N431 Care Plan # 2

Lakeview College of Nursing

Name; Destiny Bell

Demographics (3 points)

Date of Admission 4-1-2024	**Client Initials** A.J	**Age** 57 years old	**Gender** female
Race/Ethnicity African American	**Occupation** Unknown	**Marital Status** Divorced	**Allergies** Penicillin's; unknown reaction type
Code Status DNR/DNI	**Height** 160 cm 5ft 2.99in	**Weight** 97 lbs 10.6 oz)	

Medical History (5 Points)

Past Medical History:

- **N/A;** Patient's past medical history was not available in the chart and patient was unable to answer due to their condition.

Past Surgical History:

- Cesarean delivery; no known date

Family History:

- **N/A;** Patient's family history was not available in the chart and patient was unable to answer due to their condition.

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

- Tobacco usage has been 0.5 packs per day for the past 5 years.
- Denies alcohol usage.
- Recreational drug use, heroin and cocaine, for most of her adult life. Exact years of usage is unknown.

Assistive Devices: N/A

Living Situation: Lives at home with her boyfriend

Education Level: Highschool diploma

Admission Assessment

Chief Complaint (2 points): Syncope

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

A.J is a 57-year-old African American female patient who was brought to Carle foundation hospital via EMS for a witnessed syncopal episode. Upon EMS arrival, the patient had gone into ventricular fibrillation and ventricular tachycardia arrest with a possible episode of torsades. The patient required multiple rounds of CPR and shock. The patient, A.J., was then intubated while still in the emergency room and started on bicarb gtt as well as epinephrine gtt for hypotension. The patient's family states that she is actively using recreational drugs such as heroin and cocaine and has suffered from substance abuse for a very long time. A blood drug screen has been ordered and obtained.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cardiac Arrest

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points): Sudden cardiac arrest is defined as the sudden loss of all the heart's electrical activity due to an abnormal heart rhythm (Mayo Clinic, 2023). It is important not to confuse cardiac arrest with heart failure, whereas cardiac arrest is the cessation of all heart activity opposed to the heart still pumping in heart failure but not as adequately as a normal heart (Capriotti, 2020). Some common causes of cardiac arrest are a change in the heart's electrical activity that results in the heart no longer pumping blood to the rest of the body (Mayo Clinic, 2023). The most common cause of sudden cardiac arrest is ventricular fibrillation, which we see in our patient A.J (Mayo Clinic, 2023). There are various

heart conditions that can cause cardiac arrest such as coronary artery disease, cardiomyopathy, heart valve disease, myocardial infarction, and congenital heart defects (Mayo Clinic, 2023). However, sudden cardiac arrest can occur in individuals with no known heart problems.

There a many various things that can increase an individual's risk of going into sudden cardiac arrest. Some of the most common risk factors include sedentary lifestyle, diabetes, smoking, hypertension, a family history of coronary artery disease, and high cholesterol (Mayo Clinic, 2023). Our patient A.J, is a current smoker who smokes about half a pack a day which could have placed her at risk. Other factors thar could increase an individual's risk of sudden cardiac arrest are low potassium or magnesium levels, older age, and the use of recreational drugs such as cocaine or amphetamines (Mayo Clinic, 2023). A.J is a current substance abuser using the drugs cocaine and heroin which could have led her to this diagnosis.

There are many diagnostic tests that a patient can have ordered once they’re stable to help determine the cause of cardiac arrest. These tests include blood draws to assess their electrolyte levels and other varying blood testing, an electrocardiogram, and a chest x-ray (Mayo Clinic, 2023). We see in our patient that they drew labs and assessed her electrolyte levels, basic chemistry and even assessed for the presence of recreational drugs in her system since she is a user. The patient also had multiple chest x-rays obtained during her admission. Treatment for cardiac arrest is CPR. CPR is the immediate treatment option for when a patient begins to code (Mayo Clinic, 2023). The recommended ratio of compressions to breaths for an adult patient is 30: 2 (American Red Cross, NKD). Other treatment options available are the use of defibrillation and medications such as epinephrine (Mayo Clinic, 2023). The patient was treated with multiple rounds of cardiopulmonary resuscitation, defibrillation, and the utilization of epinephrine. The patient has sense been placed on comfort and hospice care.

