

N441 Care Plan

Lakeview College of Nursing

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**Demographics (3 points)**

<b>Date of Admission</b> 9/1/23	<b>Client Initials</b> D.S	<b>Age</b> 87	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian	<b>Occupation</b> Retired	<b>Marital Status</b> Unknown	<b>Allergies</b> No known allergies
<b>Code Status</b> Full	<b>Height</b> 5'0''ft (60cm)	<b>Weight</b> 139.7lbs. (63.4 kg)	

**Medical History (5 Points)**

**Past Medical History:** Hypertension, Hyperlipidemia, Atrial fibrillation, Cataracts, Dementia, Anxiety

**Past Surgical History:** Hysterectomy, Hip surgery (thirty to forty years ago patient is a poor historian)

**Family History:** No known family history

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

Patient was not able to give history of tobacco, alcohol, or drug use.

**Assistive Devices:** Patient uses a walker to get around.

**Living Situation:** Patient lives at Copper Creek Cottages an assisted living facility in Arcola.

**Education Level:** Patients educational level is unknown.

**Admission Assessment**

**Chief Complaint (2 points):** Patient came in by ambulance for complaints of nausea, vomiting, and hypertension.

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

The patient is an eighty-seven-year-old female who came by ambulance from an assisted living Copper Creek Cottages in Arcola. Patient herself is a poor historian as her baseline is alert and oriented times one. Son was present upon arrival but also was not able to provide much medical history. It was known patient felt nauseous with episodes of vomiting for a few days (unclear how many in specific). Location wise patient felt unwell unable to provide specific area of where pain was felt. These symptoms stated to last “a few days” according to the son as well as noted to be clammy. Characteristics wise unable to obtain information but upon arrival patient blood pressure was noted to be 200/61. Aggravating factors appeared to be transporting patient otherwise patient had no complaints of what aggravated these factors. No alleviating factors were noted at the time. Treatment wise patient was not able to state if she had taken any medication to treat her symptoms. At the hospital patient did receive a CT-scan showing a closed loop incarcerated hernia which doctor diagnosed as a small bowel obstruction that led to patient needing to go to surgery for a small bowel resection and requiring a drip to treat her hypertension of 222/99 during procedure. Severity was a 10/10 due to requiring emergent surgical repair.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (2 points):** Small Bowel Obstruction

**Secondary Diagnosis (if applicable):** N/A

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

A small bowel obstruction can be caused by several factors, either from surgical adhesions or hernias. In this patient's scenario, the medical problem is due to an incarcerated hernia. According to Schick & Meseeha (2023), a twisting of the intestine leads to proximal bowel distention and bowel decompression. Cellularly, this can be fatal as an obstruction is not

letting contents in the stomach flow through as they should, causing damage to the stomach. Capriotti (2020) says it interferes with the intestine's normal function, causing increased peristalsis and mucus accumulation. The intestine can get swollen and unable to absorb fluid, leading to dehydration, bowel perforation, respiratory failure, pneumonia, renal failure, and ultimately death (Schick & Meseeha, 2023). It is blocking the intestinal contents and fluids that should be going through the bowel, which causes this to be a surgical emergency.

This disease presents with abdominal pain, nausea, hyperactive bowel sounds, sharp cramping, and intermediate pain (Capriotti, 2020). In the patient's scenario, she came in with similar complaints, including nausea and vomiting. These symptoms can lead to other complications, as vomiting can cause fluid and electrolyte imbalances, leading to dehydration and hypovolemic shock. It is crucial to monitor the labs if the nurse requires further intervention. It is expected for the patient to have fluid and electrolyte depletion, hypotension, and dehydration. After surgery, it is expected to have a lower hemoglobin and hematocrit count versus when the patient is first admitted.

An X-ray, ultrasound, and computerized tomography can be used to diagnose a bowel obstruction. The golden standard to diagnose a small bowel obstruction is getting a computerized tomography done (Schick & Meseeha, 2023). The patient got a computerized tomography done, showing a closed small loop dilated to 3.8cm, which resulted in an incarcerated hernia with gangrenous bowel, which required surgical intervention. Labs were drawn to check for abnormal findings needing further intervention; a complete blood count, blood chemistry, urinalysis, and culture were collected. The urine resulted in an elevated white blood count and showed streptococcus.

Several treatments can help with the obstruction, depending on its severity. According to (Capriotti, 2020), pain management, antiemetic medication, and antibiotics help with small bowel obstructions. A nasal gastric tube is in place to decompress the bowel and remove fluid accumulation in the bowel. If it is an emergency, the physicians decide surgical intervention is required. The patient had to undergo a small bowel resection to treat her incarcerated hernia. The patient had a nasal gastric tube in place with dark green contents draining into the canister. Which then needs an x-ray to confirm the proper placement of the nasal gastric tube and remain nothing by mouth as the diet.

As stated above, the patient had several clinical data that are commonly seen with patients with small bowel obstruction. The patient had nausea and vomiting, which was then taken to a computed tomography, resulting in a small bowel obstruction that needed surgical intervention. Treatment The patient had a surgical bowel resection and a nasal gastric tube placed as it is usually seen and had to be nothing by mouth diet-wise. Although the patient was a poor historian and unable to provide much information, the medical staff could diagnose what was happening as proper assessments were done.

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

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and*

*Clinical Perspectives*. F.A. Davis.

Schick, M. A., Kashyap, S., & Meseeha, M. (2023). Small Bowel Obstruction. In *StatPearls*.

StatPearls Publishing.

