., Berg, K. M., Donnino, M. W., & Granfeldt, A. (2019). In-hospital cardiac arrest: a review. *Jama*, 321(12), 1200-1210

Capriotti, T. (2020). *Davis advantage for Pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis.

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	4.2-5.4	1.48	2.71	Pt RBC decreased due to anemia and dialysis patient (Pagana et al., 2019).
Hgb	12-16	4.6	8.7	Pt hemoglobin decreased due to anemia (Pagana et al., 2019).
Hct	37-47	14.7	26.4	Pt hematocrit decreased due to anemia (Pagana et al., 2019).
Platelets	150-400	129	171	Within normal range
WBC	4.5-11	7.9	6.2	Within normal range

Neutrophils	55-70%	73.8%	79.7%	Pt neutrophils may be increased due to stress on the body from cardiac arrest (Pagana et al., 2019).
Lymphocytes	20-40%	18.7%	20%	Within normal range
Monocytes	2-8%	6.4%	7.4%	Within normal range
Eosinophils	1-4%	0.6%	2.2%	Within normal range
Bands	0.5-1%	Na	Na	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-	136-145	142	142	Within normal range
K+	3.5-5	5.5	3.8	Within normal range
Cl-	98-106	104	102	Within normal range
CO2	23-30	20	21	Pt CO2 decreased due to renal failure (Pagana et al., 2019).
Glucose	74-106	180	155	Pt glucose elevated due to type 2 diabetes (Pagana et al., 2019).
BUN	10-20	114	33	Pt BUN increased due to renal failure (Pagana et al., 2019).
Creatinine	0.5-1.1	8.26	6.0	Pt creatinine increased due to congestive heart failure (Pagana et al., 2019).
Albumin	3.5-5	3.1	3.1	Pt albumin decreased due to stress from cardiac arrest (Pagana et al., 2019).
Calcium	9-10.5	9.2	9.5	Within normal range
Mag	1.3-2.1	2.2	Na	not completed today.
Phosphate	3.0-4.5	Na	4.7	Pt phosphate increased due to renal failure (Pagana et al., 2019).
Bilirubin	0.3-1	Na	Na	Not completed on this admission

Alk Phos	30-120	61	Na	Within normal range
AST	10-30	14	Na	Within normal range
ALT	4-36	15	Na	Within normal range
Amylase	60-120	Na	Na	Not completed on this admission
Lipase	0-160	Na	Na	Not completed on this admission
Lactic Acid	0.5-2.2	2.0	Na	Within normal range
Troponin	<0.03	<0.03	Na	Within normal range
CK-MB	0%	Na	Na	Within normal range
Total CK	30-135	Na	Na	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	2-3	1.0	Na	Not completed today
PT	9.5-11.3	11.7	Na	Not completed today
PTT	30-40	30	Na	Within normal range
D-Dimer	<250	Na	Na	Not completed on this admission
BNP	<100	Na	Na	Not completed on this admission
HDL	>60	Na	Na	Not completed on this admission
LDL	<130	Na	Na	Not completed on this admission
Cholesterol	<200	Na	Na	Not completed on this admission
Triglycerides	<150	Na	Na	Not completed on this admission
Hgb A1c	4-5.9%	Na	Na	Not completed on this admission

TSH	2-10	Na	Na	Not completed on this admission
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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	Clear; yellow	Na	Na	Not completed on this admission
pH	4.6-8	Na	Na	Not completed on this admission
Specific Gravity	1.005-1.030	Na	Na	Not completed on this admission
Glucose	Negative	Na	Na	Not completed on this admission
Protein	0-8	Na	Na	Not completed on this admission
Ketones	Negative	Na	Na	Not completed on this admission
WBC	Negative	Na	Na	Not completed on this admission
RBC	Negative	Na	Na	Not completed on this admission
Leukoesterase	Negative	Na	Na	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	7.43	Na	Within normal range
PaO2	80-100	143	Na	Increased due to hyperventilation during cardiac arrest. (Pagana et al., 2019).
PaCO2	35-45	31	Na	Decreased due to hypoxemia (Pagana et al., 2019).
HCO3	21-28	20.5	Na	Decreased due to renal failure

				(Pagana et al., 2019).
SaO2	95-100	100	Na	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<10,000 Positive>100,000	Na	Na	Not completed on this admission
Blood Culture	Negative	Positive	Na	Positive for infection growing in the blood (Pagana et al., 2019).
Sputum Culture	Normal URT	Na	Na	Not completed on this admission
Stool Culture	Normal internal flora	positive	Na	Positive for blood in stool (Pagana et al., 2019).

