N441 Care Plan

Lakeview College of Nursing

Sophia James

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
3/22/2023	DH	84	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	Retired	Married	No known allergies
Code Status	**Height**	**Weight**	
Full	5’10’’ 177.8cm	112kg 247lbs	

Medical History (5 Points)

Past Medical History:

Chronic hypertension 1/29/2020, Bowel obstruction 5/12/2020, Stage 3 chronic kidney disease 8/28/2022, Chronic Diastolic CHF 8/28/2022

Past Surgical History:

Exploratory of Abdomen, Appendectomy, Upper right arm, and elbow surgery

Family History:

Mother has a history of hypertension and heart disease.

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

The patient denies use of tobacco and other drugs. The patient states that he drinks alcohol twice a week socially.

Assistive Devices:

The patient uses a walker to get around at home.

Living Situation:

The patient lives at home with his wife.

Education Level:

The patient graduated high school and is retired. No developmental delays present.

Admission Assessment

Chief Complaint (2 points):

Abdominal pain 3/22/23 is the original admission date for bowel obstruction.

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

The patient is an 84-year-old male brought into the ED by his wife and caretaker with generalized abdominal pain. The patient has a history of colon cancer with post-hemicolectomy complications. The patient has not been able to pass gas for the past 12 hours and has not had a BM in the past 24 hours. The patient stated they vomited on 3/21/2023. The patient's pain is intermittent and diffused through the abdomen. The patient's abdomen is distended upon inspection. The patient states there are no reliving factors and has not tried to treat them himself.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):

3/22/2023 ED- Bowel obstruction with AKI

Secondary Diagnosis (if applicable):

3/26/2023 Upon discharge from the ED, the patient suffered a stroke (CVA) and was sent up to the ICU.

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

CVA aka Stroke

A stroke happens when blood flow is lost to a specific part of the brain, and one's brain cells cannot get the oxygen and nutrients they need from blood. This can cause lasting brain damage, long-term disability, or even death. Another condition similar to a stroke is a transient ischemic attack or a TIA. TIA's are sometimes called a "mini-stroke." TIAs happen when the

blood supply to the brain is blocked for a short time but does not damage the brain cells permanently.

Risk factors for stroke include hypertension, heart disease, atrial fibrillation, smoking, family history, and diabetes. Signs and symptoms include trouble speaking, weakness of one side of the body, difficulty walking, trouble to see, severe headaches, loss of coordination, or a new onset of confusion. The way a PCP will diagnose a stroke is by doing a background history assessment on the patient and doing a physical exam. If there is an expected stroke, the provider will order imaging tests to view the brain, such as a CT scan. Treatment for a stroke includes tPA, a tissue plasminogen activator to help dissolve any possible clot that caused the stroke (National Institute of Neurological Disorders and Stroke, 2021). The provider might also want the patient to be on a blood thinner to keep existing clots from getting more significant. Patients may also see physical rehab therapy to regain their strength on their weakened side.

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [FADavis]. Retrieved from https://fadavisreader.vitalsource.com/#/books/9781719641470/

National Institute of Neurological Disorders and Stroke. (2021, May 5). *Stroke, CVA, Cerebrovascular accident*. MedlinePlus: Health Information from the National Library of Medicine. https://medlineplus.gov/stroke.html#summary

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value

RBC	**4.40-5.80**	**4.90**	**4.15**	**This value is low due to the body recovering from the CVA (Capriotti, 2020).**
Hgb	**13.0-16.5**	**13.6**	**11.5**	**This value is low due to the body recovering from the CVA (Capriotti, 2020).**
Hct	**38%-50%**	**43.3**	**36.8**	**This value is low due to the body recovering from the CVA (Capriotti, 2020).**
Platelets	**140-440**	**349**	**258**	**This value is within the normal limits.**
WBC	**4-12**	**15.60**	**14.80**	**This patients WBC count was high which indication inflammation or a bacterial infection (Capriotti, 2020).**
Neutrophils	**40-68**	**82.2**	**74.6**	**Neutrophils are increased due to a sign of inflamation in the body or increased healing process (Capriotti, 2020).**
Lymphocytes	**19-49**	**6.9**	**15.8**	**The patients lymphocytes are elevated related to the body's response from the infection and healing process (Capriotti, 2020).**
Monocytes	**3-13**	**10.8**	**7.9**	**This value is within the normal limits.**
Eosinophils	**0-8**	**0**	**1.3**	**This value is within the normal limits.**
Bands	**0-5**	**0**	**0**	**This value is within the normal limits.**