**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
<b>RBC</b>	4.0-5.8x10 <sup>6</sup> /mcl	4.84 x10 <sup>6</sup> /mcl	2.98 x10 <sup>6</sup> /mcl	The red blood cells are low as expected after surgery (Capriotti, 2020). As well as patient having a JP drain after the small bowel resection surgery.
<b>Hgb</b>	12.0-15.8g/dL	13.7 g/dL	8.6 g/dL	The hemoglobin is low as expected after surgery (Capriotti, 2020). As well as patient having a JP drain after the small bowel resection surgery.
<b>Hct</b>	36.0-47.0%	42.2%	85.8 %	The hemoglobin is elevated due to improper oxygenation to the blood increasing the risk of a blood clot forming. (Capriotti, 2020).
<b>Platelets</b>	140-440K/mcl	181 K/mcl	121 K/mcl	The platelet count is expected to be lower after a surgery procedure (Capriotti, 2020).
<b>WBC</b>	4.0-12.0K/mcl	10.9 K/mcl	5.7 K/mcl	N/A
<b>Neutrophils (auto)</b>	40-60%	80.9%	46%	The patients neutrophils are elevated may indicate an infection (Capriotti, 2020). It was found that the patient has Streptococcus in her urine which can cause elevated neutrophils.
<b>Lymphocytes</b>	11.8-45.9%	11.7 %	7.0 %	The patients' lymphocytes are low

(auto)				due to an infection (Capriotti, 2020). The patient surgical culture came back with klebsiella oxytoca as well as her urine having streptococcus.
<b>Monocytes (absolute)</b>	0.3-1.1%	0.6 %	0.4 %	N/A
<b>Eosinophils</b>	0.0-6.3%	1.3 %	N/A	N/A
<b>Bands</b>	0. .0-10.0%	5.0 %	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
<b>Na-</b>	134-144mmol/L	139 mmol/L	137 mmol/L	N/A
<b>K+</b>	3.5-5.1mmol/L	3.5 mmol/L	3.6 mmol/L	N/A
<b>Cl-</b>	98-107mmol/L	106 mmol/L	104 mmol/L	N/A
<b>CO2</b>	21-31mmol/L	25 mmol/L	25mmol/L	N/A
<b>Glucose</b>	70-99mg/dL	170 mg/dL	162 mg/dL	Glucose can be elevated due to stress on the body (Capriotti, 2020). The patient was undergoing significant stress due to her medical diagnosis.
<b>BUN</b>	7-25 mg/dL	15 mg/dL	30 mg/dL	The patients BUN can be elevated due to patient being possibly dehydrated or improper function of the kidneys (Capriotti, 2020). It was noted there was low urine output. As well as patients' diet being nothing by mouth could be a factor. The nurse did mention in report the patient possibly having an acute kidney injury, but it was not confirmed.

<b>Creatinine</b>	0..50-1.20 mg/dL	0.88 mg/dL	1.07 mg/dL	N/A
<b>Albumin</b>	3.5-5.7 g/dL	3.7 g/dL	N/A	N/A
<b>Calcium</b>	8.6-10.3 mg/dL	8.2 mg/dL	6.7 mg/dL	A common cause of hypocalcemia is vitamin D deficiency and renal disease (Capriotti, 2020).The patient may have an underlying renal disease which would correlate to the elevated BUN but it is possible the patient has a vitamin D deficiency as she is not getting as much nutrition after undergoing surgery remaining nothing by mouth as her diet. The nurse did mention in report the patient possibly having an acute kidney injury, but it was not confirmed.
<b>Mag</b>	1.6-2.6 mg/dL	N/A	2.0 mg/dL	N/A
<b>Phosphate</b>	2.4-4.5 units/L	3.2 units/L	N/A	N/A
<b>Bilirubin</b>	0.3-1.0 mg/dL	0.4 units/L	N/A	N/A
<b>Alk Phos</b>	34-104 units/L	81 units/L	N/A	N/A
<b>AST</b>	13-39 units/L	21 units/L	N/A	N/A
<b>ALT</b>	7-52 units/L	12 units/L	N/A	N/A
<b>Amylase</b>	40-140 units/L	N/A	N/A	N/A
<b>Lipase</b>	0-160 units/L	N/A	N/A	N/A
<b>Lactic Acid</b>	0.5-2.0 mmol/L	N/A	N/A	N/A
<b>Troponin</b>	0.00-0.4 ng/mL	0.00 ng/mL	N/A	N/A

<b>CK-MB</b>	5-25 ng/mL	N/A	N/A	N/A
<b>Total CK</b>	22-198 units/L	N/A	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
<b>INR</b>	<1.0	1.45	1.35	It is elevated meaning the patient is at high risk for bleeding due to patients taking a longer time to clot (Capriotti, 2020). It can be indicative of a kidney disease or just a bleeding disorder but since patient was poor historian it is difficult to tell. The nurse did mention in report the patient possibly having an acute kidney injury but it was not confirmed.
<b>PT</b>	10-14 seconds	17.6 seconds	16.7 seconds	It is elevated meaning the patient is at high risk for bleeding due to patients taking a longer time to clot (Capriotti, 2020). It can be indicative of a kidney disease or just a bleeding disorder but since patient was poor historian it is difficult to tell. The nurse did mention in report the patient possibly having an acute kidney injury, but it was not confirmed.
<b>PTT</b>	30-40 seconds	56.7 seconds	92.2 seconds	It is elevated meaning the patient is at high risk for bleeding due to patients taking a longer time to clot (Capriotti, 2020). It can be indicative of a kidney disease or just a bleeding disorder but since patient was poor historian it is difficult to tell. The nurse did mention in report the patient possibly having an acute kidney injury, but it was not confirmed.