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory desk reference* (14th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): chest x-ray (1-24-23), CT and chest (1-24-23), bilateral venous duplex ultrasound (1-24-23), CT (1-31-23).

Diagnostic Test Correlation (5 points): patient had a chest x-ray to verify tube placement post intubation and to rule out pneumonia causing the shortness of breath. Patient then had a CT of the chest to rule out a pulmonary embolism. Patient had a venous duplex study completed on his bilateral lower leg; patient found to have a blood clot in his left leg. Patient had a CT of his chest completed on 1-31-2023 due to increased work of breathing and to rule out a new pulmonary embolism (Capriotti, 2020).

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for Pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis.

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

Home Medications (5 required)

Brand/Generic	Pantoprazole sodium Protonix	Albuterol sulfate Ventolin HFA	Enoxaparin sodium Lovenox	Allopurinol zyloprim	Sevelamer Carbonate renvela
Dose	40 mg	2.5 mg	40 mg	100 mg	500 mg
Frequency	daily	PRN every 4 hours for wheezing or SOB	Daily	Daily	TID
Route	PO	Nebulizer	Sub-Q	PO	PO
Classification	Pharm: Proton pump inhibitor Therapeutic: antiulcer	Pharmacological : adrenergic Therapeutic: bronchodilator	Pharm: Low molecular weight heparin Therapeutic: anticoagulant	Pharm: xanthine oxidase inhibitor Therapeutic: antigout	Pharm: polymeric phosphate binder Therapeutic: phosphate binder
Mechanism of Action	“Interferes with gastric acid secretions by inhibiting the proton pump in gastric parietal cells.” (Jones and Bartlett 2021)	“Albuterol attaches to beta2 receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert adenosine triphosphate to cyclic adenosine monophosphate.” (Jones and Bartlett 2021)	“Potentiates the action of antithrombin III, a coagulation inhibitor.” (Jones and Bartlett 2021)	” Inhibits uric acid production by inhibiting xanthine oxidase, the enzyme that converts hypoxanthine and xanthine to uric acid.” (Jones and Bartlett, 2021)	“inhibits phosphate absorption in the intestine by binding dietary phosphate, thereby lowering serum phosphorus level.” (Jones and Bartlett, 2021)
Reason Client Taking	GERD	Shortness of breath	Prevention of blood clots	gout	Dialysis pt
Contraindications (2)	Concurrent therapy with rilpivirine-containing products. Hypersensitivity	Hypersensitivity to albuterol or its components	Active major bleeding. History of HIT	Hypersensitivity to allopurinol or its components	Bowel obstruction, hypersensitivity to sevelamer hydrochloride