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**	**136**	**136**	**This value is within the normal limits.**
K+	**3.5-5.0**	**5.0**	**3.7**	**This value is within the normal limits.**
Cl-	**98-107**	**103**	**107**	**This value is within the normal limits.**
CO2	**22-30**	**14**	**18**	**The patient's CO2 levels are low due to the increase work of breathing**
Glucose	**70-99**	**152**	**98**	**This patient's glucose is elevated**

				due to his body having extra stress on it (Capriotti, 2020).
BUN	**8-26**	**79**	**17**	**The patients BUN is elevated due to the patient coming into the ED with abnormal Urine cultures.**
Creatinine	**0.70-1.30**	**3.93**	**1.56**	**The patient's creatinine is elevated due to the patient coming into the ED with abnormal Urine cultures.**
Albumin	**3.5-5.0**	**4.2**	**3.5**	**This value is within the normal limits.**
Calcium	**8.7-10.5**	**10.2**	**8.7**	**This value is within the normal limits.**
Mag	**1.6-2.6**	**None taken**	**None taken**	**This value was not taken.**
Phosphate	**40-150**	**119**	**80**	**This value is within the normal limits.**
Bilirubin	**0.2-1.2**	**0.6**	**0.4**	**This value is within the normal limits.**
Alk Phos	**40-150**	**119**	**80**	**This value is within the normal limits.**
AST	**5-34**	**18**	**28**	**This value is within the normal limits.**
ALT	**0-55**	**13**	**31**	**This value is within the normal limits.**
Amylase	**40-140**	**None taken**	**None taken**	**This value was not taken.**
Lipase	**0-160**	**None taken**	**None taken**	**This value was not taken.**
Lactic Acid	**<2**	**None taken**	**None taken**	**This value was not taken.**
Troponin	**0-0.040**	**<0.030**	**None taken**	**This value is within the normal limits.**
CK-MB	**3-5%**	**None taken**	**None taken**	**This value was not taken.**
Total CK	**55-170**	**None taken**	**None taken**	**This value was not taken.**

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

Lab Test	Normal	Value on	Today's	Reason for Abnormal

	Range	Admission	Value	
INR	**0.8-1.1**	**1.0**	**None taken**	**This value is within the normal limits.**
PT	**10.1-13.1**	**11.6**	**None taken**	**This value is within the normal limits.**
PTT	**25-36**	**35**	**None taken**	**This value is within the normal limits.**
D-Dimer	**<0.50**	**None taken**	**None taken**	**This value was not taken.**
BNP	**<100**	**None taken**	**None taken**	**This value was not taken.**
HDL	**>40**	**None taken**	**29**	**This value is within the normal limits.**
LDL	**<130**	**None taken**	**55**	**This value is within the normal limits.**
Cholesterol	**<200**	**100**	**101**	**This value is within the normal limits.**
Triglycerides	**<150**	**None taken**	**85**	**This value is within the normal limits.**
Hgb A1c	**<5.7%**	**None taken**	**None taken**	**This value was not taken.**
TSH	**0.5-5.0**	**None taken**	**None taken**	**This value was not taken.**

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 and pale**	**Cloudy and yellow**	**None taken**	**The patient came into the ED with AKI which would cause these abnormal labs.**
pH	**5-9**	**5.0**	**None taken**	**This value is within the normal limits.**
Specific Gravity	**1.003-1.030**	**1.021**	**None taken**	**This value is within the normal limits.**
Glucose	**negative**	**negative**	**None taken**	**This value is within the normal limits.**
Protein	**negative**	**+1**	**None taken**	**The patient came into the ED with AKI which would cause these abnormal labs.**
Ketones	**negative**	**positive**	**None taken**	**The patient came into the ED with AKI which would cause these abnormal labs.**