<b>D-Dimer</b>	<500	N/A	N/A	N/A
<b>BNP</b>	<100	N/A	N/A	N/A
<b>HDL</b>	>60 mg/dL	N/A	N/A	N/A
<b>LDL</b>	<100 mg/dL	N/A	N/A	N/A
<b>Cholesterol</b>	<150 mg/dL	N/A	N/A	N/A
<b>Triglycerides</b>	<150 mg/dL	N/A	N/A	N/A
<b>Hgb A1c</b>	<5.7%	N/A	N/A	N/A
<b>TSH</b>	0.4-4.0 mU/L	1.00 mU/L	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
<b>Color &amp; Clarity</b>	Yellow, Clear	Light yellow	N/A	N/A
<b>pH</b>	5.0-9.0	7.0	N/A	N/A
<b>Specific Gravity</b>	1.003-1.013	<b>1.028</b>	N/A	Elevated specific gravity is indicative of an infection or renal disease (Capriotti, 2020). The nurse was suspicious of an acute kidney injury ongoing as well as patient urine culture showing Streptococcus.
<b>Glucose</b>	Normal	<b>150</b>	N/A	It is elevated due to patient's hyperglycemia (Capriotti, 2020). It was noted in the above labs as well.
<b>Protein</b>	Normal	<b>1+</b>	N/A	Elevated due to possible kidney infection (Capriotti, 2020). The nurse was suspicious of an acute kidney injury ongoing as well as patient urine culture showing Streptococcus.
<b>Ketones</b>	Negative	<b>1+</b>	N/A	According to Capriotti, 2020 elevated ketones mean the body is

				too acidic. The patients ABG values did not represent that, but patient was vomiting which can cause soe acidity. Nurse was suspicious of an acute kidney injury ongoing as well as patient urine culture showing Streptococcus.
<b>WBC</b>	0.0-0.5	25	N/A	White blood count is elevated due to a possible urine or kidney infection (Capriotti, 2020). Nurse was suspicious of an acute kidney injury ongoing as well as patient urine culture showing Streptococcus.
<b>RBC</b>	0.0-3.0	N/A	N/A	N/A
<b>Leukoesterase</b>	Negative	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.

<b>Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Explanation of Findings</b>
<b>pH</b>	7.35-7.45	7.44	7.44	N/A
<b>PaO2</b>	75-85	77.2	85	N/A
<b>PaCO2</b>	35-45	33.6	36.2	N/A
<b>HCO3</b>	22-26	23.3	26	N/A
<b>SaO2</b>	95-98	97.8	97.8	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
<b>Urine Culture</b>	Negative	Streptococcus	N/A	It is indicating damage in the glomerular membranes. glomerulonephritis is caused by antibodies which commonly activated by Streptococcus bacteria (Capriotti, 2020 p.530).
<b>Blood Culture</b>	Negative	Negative	N/A	N/A
<b>Sputum Culture</b>	Negative	N/A	N/A	N/A
<b>Stool Culture</b>	Negative	N/A	N/A	N/A

**Lab Correlations Reference (1) (APA):**

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. F.A. Davis.

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points):**

**Electrocardiogram:** The patient had an electrocardiogram done as patient has history of atrial fibrillation. According to Capriotti (2020, pg. 372), "it records the potential difference in charge between two electrodes as the depolarization and repolarization waves move through the heart". During the assessment patients heart showed normal sinus rhythm. It is important to monitor heart rhythm in case nursing intervention is required if abnormalities are identified.

**Diagnostic Test Correlation (5 points):**

Computed tomography (CT) of abdomen and pelvis without contrast:

The patient had a CT scan to rule out any complications related to small bowel, colon, and other internal organs. An abdomen Ct scan is used to look at primary tumors, metastases, abscess, ascites, cholecystitis, appendicitis, renal calculi, pancreatitis, obstruction, lymphadenopathy, foreign body (Patel & De Jesus, 2023). As patient was a poor historian and unable to express much of her symptoms. The scan resulted in a closed loop stacked small bowel obstruction in lower central abdomen. This ultimately led to her diagnosis of small bowel obstruction which led to patient needing a small bowel resection surgical repair.

#### Chest X-Ray:

After patient was admitted for her surgery, it is common the patient to need a nasal gastric tube (NG Tube) placed to decompress the bowel and remove fluid accumulation in the bowel. Upon placement of NG tube, a chest x-ray to required to assess if the tube was placed correctly.

According to Klein & Rosado-de-Christenson (2019) a chest x-ray entails “visualization and assessment of the chest wall, mediastinum, and hila including the heart and great vessels, central airways, the lungs including the pulmonary vasculature, the pleural surfaces including the fissures and the diaphragm”. The patient’s placement of NG tube was confirmed to be in place as well as it was also discovered patient had right upper lobe pneumonia with bronchitis.

#### **Diagnostic Test Reference (1) (APA):**

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. F.A. Davis.

Klein, J. S., & Rosado-de-Christenson, M. L. (2019). A Systematic Approach to Chest Radiographic Analysis. In J. Hodler (Eds.) et. al., *Diseases of the Chest*,

*Breast, Heart and Vessels 2019-2022: Diagnostic and Interventional Imaging.* (pp. 1-16). Springer.

Patel, P. R., & De Jesus, O. (2023). CT Scan. In *StatPearls*. StatPearls Publishing.

