N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 8/28/23	**Client Initials** J.L.	**Age** 41	**Gender** Male
Race/Ethnicity White	**Occupation** Unemployed	**Marital Status** Single	**Allergies** Amlodipine Benzoate - Reaction: Swelling Benazepril - Reaction not stated
Code Status Full Code	**Height** 6’	**Weight** 95.4 kg (210 lbs)	

Medical History (5 Points)

Past Medical History: Alcohol abuse, Alcohol abuse with Intoxication Delirium, Atrial Fibrillation, Hypertension, Pancreatitis and Post Traumatic Stress Disorder.

Past Surgical History: Insertion of a Dialysis Catheter (5/20/21), Tonsillectomy (5/16/21), Upper Gastrointestinal Endoscopy (5/16/21 and 8/29/23).

Family History: Mother- Arrythmias, Sister- Arrythmias and COPD. Patients father appears to have no pertinent medical history.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient is a former smoker, approximately 0.25 packs a day. The patient quit smoking in 2017 and does not use any tobacco or nicotine products now. The patient uses alcohol every day, amount being approximately 3 liters of vodka or 3-4 pints of gin.

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

Living Situation: The patient lives at home by himself prior to hospitalization.

Education Level: The patient graduated high school but did not attend college, he instead joined the Army.

Admission Assessment

Chief Complaint (2 points): Black Stools and Alcohol Intoxication

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

The patient presented to the emergency room with a complaint black stool. The patient stated he was not sure exactly when it had started. The patient was intoxicated upon arrival and has a history of alcohol abuse. His last drink was on the date of admission (8/28/23). Patient was positive for occult blood and had a hemoglobin of 5.1. The patient received 2 pints of packed red blood cells prior to his admission for medical management.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Gastrointestinal Bleed

Secondary Diagnosis (if applicable): N/A

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

A gastrointestinal bleed or a GI bleed is an instance where damage has occurred within the gastrointestinal tract, and it actively bleeds. An upper GI bleed is considered a bleed from anywhere between the mouth and the duodenum (*Upper Gastrointestinal Bleeding* 2021). Upper gastrointestinal bleeds can be caused by peptic ulcers, tears in the esophagus, esophageal varices, and esophagitis, among others. Lower gastrointestinal bleeds are classified as bleeds occurring between the duodenum and rectum. Diverticular disease, inflammatory bowel disease, tumors, fissures, and hemorrhoids can cause these bleeds. Both symptoms are related to blood loss. Overt bleeding refers to vomiting blood that may resemble coffee grounds, rectal bleeding, and black tarry stool. With occult bleeding or hidden bleeding, lightheadedness, shortness of breath, abdominal pain, and chest pain can occur (*Gastrointestinal bleeding* 2020). The expected finding for a GI bleed is anemia. It is expected to

see a decrease in red blood cells. Hemoglobin, hematocrit, and platelets (*Gastrointestinal bleeding* 2020). This is from the loss of whole blood into the digestive tract, where it is broken down and removed from the body through stool or vomit. With a low blood volume, low blood pressure and high pulse can be a side effect of hypovolemia. After presenting with the signs and symptoms of a GI bleed, testing can include an occult stool sample, which tests the stool for hidden blood. After an EGD test is performed, this is a scope that is inserted through the throat into the stomach and duodenum with a camera to visualize the bleed (*Esophagogastroduodenoscopy (EGD test)* 2022). If the bleed is lower, a colonoscopy can be performed. There are many treatments available depending on the severity of the bleed. Some injectable medications can be administered to the bleed site to stop the bleeding; the bleed can be cauterized. Blood vessels can be closed with a band or clip (*Gastrointestinal bleeding* 2020). The patient presents with a variety of symptoms related to a GI bleed. JL presented to the emergency room with the complaint of blood in the stool; the patient is positive for occult blood in the stool. The patient also shows signs of anemia, such as low red blood cells, hemoglobin, and hematocrit. The patient has received beneficial blood transfusions but only temporarily, indicating the bleed is uncontrolled. At present, the cause of the GI bleed is undetermined

.**Pathophysiology References (2) (APA):**

Esophagogastroduodenoscopy (EGD test): Definition & procedure. Cleveland Clinic. (2022). https://my.clevelandclinic.org/health/diagnostics/22549-esophagogastroduodenoscopy-egd-test

Mayo Foundation for Medical Education and Research. (2020a, October 15). *Gastrointestinal bleeding*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/gastrointestinal-bleeding/symptoms-causes/syc-20372729

