

N431 Care Plan #2

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Lakeview College of Nursing

N431: Adult Health II

Tasha Unrein

10/30/2023

Demographics (3 points)

Date of Admission 10/28/23	Client Initials X. B.	Age 73 years old	Gender Male
Race/Ethnicity White	Occupation Unemployed	Marital Status Married	Allergies Chlorohexidine Gluconate (CHG) - rash and pruritis
Code Status Full	Height 5'5 (167 cm)	Weight 233 lbs. (106 kg)	

Medical History (5 Points)

Past Medical History: Congestive Heart Failure, Anemia due to chronic disease, End stage kidney disease, Obesity, Hypertension, Endocarditis, Nephrolithiasis, DVT, Mitral Stenosis, Hyperlipidemia

Past Surgical History: Cholecystectomy (2016), CABG (2018), Fistulotomy (07/2023)

Family History: N/A (no information about family in his chart and the patient is non- English speaking. He speaks Albanian.)

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

Smoking- never; Alcohol- never; Drugs- never

Assistive Devices: None

Living Situation: Lives with son

Education Level: Highschool

Admission Assessment

Chief Complaint (2 points): Fatigue

History of Present Illness – OLD CARTS (10 points): On October 28, 2023, X.B. was admitted to the Carle Foundation Hospital due to complaints of fatigue. The onset of this

symptom occurred while the patient returned home from dialysis. X.B. told his son he felt very tired. Because X.B.'s concerns, he was brought to the Emergency Department by his son.

Upon initial assessment by the emergency room registered nurse, lethargy and erythema was noted. The patient's condition was also noted to be severe. The nurse checked his temperature and he was feverish with a temperature of 103.2 degrees Fahrenheit. It was observed that nothing seemed to exacerbate the symptoms, but rest was reported as a known relieving factor. X.B. is currently under medical treatment in the CVICU at Carle Foundation Hospital, where prescribed medications are being administered to manage the condition.

In an effort to overcome fatigue, the patient rested and elevated extremities while at home and at the hospital. It is important to note that the patient experienced the symptoms prior to coming to the E.D. This case shows the significance of prompt medical attention and intervention when experiencing symptoms of severe infection, and the importance of continued care and monitoring in a hospital setting.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Severe sepsis

Secondary Diagnosis (if applicable):

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

Severe sepsis is a critical medical condition that occurs when sepsis progresses to a more advanced and dangerous stage (American Thoracic Society, 2020). Sepsis, is a systemic response to an infection in the body. In our patient, the infection started near the patient's vascular port for dialysis. When the systemic response becomes severe, it can lead to widespread inflammation,

organ dysfunction, and a heightened risk of death. Sepsis itself is a life-threatening condition, and severe sepsis represents a more advanced and critical stage of the disease (American Thoracic Society, 2020).

Common signs and symptoms of sepsis are high fever (seen in our patient), rapid heart rate, rapid breathing, low blood pressure (seen in our patient), and altered mental state (Mayo Clinic, 2023). Our patient did not experience all of the symptoms listed but had enough for the physician to suspect the systemic infection. Because of the signs and symptoms and diagnostic testing, X.B. was admitted to the ICU. Severe sepsis is characterized by the same symptoms as sepsis but with the added presence of organ dysfunction or failure. Organs such as the heart, kidneys, liver, and lungs may not function properly, and this can lead to life-threatening complications (Mayo Clinic, 2023).

Diagnosing severe sepsis requires a combination of test and overall clinical judgement of the healthcare provider. A physical examination, clinical assessment, and lab tests (including CBC, inflammatory markers, microbiological tests, blood gas analysis, imaging studies, and urine analysis) are used to diagnose sepsis (American Thoracic Society, 2020). Early recognition, intervention, and immediate medical attention are crucial to improving the chances of survival in cases of severe sepsis. All of the measures mentioned above were used to diagnose X.B.

Sepsis is a medical emergency and requires prompt treatment to prevent further deterioration of organ function and potential death. Patients with severe sepsis typically require intensive medical intervention, including treatment in an intensive care unit (ICU) (seen in our patient), and may need measures such as mechanical ventilation, IV fluid, medications to support blood pressure, anticoagulants, and antibiotics to target the underlying infection. In X.B. blood

pressure medicine, anticoagulants, IV fluid and antibiotics were used to treat the infection. IV fluid and antibiotics are the two most important treatments for sepsis (American Thoracic Society, 2020).

Pathophysiology References (2) (APA):

Swearingen, P. L. (2019). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, psychiatric nursing care plans* (5th ed.), Elsevier/Mosby.

Mayo Foundation for Medical Education and Research. (2023, February 10). *Sepsis*. Mayo Clinic. <https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214>

American Thoracic Society. (2020). *Sepsis, severe sepsis, and Septic Shock*.