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

**Home Medications (5 required)**

<b>Brand/Generic</b>	Acetylsalicylic acid/Aspirin	Pravachol/ Pravastatin	Aricept/ Donepezil	Coreg /Carvedilol	Zoloft /Sertraline
<b>Dose</b>	325 mg	40mg	10 mg	3.125 mg	100 mg
<b>Frequency</b>	Daily	HS	HS	B.I.D	Daily
<b>Route</b>	PO	PO	PO	PO	PO
<b>Classification</b>	Pharmacological: Salicylate Therapeutic : NSAID (anti-inflammatory, antiplatelet, antipyretic, nonopioid analgesic	Pharmacological: HMG-CoA Reductase inhibitor Therapeutic: Antilipemic	Pharmacological: Acetylcholinesterase inhibitor Therapeutic: Antidementia	Pharmacological: Nonselective beta blocker and alpha-1 blocker Therapeutic : Antihypertensive	Pharmacological: Selective serotonin reuptake inhibitor Therapeutic : Antianxiety
<b>Mechanism of Action</b>	“Blocks the activity of cyclooxygenase, the enzyme needed for	Inhibits cholesterol synthesis in the liver by blocking the enzyme needed to convert	Reversibly inhibits acetylcholinesterase and improves acetylcholine concentration	Reduces cardiac output and tachycardia (Jones, 2021, p.172).	Increases amount of serotonin available in nerve synapses which can

	prostaglandin synthesis” (Jones, 2021, p.87).	HMG-CoA to mevalonate (Jones, 2021, p.890).	at cholinergic synapses (Jones, 2021, p.337).		result in elevated mood and reduced depression (Jones, 2021, p.991).
<b>Reason Client Taking</b>	Patient takes it due to her history of Gastroesophageal reflux disease	Patient takes it due to her hyperlipemia.	Patient takes it due to her history of dementia.	Patient takes it for her history of hypertension	Patient takes it for her history of anxiety
<b>Contraindications (2)</b>	Hypersensitivity to aspirin, Active bleeding (Jones, 2021, p.88).	Active hepatic disease, persistent elevated liver enzymes (Jones, 2021, p.890).	Hypersensitivity to donepezil, Hypersensitivity to piperidine derivatives (Jones, 2021, p.337).	Bronchial asthma, cardiogenic shock (Jones, 2021, p.173).	Concurrent use of disulfiram, Concurrent use of pimozide (Jones, 2021, p.991).
<b>Side Effects/Adverse Reactions (2)</b>	Prolonged bleeding time, decreased blood level iron (Jones, 2021, p.88).	Hepatic failure, hemolytic anemia (Jones, 2021, p.890).	Abnormal ECG, abnormal gait (Jones, 2021, p.338).	Renal insufficiency, AV block (Jones, 2021, p.173).	Atrial arrhythmias, leukopenia (Jones, 2021, p.992).
<b>Nursing Considerations (2)</b>	Ask patient if tinnitus occurs when taking this medication, do not crush time released capsules unless instructed to do so (Jones 2021, p.89).	Use in precaution with patients who have hepatic impairment, use in precaution with patients who have renal impairment (Jones, 2021, p.891).	Use in caution with patients who have bladder obstructions it can obstruct outflow, use caution with patients who have asthma it may increase bronchoconstriction (Jones, 2021, p.338)	Monitor patients’ blood glucose levels as it can alter blood glucose levels, may aggravate symptoms of adrenal insufficiency (Jones,	Be aware to not give this medication to patients who experience bradycardia, expect hypokalemia and hypomagnesemia to be corrected before

				2021, p.173).	administrati on of this medicine (Jones, 2021, p.992).
<b>Key Nursing Assessment(s)/ Lab(s) Prior to Administration</b>	Check if patient is taking ibuprofen as it may reduce the cardioprotective effects Instruct patient to stop taking medication if symptoms of intestinal bleeding occur (Jones, 2020, p.89).	Monitor liver enzymes before taking medication, Monitor patients BUN and creatinine levels (Jones, 2021, p.891).	Monitor for bradycardia, monitor for signs of syncope	Monitor patients' blood pressure, as well as heart rate prior to administration	Monitor liver enzymes, Monitor BUN and creatinine levels (Jones, 2021, p.992).
<b>Client Teaching needs (2)</b>	Take with food, avoid alcohol to reduce risk of ulcers (Jones, 2021, p.89).	Instruct patient to take medication at bedtime without regards to meals, caution patient to not perform hazardous activities such as driving until effects of drugs is known (Jones, 2021, p.891).	Advise patient to take prior to going to bed, educate patient if they have gastric irritation, it may aggravate these conditions by increasing gastric acid secretions (Jones, 2021, p.339).	Ensure patient knows how to check their own blood pressure, ensure patient is educated how to check their own pulse prior to administration.	Educate patient who takes Aspirin this can increase their risk for bleeding, advise patient this medication may cause pupil dilation (Jones, 2021, p.992).

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	Lasix/ Furosemide	Tylenol/ Acetaminophen	Invanz / Ertapenem	Protonix/ Pantoprazole	Levophed / Norepinephrine
<b>Dose</b>	40mg	1,000 mg	1,000mg	40 mg	16mg + 250mL
<b>Frequency</b>	Q12h	Q6h	Daily	Daily	10mg/min
<b>Route</b>	<b>IV Push</b>	IV Piggyback	IV piggyback	IV Push	IV Drip
<b>Classification</b>	<b>Pharmacological:</b> Loop Diuretic <b>Therapeutic:</b> Antihypertensive, diuretic	<b>Pharmacological:</b> <b>Non-salicylate</b> <b>Therapeutic</b> : Non opioid analgesic	Pharmacological: Carbapenem Therapeutic: Antibiotic	Pharmacological: Proton Pump Inhibitor Therapeutic: Antiulcer	Pharmacological: Sympathomimetic Therapeutic: Vasopressor
<b>Mechanism of Action</b>	Reducing extracellular and intracellular fluid volume, drug reduces blood pressure and cardiac output (Jones, 2021, p.500).	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system (Jones, 2021, p.9).	Inhibits bacterial cell wall synthesis by binding to specific penicillin-binding proteins inside the cell wall (Jones, 2021, p.394).	Interferes with gastric acid secretion by inhibiting the hydrogen potassium adenosine triphosphate enzyme system (Jones, 2021, p.853).	Increases peripheral vascular resistance and systolic blood pressure (Jones, 2021, p.803).
<b>Reason Client Taking</b>	Patient is having excess fluid causing edema she is taking this diuretic to reduce edema and get rid of the excess	Patient takes it for pain.	Patient takes it due to ongoing bacteria infection in urine and in surgical culture.	Patients takes this medication due to history of gastroesophageal reflux disease	The patient takes this medication due patient experiencing low blood pressures.