Upper gastrointestinal bleeding. Upper Gastrointestinal Bleeding - an overview | ScienceDirect Topics. (2021). https://www.sciencedirect.com/topics/medicine-and-dentistry/upper-gastrointestinal-bleeding

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	4.4-5.8	1.74	2.51	A low RBC is normal in a GI Bleed as the patient is losing whole blood out of the circulatory system (Saltzman, 2022).
Hgb	13-16.5	5.1	6.9	A low HGB is directly correlated with the GI bleed. When a GI bleed first begins patients may be at baseline but depending on how sever the bleed is it can cause a decrease in HGB (Saltzman, 2022).
Hct	38-50	16.1	21.9	HCT levels are typically decreased when there is a decrease in HGB (Low HGB and HCT, 2022). Since the patient is bleeding into the GI tract all blood material is affected.
Platelets	140-440	136	104	The decrease is platelets is related to the continuous loss of blood. The patient is losing all blood matter into their digestive tract Saltzman, 2022).
WBC	4.0-12.0	3.0	2.8	The body is unable to keep up with the whole blood loss meaning there could be underlying issue with the spleen. The spleen controls the amount of WBC (*Spleen problems and spleen removal* 2023)
Neutrophils	40-68	60.9	48.4	
Lymphocytes	19-49	32.4	38.6	
Monocytes	3-13	6.2	11.1	
Eosinophils	0-8	0.0	1.6	

Bands	None	N/A	N/A	

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145	140	136	
K+	3.5-5.1	3.6	3.6	
Cl-	98-107	109	105	
CO2	22-30	26	25	
Glucose	70-99	95	97	
BUN	9-21	15	14	
Creatinine	0.7-1.3	0.75	0.71	
Albumin	3.5-5	3.5	N/A	
Calcium	8.7-10.5	8.3	8.3	Low calcium levels can be attributed to many disorders. For this specific patient there may be a correlation between the kidney function and calcium levels. The patient is an alcoholic and may have some damage to the kidneys. Renal failure can attribute to hypocalcemia (*Calcium blood test: What it is, purpose, procedure & results* 2021).
Mag	1.6-2.6	1.6	1.7	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	0.2-1.2	0.2	N/A	
Alk Phos	44-147	82	N/A	

AST	5-34	46	N/A	An elevated AST can be correlated with liver damage. The patient is a chronic alcoholic so liver damage is likely (*Aspartate transferase (AST) blood test: What it is, procedure & results* 2021).
ALT	0-55	37	N/A	
Amylase	**30-100**	N/A	N/A	
Lipase	**0-160**	N/A	N/A	
Lactic Acid	**0.5-10**	N/A	N/A	
Troponin	**0-0.4**	N/A	N/A	
CK-MB	**3-5%**	N/A	N/A	
Total CK	**20-30**	N/A	N/A	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**2-3**	N/A	N/A	
PT	**9.5-11.3**	N/A	N/A	
PTT	**30-40**	N/A	N/A	
D-Dimer	**220-500**	N/A	N/A	
BNP	**0.5-30**	N/A	N/A	
HDL	**>60**	N/A	N/A	
LDL	**<100**	N/A	N/A	
Cholesterol	**<200**	N/A	N/A	
Triglycerides	**<150**	N/A	N/A	

Hgb A1c	**<5.7**	N/A	N/A	
TSH	**0.4-5**	N/A	N/A	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow, Clear	N/A	N/A	
pH	4.5-8	N/A	N/A	
Specific Gravity	1.005-1.025	N/A	N/A	
Glucose	NONE	N/A	N/A	
Protein	NONE	N/A	N/A	
Ketones	NONE	N/A	N/A	
WBC	<2.5	N/A	N/A	
RBC	<2	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35-7.45**	N/A	N/A	
PaO2	**80-100**	N/A	N/A	
PaCO2	**35-45**	N/A	N/A	

HCO3	**22-26**	N/A	N/A	
SaO2	**92-100%**	N/A	N/A	

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	
Blood Culture	**Negative**	N/A	N/A	
Sputum Culture	**Negative**	N/A	N/A	
Stool Culture	**Negative**	N/A	N/A	

Lab Correlations Reference (1) (APA):

Aspartate transferase (AST) blood test: What it is, procedure & results. Cleveland Clinic. (2021a). https://my.clevelandclinic.org/health/diagnostics/22147-aspartate-transferase-ast