	y to pantoprazole.				
Side Effects/Adverse Reactions (2)	Hyperglycemia pancreatitis	Arrhythmias hypotension	CVA Thrombosis	drowsiness, renal failure	Hypotension, thrombosis
Nursing Considerations (2)	“When giving over I.V. reconstitute with 10 ml of NS.” “Flush line with NS before and after administration.” (Jones and Bartlett 2021)	“Monitor serum potassium level because albuterol may cause transient hypokalemia” “Be aware that drug tolerance can develop with prolonged use.” (Jones and Bartlett 2021)	“Test stool occult for blood.” “Do not give the injection I.M.” (Jones and Bartlett 2021)	The nurse should make sure the patient is drinking enough fluids and ensure the patient has 2 L of output each day. The nurse should stop the allopurinol if the patient develops a rash and notify the provider immediately (Jones and Bartlett, 2021).	The drug must be given 1 hour after other medications or 3 hours before other medication to prevent drug interactions. Monitor blood pressure frequently (Jones and Bartlett, 2021).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	“Monitor PT or INR.” (Jones and Bartlett 2021)	“Monitor serum potassium levels.” (Jones and Bartlett 2021)	“Check serum potassium level.” (Jones and Bartlett 2021)	the nurse should obtain a baseline CBC, renal and liver function test along with a uric acid level (Jones and Bartlett, 2021).	The nurse should monitor the patient’s phosphorus level. (Jones and Bartlett, 2021).
Client Teaching needs (2)	“Swallow pill whole do not crush or chew medication.” “Take delayed release pills 30 minutes before meals.” (Jones and Bartlett 2021)	“Shake the medication before use.” “Wait at least 1 minute between inhalations if dose requires multiple inhalations.” (Jones and Bartlett 2021)	“Notify provider of any adverse reactions or bleeding.” “Emphasize the importance of complying with follow up visits with prescriber.” (Jones and Bartlett 2021)	educate the patient to take allopurinol after meals and a full glass of water. Educate the patient to report unusual bleeding, bruising, chills, and fever (Jones and Bartlett, 2021).	Educate the patient to take the medication with meals with a full glass of water. Caution patient to take other medication 1 hour before or 3 hours after taking Sevelamer (Jones and Bartlett, 2021).

Hospital Medications (5 required)

Brand/Generic	Cefepime hydrochloride Maxipime	Metronidazole flagyl	Epoetin alfa procrit	Clarithromycin Biaxin	Iron sucrose Venofer
Dose	1G	500 mg	7,300 units	500 mg	100 mg
Frequency	Every 24 hours	Every 8 hours	3 times a week	daily	daily
Route	IV	PO	Sub- Q	PO	IV
Classification	Pharm: fourth generation cephalosporin Therapeutic: antibiotics	Pharm: nitroimidazole Therapeutic: antiprotozoal	Pharm: Erythropoietin Therapeutic: antianemic	Pharm: macrolide Therapeutic: antibiotic	Pharm: iron mineral therapeutic: hematinic
Mechanism of Action	“Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross-linking the peptidoglycan strands.” (Jones and Bartlett 2021)	“Undergoes intracellular chemical reduction during anerobic metabolism, which inhibits bacterial nucleic acid synthesis and causes cell death.” (Jones and Bartlett, 2021).	“Stimulates the release of reticulocytes from the bone marrow into the blood stream, where they develop into mature RBC.” (Jones and Bartlett, 2021)	“Inhibits RNA-dependent protein synthesis in many types of aerobic, anaerobic, gram negative and gram-positive bacteria.” (Jones and Bartlett, 2021)	“Acts to replenish iron stores lost during dialysis.” (Jones and Bartlett, 2021)
Reason Client Taking	Infection	infection	Anemia and dialysis pt	infection	Anemia and dialysis pt
Contraindications (2)	Hypersensitivity to cefepime. Hypersensitivity to penicillin	Alcohol use, The use of disulfiram	Uncontrolled hypertension, hypersensitivity to its components	History of jaundice, concurrent therapy with cisapride	Iron overload, anemia other than iron deficiency
Side Effects/Adverse Reactions (2)	Fever Renal failure	Seizures pancreatitis	CVA, seizures	Seizures, hypoglycemia	Hypotension , sepsis
Nursing Considerations (2)	“For I.V. infusion give over 30 minutes.” “Monitor BUN and serum creatinine levels for early signs of nephrotoxicity.”	“Monitor patients’ neurological status.” “Assess patients for fungal superinfections during treatment.”	“Use cautiously in patients with cardiovascular disease.” “Do not shake the vial when preparing the medication.” (Jones and	“Use cautiously in patients with renal impairments” “monitor pt for signs and symptoms of liver impairment.”	“give drug directly into dialysis line by slow I.V. injection or infusion.” “watch for evidence of iron overload