	fluids.				
<b>Contraindications (2)</b>	Anuria, hypokalemia	Hypersensitivity to acetaminophen, hepatic impairment	Hypersensitivity to local anesthetics of the amid type, Hypersensitivity to ertapenem (Jones, 2021, p.394).	Concurrent therapy with rilpivirine-containing products, Hypersensitivity to pantoprazole (Jones, 2021, p.853).	Hypersensitivity to Norepinephrine, hypovolemia (Jones, 2021, p.803).
<b>Side Effects/Adverse Reactions (2)</b>	Arrhythmia, Hypokalemia (Jones, 2021, p.500).	Hypotension, hypokalemia (Jones, 2021, p.11).	Small intestine obstruction, respiratory distress (Jones, 2021, p.394).	Hyperglycemia, leukopenia (Jones, 2021, p.854).	Bradycardia, ECG changes (Jones, 2021, p.803).
<b>Nursing Considerations (2)</b>	Obtain patients weight before and periodically during furosemide therapy, try to give dosing early in the day so patient sleep is not interrupted by needing to urinate (Jones, 2021, p.500).	Monitor for symptoms of hepatotoxicity, use in caution with patients who drink alcohol (Jones, 2021, p.11).	Make sure to not use solutions that contain dextrose, ensure antibiotic is shaken well prior to administration and given strictly as ordered (Jones, 2021, p.395).	Monitor for bone fractures as it increases a risk for osteoporosis, be aware that this medication does not rule out presence of a gastric tumor (Jones, 2021, p.855).	Monitor ECG continuously if blanching occurs along the vein change infusion site (Jones, 2021, p.803).
<b>Key Nursing Assessment(s)/ Lab(s) Prior to Administration</b>	Monitor sodium, Monitor potassium.	Monitor renal functions. (creatinine), Monitor liver functions (AST, ALT)	Obtain urine for culture and sensitive testing as ordered before	Monitor for hypomagnesium prior to administration, Monitor PT and INR	Make sure solution is not discolored before administering, preferably

			medication administration, inspect drug for particles or discoloration after reconstitution (Jones, 2021, p.395).	if patient is taking an anticoagulant as well (Jones, 2021, p.855).	have an intra-atrial monitoring for accurate readings of blood pressure (Jones, 2021, p.803)
<b>Client Teaching needs (2)</b>	Empathize importance of monitoring weight, emphasize importance of monitoring a low sodium diet (Jones, 2021, p.501).	Teach patient about hepatotoxicity symptoms such as easily bruising, bleeding, and malaise (Jones, 2021 p.10). Educate to only take as prescribed as well as cold medicine over the counter contains acetaminophen.	Instruct patients to report immediately signs of anaphylaxis, urge patient to let provider know if diarrhea is occurring for more than three days (Jones, 2021, p.395).	Educate patient to not take any herbal supplements with this medication prior to discussing with their provider, advise patient to expect relief within two weeks of taking this medication (Jones, 2021, p.855).	Urge patient to report to provider if burning occurs, notify provider if leaking or tingling occurs around the site (Jones, 2021, p.803).

**Medications Reference (1) (APA):**

Jones, D.W. 2021. *Nurse's drug handbook* (20<sup>th</sup> ed.). Jones & Bartlett Learning.

**Assessment**

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

<p><b>GENERAL:</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b></p>	<p>The patient was alerted and oriented to self only able to state her name. Patient was not alert to time, place, or situation. (A&amp;Ox1). Which is her baseline at her assisted living facility is what was passed on report. Patient did not appear distressed but seemed rather sleepy and not able to answer majority of questions asked as she seemed to keep dosing off. Overall appearance appeared weary and drowsy.</p>
<p><b>INTEGUMENTARY:</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds:</b>  <b>Braden Score:</b>  <b>Drains present:</b> Y <input checked="" type="checkbox"/>      N <input type="checkbox"/>  <b>Type:</b></p>	<p>The patient seemed to be pale and weak. Skin was moist and warm to touch noted generalized bruising all over her arms. Skin turgor was loose with no lesions or wounds present. Edema was noted on her left hand +1. Patient had a vertical incision from her small bowel resection procedure covered in a dressing to protect from any more infection occurring. Patients surgical culture came back with klebsiella oxytoca. Patients Braden score is at thirteen. Patient had a JP drain on her left side which appeared to be having a s about 50 ml of output. As well as an NG tube placed with 150 ml output during the shift.</p>
<p><b>HEENT:</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>The patient's head is normal cephalic and symmetrical. Ears are symmetrical with no serum or epistaxis. The patient's eye represented PERLA. Scleral edema noted on her right eye due to patient experiencing fluid overload. The nose showed no polyps, nor deviated septum. The patient teeth are intact and self-care hygiene was provided during visit.</p>
<p><b>CARDIOVASCULAR:</b></p>	<p>Patients' heart sounds S1 and S2 were</p>