Pathophysiology References (2) (APA):

American Red Cross. (n.d.). *CPR steps: How to perform CPR*. Red Cross. https://www.redcross.org/take-a-class/cpr/performing-cpr/cpr-steps

Capriotti, Theresa M. "Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives" 2nd ed. (2020). *F.A Davis Company*.

Mayo Clinic. (2023, January 19). *Sudden cardiac arrest*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/sudden-cardiac-arrest/symptoms-causes/syc-20350634

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	4.10-5.70 10 ^ 6/ uL	5.68	N/A	
Hgb	12.0-18.0 g/dL	15.5	N/A	
Hct	37.0-51.0 %	48.0	N/A	
Platelets	140-400 10^3 u/l	347	N/A	
WBC	4.00-11.00 10^3/uL	8.84	N/A	
Neutrophils	1.60-7.70 10^3/uL	4.65	n/a	
Lymphocytes	1.00-4.90 10^3/uL	3.74	n/a	
Monocytes	0.00-1.10 10^3/uL	0.38	n/a	
Eosinophils	0.00-0.50 10^3/uL	0.00	n/a	
Bands	2-6%	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	145	n/a	
K+	3.5-5.1 Mmol/L	3.6	n/a	
Cl-	98-107 Mmol/L	79	n/a	Possible dehydration
CO2	22.0-29.0 Mmol/L	19.0	n/a	Possible shock
Glucose	74-100 Mg/dL	117	n/a	Elevated glucose levels can be a related to a recent illness or possible dehydration.
BUN	10-20 Mg/dL	86	N/A	Recent cardiac arrest
Creatinine	0.55-1.02 Mg/dL	6.36	N/A	Reduced renal blood flow from possible dehydration?
Albumin	3.4-4.8 g/dL	4.3	N/A	
Calcium	8.9-10.6 Mg/dL	20.0	N/A	Prolonged immobilization due to her cardiac arrest
Mag	1.6-2.6 Mg/dL	n/a	n/a	
Phosphate	N/A	n/a	n/a	
Bilirubin	0.2-1.2 Mg/dL	0.6	n/a	
Alk Phos	40-150 u/l	93	n/a	
AST	5-34 U/L	207	n/a	Could be due to recent trauma
ALT	0-55 U/L	92	n/a	Acetaminophen use and recent cardiac arrest
Amylase	23-85 U/L	n/a	n/a	
Lipase	0-160 U/L	n/a	n/a	
Lactic Acid	0.5-2.0 Mmol/L	n/a	n/a	

Troponin	0.00-0.034 Ng/mL	<n/a	n/a	
CK-MB	N/A	n/a	n/a	
Total CK	22-269 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	0.9-1.1 ratio	1.1	n/a	
PT	11.7-13.8 seconds	14.5	n/a	Possible liver disease
PTT	22.4-35.9 seconds	21.1	n/a	Possible disseminated intravascular coagulation
D-Dimer	N/A	n/a	n/a	
BNP	0-99 Pg/ml	n/a	n/a	
HDL	40-59 Mg/dl	n/a	n/a	
LDL	<100 Mg/dl	n/a	n/a	
Cholesterol	<200 Mg/dl	n/a	n/a	
Triglycerides	<150 Mg/dl	n/a	n/a	
Hgb A1c	4-5.6 Mmol/L Non-diabetic	n/a	n/a	
TSH	0.270-4.200 Miu/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	Clear and Yellow	N/A	N/A	

pH	4.5-9	N/A	N/A	
Specific Gravity	1.005-1.035	N/A	N/A	
Glucose	NEG	N/A	N/A	
Protein	NEG	N/A	N/A	
Ketones	NEG	N/A	N/A	
WBC	0-25 U/L	N/A	N/A	
RBC	0-20 U/L	N/A	N/A	
Leukoesterase	NEG	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):

PhD Rn, P. K. D., & Facs, M. T. P. J. (2021). Mosby's Diagnostic and Laboratory Test Reference (Mosby's Diagnostic & Laboratory Test Reference) (15th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- CT Brain W/O Contrast (4-1-2024);
  - Findings:

    limited without coronal and sagittal reformats. Limited from retained contrast. Limited mild motion artifact.

    Brain: no evidence of hemorrhage, mass, shift, or extra axial fluid collection. The ventricles are normal in size and morphology.

