N441 Care Plan

N441: Adult Health III

Jackson Powell

Lakeview College of Nursing

Prof. Robin Potts

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Demographics (3 points)

Date of Admission 1/22	**Client Initials** G.H.	**Age** 75	**Gender** Male
Race/Ethnicity White	**Occupation** Retired	**Marital Status** Married	**Allergies** Ciprofloxacin, Iodine, Cephalexin
Code Status Full code (as of now)	**Height** 5’ 11”	**Weight** 196 lbs.	

Medical History (5 Points)

Past Medical History: Coronary artery disease, COPD, Obstructive sleep apnea, Type II diabetes mellitus, Hypertension, GERD, Benign prostatic hyperplasia, and Hyperlipidemia (All past medical history obtained by wife upon admission)

Past Surgical History: Unable to obtain information due to the patient being unconscious; wife also did not provide information.

Family History: Unable to obtain.

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

Assistive Devices: CPAP machine

Living Situation: Lives at home with wife

Education Level: Unable to obtain.

Admission Assessment

Chief Complaint (2 points): Trauma due to fall, subdural hematoma.

History of Present Illness – OLD CARTS (10 points): The patient was going to take the trash out on the night of 1/22. When he was going to take the trash out, he slipped on ice and hit his head on the ground. The patient was able to walk back into the house and said he felt tired and prepared for bed. He put his CPAP machine on and went to sleep. Approximately 15 minutes

later, the patient's wife came into the room and found him unresponsive with emesis all over the patient. The patient's wife called the ambulance and got him to the ER at their local hospital. He was then transferred Carle in Champaign.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Traumatic hematoma of brain with compression and midline shift of brain.

Secondary Diagnosis (if applicable): N/A

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

The brain is naturally centered to the middle of the body with equal right and left hemispheres. A midline shift occurs when something pushes the brain off this midline to the right or the left. For this patient he has a 23-millimeter left to right midline shift with a pool of blood filling in the shifted area. Midline shifts often occur when there is a trauma to the head that causes an increase in intracranial pressure. With an impactful blow to the head, blood vessels can rupture and bleed into the brain. And since the heart is continuously pumping blood into the brain this can cause a pool of blood to build up, this is called a hematoma. The blood then pushes into the brain tissue and causes the brain to shift off the midline (Hvingelby, 2021). The best way to diagnose any kind of brain trauma is to use a computed tomography (CT) scan. A CT scan looks down at the brain from the top of the head to assess for abnormalities. This patient received a CT scan where the physicians noted the 23-millimeter shift of the brain from left to right along with blood pooled up on the left side where the brain was.

Subdural hematomas can cause many symptoms that vary based on how severe the trauma to the head was. Some signs and symptoms include headaches that do not go away,

confusion, drowsiness, nausea, vomiting, slurred speech, dizziness, loss of balance. For this patient he was experiencing a headache and drowsiness before going to bed, then when he was asleep, he vomited. Some of the lab findings that would be expected with a subdural hematoma would be an increase in intracranial pressure, decreased pupil activity, decreased motor responses, decreased level of consciousness, and poor balance. The patient has had decreased pupil function by either no reaction or very little reaction to light. He is also unconscious and unresponsive with decreased motor reflexes. Although intracranial pressure was not documented in the chart, it is likely high due to the amount of blood putting pressure on the brain. With a hematoma of this size, treatment would usually have to be decompression surgery. Decompression surgery is when a surgeon drills a whole into the skull to drain the blood out, this helps by relieving the pressure of the blood pushing on the brain (Cleveland Clinic, 2020). For this patient, the shift in the brain is too significant, and the family of the patient decided not to continue with surgery.