<p><b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Location of Edema:</b></p>	<p>auscultated. No present murmurs heard. Cardiac rhythm was normal sinus rhythm it was noted patient does go into atrial fibrillation throughout the shift occasionally but not while I was present. Peripheral pulses pulse demonstrating a rating of 3+. Capillary refill less than three seconds. No neck vein distention. Patient had 1+ edema on left hand as well as scleral edema on right eye due to fluid overload.</p>
<p><b>RESPIRATORY:</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p> <p><b>ET Tube:</b>  <b>Size of tube:</b>  <b>Placement (cm to lip):</b>  <b>Respiration rate:</b>  <b>FiO2:</b>  <b>Total volume (TV):</b>  <b>PEEP:</b>  <b>VAP prevention measures:</b></p>	<p>No accessory muscles were used. The patient's breath sounds were auscultated anterior and posterior sounding clear upper and lower lobes and slightly diminished bilaterally on lower lobes. Patient did not have ET tube in place.</p>
<p><b>GASTROINTESTINAL:</b>  <b>Diet at home:</b>  <b>Current Diet</b>  <b>Height:</b>  <b>Weight:</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</b>  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>  <b>Distention:</b>  <b>Incisions:</b>  <b>Scars:</b>  <b>Drains:</b>  <b>Wounds:</b>  <b>Ostomy:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Nasogastric:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Size:</b>  <b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>Patients diet as home is regular, current diet remains nothing by mouth since she had an NG tube placed due to a bowel obstruction. The patient's height is 60cm and 63.4kgs. Bowel sounds were hypoactive in all four quadrants. Last bowel movement was noted during night shift 9/2/23. No distention or wounds present. Upon palpation no masses or pain noted otherwise than near the incision line. Patient had a vertical incision around three to five inches long. The incision appeared clean and intact dressing changed during the shift. Patients surgical culture came back with klebsiella oxytoca. Patient did not have an ostomy nor a feeding tube, Patient did have an NG tube in place with 150 mL dark green output during the shift. Ng tube size was 14 Fr.</p>
<p><b>GENITOURINARY:</b>  <b>Color:</b>  <b>Character:</b>  <b>Quantity of urine:</b></p>	<p>Patients' urine is light yellow and clear. No foul odor noted. Patients output during shift was 100mL. No pain while urination was expressed.</p>

<p><b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Dialysis:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Inspection of genitals:</b></p> <p><b>Catheter:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>Type:</b></p> <p><b>Size:</b></p> <p><b>CAUTI prevention measures:</b></p>	<p>Patient is not on dialysis. Genitals were free of inflammation and nodules. A 16'' coude catheter was in place with sterile procedure used while inserting foley as well as foley catheter care done twice daily.</p>
<p><b>MUSCULOSKELETAL:</b></p> <p><b>Neurovascular status:</b></p> <p><b>ROM:</b></p> <p><b>Supportive devices:</b></p> <p><b>Strength:</b></p> <p><b>ADL Assistance:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fall Risk:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fall Score:</b> 75</p> <p><b>Activity/Mobility Status:</b></p> <p><b>Independent (up ad lib)</b> <input type="checkbox"/></p> <p><b>Needs assistance with equipment</b> <input type="checkbox"/></p> <p><b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>Patients' neurovascular status is intact other than little to no range of motion present. Range of motion was weak upon assessment. Patient at the assisted living home usually uses a walker and can perform activity of daily livings with little to no assistance to get around but during hospitalization patient was bedridden. 3/5 strength bilaterally on upper and lower extremities with passive range of motion. As patient was unable to follow commands when prompted to follow active range of motion. Patient needs complete assistance with activates as she is unable to perform her activity of daily livings currently with a fall score of 75. Patient does require assistive equipment's including a walker and gait belt with max assistance to stand and walk which is not preferred at the time as she is bedridden at the time.</p>
<p><b>NEUROLOGICAL:</b></p> <p><b>MAEW:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -</p> <p><b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/></p> <p><b>Orientation:</b></p> <p><b>Mental Status:</b></p> <p><b>Speech:</b></p> <p><b>Sensory:</b></p> <p><b>LOC:</b></p>	<p>Patient is not able to move all extremities well unless passive range of motion is prompted for all extremities. Strength with a 3/5 bilaterally on extremities hen passive range of motion is prompted. Patient is not alert and oriented to time and place. Mental status seems to be decreasing as patient is not able to verbally express her needs and answer questions when prompted. Speech seems to be clear when she can answer yes and no questions and when she is conversing with her son as well as when asked about pain. Although speech seems to be gradually decreasing in efforts to communicate. No loss of consciousness.</p>
<p><b>PSYCHOSOCIAL/CULTURAL:</b></p> <p><b>Coping method(s):</b></p> <p><b>Developmental level:</b></p> <p><b>Religion &amp; what it means to pt.:</b></p> <p><b>Personal/Family Data (Think about home</b></p>	<p>Patient was unable to give information about coping methods, religion, personal and family data. Upon report it is noted the son Chad is the power of attorney. Patients developmental level seems is in integrity vs despair. Patient appears</p>

<b>environment, family structure, and available family support):</b>	to be in despair as her health seems to be deteriorating.
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**Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
07:30	67	124/58	20	36.4 °C	95% (2L nasal cannula)
10:30	65	125/58	20	36.0 °C	95% (2L nasal cannula)

**Vital Sign Trends/Correlation:**

The patient’s heart rate seems to be around the same rate and within normal limits. Patients blood pressure seemed to increase just slightly but around the same range as before. Diastolic blood pressure seems to be on the lower end, but patient is receiving norepinephrine to maintain blood pressure in a stable range. As blood pressure can tend to fluctuate ue to her stress of medical conditions ongoing issues. Patients’ temperature is decreasing upon shift change report it was noted a bear hugger was applied as her temperature had previously dropped to 35.7 °C.

Hypothermia can occur with patients after surgery which is why it needs to me closely monitored in case an intervention is needed. The patient’s oxygenation seems to remain stable as long as she is wearing the nasal cannula which at home she regularly does not need. Patients increased need for oxygen demand is probable to her fluid overload status as well as ongoing pneumonia that showed on chest x-ray.

