N441: Adult Health III Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
2/29/2024	D.D	57	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Single	No known allergies
Code Status	**Height**	**Weight**	
Full code	134.6 cm	70.3 kg	

Medical History (5 Points)

Past Medical History: The patient has a medical history including dwarfism, anemia, spinal stenosis of the cervical region, vitamin D deficiency, a history of non-ischemic cardiovascular stress test (06/14/2021), and an open wound of the back right, subsequent encounter.

Past Surgical History: The patient has a past surgical history that includes a cervical fusion 6/23/2021), colonoscopy (2/1/2024), ear surgery, kidney stone removal, laparoscopic appendectomy, lumbar discectomy, total hip arthroplasty, and a wisdom tooth extraction.

Family History: The patient reports that he has a sister with diabetes. There was no pertinent history from the patient's mother or father.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient reports that he never smoked or used smokeless tobacco. The patient reports that he currently is not drinking alcohol.

Assistive Devices: The patient reports that he uses a walker and a wheelchair.

Living Situation: The patient reports that he lives with his parents.

Education Level: The patient graduated from high school with his diploma and has some college credits but did not graduate with any degree.

Admission Assessment

Chief Complaint (2 points): The patient came to the clinic with a concern for CSF leakage.

History of Present Illness – OLD CARTS (10 points): D.D., a male patient who is 57 years old, has a lengthy medical history, including a total hip arthroplasty, cervicalopic appendectomy, a lumbar discectomy, ear surgery, kidney stone removal, and a cervical fusion (6/23/21). The patient is complaining of drainage from the location of the incision following a decompressive lumbar laminectomy L1-L4 (1/25/24). When he arrived at the clinic, the physician assessed the incision and saw a small area of superficial dehiscence in the inferior section, along with some granulation tissue. A transparent liquid was seeping out due to the surrounding tissue being compressed. A bandage was applied, and the patient was admitted to the hospital. Upon examination, the patient is conscious, awake, and oriented; he obeys commands and has motor strength in all five limbs (5/5), with the exception of the bilateral hip flexors (4/5). He currently denies having any back problems. The patient also denies having any weakness, tingling, pain, or numbness in their legs.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cerebrospinal fluid leak

Secondary Diagnosis (if applicable): N/A

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

Brain or spinal cord fluid seeping into the surrounding tissues is known as a cerebrospinal fluid (CSF) leak. It can happen for several reasons, including surgery, trauma, and unknown causes. This patient arrived at the hospital because he was worried about a CSF leak after undergoing

spine surgery in January. The patient was found to have a cerebrospinal fluid leak following the provider's evaluation.

CSF leak symptoms can appear in various ways, most commonly as severe headaches that don't go away (professional, 2024). Usually, these headaches are positional, meaning they get better when lying down and worse when standing or sitting upright. In addition, patients may suffer a runny nose, clear fluid draining from their ears or nose, and a salty taste in their mouths as a result of the fluid leakage. Some people may experience nausea, vomiting, neck stiffness, or vision abnormalities.

The underlying cause and degree of CSF leaks determine how the problem is treated. Conservative methods include staying in bed, drinking more water, and avoiding activities that aggravate symptoms. However, medical intervention becomes required if conservative methods are ineffective in symptom relief or if the leak is substantial. The most common course of treatment for CSF leaks is surgical correction. Surgeons use a variety of procedures, including lumbar spinal patching and endoscopic endonasal surgery, to seal the leak and prevent further drainage of cerebrospinal fluid (Clinic, 2023). The provider fixed the patient's leak and installed a lumbar drain to drain any fluid that remained around his spine.

These articles stress the importance of getting medical help if you think there may be a CSF leak. To avoid complications like meningitis or cerebral hypotension, early diagnosis and treatment are essential. Diagnostic procedures such as lumbar punctures and imaging examinations like MRIs and CT scans confirm the diagnosis and pinpoint the leak's location.

In conclusion, a cerebrospinal fluid (CSF) leak requires immediate medical attention due to its unique symptoms, which include severe headaches and clear fluid discharge. The goals of treatment strategies range from conservative measures to surgical intervention and are all intended to reduce symptoms and avoid problems. Patients can improve their prognosis and quality of life by receiving prompt and proper care for CSF leaks and being aware of the symptoms and available treatment choices to correct this issue.