    Soft tissues and orbits: retention cyst/polyp in the left maxillary sinus. Air filled level right maxillary sinus. Bones, paranasal sinuses, and mastoid air cells. Intact calvarium.
- CTA PE Chest Venous Abdomen/Pelvis with Contrast (4-1-2024);
  - Impression;
    1. No evidence of PE or other acute thoracic pathology.
    2. Bilateral peripheral hypo-enhancement of the kidneys which may be related to pyelonephritis or renal infarcts.
    3. Other incidental and senescent findings, as above.
- XR Chest AP or PA only (4-2-2024);

- Impression:
    1. Adequate ETT placement.
    2. NGT sidenote is located at the expected location of gastroesophageal junction consider advancing by 5 cm.
    3. No radiographically evident acute cardiopulmonary pathology.

- XR Chest AP/PA Only (4-2-2024);
    - Findings: endotracheal tube 2.7cm above carina, left approach central line tip overlies the caval junction. Enteric tube tip overlies the gastric body, side port at the GE junction it is recommended to advance 5cm. The lungs are clear.
- XR KUB (4-5-2024);
    - Findings: NG tube seen in terminating in the distal stomach. Two catheters visualized in the rectum. Nonobstructive bowel gas pattern. Minimal air is seen in the small and large bowel. No gross free air.
- XR Chest AP or PA only (4-8-2024);
    - Findings: the lungs appear clear. No radiographic evidence of aspiration. Heart size is within normal limits. Endotracheal tube is in good position. Ng tube extends below the diaphragm. Central line with tip in the superior vena cava.
- MRI Brain W/O Contrast (4-10-2024);
    - Impression:
        1. Multiple foci of T2 shine through artifact within the supratentorial and infratentorial brain, concerning for subacute ischemic injury. Given the patient's history this is concerning for hypoxic ischemic encephalopathy.
        2. Small acute infarction within the left occipitotemporal region.

3. Small acute sub-infarction in the left cerebellum.
4. Scattered chronic microhemorrhages within the supratentorial and infratentorial brain.
5. Mild to moderate microvascular disease.

Diagnostic Test Correlation (5 points):

A Chest x-ray is a diagnostic procedure that can be used to diagnose a patient with cardiac arrest. The chest x-ray was used to visualize the patient's ETT tube placement from when she was intubated during CPR. A MRI was obtained to assess for any brain bleeds or infarctions from her going into sudden cardiac arrest.

Diagnostic Test Reference (1) (APA):

PhD Rn, P. K. D., & Facs, M. T. P. J. (2021). Mosby's Diagnostic and Laboratory Test Reference (Mosby's Diagnostic & Laboratory Test Reference) (15th ed.). Mosby.

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

Home Medications (5 required)

Brand/Generic	Buspirone	Memantine	Perampanel	Docusate sodium	Famotidine
Dose	30mg	10mg	12mg	8.6mg	20mg
Frequency	Q8HR	Twice a day	Daily at bedtime	Twice a day	Twice a day
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharmacologic class: Azaspirone Therapeutic class: Anxiolytic	Pharmacologic class: N-methyl-D-aspirate receptor antagonist Therapeutic class: antidementia agent	Pharmacologic class; AMPA glutamate receptor antagonist Therapeutic class: anticonvulsant	Pharmacologic class: surfactant therapeutic class: laxative, stool softener	Pharmacological: histamine 2 blocker therapeutic class: anti ulcer agent
Mechanism of	may act as a partial	The excitatory	Acts as a non	Acts as a	Reduces HCL