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
07:30	Numerical	N/A	0/10	N/A	Patient was provided a bed bath and comforted with a warm blanket to maintain pain at a tolerable level.
10:30	Numerical	N/A	0/10	N/A	Patient was administered pain medications as prescribed by physician

**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV:N/A</b> <b>Location of IV:N/A</b> <b>Date on IV:N/A</b> <b>Patency of IV:N/A</b> <b>Signs of erythema, drainage, etc.:N/A</b> <b>IV dressing assessment:N/A</b>	Fluids patient is receiving is Furosemide 40 mg IV push Q12H.
<b>Other Lines (PICC, Port, central line, etc.)</b>	
<b>Type:</b> <b>Size:</b> <b>Location:</b> <b>Date of insertion:</b> <b>Patency:</b> <b>Signs of erythema, drainage, etc.:</b> <b>Dressing assessment:</b> <b>Date on dressing:</b> <b>CUROS caps in place: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b> <b>CLABSI prevention measures:</b>	<b>Arterial Blood Line:</b> Left side of axillary artery 9/2/23 Dressing clean/dry/intact. No signs of <b>erythema or drainage.</b> Dressing is in tact,clean and dated. 9/3/23 CHG baths given for CLABSI preventions. <b>Midline:</b> 18 gauge Left arm 8/31/23 Dressing is patent clean, dry and intact. No signs of <b>erythema or drainage.</b>

	9/1/23 Curoc cap in place CHG baths provided daily to prevent CLABSI
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**Intake and Output (2 points)**

<b>Intake (in mL)</b>	<b>Output (in mL)</b>
Patient is currently NPO and in fluid overload  40 mg IV furosemide	<b>100mL Urine</b>  <b>50 mL Jp drain</b>  <b>150ml N-G Tube</b> <hr/> <b>300 mL</b>

**Nursing Care**

**Summary of Care (2 points)**

**Overview of care:**

Overall patients' status seems to be detouring upon physicians' updates as they see a possibility of the patient not surviving hospitalization. Patient barely responds to verbal communication. Patient medicated with antibiotics, Vaso-pressors, and NG-tube and JP drain in place. Fluid overload is noted and being watched closely. Patient was given a bed bath during shift, safety, and comfort measures in place. Patient did not leave the floor for any testing or procedures. No complaints currently. Vital signs remained stable temperature and blood pressure monitored

closely. No changes from previous shifts other than doctors ordered which were applied to patients care. Client is still bedridden for activity and diet maintained nothing by mouth. Patient recommended skilled nursing home facility with physical and occupational therapy on board.

**Procedures/testing done:** Patient had an EKG, CT-Scan, Chest X-Ray and a small bowel resection done.

**Complaints/Issues:** Patient did not express any complaints or issue. Physicians' complaints were the worry of patient being in fluid overloaded as well as multiple medical problems on going worry some of patient not surviving hospitalization.

**Vital signs (stable/unstable):** Vital signs are stable currently if temperature does not drop below 36°C and a close eye is kept on blood pressure.

**Tolerating diet, activity, etc.:** Patient is currently nothing by mouth, activity is minimal to none as she is bedridden and can barely wake up to answer questions.

**Physician notifications:** Physician ordered to stop heparin drip and be put on lovenox instead, change antibiotics to Zosyn, monitor patient's edema and fluids due to being in fluid overload, possible ostomy placed if patient is stable enough, physician did discuss there is possibility patient may not survive hospitalization.

**Future for client:** Patient to follow up with primary care physician. Patient to go to a skilled nursing facility with physical and occupational therapy on board. Furthermore, if stable enough a possible ostomy was discussed by physician.

### **Discharge Planning (2 points)**

**Discharge location:** Patient will require to be admitted to a skilled nursing facility with physical and occupational therapy on board.

**Home health needs (if applicable):** Patient already has a walker upon further assessment home health needs will be addressed.

**Equipment needs (if applicable):** Oxygen if patient can not maintain oxygen level stable without 2L of nasal cannula.

**Follow up plan:** Patient to follow up with primary care provider within a week to assess her health status if further medical intervention is needed.

**Education needs:** Educate son on possibility of the patient not making it out of the hospital as the doctors have addressed this as they see slim chances of the patient surviving the hospitalization. As well as educate son on what is currently going on with the patient’s condition which nurse and physician answered any question the son had.

**Nursing Diagnosis (15 points)**

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

<p><b>Nursing Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> <li>• Listed in order by priority – highest priority to lowest priority pertinent to this client</li> </ul>	<p><b>Rationale</b></p> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<p><b>Interventions (2 per dx)</b></p>	<p><b>Outcome Goal (1 per dx)</b></p>	<p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• How did the client/family respond to the nurse’s actions?</li> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul>
<p>1. Acute pain related to surgical procedure as</p>	<p>This nursing diagnosis was chosen due to post</p>	<p>1.Patient was administered pain medication as ordered on time.</p>	<p>1. Maintain patient at a tolerating pain level</p>	<p>The family was content to see nurses taking proper care of</p>

<p>evidenced by pain medicine administered every six hours.</p>	<p>operation patients experience pain.</p>	<p>2.Patient was maintained comfortable provided a bed bath and a warm blanket.</p>	<p>and show little to no signs of discomfort.</p>	<p>the patient and making sure she is as comfortable as possible with little to no pain expressed. The client did not seem to be in physical pain as goal was achieved in maintaining pain at tolerating level as patient rested peacefully.</p>
<p>2. At risk for further complications of infection related to active infection as evidenced by patient experiencing klebsiella oxytoca.</p>	<p>This nursing diagnosis was chosen due to patient having an ongoing infection as well as the incision site is prone to getting further infections.</p>	<p>1. The patients incision site is being monitored and changing the dressing as needed.  2.Patients antibiotics administered on time as ordered.</p>	<p>1. Maintain infection from worsening as well as from any new bacteria being exposed to the incision site.</p>	<p>The family was not content to be aware that the patient was exposed to klebsiella oxytoca but was content that the infection was being treated. The client response seemed to be well as no new signs of infection was present and incisions site was kept clean and maintained from new bacteria entering the incision site.</p>
<p>3. At risk for pressure injures related to elder age as evidenced by</p>	<p>This nursing diagnosis was chosen due to patients skin assessment requiring skin</p>	<p>1. Wound camera pictures taken to assess for any changes</p>	<p>1. The goal is to maintain the patient free of any ulcers or</p>	<p>The family was content to know nurses care about the client's skin and the preventive</p>