Calcium blood test: What it is, purpose, procedure & results. Cleveland Clinic. (2021b, November). https://my.clevelandclinic.org/health/diagnostics/22021-calcium-blood-test

Saltzman, J. R. (2022). *Approach to acute upper gastrointestinal bleeding in adults*. UpToDate. https://www.uptodate.com/contents/approach-to-acute-upper-gastrointestinal-bleeding-in-adults/print

Spleen problems and spleen removal2023. NHS inform. (2023, May 26). https://www.nhsinform.scot/illnesses-and-conditions/stomach-liver-and-gastrointestinal-tract/spleen-problems-and-spleen-removal

Normal lab values are OSF standard lab values.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

The patient received an esophagogastroduodenoscopy to locate the bleed in the digestive tract. It was assumed with the patient's history of alcohol abuse there would be evidence of esophageal varices. The endoscopy results were normal with no evidence of bleeding in the upper gastrointestinal tract.

Diagnostic Test Correlation (5 points):

An EGD or esophagogastroduodenoscopy is a procedure that uses a lit camera on the end of tube to pass down the throat to visualize the upper gastrointestinal tract. This tract includes the esophagus, stomach, and duodenum (*Esophagogastroduodenoscopy (EGD test)* 2022).

Diagnostic Test Reference (1) (APA):

Esophagogastroduodenoscopy (EGD test): Definition & procedure. Cleveland Clinic. (2022). https://my.clevelandclinic.org/health/diagnostics/22549-esophagogastroduodenoscopy-egd-test

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

Home Medications (5 required)

Brand/Generic	**Lopressor/ metoprolol**	**Thiamine Vitamin**	**Effexor/ venlafaxine**	**Protonix/ pantoprazole**	**Mirtazapine/ Remeron**
Dose	75 mg	100 mg	150 mg	40 mg	30 mg
Frequency	2x Daily BID	Daily	Daily	Daily	Nightly
Route	Oral	Oral	Oral	Oral	Oral

Classification	Pharacologic: Beta-anergic Blocker Therapeutic: Antihypertensive	Pharacologic: Therapeutic:	Pharacologic: selective serotonin and norepinephrine reuptake inhibitor. Therapeutic: Antidepressant	Pharacologic: proton pump inhibitor Therapeutic: antiulcer	Pharacologic: Tetracyclic antidepressant Therapeutic: antidepressant
Mechanism of Action	Inhibits beta receptor sites located in the heart reducing the excitability of the heart and decreases cardiac output.		Inhibits neuronal reuptake of norepinephrine and serotonin.	Inhibits the hydrogen-potassium-adenosine enzyme system interfering with gastric secretion.	Inhibits the neuronal reuptake of norepinephrine and serotonin.
Reason Client Taking	The client has hypertension		The client has severe depression	The patient has gastric reflux.	The client has severe depression.
Contraindications (2)	Heart block greater than 1st degree and sinus bradycardia.		Use of MAOI within the last 14 days and a hypersensitivity to venlafaxine.	Reoccurring therapy with rilpivirine and hypersensitivity to pantoprazole.	Hypersensitivity to mirtazapine and the use of MAOI.
Side Effects/Adverse Reactions (2)	Arrythmias and arterial insufficiencies.		Hypotension and GI hemorrhage.	Hepatotoxicity and pancreatitis.	Seizures and ventricular arrythmias.
Nursing Considerations (2)	Use with caution in patients with heart failure and metoprolol can interfere with the effects of insulin.		Should not be given to patients with bradycardia. Use with caution in patients with a history of mania as it could make it worse.	This is continuous therapy and stopping could have adverse effects. Do not give if within 4 weeks of testing for H. Pylori.	Use cautiously in elderly patients and d not give within 14 days of a MAOI.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Blood Pressure and Pulse. ECG upon initial assessment could help.		Blood pressure (It can increase systolic BP) and electrolyte labs as it can cause hyponatremia.	Electrolyte panel for magnesium and medication reconciliation.	Assess patient using SIWA and medication reconciliation.

Client Teaching needs (2)	Take metoprolol with food and at the same time each day.		The client should avoid alcohol while taking this medication and that they should not suddenly stop taking the medication.	Swallow medication whole and do not crush. Tell the patient to notify the provider if some relief is not felt in two weeks of starting the therapy.	The patient should be taught about the suicide hotline and what to do if they feel like they may hurt themselves.