Pathophysiology References (2) (APA):

Hvingelby, E. (2020). *Midline Shift After Head Trauma.* Verywell health, https://www.verywellhealth.com/the-brain-can-undergo-a-midline-shift-1720044

Cleveland Clinic. (2020). *Subdural Hematoma.* Cleveland Clinic, https://my.clevelandclinic.org/health/diseases/21183-subdural-hematoma

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	**3.8-5.9**	4.3	N/A	Lab results within normal range. "Today's values" were not documented.
Hgb	**12.0-15.8**	13.8	N/A	Lab results within normal range. "Today's values" were not documented.
Hct	**36.0-47.0**	38.9	N/A	Lab results within normal range. "Today's values" were not documented.
Platelets	**140-440**	150	N/A	Lab results within normal range. "Today's values" were not documented.
WBC	**4.0-12.0**	14.87	N/A	White blood cells are increased due to subdural hematoma (Capriotti, 2022). "Today's values" were not documented.
Neutrophils	**1.5-8.0**	13.29	N/A	Neutrophils are increased due to subdural hematoma (Capriotti, 2022). "Today's values" were not documented.
Lymphocytes	**1.0-4.8**	3.8	N/A	Lab results within normal range. "Today's values" were not documented.
Monocytes	**2.0-8.0**	4.7	N/A	Lab results within normal range. "Today's values" were not documented.
Eosinophils	**0.0-0.5**	0.1	N/A	Lab results within normal range. "Today's values" were not documented.
Bands	**0-4**	N/A	N/A	Lab values not collected

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-	**132- 144**	143	144	Lab results within normal range.

K+	**3.5- 5.1**	3.1	3.4	Potassium is decreased likely due to the patient experiencing trauma to the head (Capriotti, 2022).
Cl-	**98- 107**	104	106	Lab results within normal range.
CO2	**21- 31**	27.0	30.0	Lab results within normal range.
Glucose	**70- 99**	242	156	Glucose is increased likely due to the patient having type II diabetes mellitus (Capriotti, 2022).
BUN	**7- 25**	12	17	Lab results within normal range.
Creatinine	**0.50- 1.20**	0.88	0.93	Lab results within normal range.
Albumin	**3.5- 5.7**	4.3	N/A	Lab results within normal range.
Calcium	**8.8- 10.2**	9.0	9.0	Lab results within normal range.
Mag	**1.5- 2.5**	1.5	N/A	Lab results within normal range.
Phosphate	**34- 104**	N/A	N/A	Lab values not collected
Bilirubin	**0.2- 1.2**	1.0	N/A	Lab results within normal range.
Alk Phos	**34- 104**	74	N/A	Lab results within normal range.
AST	**10- 30**	20	N/A	Lab results within normal range.
ALT	**10- 40**	16	N/A	Lab results within normal range.
Amylase	**60- 120**	N/A	N/A	Lab values not collected
Lipase	**0- 160**	N/A	N/A	Lab values not collected
Lactic Acid	**0.5- 2.2**	1.61	N/A	Lab results within normal range.
Troponin	**1.0-4.0**	N/A	N/A	Lab values not collected
CK-MB	**20-223**	N/A	N/A	Lab values not collected
Total CK	**0-5**	0.88	0.93	Lab results within normal range.

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	**0.8-2.0**	1.1	N/A	Lab results within normal range.
PT	**11.0-13.8**	13.3	N/A	Lab results within normal range.
PTT	**30- 40**	25.6	N/A	PTT was decreased likely due to the patient having type II diabetes (Capriotti, 2022).
D-Dimer	**>250**	N/A	N/A	Lab values not collected
BNP	**100- 400**	N/A	N/A	Lab values not collected
HDL	**>60**	N/A	N/A	Lab values not collected
LDL	**< 130**	N/A	N/A	Lab values not collected
Cholesterol	**< 200**	N/A	N/A	Lab values not collected
Triglycerides	**40- 180**	109	N/A	Lab results within normal range.
Hgb A1c	**< 7**	N/A	N/A	Lab values not collected
TSH	**0.5- 5.0**	N/A	N/A	Lab values not collected

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Clear/ yellow**	N/A	N/A	The provider did not order a Urinalysis for the patient.
pH	**4.6- 8.0**	N/A	N/A	The provider did not order a Urinalysis for the patient.
Specific Gravity	**1.005- 1.030**	N/A	N/A	The provider did not order a Urinalysis for the patient.
Glucose	**Negative**	N/A	N/A	The provider did not order a Urinalysis for the patient.
Protein	**Negative**	N/A	N/A	The provider did not order a Urinalysis for the patient.