<https://www.thoracic.org/patients/patient-resources/managing-the-icu-experience/sepsis-severe-sepsis-and-septic-shock.php#:~:text=Severe%20sepsis%20develops%20when%20the,shock%2C%20die%20in%20the%20hospital.>

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80- 5.30	3.93	3.97	
Hgb	12.0- 15.8	11.1	10.7	Reduced red blood cell production due to systemic inflammatory response-sepsis (Pagana et al., 2018).
Hct	36.0- 47.0	34.2	33.8	Reduced red blood cell production due to systemic inflammatory response-sepsis (Pagana et al., 2018).

Platelets	140- 440	170	149	
WBC	4.0- 12.0	19.23	10.35	Leukocytosis was due to sepsis infection (Pagana et al., 2018).
Neutrophils	1.60- 7.70	16.93	8.35	Neutrophilia is due to sepsis infection (Learning, 2019).
Lymphocytes	1.4- 4.4	2.7	0.86	Lymphocytosis is due to sepsis infection (Pagana et al., 2018).
Monocytes	1.7- 9.3	7.0	0.72	Monocytopenia is caused by sepsis infection (Pagana et al., 2018).
Eosinophils	0.0- 0.7	0.2	0.31	
Bands	0-10%	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-	135-145	140	138	
K+	3.5-5.1	2.8	3.6	Hypokalemia may be caused by sepsis (Pagana et al., 2018).
Cl-	98-107	103	103	
CO2	22.0-29.0	23.0	22.0	
Glucose	74-100	131	97	When fighting an infection, more glucose is released into bloodstream (Pagana et al., 2018).
BUN	10-20	32	72	End stage renal disease, primarily, but sepsis may have caused the significant elevation (Pagana et al., 2018).
Creatinine	0.55-1.02	2.65	4.18	End stage renal disease, primarily, but sepsis may have caused the significant elevation (Pagana et al., 2018).
Albumin	3.4-4.8	3.4	2.8	Sepsis may have cause liver dysfunction (Pagana et al., 2018).
Calcium	8.9-10.6	9.4	9.1	
Mag	1.6-2.6	1.7	2.1	

Phosphate	2.5-4.5	n/a	n/a	
Bilirubin	0.2-1.2	0.9	n/a	
Alk Phos	44-147	80	n/a	
AST	5-34	37	n/a	Sepsis may have cause liver dysfunction (Pagana et al., 2018).
ALT	0-55	17	n/a	
Amylase	40-140	n/a	n/a	
Lipase	10-140	n/a	n/a	
Lactic Acid	4.5-19.8	4.7	n/a	
Troponin	0-0.04	n/a	n/a	
CK-MB	3-5%	n/a	n/a	
Total CK	55-170	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	11.7-13.8	2.2	n/a	Sepsis increases coagulopathy (Pagana et al., 2018).
PT	0.9-1.1	25.1	n/a	Sepsis increases coagulopathy (Pagana et al., 2018).
PTT	22.4-35.9	37.6	n/a	Sepsis increases coagulopathy (Pagana et al., 2018).
D-Dimer	negative	n/a	n/a	
BNP	<127	n/a	n/a	
HDL	>59	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	0.4-4.0	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	Light yellow and clear	n/a	n/a	
pH	5-9	n/a	n/a	
Specific Gravity	1.000-1.060	n/a	n/a	
Glucose	<20	n/a	n/a	
Protein	<20	n/a	n/a	
Ketones	<3	n/a	n/a	
WBC	5-15	n/a	n/a	
RBC	5-15	n/a	n/a	
Leukoesterase		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	n/a	N/A	N/A	

PaO2	n/a	N/A	N/A	
PaCO2	n/a	N/A	N/A	
HCO3	n/a	N/A	N/A	
SaO2	n/a	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	N/A	N/A	N/A	
Blood Culture	N/A	N/A	N/A	
Sputum Culture	N/A	N/A	N/A	
Stool Culture	N/A	N/A	N/A	

Lab Correlations Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-Ray 10/29

Diagnostic Test Correlation (5 points): To check catheter placement and show signs of infection.