WBC	**negative**	**positive**	**None taken**	**The patient came into the ED with AKI which would cause these abnormal labs. The patient could have a possible UTI that lea to this AKI.**
RBC	**negative**	**negative**	**None taken**	**This value is within the normal limits.**
Leukoesterase	**negative**	**negative**	**None taken**	**This value is within the normal limits.**

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

No ABG's were found in the client's records or chart.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35-7.35**	**N/A**	**N/A**	**This value was not taken.**
PaO2	**80-100**	**N/A**	**N/A**	**This value was not taken.**
PaCO2	**35-45**	**N/A**	**N/A**	**This value was not taken.**
HCO3	**22-26**	**N/A**	**N/A**	**This value was not taken.**
SaO2	**90-100%**	**N/A**	**N/A**	**This value was not taken.**

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**	**Positive**	**negative**	**The patient came into the ED with AKI which would cause these abnormal labs. The patient could have a possible UTI that led to this AKI.**

Blood Culture	**Negative**	**negative**	**negative**	**This finding is not abnormal.**
Sputum Culture	**Negative**	**negative**	**negative**	**This finding is not abnormal.**
Stool Culture	**Negative**	**negative**	**negative**	**This finding is not abnormal.**

Lab Correlations Reference (1) (APA):

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

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

CT head and neck without contrast 3/27/23

Stroke follow-up –

- No new aneurysms noted
- Hypodensity noted in the left occipital lobe

MRI brain without contrast 3/27/23

- Showed an area of restricted diffusion in the left posterior occipital
- No hemorrhage noted

Diagnostic Test Correlation (5 points):

This patient suffered a CVA while leaving the hospital on 3/26/2023. The patient scans returned with no aneurysms or hemorrhage, but a small portion of his left occipital lobe had restricted diffusion of the rest.

Diagnostic Test Reference (1) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [FADavis]. Retrieved from https://fadavisreader.vitalsource.com/#/books/9781719641470/

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Elsevier.

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

Home Medications (5 required)

Brand/Generic	**Acetaminophen Tylenol**	**Labetalol Normodyne**	**Ondansetron Zofran**	**Sodium Salicylate Aspirin**	**There were no more medications listed in that patient's MAR.**
Dose	**650mg**	**10mg**	**4mg**	**81mg**	**N/A**
Frequency	**Q6hr PRN**	**Q1hr PRN**	**Q6hr**	**Every evening**	**N/A**
Route	**Oral**	**IV**	**IV**	**Oral**	**N/A**
Classification	**Non-opioid analgesic**	**Non-opioid analgesic**	**Serotonin receptor agents**	**Non-steroid anti-inflammatory**	**N/A**
Mechanism of Action	**Blocks the prostaglandin production and interferes with pain**	**This drug relaxes the blood vessels and slows the heart rate down to**	**Zofran blocks the action of serotonin that reduces the cause of**	**Inhibits enzyme COX by inhibiting the prostaglan**	**N/A**

	impulses generated by the peripheral nervous system	**improve blood flow and decrease the BP.**	**vomiting and nausea.**	**din synthesis which is associated with inflammation and pain.**	
Reason Client Taking	**Pain control**	**Control hypertension**	**Nausea and vomiting**	**pain**	**N/A**
Contraindications (2)	**Hypersensitivity to acetaminophen or its components, severe hepatic impairment, severe active liver disease**	**This mediation is contraindicated for patient's with severe bradycardia and bronchial asthma.**	**Do not give this medication if the patient has low amounts of calcium in the blood. Do not give if the client is experiencing extrapyramidal disease.**	**Do not give to children due to cause of Reye's syndrome. Do not give if the patient has any bleeding abnormalities.**	**N/A**
Side Effects/Adverse Reactions (2)	**Hypotension, hepatotoxicity, hypo magnesium**	**Sleepiness and headache**	**Constipation drowsiness**	**Abdominal pain, ringing in ears, bloody or black tarry stools.**	**N/A**
Nursing Considerations (2)	**Use acetaminophen cautiously and patience with hepatic impairment or active hepatic diseases, alcoholism, chronic malnutrition, severe hypovolemia,**	**The nurse should monitor the clients BP and heart rate while giving this medication. The client should watch for signs of respiratory distress.**	**Administer this medication slowly into the IV. Respiratory status must be checked prior.**	**Monitor the patients CBC and H&H. Monitor clotting times if they are at risk for bleeding.**	**N/A**