	" (Jones and Bartlett 2021)	"(Jones and Bartlett, 2021)	Bartlett, 2021)	(Jones and Bartlett, 2021)	such as bleeding in the GI tract and lungs and decreased activity." (Jones and Bartlett, 2021)
Key Nursing Assessment(s)/Lab(s) Prior to Administration	"Obtain culture and sensitivity before giving drug." (Jones and Bartlett 2021)	Monitor pt CBC and culture and sensitivity (Jones and Bartlett, 2021).	Monitor pt serum iron (Jones and Bartlett, 2021).	Obtain culture and sensitivity prior to first dose (Jones and Bartlett, 2021).	Monitor hematocrit, hemoglobin, serum ferritin and transferrin (Jones and Bartlett, 2021).
Client Teaching needs (2)	"Report any hypersensitivity such as itching or hives." "Diarrhea is a common problem by antibacterial drugs." (Jones and Bartlett 2021)	Educate patients to avoid alcohol while taking medication. Encourage patient to follow up with doctor to ensure infection is gone after therapy. (Jones and Bartlett, 2021)	Encourage patient to eat iron rich food. Educate patient to notify provider if experiencing adverse effects such as chest pain, headaches, hives, shortness of breath or swelling. (Jones and Bartlett, 2021)	Advise pt to take medication with food. Instruct patient to notify provider of adverse effects such as itching, rash or nausea (Jones and Bartlett, 2021).	Educate s/s of iron deficiency include decreased stamina, fatigue, learning problems and shortness of breath. Instruct patient to report s/s of allergic reaction such as itching, dizzy, rash and swelling (Jones and Bartlett, 2021).

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2021). 2021 Nurse's Drug Handbook (20th ed.).

Assessment

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

GENERAL:	<i>Patient is alert and oriented times 4. Patient</i>
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Alertness: A&O x's 4 Orientation: : oriented to person, place, time and event. Distress: patient noted to be in no distress at this time Overall appearance: patient is well groomed laying supine in bed with the head of the bed elevated. patient is pleasant.	<i>appears to be in no apparent distress currently. Patient is well groomed and is laying supine in bed with head of bed elevated. Patient is pleasant and answers all questions when asked.</i>
INTEGUMENTARY: Skin color: appropriate for ethnicity Character: dry Temperature: warm Turgor: rapid recoil Rashes: none Bruises: none Wounds: none Braden Score: 27 Drains present: Y ☐ N ☒ Type:	<i>Patient skin is pink warm, dry and appropriate for ethnicity. Patient noted to have rapid recoil with turgor test. When completing a skin assessment patient noted to have no rashes, bruises or wounds. Patient does not have any drains and has a Braden score of 17.</i>
HEENT: Head/Neck: normal cephalic, head and neck are symmetrical, trachea is midline without deviation. Thyroid is not palpable. Carotid pulses +2 bilaterally Ears: auricle is moist, and pink noted to have no cerebrium build up. Patient dose wear hearing aids. Eyes: pupils are a size 4 and sluggish. Patient is blind Nose: sinuses are nontender upon palpitation, patient noted to have no drainage from both nostrils. Teeth: uvula is midline soft palate rises and falls symmetrical. oral mucosa is moist, pink and no lesions were seen or noted. Patient noted to be missing multiple teeth at the top and bottom.	Patient head is normal shape and size, head and neck are symmetrical, trachea is midline with no deviation. Thyroid is not palpable carotid pulses are + 2 bilaterally. Ears are symmetrical, auricle is moist and pink, no cerebrium build up noted along with no drainage. Eyes symmetrical, pupils are a size 4 bilaterally and are sluggish to light. Patient is blind. Sclera is white, conjunctiva is clear no drainage from eyes noted. Patient sinuses are nontender upon palpitation, patient noted to have no drainage from both nostrils. Patient mouth is moist and pink, uvula is midline, soft palate rises and falls symmetrically. Patient notes to have no lesions in moth nut is noted to be missing teeth in the top and bottom.
CARDIOVASCULAR: Heart sounds: heart sounds heard in all fields S1 and S2 audible S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): normal sinus Peripheral Pulses: peripheral pulses +2 in all fields	<i>Patient heart sounds are clear upon auscultation, S1 and S2 are heard. No murmurs were heard peripheral pulse are present, strong and regular +2. Capillary refill is less than three seconds in fingers and toes. Patient noted to have no neck vein distention. Patient noted to have edema in arms and face.</i>