Ketones	**Negative**	N/A	N/A	The provider did not order a Urinalysis for the patient.
WBC	**Negative**	N/A	N/A	The provider did not order a Urinalysis for the patient.
RBC	**Negative**	N/A	N/A	The provider did not order a Urinalysis for the patient.
Leukoesterase	**Negative**	N/A	N/A	The provider did not order a Urinalysis for the patient.

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35-7.45**	7.43	7.45	Lab results within normal range.
PaO2	**75-100**	N/A	N/A	Lab values not collected.
PaCO2	**35-45**	44.2	38.7	Lab results within normal range.
HCO3	**22-26**	28.7	26.8	HCO3 is increased due to the patient vomiting (Capriotti, 2022).
SaO2	**94-100**	99	98.5	Lab results within normal range.

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**Negative <10,000 Positive >10,000**	N/A	N/A	The provider did not order this test for the patient.
Blood Culture	**Negative**	N/A	N/A	The provider ordered this test, but the results were still pending.
Sputum Culture	**Normal**	N/A	N/A	The provider ordered this test, but

	URT			the results were still pending.
Stool Culture	**Normal Intestinal Flora**	N/A	N/A	The provider did not order this test for the patient.

Lab Correlations Reference (1) (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

CT of the brain without contrast

X-ray of Chest

Diagnostic Test Correlation (5 points):

CT of the brain without contrast: A CT scan of the brain is used to assess the brain for injuries, intracranial bleeding, or other abnormalities (Phelps, 2020). The CT scan found a large left frontal parietal subdural hematoma. Left to right midline shift 23 millimeters, a small amount of blood extends into the interhemispheric fissure.

X-ray of Chest: A chest X-ray is usually acquired after the placement of an endotracheal tube (ET tube) to determine its position (Phelps, 2020). The chest X-ray found the ET tube terminates 5 cm above the carina and in the stomach.

Diagnostic Test Reference (1) (APA):

Phelps, L. L. (2020). In *Spark's & Taylor's Nursing Diagnosis Reference Manual* 11th ed. essay, Wolters Kluwer.

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

Home Medications (5 required)

<u>The patient did not have any home medications documented. The patient was unconscious, and the wife was not present to provide the information.</u>

Hospital Medications (5 required)

Brand/Generic	ampicillin (Unasyn)	fentanyl	Insulin lispro (Humalog)	nicardipine (Cardene)	senna
Dose	3g in 100ml	25 mcg/hr	1-20 units	10 mg/hr	176 mg
Frequency	Q6H	Continuous	Q4H	Continuous	BID
Route	IVPB	IV	Subcutaneous	Peripheral IV	Oral
Classification	Aminopenicillin, antibiotic	Opioid agonist, Opioid analgesics	Human insulin, Antidiabetic	Calcium channel blocker, Antihypertensive	Stimulant laxative
Mechanism of Action	Inhibits bacterial cell wall synthesis, causing cell lysis death.	Binds to CNS and alters levels of pain.	Lowers blood glucose levels by inhibiting hepatic glucose production.	Slows extracellular calcium movement into. myocardial and vascular smooth muscle cells	Increases fluid secretion and contraction of large intestine.
Reason Client Taking	To treat bacterial infections	Pain	Type II diabetes	Hypertension	No bowel movements
Contraindications (2)	Allergies to penicillin. Infections caused by penicillinase-producing organisms	Opioid nontolerance. Respiratory depression	Chronic lung disease. During an episode of hypoglycemia.	Advanced aortic stenosis. Hypotension	GI obstruction or perforation, fecal impaction
Side	Thrombocytope	Asystole and	Hypoglycemi	Bradycardia and	Diarrhea