Hospital Medications (5 required)

Brand/Generic	**Ativan/ lorazepam**	**Benadryl/ diphenhydramine**	**Zofran/ ondasteron**	**N/ A**	**N/A**
Dose	2 mg	25 mg	4 mg	N/ A	N/A
Frequency	PRN	PRN	Every 6 hours PRN	N/ A	N/A
Route	IV	IV	IV	N/ A	N/A
Classification	Pharacologic: Benzodiazepine Therapeutic: Anxiolytic	Pharacologic: antihistamine Therapeutic: antianaphylactic	Pharacologic: selective serotonin receptor antagonist Therapeutic: antiemtic	N/ A	**N/A**
Mechanism of Action	Potentiates the effects of GABA and inhibitory factors by binding to benzodiazepine receptors in the limbic system.	Binds to H1 receptors competing with histamines for the same sites preventing the histamines from acting.	Blocks receptors of serotonin in the chemoreceptor trigger zone and peripherally at the vagal nerve.	N/ A	N/A

Reason Client Taking	Helps control the shaking from withdrawal.	The client is receiving blood transfusions and this is preventative of a possible reaction.	The patient was experiencing some nausea with withdrawal.	N/A	N/A
Contraindications (2)	Acute angle-closure glaucoma and sensitivity to benzodiazepines	Breastfeeding and sensitivity to diphenhydramine or other antihistamines.	Concomitant use of apomorphine and hypersensitivity to ondansetron	N/A	N/A
Side Effects/Adverse Reactions (2)	Suicidal ideation and seizures.	Drowsiness and hemolytic anemia.	Prolonged QT wave and abdominal pain.	N/A	N/A
Nursing Considerations (2)	Be cautious when using in patients with a history of alcohol or drug dependence as there is an increased risk of dependency, be cautious using in the elderly and those with respiratory issues as this can cause respiratory depression.	Parenteral form should only be given if the oral cannot be. Elixir versions should be kept from the light.	Hypomagnesemia and hypokalemia should be corrected prior to administration. Monitor patient for serotonin syndrome.	N/A	N/A
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Medication reconciliation to check for any other benzodiazepines or antidepressants as there is an increased risk of suicide. Oxygen saturation and alertness as this has a sedative effect.	The nurse should assess for an allergic reaction prior to administration and alertness of the patient.	A baseline ECG should be performed to determine if there is a prolonged QT. The client baseline of nausea so there is something to compare to.	N/A	N/A
Client Teaching needs (2)	Take medication as prescribed and do not stop the medication	The patient should be told that the medication can cause drowsiness	The client should be taught to look for a rash as this is an adverse effect.	N/A	N/A

	unexpectedly. Urge the patient to not use alcohol while taking.	and that they should avoid activities that require motor function until the effects are known.	They should be taught about transient blindness that can occur will last between a few minutes and 48 hours.		

Medications Reference (1) (APA):

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

Assessment

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

GENERAL: **Alertness: Alert** **Orientation: x4** **Distress: NONE** **Overall appearance: Appropriate**	The patient is alert and oriented to person, place, self and situation. The patient is easily arousable. The patient appears to be in no distress and overall appearance is appropriate.
INTEGUMENTARY: **Skin color: pink, appropriate** **Character: Intact** **Temperature: Warm** **Turgor: Normal** **Rashes: Normal** **Bruises: Normal** **Wounds: Small Laceration on the back of the head.** **Braden Score: 21** **Drains present: Y☐ N ☒**	The patient's skin is pink, warm and intact. The skin turgor is non- tenting. A small laceration is present on the back of the patient's head from a previous fall. There is no edema or redness noted around the wound. The patient has a Braden score of 21 and is able to readjust and stand from the bed on their own.