Capillary refill: less than 3 seconds Neck Vein Distention: Y ☐ N ☒ Edema Y ☒ N ☐ Location of Edema: arms and face	
RESPIRATORY: Accessory muscle use: Y ☐ N ☒ Breath Sounds: Location, character Patient noted to have expiratory wheezes and diminished breath sounds in the lower left ET Tube: Size of tube: NA Placement (cm to lip): NA Respiration rate: NA FiO2: NA Total volume (TV): NA PEEP: NA VAP prevention measures: NA	<i>Patient has no accessory muscle use. Lung sounds are heard in all fields but diminished in the lower left. The patient was noted to have expiratory wheezes in the upper lobes. Patient does not have an ET tube.</i>
GASTROINTESTINAL: Diet at home: regular Current Diet Diabetic Height: 5'6" Weight: 160lbs Auscultation Bowel sounds: Active in all 4 quadrants Last BM: 1-31-2023 Palpation: Pain, Mass etc.: no pain or masses felt Inspection: Distention: no distension noted Incisions: no incisions noted Scars: no scars noted Drains: no drains noted Wounds: no wounds noted Ostomy: Y ☐ N ☒ Nasogastric: Y ☐ N ☒ Size: Feeding tubes/PEG tube Y ☐ N ☒ Type:	Patient is on a regular diet at home but on a diabetic diet while admitted to the hospital. Patient is 5 foot 6 inches and weighs 160 pounds. Patient bowel sounds are active in all 4 quadrants. Patient last bowel movement was 1-31-23. patient noted to have loos dark stools. Sample collected for the lab. Patient noted to have no pain or masses upon palpation. Patient noted to have no distension, no incisions, no scars, no drains or wounds. Patient does not have an ostomy, nasogastric or feeding tubes.
GENITOURINARY: Color: NA Character: NA Quantity of urine: NA	<i>Patient is a dialysis patient and did not create any urine while on shift.</i>

Pain with urination: Y ☐ N ☒ Dialysis: Y ☒ N ☐ Inspection of genitals: NA Catheter: Y ☐ N ☒ Type: Size: CAUTI prevention measures:	
MUSCULOSKELETAL: Neurovascular status: weakness in the lower right leg, amputation of the lower right leg ROM: full range of motion in upper and lower Supportive devices: wheelchair Strength: patient has equal strength in the upper extremities and good strength in the lower left leg ADL Assistance: Y ☒ N ☐ Fall Risk: Y ☒ N ☐ Fall Score: 80 Activity/Mobility Status: Independent (up ad lib) ☐ Needs assistance with equipment ☒ Needs support to stand and walk ☐	Patient has full range of motion with upper extremities and equal strength in upper extremities. Patient has good strength in the left leg and some weakness in the right leg. Patient right lower leg is amputated below the knee. Patient uses a wheelchair at home and needs assistance with ADLs. Patient has a fall score of 80 and is a high fall risk.
NEUROLOGICAL: MAEW: Y ☐ N ☒ PERLA: Y ☐ N ☒ Strength Equal: Y ☐ N ☒ if no - Legs ☒ Arms ☐ Both ☐ Orientation: A&O 4 Mental Status: alert and orientated Speech: clear Sensory: blind LOC: alert	Patient moves upper extremities well and left leg well but does not move right leg well. Patient has equal strength in the upper extremities and good strength in the lower leg but has some weakness on the right leg. Patient is alert and orientated to person, place, time and event. Patient is legally blind. Patient speech is clear and audible. Patient is alert with no decrease of LOC
PSYCHOSOCIAL/CULTURAL: Coping method(s): listening to the TV and talking on the phone. Developmental level: average Religion & what it means to pt.: believe in God Personal/Family Data (Think about home environment, family structure, and available family support): lives with wife and has good family support	Patient states he "likes to watch tv and talk on the phone." Patient is average developmental level. Patient states he believes in God. Patient states he lives with his wife and has good family support system.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0853	106	128/76	18	97.8° F	100%
1201	106	141/90	16	97.8° F	100%