Effects/Adverse Reactions (2)	nia and laryngeal stridor	seizures.	a and hypokalemia.	hypotension.	and stomach cramps
Nursing Considerations (2)	Monitor patient closely for anaphylaxis. Monitor results of renal and liver function tests (Jones and Bartlett, 2022).	Use with caution with patients with COPD. Use with caution with patients with head injuries (Jones and Bartlett, 2022).	Monitor patient's blood glucose levels to adjust dose. Monitor for signs and symptoms of hypoglycemia (Jones and Bartlett, 2022).	Monitor renal and liver function. Monitor fluid intake and output (Jones and Bartlett, 2022).	Do not use it if patient is experiencing abdominal pain. Discontinue in the event of diarrhea or watery stool (Jones and Bartlett, 2022)
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess respiratory function before giving (Jones and Bartlett, 2022).	Assess levels of pain before and after administration (Jones and Bartlett, 2022).	Assess blood glucose levels before administration (Jones and Bartlett, 2022).	Check blood pressure and pulse before administration (Jones and Bartlett, 2022).	Assess for abdominal distention and bowel sounds (Jones and Bartlett, 2022).
Client Teaching needs (2)	Take full course of medication. Review signs of an allergic reaction (Jones and Bartlett, 2022).	Do not take more than what is prescribed. Avoid alcohol while taking medication (Jones and Bartlett, 2022).	Teach patient how to measure blood glucose level. Review signs and symptoms of hypoglycemia (Jones and Bartlett, 2022).	Take medication as prescribed. Change positions slowly to minimize orthostatic hypotension (Jones and Bartlett, 2022).	Take medication exactly as prescribed. Stop taking if diarrhea occurs (Jones and Bartlett, 2022).

Medications Reference (1) (APA):

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

Assessment

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

GENERAL: **Alertness:** Unresponsive **Orientation:** Unconscious **Distress:** No acute distress **Overall appearance:** Well groomed	Patient is unconscious and unresponsive. Patient does not appear to be in any distress. The patient is well groomed.
INTEGUMENTARY: **Skin color:** Tan/pale **Character:** Dry and intact **Temperature:** Warm **Turgor:** Normal **Rashes:** None **Bruises:** None **Wounds:** None **Braden Score:** 10 **Drains present: Y☐ N ☒** **Type:**	The patient's skin is pale, warm, dry, and intact. There are no rashes, bruises, or wounds noted upon inspection. Skin turgor has normal mobility. Braden score is 10.
HEENT: **Head/Neck:** Head and Neck are symmetrical. **Ears:** Hearing is appropriate **Eyes:** Pupils are nonreactive to light. **Nose:** Turbinate's pink and moist **Teeth:** Good dentition	The patient's head and neck are symmetrical. Ears are clear with no lumps, lesions, or deformities. The right pupil is 2 mm in size, the left pupil is 3 mm in size, and both are nonreactive to light. The nose is midline with pink and moist turbinates. Teeth have overall good denition. .
CARDIOVASCULAR: **Heart sounds:** Normal rate and rhythm **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** Clear S1, and S2 with no murmurs, gallops, or rubs. **Peripheral Pulses:** +2 **Capillary refill:** < 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	Heart has normal rate and rhythm with a clear S1 and S2 with no murmurs gallops or rubs. Peripheral pulses are +2 bilaterally. Capillary refills are less than 3 seconds bilaterally.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character:**	Breath sounds are clear bilaterally with normal rate and rhythm. Patient's respirations are supported with mechanical ventilation.