Diagnostic Test Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

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

Home Medications (5 required)

Brand/Generic	Bayer/ acetylsalicylic acid	Torsemide/ Damedex	Gabapentin	Toprol- XL/ metoprol ol succinate	Cholecalcifer ol
Dose	81 mg/ tablet	100 mg	(Neurontin)	25 mg	1 capsule 50,000 units
Frequency	Every day	4x/ week	100 mg	Daily	Every 7 days
Route	PO	PO		PO	PO
Classification	NSAID	Loop Diuretic	TID		
Mechanism of Action	Blocks the activity of cyclooxygena se, the enzyme needed for prostaglandin synthesis	Blocks active chloride and sodium reabsorptio n in the ascending loop pf Henle	Oral		
Reason Client Taking	To reduce the severity of or prevent acute	To treat edema in heart	Peripheral nerve damage		

	MI	failure			
Contraindications (2)	Active bleeding; Hypersensitivity to aspirin	Anuric patients, hepatic coma	Pharmacologic: 1-amino-methyl-cyclohexane acetic		
Side Effects/Adverse Reactions (2)	CNS depression and GI bleeding	Hypotension, ECG abnormalities	Therapeutic: Anticonvulsant		
Nursing Considerations (2)	Don't crush time-release or controlled release aspirin tablets unless directed	Inject furosemide slowly over 2 minutes. Monitor patient with hepatic disease	Check the patient's allergy status. Check drug interactions with other drugs		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess patient's allergy to aspirin; Assess for signs of bleeding	Assess patients blood pressure and heart rate	Assess history of seizures Assess white blood count		
Client Teaching Needs (2)	Do not use aspirin if it has a strong vinegar like odor; Tell the patient to consult prescriber before taking aspirin with any other drug for a blood disorder	Advise patient to change positions slowly to minimize orthostatic hypertension Tell patient to maintain adequate fluid intake	Avoid aluminum and magnesium antacids within 2 hours		

Hospital Medications (5 required)

Brand/Generic	Cefazolin	Atorvastatin	Heparin Sodium Injection/ heparin sodium	Miralax	Midodrine
Dose	1 mg	20 mg	100	8.6 mg	5 mg
Frequency	Daily	Bedtime	20 mL hour	BID	BID
Route	IV	PO	Subcutaneous	PO	PO
Classification			Anticoagulant		
Mechanism of Action			Binds with antithrombin III, enhancing antithrombin III's inactivation of the coagulation enzymes thrombin (factor IIa) and factors Xa and Xia.		
Reason Client Taking			To prevent arterial or pulmonary embolisms		
Contraindications (2)			Hypersensitivity to heparin; severe thrombocytopenia		
Side Effects/Adverse Reactions (2)			Chills, fever		
Nursing Considerations (2)			Use heparin cautiously in alcoholics; Use cautiously in patients that increase risk hemorrhage		
Key Nursing Assessment(s)/Lab(s) Prior to Administration			PT/INR		
Client Teaching Needs (2)			Advise patient to avoid drugs that		

			interact with heparin, such as aspirin and ibuprofen		
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Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *Nurse's Drug Handbook*. Composition and Project Management: S4Carlisle Publishing Services.

Assessment

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

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Patient appears alert and oriented to person, place, and time. Patient is well groomed and seems to be in no acute distress unless ambulating.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: 20 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Skin is pale and pink and warm and dry upon palpation. No rashes or lesions. Patient has no wounds or bruises. Normal skin turgor No visible wounds other than IV removals.

Type:	
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	<p>Head/Neck: Symmetrical, trachea is midline without deviation, thyroid is non- palpable, no noted nodules. Bilateral carotid pulses 2+, no prominent lymphadenopathy.</p> <p>Ears: No palpable deformities, lumps, or lesions.</p> <p>Eyes: Bilateral sclera white with slight redness from dryness/discomfort. Left cornea shows nuclear cataract. Bilateral conjunctiva pink, no visible drainage. Lids are moist and pink without lesions.</p> <p>Nose: Septum is midline with no visible drainage production. Sinuses are nontender.</p> <p>Throat: Posterior pharynx and tonsils look moist and pink without exudate noted. Uvula is midline, soft palate rises and falls symmetrically. Hard palate intact. Dentition is good, oral mucosa is moist and pink without lesions noted.</p>
CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:	<p>. S1 and S2 are clear without murmurs, gallops, or rubs. Normal rate and rhythm. Peripheral pulses are diminished; Lower legs are nonpalpable. Capillary refill is less than 3 seconds. Edema is 2+ mild and located on lower legs and ankles.</p>
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character	<p>Normal rate and pattern of respirations.</p> <p>Symmetrical and non-labored, no cough. Posterior lung sounds are diminished in all fields.</p>
GASTROINTESTINAL: Diet at home: Regular Current Diet: Cardiac Height: 167 cm Weight: 106 kg Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection:	<p>Abdomen is soft, nontender, no organomegaly or masses upon palpation in all four quadrants.</p> <p>Bowel sounds are hypoactive in all four quadrants.</p> <p>Last bowel movement was today 10/30/23 and was large, hard, and dark brown.</p> <p>No visible distention, incisions, scars, drains, or wounds on abdomen are noted.</p>