Vital Sign Trends/Correlation: patient blood pressure increased after moving him from one bed to a different bed

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	0-10	None	0	NA	Keep pt comfortable
1200	0-10	None	0	NA	Keep pt comfortable

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 G Location of IV: left shoulder/chest Date on IV: 1-24-2023 Patency of IV: good Signs of erythema, drainage, etc.: none IV dressing assessment: dirty, falling off	Pt has a 20 G IV in the left shoulder/chest area. The IV was placed on 1-24-23 in the ED. The IV is good and flushes well. There are no signs of erythema or drainage. The dressing was dirty and not secured to the skin properly. The dressing was changed.
Other Lines (PICC, Port, central line, etc.)	
Type: midline Size: 18 g Location: right upper arm Date of insertion: 1-31-2023 Patency: good Signs of erythema, drainage, etc.: none Dressing assessment: clean, dry and well intact	Pt has a 18 G midline in the left upper arm. Pt midline placed on 1-31-2023. IV works good and flushes well. The dressing is clean, dry, and intact. There is no signs of erythema or drainage. Green caps on IV line in place to reduce risk for infection.

Date on dressing: 1-31-2022 CUROS caps in place: Y ☒ N ☐ CLABSI prevention measures: green caps in place	
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Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 ML of water	2 liquid bowel movements while on shift 1 emesis

Nursing Care

Summary of Care (2 points)

Overview of care: Patient awake and watching TV at the beginning of shift. Patient given his morning meds at 0830. Patient had 1 episode of emesis after morning medication. Patient then was taken to the radiology department for a CT. patient was changed upon arrival back to the unit due to bowel movement. Patient then cleaned up a second time due to second bowel movement. Patient transported for inpatient dialysis and remained in dialysis at the end of shift.

Procedures/testing done: The patient had a CT chest completed to rule out a new pulmonary embolism. Patient was then transported to dialysis at the end of this students shift.

Complaints/Issues: The patient voiced no complaints and stated, “all I need is another round of dialysis to get the rest of this fluid off.”

Vital signs (stable/unstable): The patients’ vital signs remained stable throughout the shift.

Tolerating diet, activity, etc.: Patient states he did not have an appetite and was unable to get up for physical therapy due to retaining fluid and going to dialysis.

Physician notifications: The physician was notified about the patient's abnormal breath sounds and his decreased appetite.

Future plans for client: Future plans for the patient include reassessing the patient in the morning after a round of dialysis today.

Discharge Planning (2 points)

Discharge location: Patient is expected to be discharged home.

Home health needs (if applicable): none, patient states his wife is his caretaker and had taken care of him for a long time.

Equipment needs (if applicable): No new equipment is needed after discharge.

Follow up plan: The patient is to follow up with his primary care provider within in 1 week along with continuing his dialysis treatment on Monday, Wednesday, and Friday.

Education needs: Patient needs further education about proper diet at home and monitoring his fluid consumption.