Pathophysiology References (2) (APA):

Clinic, M. (2023). *CSF leak (cerebrospinal fluid leak)*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/csf-leak/symptoms-causes/syc-20522246

professional, C. C. medical. (2024). *Cerebrospinal fluid (CSF) leak: Symptoms & treatment*. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/16854-cerebrospinal-fluid-csf-leak

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**4.40 – 5.80 mcl**	4.90	4.39	
Hgb	**13.0 – 16.5 g/dL**	13.4	11.7	The patient has anemia. (Pagana, 2019)
Hct	**38.0 – 50.0%**	40.7	35.7	The patient has anemia. (Pagana, 2019)
Platelets	**140 – 440 mcl**	299	257	
WBC	**4.00 – 12.00**	9.05	12.28	The patient has inflammation.

	mcl			(Pagana, 2019)
Neutrophils	**1.40 – 5.30 mcl**	6.66	9.33	The patient has trauma as well as physical and emotional stress. (Pagana, 2019)
Lymphocytes	**19.0 – 49.0%**	1.26	1.52	
Monocytes	**3.0 – 13.0%**	0.70	0.93	
Eosinophils	**0.0 – 8.0%**	0.26	0.35	
Bands	**0 -5**	N/A	N/A	

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

Lab	**Normal Range**	**Admission Value**	**Today's Value**	**Reason For Abnormal**
Na-	**136 – 145 Mmol/L**	135	128	The patient has a deficient dietary intake. (Pagana, 2019)
K+	**3.5 – 5.1 mmol/L**	4.3	3.9	
Cl-	**98 – 107 mmol/L**	102	101	
CO2	**22 – 30 mmol/L**	23.0	20.0	The patient has anxiety. (Pagana, 2019)
Glucose	**74 – 100 mg/dL**	109	85	The patient's glucose was high due to an acute stress response. (Pagana, 2019)
BUN	**8 – 26 mg/dL**	15	14	
Creatinine	**0.70 – 1.30 mg/dL**	0.68	0.60	The patient has decreased muscle mass. (Pagana, 2019)
Albumin	**3.5 – 5.0 g/dL**	3.5	N/A	
Calcium	**8.9 – 10.6 mg/dL**	9.7	9.1	
Mag	**1.6 – 2.6 mg/dL**	N/A	1.9	
Phosphate	**3.0 – 4.5 mg/dL**	N/A	N/A	
Bilirubin	**0.2 – 1.2 mg/dL**	0.4	N/A	

Alk Phos	**40 – 150 u/L**	114	N/A	
AST	**5 -34 u/L**	11	N/A	
ALT	**0 – 55 u/L**	15	N/A	
Amylase	**60 – 120 u/L**	N/A	N/A	
Lipase	**8 – 78 u/L**	N/A	N/A	
Lactic Acid	**0.50 – 2.20 mmol/L**	N/A	N/A	
Troponin	**0.00 – 0.03 ng/mL**	N/A	N/A	
CK-MB	**0.5 – 3.6 ng/mL**	N/A	N/A	
Total CK	**30 – 200 u/L**	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	**0.8 – 1.1**	1.0	N/A	
PT	**10.1 – 13.1 sec**	13.3	N/A	
PTT	**25 – 36 sec**	35.8	N/A	
D-Dimer	**0 – 622 ng/mL**	N/A	N/A	
BNP	**0 – 100**	N/A	N/A	
HDL	➢ **60**	N/A	N/A	
LDL	**< 130**	N/A	N/A	
Cholesterol	**< 200**	N/A	N/A	
Triglycerides	**40 – 180 mmpl/L**	N/A	N/A	