<p>Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Patient produces very limit urine due to end stage kidney disease. There was no urine to evaluate.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 8 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walkX <input type="checkbox"/></p>	<p>Lower extremities have limited ROM due to generalized weakness and pain. Hand grips demonstrate equal and normal strength. Pedal pushes are weak but equal in strength. Gait is not well balanced and smooth; the patient requires assistance with ambulation. Patient is alert and oriented to person, place, and time. PERRLA intact. Cranial nerves intact.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Patient is spontaneous to stimuli, obeys commands, and A&Ox4. Strength is normal and equal in the upper extremities but equal and weakened in lower extremities. Mental status, speech, sensory, and LOC are all intact.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s):</p>	<p>Ego Integrity vs. Despair (65+) Patient is calm and cooperative. He is not</p>

Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	religious. His son visits and lifts his spirits when they do come, we've observed.
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Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1200	68	122/78	18	98.4 oral	98
1530	75	124/80	20	98.6 oral	99

Vital Sign Trends: Vital signs are back to normal and staying there.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1500	0-10	N/A	N/A	N/A	No interventions needed; patient had no pain
1600	0-10	N/A	N/A	N/A	No interventions needed; patient had no pain

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 Location of IV: Peripheral Date on IV: 10/28/23 Patency of IV: Transparent Signs of erythema, drainage, etc.: IV dressing assessment:	Heparin 100 units/ml 5% dextrose in water 20 mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240	n/a

Nursing Care

Overview of care: Patient is being treated for Sepsis

Procedures/testing done: Chest Xray

Complaints/Issues: Fatigue and weakness

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: The patient has a regular diet and is tolerating it well.

Physician notifications: Patient is still fatigued.

Future plans for client: Patient do not have a projected discharge date or time.

Discharge Planning (2 points)

Discharge location: The patient is going home with his son.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: The patient will follow up with his primary physician and cardiologist.

Education needs: The patient needs to eat healthier, monitor B/P, and establish an exercise routine.

Follow up plan: Will follow up with PCP

Education needs: Signs and symptoms of infection

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rationale	Interventions	Outcome	Evaluation
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<ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components • Listed in order by priority – highest priority to lowest priority pertinent to this client 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	(2 per dx)	Goal (1 per dx)	<ul style="list-style-type: none"> • How did the client/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for infection related to chronic disease evidenced by End Stage Renal Disease	X.B.’s dialysis port is thought to be the cause of the infection.	1. Patient will check his temperature 2x daily 2. Patient will contact physician if feeling abnormally weak and/ or tired	1. Patient will know sooner if he has an infection. This will help him seek treatment sooner.	The family is supportive and will help patient cooperate
2. Ineffective tissue perfusion related to an interruption of blood flow as evidenced by slow capillary refill and lower extremity diminished pulses.	I chose this as the 2nd priority because his body is started to pick and choose what areas of the body are worth perfusing properly.	1. Administer oxygen supplementation as needed. 2. Monitor vitals regularly 3x daily	1. Patient will continue to have normal vital signs and tissue perfusion will be better.	The family will provide assistance to patient as need to help prevent ineffective tissue perfusion.
3. Knowledge deficit due to language	I listed this as the third priority	1. Have an interpreter whenever	1. The patient will be able to	The family will assist with explaining the

barrier evidenced by patients' inability to speak or understand English	because the patient is Albanian and cannot have a conversation with an English-speaking individual without an interpreter.	possible to get a clear understanding of what is being said and asked. 2. Have a communication board when an interpreter is not available.	communicate with his healthcare team	language of the patient and will be pleased because of the translation abilities of an interpreter.
4. Ineffective coping related to a lack of motivation as evidenced by refusing physical therapy.	I listed this at fourth priority because coping is something we can actively work on to be better.	1. Assess for influences that motivate the patient. 2. Assist the patient to set realistic goals and identify personal skills and strengths.	1. The patient's spirits were lifted when his son was visiting, it is possible his presence would motivate the patient to be active in PT.	The patient understood and was open to discussing goals and plans that revolve around his own skill set and strengths.

Other References (APA):

Concept Map (20 Points):

Subjective Data

Patient reports his pain 0 out of 10
Patient states he is too tired to attend therapy

Nursing Diagnosis/Outcomes

1. Risk for infection related to chronic disease evidenced by End Stage Renal Disease
 2. Impaired tissue perfusion related to an interruption of blood flow as evidenced by diminished capillary refill and lower extremity pulses
 3. Knowledge deficit due to language barrier evidenced by patients inability to speak or understand English
 4. Ineffective coping related to a lack of motivation as evidenced by refusing physical therapy.

Objective Data

Gender: Male
 Ethnicity: Caucasian
 Admission: new
 Height: 167 cm (5'5")
 Weight: 106 kg (233 lbs)
 Code Status: Full Code

Nursing Interventions:

Therapeutic communication (verbal with interpreter and non-verbal)
 Vitals every four hours
 Pain assessment
 Administering medications