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
Include full nursing diagnosis with "related to" and "as evidenced by" components	Explain why the nursing diagnosis was chosen			- How did the client/family respond to the nurse's actions? - Client

Listed in order by priority – highest priority to lowest priority pertinent to this client				response, status of goals and outcomes, modifications to plan.
1. Risk for impaired gas exchange related to cardiac arrest as evidence by low PaCO ₂ on ABGs.	Patient is at increased risk for impaired gas exchange due to cardiac arrest and not breathing.	1. Assess pulmonary status every 4 hours and ensure patient is in good position for optimal chest expansion. 2. encourage patient to turn, cough and deep breath every 2 hours.	1. The patients will maintain adequate ventilation and have improved breath sounds on auscultation.	The patient was responsive the interventions and actively participated in the turn cough and deep breathing exercises.
2. Risk for decreased cardiac tissue perfusion related anemia as evidence by low hemoglobin .	Patient is at an increased risk for having poor tissue perfusion to the heart due to having a low hemoglobin and not enough oxygen in the body.	1. Assess the blood pressure, heart rate and oxygen saturation every 2 hours. 2. draw labs daily to monitor hemoglobin and red blood cells.	1. the patient hemoglobin and red blood cell count will increase.	The patient was understanding of the need to monitor vitals and complete routine blood work.
3. Risk for infection related to decreased immune system as evidence by positive blood culture.	Patient is at an increased risk for infection due to having positive blood culture which means there is bacteria growing in	1. Monitor temperature every 4 hours. 2 maintain sterile technique when the patient receives dialysis.	1. the patient will have now further growth in the blood and the bacteria will decrease.	The patient understood the need for temperature monitoring.

	the blood.			
4. Impaired urinary elimination related to renal failure and evidence by no urinary output.	Patient is at an increased risk for impaired urinary elimination due to having renal failure and being a dialysis patient.	1. Educate the patient on the importance of attending every dialysis appointment 2. educate the patient in the importance of eating right and measuring the fluids he takes in.	1. The patients will understand the importance of attending every dialysis appointment each week and will have a better understanding of the diet choices he should be making.	The patient understood the importance of attending dialysis every week on his scheduled days. The patient said he would try to do better about his eating habits.
5. Deficient knowledge related to ulcers as evidence by GI bleed from ulcers.	Patient has deficient knowledge in the proper care of ulcers as evidence by a GI bleed caused from the ulcers bleeding.	1. Assess patients' knowledge about ulcers. 2. work with the patient to set goals to better care for his health.	1. The patients will be able to identify foods that he should not be eating and begin to start to eliminate them from his diet.	The patient was an active listener and was able to determine a few foods to eliminate.

Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's Nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Patient is in now pain throughout shift only states he needs to go to dialysis to get rid of the extra fluid. Patient states he can tell he is retaining a lot of fluid even after receiving dialysis the day prior.

Objective Data

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0853	106	128/76	18	97.8° F	100%
1201	106	141/90	16	97.8° F	100%

Client Information

K.S.
49-year-old African American male
Married
Legally blind

Nursing Diagnosis/Outcomes

1. Risk for impaired gas exchange related to cardiac arrest as evidence by low PaCO₂ on ABGs.
- The patient was responsive the interventions and actively participated in the turn cough and deep breathing exercises.
2. Risk for decreased cardiac tissue perfusion related anemia as evidence by low hemoglobin.
- The patient was understanding of the need to monitor vitals and complete routine blood work.
3. Risk for infection related to decreased immune system as evidence by positive blood culture.
- The patient understood the need for temperature monitoring.
4. Impaired urinary elimination related to renal failure and evidence by no urinary output.
- The patient understood the importance of attending dialysis every week on his scheduled days. The patient said he would try to do better about his eating habits.
5. Deficient knowledge related to ulcers as evidence by GI bleed from ulcers.
- The patient was an active listener and was able to determine a few foods to eliminate.

Nursing Interventions

1. Assess pulmonary status every 4 hours and ensure patient is in good position for optimal chest expansion.
2. encourage patient to turn, cough and deep breath every 2 hours.
1. Assess the blood pressure, heart rate and oxygen saturation every 2 hours.
2. draw labs daily to monitor hemoglobin and red blood cells.
1. Monitor temperature every 4 hours.
- 2 maintain sterile technique when the patient receives dialysis.
1. Educate the patient on the importance of attending every dialysis appointment
2. educate the patient in the importance of eating right and measuring the fluids he takes in.
1. Assess patients' knowledge about ulcers.
2. work with the patient to set goals to better care for his health.