Hgb A1c	**4.0 – 6.0%**	N/A	N/A	
TSH	**0.300 – 5.000 mlu/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
Color & Clarity	**Yellow & clear**	N/A	N/A	
pH	**5.0 – 9.0**	N/A	N/A	
Specific Gravity	**1.003 – 1.030**	N/A	N/A	
Glucose	**Negative**	N/A	N/A	
Protein	**Negative Mg/dL**	N/A	N/A	
Ketones	**Negative Mg/dL**	N/A	N/A	
WBC	**Negative 0 – 5/hpf**	N/A	N/A	
RBC	**Negative 0 – 2/hpf**	N/A	N/A	
Leukoesterase	**Negative**	N/A	N/A	

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

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

	mmHg			
PaCO2	**35 – 45 mmHg**	N/A	N/A	
HCO3	**22 – 26 mEq/L**	N/A	N/A	
SaO2	**95% - 100%**	N/A	N/A	

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

Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Explanation of Findings**
Urine Culture	**Negative < 10,000 Positive > 10,000**	N/A	N/A	N/A
Blood Culture	**Negative**	N/A	N/A	N/A
Sputum Culture	**Normal upper respiratory tract**	N/A	N/A	N/A
Stool Culture	**Normal intestinal flora**	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The patient had a chest X-ray done to rule out atelectasis. Test not resulted

Diagnostic Test Correlation (5 points): The test did not result, so we were unsure if there were any abnormalities.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	Dulcolax/ Bisacodyl	Tums/ Calcium carbonate	Neurontin/ Gabapentin	Potassium chloride	Flomax/ Tamsulosin
Dose	10 mg	500 mg	300 mg	40 mEq	0.4 mg
Frequency	Everyday	Every 6 hours PRN	Everyday	Daily	Every day after meals
Route	Rectally	Oral	Oral	Oral	Oral
Classification	Laxative	Antacid	Anticonvulsant	Electrolyte replacement	Benign prostatic hyperplasia agent
Mechanism of Action	Works locally in the large bowel by directly enhancing motility,	Increases intracellular and extracellular calcium	It inhibits the rapid firing of neurons associated	Acts as the major cation in intracellular fluid,	Blocks alpha-adrenergic receptors

	reducing transit time, and increasing the water content of the stool.	levels, which is needed to maintain homeostasis.	with seizures; it is also effective in relieving postherpetic neuralgia and restless legs syndrome symptoms.	activating many enzymatic reactions essential for physiologic processes, including nerve impulse transmission and cardiac and skeletal muscle contraction	in the prostate to inhibit smooth muscle contraction in the bladder, neck, and prostate, which improves the rate of urine flow and reduces symptoms of BPH.
Reason Client Taking	Constipation	To treat acid reflux	To treat restless leg syndrome	To prevent hypokalemia	To treat BPH
Contraindications (2)	Bowel obstruction, ulcerative colitis	Concurrent use of calcium supplements, hypercalcemia	Myasthenia gravis, myoclonus	Addison's disease, a disorder that may delay drugs passing through the GI tract	Prostate cancer, liver, or kidney disease
Side Effects/Adverse Reactions (2)	Abdominal cramping, electrolyte depletion	Hypotension, hypercalcemia	Agitation, anxiety	Arrhythmias, ventricular fibrillation	Dyspnea, erythema
Nursing Considerations (2)	Monitor electrolytes(sodium, potassium, calcium). If you are using mineral oil, you should	Be aware that patients with kidney failure on dialysis may develop	Monitor renal function test results. Monitor the patient	Monitor serum potassium levels before and	Be aware that prostate cancer should be ruled out

	not use bisacodyl.	hypercalcemia when treated with calcium, monitor serum calcium levels.	closely for evidence of suicidal thinking or behavior.	during administration and regularly assess the patient for signs of hypokalemia.	before tamsulosin therapy begins; know that if the drug is given on an empty stomach, the patient's blood pressure should be monitored because of the increased risk of orthostatic hypotension.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess for allergy to bisacodyl and check electrolytes prior to administration.	Review the patient's serum calcium levels before administration.	Assess the patient's mental health status prior to administration/ Review CBC count.	Review the patient's medical history before administering potassium chloride.	Assess patient for orthostatic hypotension and syncope.
Client Teaching needs (2)	You should have a bowel movement within 15 to 60 minutes after using a rectal suppository. Try to empty your bladder just before using rectal bisacodyl.	Urge the patient to chew chewable tablets thoroughly before swallowing and drink a glass of water afterward;	Instruct patient not to take drug within 2 hours of taking an antacid. Caution: the patient is not to stop the drug abruptly.	Instruct the patient to take the drug with or right after food, Teach the patient how to take his radial pulse, and	Advise the patient to change position slowly, especially after the initial dose. Instruct patient