Action	agonist at serotonin 5-hydroxytryptamine 1A receptors in the brain producing anti-anxiety effects (Jones & Bartlett, 2019).	amino acid glutamate on NMDA receptor cells in the central nervous system. Replaces magnesium on the NMDA receptors of the brain cells closing ion channels and preventing calcium influx and the resulting damage to the brain cells by preventing excessive brain cell death this medication slows the progression of Alzheimer's.	competitive antagonist on the AMP a glutamate receptor on post synoptic neurons. Glutamate is the primary excitatory neurotransmitter in the CNS the spy preventing glutamate action the CNS system experiences less stimulation resulting in less seizure activity.	surfactant that softens stool by decreasing surface tension between oil and water in the feces.	formation by preventing histamine from binding with H2 receptors on the surface of parietal cells and by doing so helps prevent peptic ulcers from forming and helps heal existing ones.
Reason Client Taking	To manage anxiety	To treat dementia from Alzheimer's	To treat partial onset seizures	To treat Constipation	to treat gerd
Contraindications (2)	Hypersensitivity to buspirone or its components and severe hepatic or renal impairment.	Hypersensitivity to memantine, amantadine, or their components.	Hypersensitivity to parampanel or its components.	Fecal impaction, intestinal obstruction, symptoms of appendicitis, and undiagnosed abdominal pain.	Hypersensitivity to Famotidine, other H2 receptor antagonist, or their components
Side Effects/Adverse Reactions (2)	Tachycardia and nausea or vomiting	supraventricular tachycardia and leukopenia	suicidal and homicidal ideation and weight gain	Syncope and palpitations	cardiac arrhythmias and bronchospasm
Nursing Considerations (2)	use cautiously in patients with hepatic or renal impairment and institute safety precautions because of possible central nervous system reactions such as confusion and decreased concentration.	Monitor patient closely for suicidal thoughts and use cautiously in patients with severe hepatic impairment because the drug undergoes A partial hepatic metabolism which may increase the risk of adverse effects.	Monitor patient closely for behavioral and psychiatric reactions and monitor patient especially if they are elderly for dizziness and gait disturbance.	Assess for laxative abuse syndrome and expect long term users to have a dependence on laxatives for bowel movements and the possibility of electrolyte imbalances.	Shake Famotidine oral suspension vigorously for five to 10 seconds before administration and dilute injection form with normal saline solution to yield a total amount of five to 10 ML.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Vital signs and level of consciousness	Blood glucose level as this medication can cause hypoglycemia and vital signs as this medication can cause tachycardia.	Assess for suicidal/homicidal ideation and assess for any dizziness headache or hallucinations	assess for any abdominal pain in nausea or diarrhea as you would want to hold this medication if	Vital signs and airway as this medication can cause bronchospasm.

				the patient is experiencing abdominal pain.	
Client Teaching Needs (2)	advise the patient to take the medication consistently either always with or without food and inform the patient that it could take up to two weeks of therapy before she notices the anti-anxiety effects of the medication.	Instruct the patient to take the medication exactly as prescribed and caution the patient to avoid hazardous activities until CNS activities until the effects are known.	Instruct patient and family members to be alert for a new onset or worsening of depression and tell the patient to alert the provider of any persistent severe or unusual signs and symptoms such as a rash.	Advise patient to take the medication with a full glass of milk or water and encourage the patient to increase fiber intake as well as exercise regularly.	Instruct patient to carefully chew chewable tablets thoroughly before swallowing and caution patient to avoid alcohol and smoking during Famotidine therapy because they irritate the stomach and can delay healing.

Hospital Medications (5 required)

Brand/Generic	Acetaminophen	Hydromorphone	Lorazepam	Miralax	Haloperidol
Dose	500mg	0.4mg	0.5mg	17g	2mg
Frequency	Q4hr PRN	Q15minutes PRN	Q2HR PRN	Twice a day	Q1HR PRN
Route	Gastric Tube	IV Push	IV PUSH	Gastric tube	IV push
Classification	Pharmacologic class: nonsalicylate, paraminophenol derivative Therapeutic class: antipyretic, nonopioid analgesic Pregnancy class: B	pharmacological class: opioid therapeutic class: opioid analgesic	pharmacological: benzodiazepine therapeutic: anxiolytic		Pharmacological: Butyrophenone derivative Therapeutic: Antipsychotic
Mechanism of Action	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and	May bind with opioid receptors in the spinal cord and higher levels in the central nervous system.	May potentiate the effects of GABA and other inhibitory neurotransmitters by binding to		May blog post synaptic dopamine receptors in the limbic system and increase