<p>Braden score of thirteen.</p>	<p>injury preventions.</p>	<p>throughout hospitalization or any wounds present upon admission.</p> <p>2 Turn patient every two hours.</p>	<p>wounds forming while she is hospitalized .</p>	<p>measures taken to ensure the patient did not acquire any sores while hospitalized. The client did not seem to content being moved around every two hours as she was not alert and oriented x4 to know what was going on. The outcome was met as she maintained free from developing pressure injuries during hospitalization.</p>
<p>4. At risk for activity intolerance related to decreasing range of motion as evidenced by patient being bedridden during hospitalization.</p>	<p>This nursing diagnosis was chosen due to prior to admission patient being able to ambulate per self with a walker and during hospitalization patient was unable to complete activity of daily livings per self.</p>	<p>1. Passive range of motion provided to maintain muscle tone.</p> <p>2. Ensuring physical therapy and occupational therapy are on board and assisting with activity of daily livings.</p>	<p>1. The goal is to get the patient back to strength she had prior to admission and be able to complete activity of daily livings by herself with little to no assistance.</p>	<p>The family was saddened to see the patient unable to perform activity of daily livings but content that nurses were aiding with any tasks needed. The client seemed to attempt to help but remained weak. The goal is slowly and gradually being met to being able to help herself complete activity of daily livings.</p>
<p>5. At risk for</p>	<p>This nursing</p>	<p>1. Nurses</p>	<p>1. The goal</p>	<p>The family was</p>

<p>improper nutrition related to patients diet as evidenced by patient being nothing by mouth</p>	<p>diagnosis was chosen due to patients' current diet being nothing by mouth and health declining as she has dementia and may need a reminder to eat three meals a day once she is discharged.</p>	<p>following orders and administering total parental nutrition as well as monitoring weight daily.</p> <p>2. Monitor labs for any sings of dehydration or abnormalities due to decrease in nutrition.</p>	<p>is for the patient to remain healthy nutrition wise and avoid an abnormal amount of loss of weight.</p>	<p>content the steps the nurses were taking to ensure patient is receiving nutrients needed. The client seemed to be content with the nurse's interventions. The outcome was met weight remained the same and nutrition was administered as ordered.</p>
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**Other References (APA):**

N/A

**Concept Map (20 Points):**

### Subjective Data

Surgical culture: klebsiella oxytoca  
 Urine Culture: Streptococcus  
 Range of motion: 3/5 passive range of motion  
 Hypertension of systolic in 200's upon admission  
 BUN: 30 mg/dL  
 Clamminess  
 Hypoactive bowel sounds  
 \*Patient did not verbalize much while son was present, he  
 stated tachycardia and Y crems on left hand  
 Client was able to say the patient had been feeling sick for "a  
 few days".  
 CT scan closed loop stacked small bowel obstruction  
 in lower central abdomen  
 Vitals: 07:30 and 10:30  
 B/P: 124/58 : 125/50  
 Heart Rate: 67 : 63  
 Oxygen: 95% : 99% 2L nasal cannula  
 Respirations: 20:20  
 Temperature: 36.4 °C: 36.0°C

### Objective Data

### Nursing Diagnosis/Outcomes

1: Acute pain related to surgical procedure as evidenced by pain medicine administered every six hours. **Outcome:** Maintain patient at a tolerating pain level and show little to no signs of discomfort.  
 2: Active infection as evidenced by patient experiencing klebsiella oxytoca. **Outcome:** Maintain infection from worsening as well as from any new bacteria being exposed to the incision site.  
 3: At risk for pressure injuries related to elder age as evidenced by Braden score of thirteen  
 4: Impaired physical mobility related to closed loop stacked small bowel obstruction as evidenced by patient being bedridden during hospitalization. **Outcome:** The goal is to get the patient back to strength the patient to be able to complete activity of daily livings by herself with little to no assistance.  
 5: Risk for dehydration related to patient being nothing by mouth. **Outcome:** The goal is to ensure the patient receives adequate hydration and avoid an abnormal amount of loss of weight.

1:

A: Patient was administered pain medication as ordered on time.  
B: Patient was maintained comfortable provided a bed bath and a warm blanket.

2: Patient was administered antibiotics as ordered on time. **Outcome:** Maintain patient at a tolerating pain level and show little to no signs of discomfort.

A: The patients incision site is being monitored and changing the dressing as needed.  
B: Patients antibiotics administered on time as ordered.

3: The goal is to maintain the patient free of any ulcers or wounds forming while she is hospitalized.

A: Wound camera pictures taken to assess for any changes throughout hospitalization or any wounds present upon admission.  
B: Turn patient every two hours.

4:

A: Passive range of motion provided to maintain muscle tone.  
B: Ensuring physical therapy and occupational therapy are on board and assisting with activity of daily livings.

5:

A: Nurses following orders and administering total parental nutrition as well as monitoring weight daily.  
B: Monitor labs for any sings of dehydration or abnormalities due to decrease in nutrition.

### Client Information

An eighty-seven-year-old client came in via ambulance from Copper Creek Cottage accompanied by the son. No known medical allergies noted. Patient came in with complaints of hypertension and clamminess. Patient is a poor historian alert and oriented x1. A CT scan was ordered which resulted in a closed loop obstruction which required surgical medical intervention and admitted for further monitoring as blood pressure was unstable and further medical issues.

### Nursing Interventions