Type: N/A	
HEENT: **Head/Neck: Normal, Symmetrical** **Ears: Normal, Bilateral** **Eyes: Normal, Bilateral** **Nose: Normal, Symmetrical** **Teeth: Intact**	The head and neck assessment performed appears normal. The head and neck are symmetrical. Ears appear normal without any wounds, bumps, or lesions bilaterally, The nose is centered without septum deviation. Eyes are reactive and PERRLA bilaterally. Dentition is normal with all teeth intact.
CARDIOVASCULAR: **Heart sounds: Normal, Present** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): Normal Sinus Rhythm** **Peripheral Pulses: 2+** **Capillary refill: <3 seconds** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: N/A**	The patient's cardiac rhythm is normal sinus. Heart sounds are normal with audible S1 and S2 heart tones. No murmurs noted. Peripheral pulse is 2+ in both arms and legs bilaterally. Capillary refill is less than 3 seconds in all extremities bilaterally. No edema noted.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character Normal** **ET Tube: NONE** **Size of tube: N/A** **Placement (cm to lip): N/A** **Respiration rate: N/A** **FiO2: N/A** **Total volume (TV): N/A** **PEEP: N/A** **VAP prevention measures: N/A**	Breath sounds are normal and clear. The patient's chest rises and falls symmetrically bilaterally. Patient is using no supplemental oxygen and maintaining a 99% SpO2.
GASTROINTESTINAL: **Diet at home: Regular** **Current Diet: Regular** **Height: 6'** **Weight: 95.4 kg (210 lbs)** **Auscultation Bowel sounds: Present, Normal** **Last BM: 8/30/23** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** N/A **Incisions:** N/A **Scars:** N/A **Drains:** N/A	The Patient's bowel sounds are normal and present in all four quadrants. No distention, scars, drains, or wounds noted on the abdomen. The patient has no complaint of pain upon palpating the stomach. The patient has not accessory use.

Wounds: N/A **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size: N/A** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY: **Color: Yellow** **Character: Clear** **Quantity of urine: 750 ml** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: N/A** **Catheter: Y ☐ N ☒** **Type: N/A** **Size: N/A** **CAUTI prevention measures: N/A**	**Urine is clear and yellow upon inspection. Patient has no pain upon urination. No catheter present.**
MUSCULOSKELETAL: **Neurovascular status: Normal** **ROM: Full** **Supportive devices: None** **Strength: Appropriate** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 40** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	The patient's neurovascular statis appears normal. Range of motion is fully intact. The patient shows not signs of weakness in all extremities. The patient has a low fall risk and can perform ADLs without assistance.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: x4** **Mental Status: Normal** **Speech: Normal** **Sensory:Normal** **LOC:**	The patient is oriented x4 to person, place, self, and orientation. Patient is fully alert. Patient's speech is normal without any slurring. Patient PERRL in both eyes. There is no sign of weakness in the extremities.
PSYCHOSOCIAL/CULTURAL: **Coping method(s): Drinking** **Developmental level: Appropriate** **Religion & what it means to pt.: None** **Personal/Family Data (Think about home**	The patient is a Veteran who served in Iraq and now suffers from post-traumatic stress disorder. The patient uses drinking as his coping mechanism. The patient is aware that this is not a healthy way to cope. The patient's mother is not

environment, family structure, and available family support): Mother is present	present at bed side but does call for updates about the patient.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1045	**77**	**144/96**	**16**	**98.2**	**99%**
1415	**79**	**127/79**	**14**	**97.8**	**98%**

Vital Sign Trends/Correlation:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1020	**Numbers**	**N/A**	**N/A**	**N/A**	**N/A**
1400	**Numbers**	**N/A**	**N/A**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22 g **Location of IV: Right antecubital** **Date on IV: 8/29/23** **Patency of IV: Patent** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: Clean and intact**	The IV is saline locked and is primarily used for medication administration. Patient has no fluids running at this time.
Other Lines (PICC, Port, central line, etc.)	
Type: N/A	

Size: N/A **Location: N/A** **Date of insertion: N/A** **Patency: N/A** **Signs of erythema, drainage, etc.: N/A** **Dressing assessment: N/A** **Date on dressing: N/A** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures: N/A**	

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
800 mL	**750 mL**

Nursing Care

Summary of Care (2 points)

Overview of care: Care was complete and appropriate. Patient received another pint of packed red blood cells. Patient awaiting consult and possible transfer.

Procedures/testing done: Upper gastrointestinal endoscopy and nuclear medical scan.

Complaints/Issues: No complaints or issues.

Vital signs (stable/unstable): Vital signs remained stable, small elevation that was treated with the patients regular dose of metoprolol.

Tolerating diet, activity, etc.: The patient is tolerating meals and fluids. Patient is able to ambulate to the restroom.

Physician notifications: Physician was not notified as there was not an applicable reason.

Future plans for client: The client is awaiting consultation at Carle Foundation Hospital for possible transfer.

Discharge Planning (2 points)

Discharge location: The patient is not currently up for discharge.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: N/A

Education needs: The patient will need education about the effects of excessive use of alcohol. The patient will also need education about what medications can further cause bleeding.