		remind the patient to take calcium separate from other prescribed drugs.		advise him to notify the provider about significant changes in heart rate or rhythm.	not to chew, crush, or open tamsulosin capsules and take drug about 30 minutes after the same meal each day.

Hospital Medications (5 required)

Brand/Generic	Tylenol/ Acetaminophen	Cepacol/ Benzocaine menthol	Lovenox/ Enoxaparin	Robaxin/ methocarbamol	Zofran/ Ondansetron HCL
Dose	500 mg	1 lozenge	40 mg	750 mg	4 mg
Frequency	Every 6 hours	Every 2 hours	Daily	4 times daily PRN	Daily
Route	Oral	Oral	Subcutaneous	Oral	IV push
Classification	Analgesic	Local anesthetics	Anticoagulant	Skeletal muscle relaxant	Antiemetic
Mechanism of Action	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering	A local anesthetic that works by numbing the painful area	Potentiates the action of antithrombin III, a coagulation inhibitor. Enoxaparin rapidly binds	It may depress the CNS, which leads to sedation and reduced skeletal muscle	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and

	with pain impulse generation in the peripheral nervous system.	providing a cooling feeling and increasing saliva in the mouth.	with and inactivates clotting factors by binding with antithrombin III.	spasms. Alter perception of pain also	peripherally at the vagal nerve terminal in the intestine to reduce nausea and vomiting by preventing serotonin release in the small intestine and blocking signals to the CNS
Reason Client Taking	Pain	Sore throat	Blood pressure	Muscle spasm	Nausea/ vomiting
Contraindications (2)	Severe active liver disease, Renal impairment	Heart disease, certain blood disorders	Active major bleeding, history of immune-mediated heparin-induced thrombocytopenia within the past 100 days.	Myasthenia gravis, allergic reaction to methocarbamol	Concomitant use of apomorphine, hypersensitivity to ondansetron.
Side Effects/Adverse Reactions (2)	Hypotension, Agitation	Wheezing, itching	Confusion, Congestive heart failure	Dizziness, drowsiness	Hypotension, serotonin syndrome
Nursing Considerations (2)	Use cautiously in patients with active hepatic disease or hepatic impairment, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal	Use cautiously in patients who have swelling, burning, redness, or irritation of the throat. Monitor for	Use enoxaparin with extreme caution in patients with a history of HIT. Use extreme caution in patients with an increased risk of hemorrhage.	Monitor patients for hypersensitivity reactions, especially with parenteral administration. Be aware that the parenteral dosage form shouldn't be used in	Monitor patients for chest pain that may be caused by myocardial ischemia, which may appear immediately after administration of the drug. Monitor the patient

	impairment. Monitor liver function tests when taking long-term.	allergic reaction to benzocaine menthol.		patients with renal dysfunction because the polyethylene glycol 300 vehicle is nephrotoxic.	closely for serotonin syndrome, which may include agitation, chills, confusion, diaphoresis, diarrhea, fever, hyperactive reflexes, poor coordination, restlessness, and shaking.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess pain and assess for chronic conditions that warrant the use of acetaminophen.	Assess the patient for a cough and a sore throat.	Assess most recent labs (CBC and platelet count). Assess for signs of bleeding and hemorrhage.	Assess heart rate, heart sounds, and ECG,	Assess patients for nausea, vomiting, abdominal distention, and bowel sounds.
Client Teaching needs (2)	Caution patient is not to exceed the recommended dosage or take other drugs containing acetaminophen at the same time because of the risk of liver disease.	Teach the patient to suck the lozenge. Do not chew, break, or crush it. Do not swallow it whole.	Teach the patient how to give the drug by deep subcutaneous injection. Inform the patient that he may bruise and bleed easily and that it may take longer than usual to stop bleeding while taking enoxaparin.	Tell the patient to take the drug exactly as prescribed. Advise patient to take drugs with food or milk to avoid nausea.	Advise the patient to use a calibrated container or oral syringe to measure oral solution. Instruct patient to immediately report signs of hypersensitivity, such as a rash or development of sudden chest pain or tightness.