	or severe renal impairment.				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**The nurse should monitor the patients CBC prior to administering this medication.**	**The nurse should ALWAYS check the patients pulse rate prior to giving this medication.**	**Check respiratory status and monitor EKG**	**Monitor blood clotting times.**	**N/A**
Client Teaching needs (2)	**Educate the client on effects of taking too much. Teach the client to take food with this drug if it causes stomach upset.**	**The client should watch for signs of respiratory distress and severe bradycardia.**	**Do not take this medication if you do not absolutely need it. The first does is usually always given before starting chemo or radiation treatment.**	**Do not give this medication to children. Do not take this medication if you are experiencing bloody stools or bloody emesis.**	**N/A**

Hospital Medications (5 required)

Brand/Generic	**Furosemide Lasix**	**Aspirin Suppository**	**There were no more medications listed in that patient's MAR.**	**There were no more medications listed in that patient's MAR.**	**There were no more medications listed in that patient's MAR.**
Dose	**40 mg**	**300 mg**	**N/A**	**N/A**	**N/A**

Frequency	**2 daily with meals**	**Every evening**	**N/A**	**N/A**	**N/A**
Route	**oral**	**rectal**	**N/A**	**N/A**	**N/A**
Classification	**Diuretic**	**NSAIDS**	**N/A**	**N/A**	**N/A**
Mechanism of Action	**Inhibits the reabsorption of sodium and chloride from the renal system.**	**Inhibits enzyme COX by inhibiting the prostaglandin synthesis which is associated with inflammation and pain.**	**N/A**	**N/A**	**N/A**
Reason Client Taking	**Can help treat high blood pressure but also removes fluid from the body.**	**Bowel Obstruction**	**N/A**	**N/A**	**N/A**
Contraindications (2)	**Hypersensitivity to furosemide. Monitor for hepatic cirrhosis or ascites.**	**Do not give to the patient if they have any rectal bleeding or nausea and vomiting.**	**N/A**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	**Loss of appetite, blurred vision.**	**Bloody vomit Black tarry stools**	**N/A**	**N/A**	**N/A**
Nursing Considerations (2)	**Monitor blood pressure and oliguria**	**Hepatitis and severe hepatic or renal failure are huge considerations for nurses to consider.**	**N/A**	**N/A**	**N/A**
Key Nursing Assessment(s)/Lab (s) Prior to	**Monitor serum glucose and uric acid**	**Monitor the client's pain before and**	**N/A**	**N/A**	**N/A**

Administration	**levels before administration.**	**after the suppository.**			
Client Teaching needs (2)	**Educate the patient on frequent urination and the possible need of supplemental electrolytes.**	**Teach the client to monitor for any rectal bleeding and monitor for signs and symptoms or dizziness or nausea.**	**N/A**	**N/A**	**N/A**

(Jones & Bartlett Learning, 2022).

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2022). *2022 Nurse's Drug Handbook* (20th ed.).

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient is alert and oriented x2. The patient appears to be in no distress and his overall appearance is swollen, but comfortable.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 13** **Drains present: Y☐ N ☒** **Type:**	**The patient's skin was dry and intact with slight bruising on his arms from previous puncture sites. Skin turgor is quick to return. No rashes, wounds, or tears. No drains are present.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is symmetrical with neck. Slight right sided drooping is noted in the client's face. When the client is instructed to smile, they can only smile on the left side.

CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:**	**No murmur or abnormal heart rate. Peripheral pulses palpable, doppler used for right leg pulse. Generalized edema in all extremities +2. Right arms and legs +3 edema. Capillary refill <3 seconds bilaterally.**
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character** **ET Tube: None** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	Respiration rate was high at 24 breaths per minute. Lung sounds were clear bilaterally. Accessory muscle use was noted upon assessment. No ET tubes.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM: 3/25/23** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**The patient eats a normal diet. All bowel sounds were heard in all 4 quadrants. The patient had no pain with palpitation of the abdomen. The abdomen is slightly distended but not tender. No wounds or drains are noted.**
GENITOURINARY: **Color:**	**The patient used a urinal independently. Upon assessment the urine was amber. There was no**

Character: **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **CAUTI prevention measures:**	**pain with urination. Output- 475ml.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength: +2** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 54** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☒**	**The patient active ROM was present but limited and needed to be reminded on what extremity to move. The patient uses a walker to stand and walk. Chair fast with assistance in standing and ambulating.**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient presented with right sided weakness in both upper and lower extremities. The patient was oriented x2 to person and situation. The patient showed no speech or sensory disruptions.
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):**	**The client is A&O x 2. The client's wife was at the bedside. No developmental delays were noted. The patient lives at home with his wife.**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1000	**91**	**152/89**	**19**	**98.1**	**98%**

1300	**108**	**173/87**	**30**	**97.9**	**98%**

Vital Sign Trends/Correlation:

1000 – patient's blood pressure is high, but he received his BP medication at this time.

1300 – patient's vital signs were taken during a therapy session, explaining the elevation.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1000	**Numeric**	**Denies Pain**	**0**	**None**	**None Needed**
1300	**Numeric**	**Denies Pain**	**0**	**None**	**None Needed**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g **Location of IV: L AC** **Date on IV: 3/26/23** **Patency of IV: flows easily** **Signs of erythema, drainage, etc.: None** **IV dressing assessment: Dry and intact**	Dextrose 5% solution 100ml/hr IV continuous
Other Lines (PICC, Port, central line, etc.):	None noted
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	No other lines or drains noted.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

720ml PO	**475ml urine**

Nursing Care

Summary of Care (2 points)

Overview of care:

The client was very cooperative and active in care. The patient was A&O x2 to person and situation. Not to place or time. The patient is being monitored and continuing with orders for physical therapy.

Procedures/testing done:

The patient had an MRI and CT of the brain/head on 3/26. No procedures were done today.

Complaints/Issues:

The patient was cooperative and calm while explaining care. There were no signs of pain or discomfort during care.

Vital signs (stable/unstable):

Unstable due to hypertension and therapy sessions**.**

Tolerating diet, activity, etc.:

Tolerating diet well, tolerating activity in moderation. The patient needs stand-by commands for moving extremities, and one person assist for sitting up and ambulating.

Physician notifications:

Continue with care until more strength returns to the client's right side.

Future plans for client:

The future plans for the client include discharging to OSF PT rehab facility to work on strength and coordination for the patient's right side.

Discharge Planning (2 points)

Discharge location: OSF rehab in Urbana

Home health needs (if applicable): physical therapy/home checks.

Equipment needs (if applicable): Walker

Follow up plan: continue with physical therapy and speech therapy.

Education needs: The patient will need post-CVA education on future signs to look for.

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 • Listed in order by priority – highest priority to lowest	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes,

priority pertinent to this client				modifications to plan.
1. Acute pain related to constipation as evidenced by cramping, stomach upset, and no passing of flatus.	**This nursing diagnosis was picked due to the fact the patient come into the ED with abdominal pain and not having a BM for 24 hours.**	**1. Assess for pain before and after pain medications are given** **2. Assess bowel sounds and the presence of passing gas.**	**1. The patient will express less pain and less abdominal distention.**	**The nurse should assess to see if the patient passed gas or had a bowel movement.**
2. Imbalanced nutrition related to altered absorption as evidenced by CBC and electrolytes being abnormal.	**This patient had a decrease of protein and electrolytes in his body due to coming into the ED with AKI and Bowel Obstruction.**	**1. The nurse should assess the patient's CBC and lab values when they are submitted into their chart.** **2.The nurse should have strict I&Os on this client.**	**1. The patient's lab values and electrolytes will return to normal, and the patient will show adequate intake and output.**	**The nurse should assess to see if the patient has any signs of malabsorption of their intake.**
3. Risk for falls related to right sided weakness.	**This patient is at a risk for falling due to their recent stroke and right sided weakness.**	**1. The nurse should preform active and passive ROM with the client.** **2 The nurse should assess for any pain or trouble moving his Right sided extremities.**	**1. The patient will have full range of motion back in their right side without needing commands.**	**The client will experience no falls when gaining full strength back.**
4. Self-care	**This**	**1. The nurse**	**1. The**	**The patient**