	interfering with pain impulse generation in the peripheral nervous system. Also acts directly on the temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2.	It is believed that hydromorphone stimulate Kappa and MU receptors thus altering the perception of and the emotional response to pain.	specific Vincenzo diazepine receptors in cortical and limbic areas of the CNS. G ABA inhibits excitatory stimulation which helps control emotional behavior.		brain turnover of dopamine, producing an antipsychotic effect.
Reason Client Taking	To manage pain	To manage pain	to treat anxiety		To treat psychotic disorders
Contraindications (2)	Hypersensitivity to acetaminophen or its components, severe hepatic impairment, sever liver disease.	Paralytic ileus, increased intracranial pressure, and severe respiratory depression.	Acute angle-closure glaucoma and hypersensitivity to lorazepam its components or benzodiazepines.		Hypersensitivity to haloperidol or its components and Parkinson's disease or severe toxic CNS comatose states or depression.
Side Effects/Adverse Reactions (2)	Hypotension, stridor, anxiety, fatigue, abdominal pain	respiratory depression and hypertension	Tachycardia and abdominal pain		Seizures and torsades de pointes
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment. Monitor renal function	be aware that hydromorphone therapy increases the risk of abuse, addiction and misuse. To improve analgesic action give hydromorphone before pain becomes too intense.	Before starting lorazepam in a patient with depression be sure that they are on an antidepressant due to the risk of suicidal ideation and use cautiously in elderly patients with compromised respiratory function as this drug can cause respiratory depression, sedation, and unsteadiness.		Monitor CBC especially if the patient has a low WBC count or a history of drug induced leukopenia. Dilute oral solution with a beverage such as apple, orange, or tomato juice.
Key Nursing Assessment(s)/Lab(s	Vital signs and pain assessment	Vital signs and pain assessment.	Vital signs and a respiratory		Assess patient for fall risk and

) Prior to Administration		Respiratory assessment.	assessment.		monitor white blood cell count as if the white blood cell count drops below 1000 the medication will be discontinued
Client Teaching Needs (2)	Do not exceed the recommended dosage daily. And do not take any other medications containing acetaminophen while taking this medication.	Instruct patient to take the drug exactly as prescribed and before pain is too severe and instruct patient not to break, crush, chew, or dissolve tablets but to swallow them whole.	Instruct patient to take lorazepam exactly as prescribed and not to stop without consulting provider because of the risk of withdrawal symptoms and instruct patient to report excessive drowsiness and nausea.		Patient to take haloperidol exactly as prescribed and to not stop abruptly and advise the patient to take tablets with food or full glass of milk or water to reduce GI distress.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). *2020 Nurse's Drug Handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient is alert and oriented x 0, she is unable to answer questions but arouses to a sternal rub. Patient appears stated age and is dressed in a hospital grown**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 8**	**Skin is pale, warm, and dry. Skin is free of rashes and there is a right ear pressure injury. Bruising is not noted. Skin turgor is fair. No drains are present.** **Braden score 8**

Drains present: Y☐ N ☒ **Type:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Eyes, ears, and nose are free of drainage. Oral mucosa is pink and moist. Dental carries are noted upon examination. Patient is unable to swallow.** .
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 2 +** **Capillary refill: < 3 seconds** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema: N/A**	**S1 and S2 are present, no murmurs heard upon auscultation. Peripheral pulses are equal strength and quality, 2+ bilaterally throughout. Capillary refill is less than 3 seconds on fingers and toes bilaterally. No edema visualized.**
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Breath sounds are shallow, tachypneic and course upon auscultation bilaterally throughout. The use of accessory muscle was visualized and noted.
GASTROINTESTINAL: **Diet at home: normal** **Current Diet: NPO; Hospice/Comfort Care** **Height: 182.9cm** **Weight: 114.6kg** **Auscultation Bowel sounds:** **Last BM: 4-12-2024** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Patient is on hospice/comfort care is on a NPO diet. **Bowel sounds are present and hypoactive in all 4 quadrants.** **Last BM: 4/12/2024** **Abdomen is nondistended, nontender and free of pain upon palpation. No drains, incisions, or wounds noted.**
GENITOURINARY: **Color:**	**Patient has a urethral catheter. Urine is clear and yelloe in color. There is no pain noted**

Character: **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: urethral** **Size: 16 FR**	**during urination.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices: none** **Strength: moderate** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒** **Fall Score: 0** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Fall risk: 0 **Patient is on hospice and comfort care. The patient is unable to ambulate or perform any ADL's without assistance.** **Active ROM is significantly impaired.** **Patient is visually weak and bedbound.**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is unresponsive, unable to speak or answer questions. **Patient does respond touch, temperature, and pain.** **Patient is alert and oriented x0 but responds to a sternal rub.** **Strength is 3+ in bilateral extremities.** **No gross focal or neurological deficits noted.**
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):**	Patient is accompanied in the hospital by her two sons. They stated she lives at home with her boyfriend and there is a concern of her still using recreational drugs such as cocaine and heroin. **No religious beliefs were stated or noted.**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0300	**97 bpm**	**126/77 (93) mmhg**	**22**	**98.3 F Axillary**	**87% Room air**
0717	**122 bpm**	**130/89 (103) mmhg**	**32**	**98.2 axillary**	**77% Room air**