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 –	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions? • Client response, status of

highest priority to lowest priority pertinent to this client				goals and outcomes, modifications to plan.
1. Risk for decreased cardiac tissue perfusion related to hypovolemia as evidenced by the decrease in all blood cells.	The patient has a consistent bleed that the body is unable to compensate for and has to receive blood transfusions to try and maintain proper volume and cell count.	**1.**Assess the hemodynamic status of the patient (BP, HR, SpO2) **2.**Monitor cardiac rhythm for irregularities.	**1.** The patient maintains stability and cardiac perfusion.	The client is aware that the vital signs and continuous monitoring are necessary. The client wants to return home but understands that it is in his best interest to stay in the hospital.
2. Risk for impaired gas exchange related to uncontrolled bleeding as evidenced by a low HGB count.	The patient has a low HGB count meaning oxygen could deteriorate because there are no blood cells to distribute oxygen.	**1.** Frequently assess the patients respiratory and oxygen status. **2.**Administer oxygen therapy as needed.	**1.** The patient will maintain clear airways and an adequate SpO2.	The patient is ok with the monitoring of their oxygen. They have not had to receive oxygen therapy yet.
3. Ineffective breathing patterns related to possible allergic reaction as evidenced by a blood antigen developed from blood	The patient has received many blood transfusions in their life causing an antigen allergy that makes it more difficult to find blood matches.	1. Observe for signs of respiratory distress **2.** Have the patient notify you if they feel short of breath.	**1.** The patient's respiratory rate will stay within normal limits.	The patient is aware to notify the nurse if any shortness of breath occurs.

transfusions.				
4. Acute substance withdrawal syndrome related to chronic alcoholism and evidenced by the patient's reoccurring admission for alcohol related illnesses.	The patient is a chronic alcoholic who drinks 3 liters of vodka a day.	**1.** Monitor the patient alertness. **2.** Give the patient ordered medications such as lorazepam for withdrawal symptoms.	**1.** The patient will remain comfortable.	The patient is aware of the process of withdrawal and knows they can request medication to help.
5. Risk for impaired Liver function related to alcoholism as evidenced by an elevated AST.	The patient is a chronic alcoholic. The patient has an elevated AST indicating there may be damage to the liver already.	**1.** Educate the patient on the effects of alcohol systemically. **2.** Monitor lab results and for symptoms of liver failure.	**1.** The patient will have liver enzymes within normal limits.	The patient is aware that the alcohol is negatively effecting his body but he does not feel like he can stop.

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient mentioned their alcohol use. The patient also mentioned they were not experiencing any pain but felt tired.

Nursing Diagnosis/Outcomes

Risk for decreased cardiac tissue perfusion related to hypovolemia as evidenced by the decrease in all blood cells. The expected outcome is the patient maintains stability and cardiac perfusion. Risk for impaired gas exchange related to uncontrolled bleeding as evidenced by a low HGB count. The expected outcome is the patient will maintain clear airways and an adequate SpO2. Ineffective breathing patterns related to possible allergic reaction as evidenced by a blood antigen developed from blood transfusions. The expected outcome is the patient's respiratory rate will stay within normal limits. Acute substance withdrawal syndrome related to chronic alcoholism and evidenced by the patient's reoccurring admission for alcohol related illnesses. The expected outcome the patient will remain comfortable. Risk for impaired Liver function related to alcoholism as evidenced by an elevated AST. The expected outcome is The patient will have liver enzymes within normal limits.

Client Information

Client Initials: J.L.
Age: 41
Gender: Male
Race: White
Occupation: Unemployed
Marital Status: Single
Code status: Full
Height: 6'
Weight: 210 lbs (95.4 kg)

Objective Data

- Vital signs
- Lab results
- Diagnostic imaging results
- Full body assessment
- Allergies
- Medications and doses.

Nursing Interventions

Assess the hemodynamic status of the patient (BP, HR, SpO2)

Monitor cardiac rhythm for irregularities.

Frequently assess the patients respiratory and oxygen status.

Administer oxygen therapy as needed.

Observe for signs of respiratory distress.

Have the patient notify you if they feel short of breath.

Monitor the patient alertness.

Give the patient ordered medications such as lorazepam for withdrawal symptoms.

Educate the patient on the effects of alcohol systemically.

Monitor lab results and for symptoms of liver failure