deficit related to loss of muscle strength as evidenced by difficulty doing ADLs.	**diagnosis was chosen by the student due to the fact that the patient has right sided weakness and is having trouble performing daily tasks without assistance.**	**should encourage the client to perform as many tasks as possible on their own.** **2. The nurse should always give positive feedback when the patient does any sort of self-care.**	**patient is able to assess the needs for help and asks for self-care assistance when needed.**	**recognizes when they need help and is able to assist in the daily help with the care giver.**
5. Risk for unilateral neglect related to right sided weakness.	**The student chose this diagnosis due to patient suffering a stroke and having right sided weakness. The patient is right-handed so he might start to favor his left side more now due to this weakness.**	**1. The nurse should encourage movement and activity on the weakened side.** **2. The nurse should assess for signs of unilateral neglect such as the client laying awkwardly to avoid hurting one side.**	**1. The patient shows interest in using his weakened side more often on his own without being commanded to.**	**The patient performs task with his right side and performs active ROM with all extremities.**

Other References (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [FADavis]. Retrieved from https://fadavisreader.vitalsource.com/#/books/9781719641470/

Concept Map (20 Points)

Subjective Data

The patient has not been able to pass gas for 12 hours or have a bowel movement for 24 hrs. The patient's abdominal pain is diffused though his abdomen. The penitent stated he was in no pain after the stroke but this right arm was more swollen to him.

Objective Data

The patient has right sided weakness, drooping, and swelling. The patients neuros are all intact besides being A&O x 2. The patient has had a bowel obstruction in the past after a post-hemicolectomy. Vitals: pulse 91, BP 152/89, Temp 98.1, Respirations 19, O2 98%.

Client Information

84-year-old male.

Chronic hypertension 1/29/2020,

Bowel obstruction 5/12/2020,

Stage 3 chronic kidney disease 8/28/2022,

Chronic Diastolic CHF 8/28/2022

Weight: 112kg. height: 5'10'"

Lives at home with his wife

Nursing Diagnosis/Outcomes

Acute pain related to constipation as evidenced by cramping, stomach upset, and no passing of flatus.

- **The patient will express less pain and less abdominal distention.**

Imbalanced nutrition related to altered absorption as evidenced by CBC and electrolytes being abnormal.

- **The patient's lab values and electrolytes will return to normal, and the patient will show adequate intake and output.**

Risk for falls related to right sided weakness.

- **The patient will have full range of motion back in their right side without needing commands.**

Self-care deficit related to loss of muscle strength as evidenced by difficulty doing ADLs.

- **The patient is able to assess the needs for help and asks for self-care assistance when needed.**

Risk for unilateral neglect related to right sided weakness.

- **. The patient shows interest in using his weakened side more often on his own without being commanded to.**

Nursing Interventions

- **Assess bowel sounds and the presence of passing gas.**
- **The nurse should have strict I&Os on this client.**
- **The nurse should preform active and passive ROM with the client.**
- **The nurse should assess for any pain or trouble moving his Right sided extremities.**
- **The nurse should encourage movement and activity on the weakened side.**
- **The nurse should assess for signs of unilateral neglect such as the client laying awkwardly to avoid hurting one side.**
- **The nurse should encourage the client to perform as many tasks as possible on their own.**
- **The nurse should always give positive feedback when the patient does any sort of self-care.**
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