Vital Sign Trends: Vital signs are unstable, but she is in a normal sinus rhythm, blood pressure systolic and diastolic has slightly increased. Patient's oxygen saturation has dropped, and respirations have increased.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0300	**FACES**	**Denies pain**	**n/a**	**n/a**	**Continue to monitor**
0717	**FACES**	**Denies pain**	**n/a**	**n/a**	**Continue to monitor**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Central Line Triple Lumen **Location of IV: Left jugular** **Date on IV: 4-2-2024** **Patency of IV: patent, flushes easily** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: intact**	none

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

None	**750ml urine**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was admitted via ems transfer for a chief complaint of a witnessed syncopal episode. The patient was then admitted after going into ventricular fibrillation and ventricular tachycardia cardiac arrest which required multiple rounds of CPR and defibrillation.

Procedures/testing done: The patient had a CBC, CMP, KUB, MRI and CT scan and chest x-ray performed upon admission. With a follow up CT and chest x-ray being performed on 4-2-2024 and 4-8-2024.

Complaints/Issues: no complaints or issues

Vital signs (stable/unstable): Unstable but patient is on hospice care. The patient has a blood pressure of 130/89, pulse of 122 bpm, respiratory rate of 32, and an oxygen saturation on 77% on room air.

Tolerating diet, activity, etc.: Patient is NPO, comfort care/hospice care.

Physician notifications:

- NONE listed in the chart, I was unsure if this is because the patient is on hospice, and we are trying to keep her comfortable.

Future plans for client: Hospice care

Discharge Planning (2 points)

Discharge location: Inpatient hospice but ultimately home hospice is the goal.

Home health needs (if applicable): Hospice care aid

Equipment needs (if applicable): N/A

Follow up plan: Follow up with hospice home health.

Education needs: Educate patient's family on Hospice care and what this means for the patient. dia

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. Powerlessness related to change in health status as evidenced by loss of independence	**Patient was unresponsive and unable to make decisions for herself**	**1. Do not provide false hope.** **2. Advocate for the patient's and family's wishes.**	**1. patient's family and patient will participate in end-of-life care.**	**The patient is unable to speak and make decisions for herself so her son who is poa was making end of life care decisions for her.**
2. Death anxiety related to the anticipation of death as evidenced by powerlessness	**The patient is unable to express her feelings and her family is**	**1. explain signs and symptoms of impending death** **2. involve mental, spiritual, and**	**1. patient and patient's family will express acceptance of impending**	**The patient was unable to verbalize her understanding but patient's sons are**