Medications Reference (1) (APA):

Jones & Bartlett Learning, (2023). *Nurse's Drug Handbook* (22nd ed.). Jones & Bartle

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert and responsive Person, place, situation, time No acute distress Appropriate
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type:** Lumbar drain	 Usual for ethnicity Intact, dry Warm Normal elasticity No rashes Bruising on right forearm from IV placement. No wounds 17
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Normocephalic and atraumatic No abnormal findings are present. PERRLA present, EOM intact No polyps, lumps, bumps, or bleeding No dentures
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	 Normal heart sounds S1, S2 present Normal 3+ Less than 3 seconds .

RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** N/A **Size of tube:** N/A **Placement (cm to lip):** N/A **Respiration rate:** N/A **FiO2:** N/A **Total volume (TV):** N/A **PEEP:** N/A **VAP prevention measures:** N/A	Respirations are regular and unlabored, and breath sounds clear throughout bilaterally.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	 Regular Regular 134.6 cm (4'5ft) 70.3 kg (155lb) Active bowel sounds 3/4/2024 N/A Slightly distended No Incisions No scars No drains No open wounds
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	 Yellow Clear 235 ml The patient states there are no abnormal findings. This nursing student did not assess genitals. Urethral catheter 16 F N/A

MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 2** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☒**	 Nail beds intact, extremities warm and dry Active ROM N/A 5/5 bilateral extremities, bilateral hip flexor 4/5 Strict bed rest N/A
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	 Person, place, situation, and time Normal cognition Clear Normal sensory Alert – awake and answers questions appropriately
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Talking with his parents and watching tv. The patient can read and write and graduated high school. N/A The patient lives at home with his parents.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	102	148/78	24	99.5	96% room air
1100	102	141/72	26	98.6	97% room air

Vital Sign Trends/Correlation: The patient's vital signs remained within normal limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	No	P	A	I	N
1100	No	P	A	I	N

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 G **Location of IV:** Anterior, lower right forearm **Date on IV:** 02/29/2024 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** occlusive dressing, clean, dry, and intact	0.9% NaCl infusion
Other Lines (PICC, Port, central line, etc.)	
Type: N/A **Size:** N/A **Location:** N/A **Date of insertion:** N/A **Patency:** N/A **Signs of erythema, drainage, etc.:** N/A **Dressing assessment:** N/A **Date on dressing:** N/A **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
269 mL IV fluid	235 mL

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was quiet but seemed in a good mood; I delivered his medications at 0815. I got his vitals and then watched as the nurse did a head-to-toe assessment and then drained his lumbar drain.

Procedures/testing done: The patient had a chest X-ray to check that his lungs were clear, and he didn't have pneumonia.

Complaints/Issues: N/A

Vital signs (stable/unstable): The patient's vital signs were regular and stable.

Tolerating diet, activity, etc.: The client is tolerating his regular diet but is currently on strict bed rest with no activity due to his lumbar drain.

Physician notifications: None

Future plans for client: To have the patient get out of bed as soon as possible to prevent clots or bed sores. He has been on strict bedrest for 5 days and is ready to get out of bed.

Discharge Planning (2 points)

Discharge location: The patient will be discharged home with his mother and father.

Home health needs (if applicable): N/A

Equipment needs (if applicable): The patient already has the equipment he needs at home. He uses a wheelchair and a walker to help him move around.

Follow-up plan: Continue to monitor the site where his lumbar drain was and contact his provider if he notices any fluid leaking, pain, tenderness, or inflammation.