Lungs sound clear bilaterally. **ET Tube:** **Size of tube:** 7.5 **Placement (cm to lip):** 25 cm (lip) **Respiration rate:** 15 **FiO2:** 40 **Total volume (TV):** 825 **PEEP:** 8.1 **VAP prevention measures:** Manual resuscitation/ mask/ PEEP value in room.	
GASTROINTESTINAL: **Diet at home:** Not stated. **Current Diet:** NPO **Height:** 5' 11" **Weight:** 196 lbs. **Auscultation Bowel sounds:** Normoactive **Last BM:** Not stated. **Palpation: Pain, Mass etc.:** None **Inspection:** Abdomen appeared normal. **Distention:** N/A **Incisions:** N/A **Scars:** N/A **Drains:** N/A **Wounds:** N/A **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Bowel sounds are normoactive in all four quadrants with no wounds lesions or distention noted upon inspection. Patient does not seem to have any pain upon palpation to the abdomen.
GENITOURINARY: **Color:** Orange **Character:** Clear **Quantity of urine:** 800 ml **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** Clean/dry **Catheter: Y ☒ N ☐** **Type:** Indwelling urinary catheter **Size:** 10 ml **CAUTI prevention measures:** Sterile technique used with insertion.	Urine had an orange appearance but was clear. Patient voided 800 ml through a 10 ml indwelling urinary catheter. Genitals appeared to be clean and dry.
MUSCULOSKELETAL: **Neurovascular status:** Unconscious **ROM:** Unresponsive	Patient is unconscious and unresponsive to any stimulation. ROM and strength could not be tested due to patient being unresponsive. Patient

Supportive devices: None **Strength:** Unresponsive **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** 0 (unconscious) **Activity/Mobility Status:** Unconscious **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	is posturing to discomfort.
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☐ N☒** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** Unresponsive **Mental Status:** Unresponsive **Speech:** Unresponsive **Sensory:** Unresponsive **LOC:** Unconscious	Patient is unconscious and unresponsive to any stimuli. PERLA is not intact; pupils have little to no reaction to light.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** Unable to obtain information **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient is unconscious and was not able to provide information. The patient's wife lives at home with the patient, and they have 3 daughters. The wife wants all the family to visit the patient one last time before they discontinue treatment.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	85	137/58	15	98.0	100
.1200	93	153/69	16	98.5	100

Vital Sign Trends/Correlation: Blood pressure was consistently high likely due to the patient having hypertension.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Nonverbal indicators		No pain		
1200	Nonverbal indicators		No pain		

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 16G **Location of IV:** Anterior, left antecubital. **Date on IV:** 1/23 **Patency of IV:** Patent and in use **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** Dry/intact	Fentanyl infusing at 25 mcg/hr
IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: 18G **Location of IV:** Anterior, right antecubital. **Date on IV:** 1/23 **Patency of IV:** Patent and in use **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** Dry/intact	Nicardipine infusing at 10 mg/hr
IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: 18G **Location of IV:** Anterior, left lower forearm. **Date on IV:** 1/23 **Patency of IV:** Patent and in use **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** Dry/intact	3% NaCl hypertonic infusing at 20 ml/hr
IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: 16G **Location of IV:** Anterior, right lower forearm. **Date on IV:** 1/23 **Patency of IV:** Patent and in use **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** Dry/intact	0.9% NaCl infusing at 50 ml/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

1200 ml (IV medications)	800 ml (Urine)

Nursing Care

Summary of Care (2 points)

Overview of care: The student nurse arrived at the clinical site at around 0700. The student met the nurse he would be shadowing for the day and got report on the patients he would be caring for. The student and the nurse did assessments on the patients. Then, the nurse started charting, and the student started working on his care plan. Around 0900, the nurse and the student gave out medications to the patients and answered patient or family questions about the care. At 1200, the physicians started rounding and discussed treatment options for the patients. The student's patient did not have any treatment options at the time; they were waiting for the family to arrive. After that, the student finished his care plan and joined the nurse charting. At 1330, the student said goodbye to his patients and thanked the nurse for teaching him.

Procedures/testing done: CT of the brain without contrast and a chest X-ray.

Complaints/Issues: The patient was unresponsive and could not complain.

Vital signs (stable/unstable): Blood pressure was high but overall stable.

Tolerating diet, activity, etc.: Patient is bedridden and on an NPO diet.

Physician notifications: None

Future plans for client: Waiting for family to arrive to discontinue treatment.