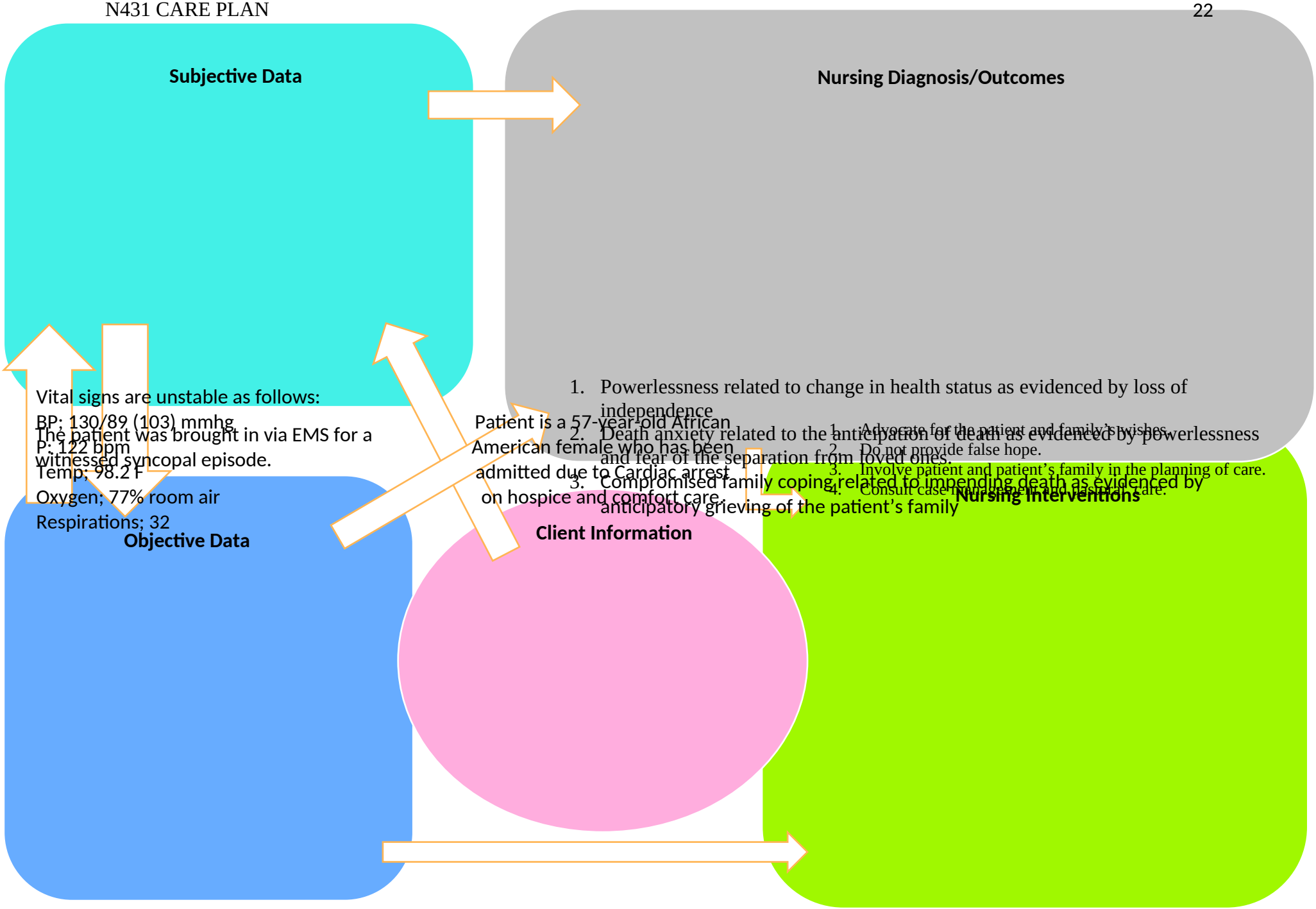
	and fear of the separation from loved ones	**noticeably anxious as they know she is going to pass soon.**	**social support**	**passing of the patient.**	**accepting and aware of diagnosis.**
3. Compromised family coping related to impending death as evidenced by anticipatory grieving of the patient's family	**The patient's family is going to experience a huge loss with the loss of their mother, the patient.**	**1. Involve the patient and patient's family in planning of care.** **2. Get case management and spiritual services involved in the patient's care.**	**1. patient and patient's family will demonstrate effective coping strategies during the patient's end of life.**	**The patient's family was coping well and comforting their mother, the patient, as much as possible during her possible last days.**
4.		**1.** **2.**	**1.**	

Other References (APA):

Swearingen, P. L., & Wright, J. (2018). All-in-One Nursing Care Planning Resource: Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health (5th ed.). Mosby.

Wagner, M. (2023, March 11). *End-of-life (hospice care) nursing diagnosis & care plan*. NurseTogether. https://www.nursetogether.com/end-of-life-hospice-nursing-diagnosis-care-plan/

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Vital signs are unstable as follows:
BP; 130/89 (103) mmhg
P; 122 bpm
Temp; 98.2 F
Oxygen; 77% room air
Respirations; 32
Objective Data
The patient was brought in via EMS for a witnessed syncopal episode.
Patient is a 57-year-old African American female who has been admitted due to Cardiac arrest on hospice and comfort care.
Client Information
1. Powerlessness related to change in health status as evidenced by loss of independence
2. Death anxiety related to the anticipation of death as evidenced by powerlessness and fear of the separation from loved ones.
3. Compromised family coping related to impending death as evidenced by anticipatory grieving of the patient's family
1. Advocate for the patient and family's wishes.
2. Do not provide false hope.
3. Involve patient and patient's family in the planning of care.
4. Consult case management and hospital care.
Nursing Interventions