Education needs: N/A

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 venous thromboembolism related to immobility as evidenced by strict bed rest.	The patient is on strict bed rest.	**1.** Perform comprehensive assessments of peripheral circulation and pulses to identify s/s of thromboembolism**.** **2.** Apply and maintain elastic compression stockings; remove 15 to 20 minutes every 8 hours to avoid VTE.	**1.** The patient will be free of VTE.	The patient responded well, had normal blood flow, and returned to the extremities.
2. Risk for infection related	The patient had a Foley	**1.** Minimize the patient's risk of	**1.** The patient will	The patient's urine remains

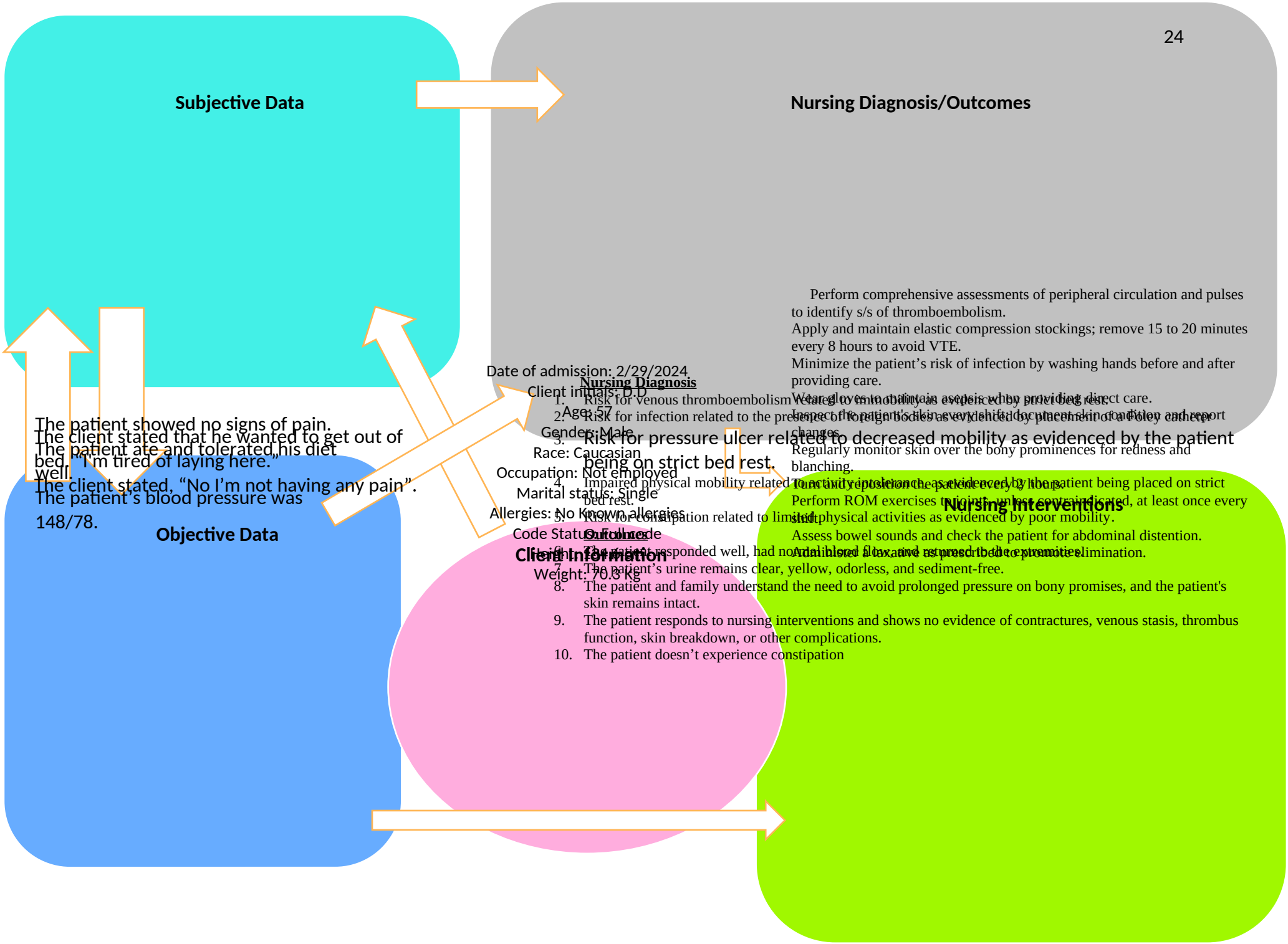
to the presence of foreign bodies as evidenced by placement of a Foley catheter.	catheter for multiple days.	infection by washing hands before and after providing care. **2.** Wear gloves to maintain asepsis when providing direct care.	remain free from signs and symptoms of infection.	clear, yellow, odorless, and sediment-free.
3. Risk for pressure ulcer related to decreased mobility as evidenced by the patient being on strict bed rest.	The patient has a lumbar drain and must remain flat in the bed.	**1.** Inspect the patient's skin every shift; document skin condition and report changes. **2** Regularly monitor skin over the bony prominences for redness and blanching.	**1.** The patient will not experience a pressure ulcer.	The patient and family understand the need to avoid prolonged pressure on bony promises, and the patient's skin remains intact.
4. Impaired physical mobility related to activity intolerance, as evidenced by the patient being placed on strict bed rest.	The patient has to lie flat to avoid the drain from coming out**.**	1. Turn and reposition the patient every 2 hours. **2.** Perform ROM exercises to joints, unless contraindicated, at least once every shift.	**1.** The patient will maintain muscle strength and joint ROM.	The patient responds to nursing interventions and shows no evidence of contractures, venous stasis, thrombus function, skin breakdown, or other complications.
5. Risk for constipation related to limited physical activities as evidenced by poor mobility.	The patient has poor mobility and is on bed rest.	1. Assess bowel sounds and check the patient for abdominal distention.	**1.** The patient will maintain bowel movements every day without experiencin g	The patient doesn’t experience constipation.