Discharge Planning (2 points)

Discharge location: No discharge planning at the time, family is coming to discuss withdrawal of care.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: N/A

Education needs: Coping skills for family

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • 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	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for	The patient	**1.** Assess	**1.** Airway will	Patient maintained

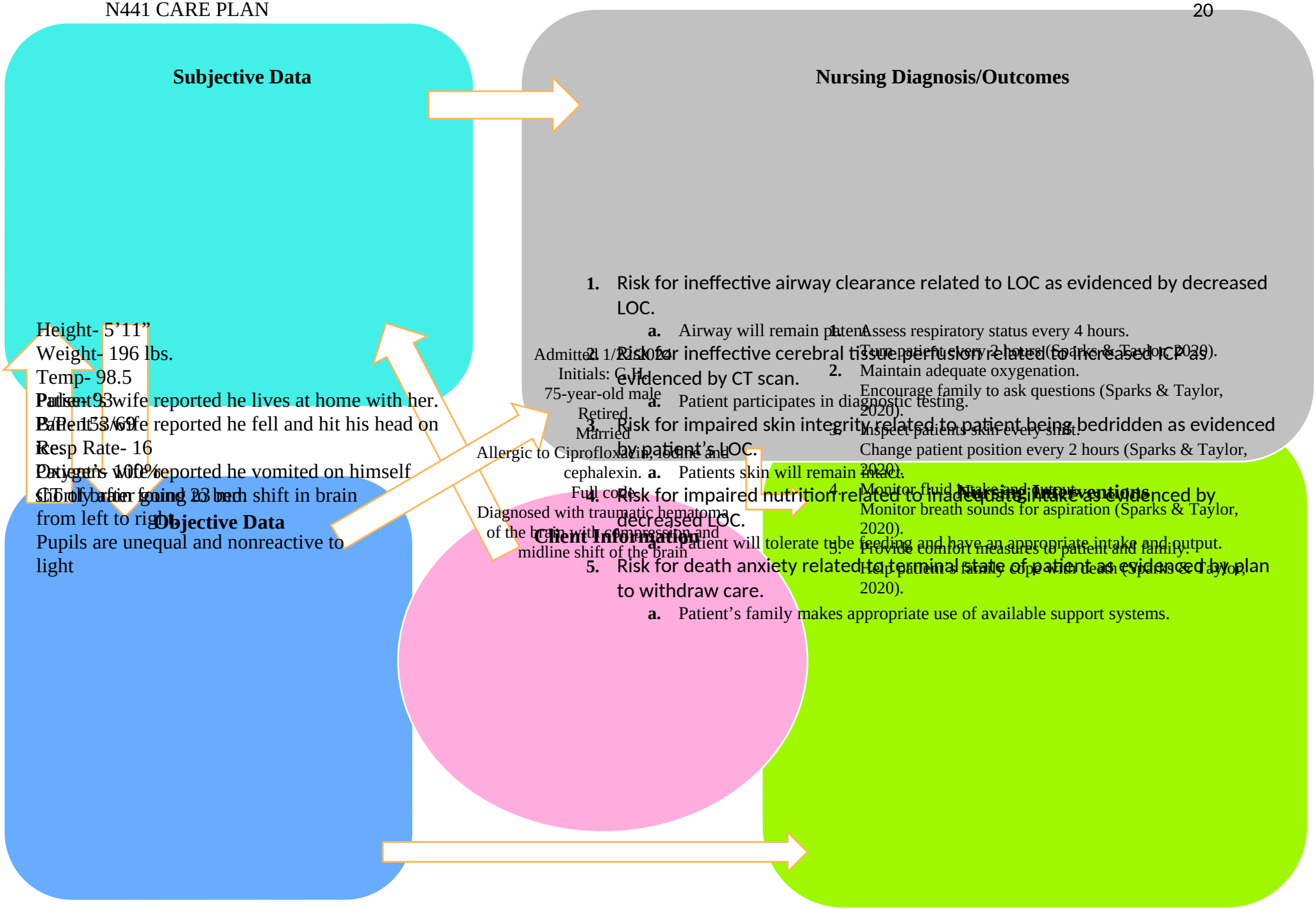
	ineffective airway clearance related to LOC as evidenced by decreased LOC	is unconscious due to a brain injury and may have trouble clearing his airway on his own	respiratory status every 4 hours. **2.**Turn patient every 2 hours (Sparks & Taylor, 2020).	remain patent	a clear airway and did not show any signs of dyspnea.
2.	Risk for ineffective cerebral tissue perfusion related to increased ICP as evidenced by CT scan.	The patient has a midline shift of 23 mm with blood pushing in on the brain.	**1.** Maintain adequate oxygenation. **2.** Encourage family to ask questions (Sparks & Taylor, 2020).	**1.**Patient participates in diagnostic testing.	Patient's family agrees to diagnostic testing and ask questions about care.
3.	Risk for impaired skin integrity related to patient being bedridden as evidenced by patient's LOC.	The patient is unconscious and unresponsive and cannot get out of bed.	**1.**Inspect patients skin every shift. **2.**Change patient position every 2 hours (Sparks & Taylor, 2020).	**1.** Patients skin will remain intact.	Patient was assessed and turned frequently and maintained good skin integrity.
4.	Risk for impaired nutrition related to inadequate intake as evidenced by decreased	Patient is unconscious and is unable to eat anything solid.	**1.**Monitor fluid intake and output **2.** Monitor breath sounds for aspiration (Sparks & Taylor, 2020).	**1.** Patient will tolerate tube feeding and have an appropriate intake and output.	Patient tolerated tube feeding without aspiration.