		2. Administer a laxative as prescribed to promote elimination.	constipation.	

Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's Nursing Diagnosis Reference Manual*. Wolters Kluwer.

Concept Map (20 Points):


Subjective Data
The client stated that he wanted to get out of bed, "I'm tired of laying here."
The client stated, "No I'm not having any pain".
Objective Data
The patient showed no signs of pain.
The patient ate and tolerated his diet well.
The patient's blood pressure was 148/78.
Nursing Diagnosis/Outcomes
Nursing Diagnosis
1. Risk for venous thromboembolism related to immobility as evidenced by strict bed rest.
2. Risk for infection related to the presence of foreign bodies as evidenced by placement of a Foley catheter
3. Risk for pressure ulcer related to decreased mobility as evidenced by the patient being on strict bed rest.
4. Impaired physical mobility related to activity intolerance as evidenced by the patient being placed on strict bed rest.
5. Risk for constipation related to limited physical activities as evidenced by poor mobility.
Outcomes
6. The patient responded well, had normal blood flow, and returned to the extremities.
7. The patient's urine remains clear, yellow, odorless, and sediment-free.
8. The patient and family understand the need to avoid prolonged pressure on bony promises, and the patient's skin remains intact.
9. The patient responds to nursing interventions and shows no evidence of contractures, venous stasis, thrombus function, skin breakdown, or other complications.
10. The patient doesn't experience constipation
Client Information
Date of admission: 2/29/2024
Client initials: D.D
Age: 57
Gender: Male
Race: Caucasian
Occupation: Not employed
Marital status: Single
Allergies: No Known allergies
Code Status: Full code
Weight: 70.3 kg
Nursing Interventions
Perform comprehensive assessments of peripheral circulation and pulses to identify s/s of thromboembolism.
Apply and maintain elastic compression stockings; remove 15 to 20 minutes every 8 hours to avoid VTE.
Minimize the patient's risk of infection by washing hands before and after providing care.
Wear gloves to maintain asepsis when providing direct care.
Inspect the patient's skin every shift, document skin condition and report changes.
Regularly monitor skin over the bony prominences for redness and blanching.
Turn and reposition the patient every 2 hours.
Perform ROM exercises to joints, unless contraindicated, at least once every shift.
Assess bowel sounds and check the patient for abdominal distention.
Administer laxative as prescribed to promote elimination.