LOC.				
5. Risk for death anxiety related to terminal state of patient as evidenced by plan to withdraw care.	Patient's family is likely going to withdraw care.	**1.**Provide comfort measures to patient and family. **2.**Help patient's family cope with death (Sparks & Taylor, 2020).	**1.** Patient's family makes appropriate use of available support systems.	Patient and family were both comforted and used coping skills provided by the nurse.

Other References (APA):

Sparks & Taylors, (2020). Nursing Diagnosis Reference Manual (11th ed.). Linda Lee Phelps

Concept Map (20 Points):


Subjective Data
Height- 5’11”
Weight- 196 lbs.
Temp- 98.5
Pulse- 93
BP- 153/69
Resp Rate- 16
Oxygen- 100%
Patient’s wife reported he lives at home with her.
Patient’s wife reported he fell and hit his head on the floor after losing his balance.
Patient’s wife reported he vomited on himself shortly after hitting his head.
Admitted 1/25/2020
Initials: C.H.
75-year-old male
Retired
Married
Allergic to Ciprofloxacin, Iodine and cephalexin.
Full code
Diagnosed with traumatic hematoma of the brain with compression and midline shift of the brain
Client Information
CT of brain showing 23 mm shift in brain from left to right
Objective Data
Pupils are unequal and nonreactive to light
Nursing Diagnosis/Outcomes
1. Risk for ineffective airway clearance related to LOC as evidenced by decreased LOC.
a. Airway will remain patent.
2. Risk for ineffective cerebral tissue perfusion related to increased ICP as evidenced by CT scan.
a. Patient participates in diagnostic testing.
3. Risk for impaired skin integrity related to patient being bedridden as evidenced by patient’s LOC.
a. Patients skin will remain intact.
4. Risk for impaired nutrition related to inadequate intake as evidenced by decreased LOC.
a. Patient will tolerate tube feeding and have an appropriate intake and output.
5. Risk for death anxiety related to terminal state of patient as evidenced by plan to withdraw care.
a. Patient’s family makes appropriate use of available support systems.
Nursing Interventions
1. Assess respiratory status every 4 hours.
Turn patient every 2 hours (Sparks & Taylor, 2020).
2. Maintain adequate oxygenation.
Encourage family to ask questions (Sparks & Taylor, 2020).
3. Inspect patients skin every shift.
Change patient position every 2 hours (Sparks & Taylor, 2020).
4. Monitor fluid Intake and Output.
Monitor breath sounds for aspiration (Sparks & Taylor, 2020).
5. Provide comfort measures to patient and family.
Help patient’s family cope with death (Sparks & Taylor, 2020).