N431 CARE PLAN #1

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Lakeview College of Nursing

N441: Adult Health 3

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Date: 9/22/2024

Demographics

Date of Admission 9/17/2024	**Client Initials** B. S	**Age** 62	**Biological Gender** Male
Race/Ethnicity African American	**Occupation** Retired	**Marital Status** Single	**Allergies** Lisinopril (High alert), Chantix (Medium alert), Dilaudid, Ketor alac, morphine, oxycodone, amlodipine, atorvastatin calcium, gabapentin, temazepam, adhesive tapes/silicones, and Mobic.
Code Status Attempt CPR/Full treatment	**Height** 5’ 6” (167.6 cm.)	**Weight** 166 Lb. 7.2 oz. (75.5 kg.)	

Medical History

Past Medical History: Allergic conjunctivitis, allergic rhinitis, AVM of small bowel-acquired, back ache/bulging disc, CAD (s/p left heart catheterization 2/17/21), chronic anemia, chronic pain of shoulders and knees, chronic respiratory failure, COPD, CVA (5/21/18), degenerative disc disease (lumbar), CVA 9/17/18), duodenitis, epigastric pain 11/24/18, essential hypertension, GERD 11/24/18, HRrEF 9/17/18, hyperlipidemia, neuropathic pain both feet and hands 9/21/18, NSTEMI/MI 2/4/19, polysubstance use disorder, pulmonary HTN, S/P mitral valve clip implantation, severe tricuspid regurgitation (echo 9-29-23), sleep apnea w/use of CPAP at night, tobacco use, acute fluid overload, chronic kidney disease, and acute on chronic hypoxic respiratory failure.

Past Surgical History: AV fistula creation left arm 10/15/19, AV fistula ligation 9/18/23, arm/hand soft tissue procedure/right arm evacuation of hematoma 12/18/22, left AV fistula gram 9/10/20, catheterization lab 4-25-23, colonoscopy 9/15/15, colonoscopy 2/12/20, colonoscopy

1/20/22, colonoscopy 8/26/22, colonoscopy 2/25/23, colonoscopy 5/29/24, double balloon upper antegrade endoscopy 12/29/22, double balloon upper antegrade endoscopy 12/1/23, EGD colonoscopy/gastroscopy (upper/lower GI) 9/14/21, EGD colonoscopy/gastroscopy (upper/lower GI) 12/4/21, EGD colonoscopy/gastroscopy (upper/lower GI) 7/19/22, EGD sigmoidoscopy 8/13/20, ICD insertion 11/18/20, IR ash catheter removal 11/18/20, IR chest tube placement (left) 1/21/22, IR chest tube placement (left) 4/17/23, IR chest tube placement (right) 1/21/21, IR tunneled dialysis catheter insertion 10/11/19, IR tunneled dialysis catheter insertion 8/25/20, IR tunneled dialysis catheter insertion 8/11/23, IR US abdomen 4/17/23, IR US abdomen 1/21/22, IR US venous access 10/11/19, IR US venous access 8/25/20, IR US venous access 9/10/20, IR US venous access 8/11/23, right knee arthroscopy (no date given), left heart catheterization 2/7/19, right and left heart catheterization 2/17/21, right and left heart catheterization 10/6/22, right heart catheterization 8/23/19, right heart catheterization 4/25/23, left rotator cuff repair (no date given), sigmoidoscopy 6/12/20, single balloon endoscopy 2/27/23, 6/9/23, single balloon endoscopy 8/3/23, small bowel endoscopy 8/24/22, small bowel endoscopy 11/19/23, small bowel endoscopy 2/2/24, small bowel endoscopy 5/28/24, TMVR 11/1/22, video capsule endoscopy 1/20/22, video capsule endoscopy 7/19/23, and wisdom teeth extraction (no date given).

Family History: The patient reports a maternal history of diabetes, stroke, glaucoma, and hyperlipidemia. A paternal history of CAD.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient reports cigarette use of 0.25 packs per day for 20 years. The patient denies the use of smokeless tobacco and vapes. The patient reports no current drug use and no use of alcohol.

Education: The patient reports that he obtained a high school diploma and denies any higher-level education.

Living Situation: The patient reports that he currently lives with his brother and depends on his brother for assistance with transportation needs and any care that he is not able to provide for himself.

Assistive devices: The patient reports utilization of 6 L. O2 via nasal canula while at home and in the hospital. The patient denies the use of a walker or other assistive devices outside of the hospital setting.

Admission History

Chief Complaint: The patient reports experiencing extreme chest pain, SOB, diarrhea, abdominal pain, and COPD related complications after a fall three days prior to being transported to the ER.

History of Present Illness (HPI)– OLD CARTS

The patient a 62-year-old African American male presented to the ER on 9/17/2024 experiencing extreme chest pain, SOB, diarrhea, abdominal pain, and COPD related complications. The patient reports that he lives with his brother and that his brother called the ambulance when he realized that his condition was worsening. The patient reports a fall three days prior to reporting to the hospital but denies hitting his head during the occurrence. The patient reports experiencing jaw pain and swelling below his ear following the fall and that he has experienced total body pain including his chest, abdomen, and face since the fall as well. The patient reports that he has not experienced any dizziness, fever, or headache. The patient states that “chest pain is worse with exertion and that nothing relieves the pain”. The patient utilizes 6 L. of continuous oxygen via nasal canula at home and reports that he is non-compliant with his

dialysis that is ordered for 3 days per week. The patient reports that he has not attended dialysis in the past three weeks. Peripheral IV placement located in the proximal right forearm placed in the ER 9/17/24 and noted at a 20 G. AV fistula located in left arm.

Admission Diagnosis

Primary Diagnosis: Noncompliance with dialysis related to chronic kidney disease diagnosis.

Secondary Diagnosis (if applicable): Uncontrolled HTN and emphysema.

Pathophysiology

Chronic kidney disease (CKD) left untreated can progress into end stage kidney failure resulting in the loss of kidney function, electrolyte imbalance, anemia, fluid retention, and death. CKD is often not detected until the condition has reached an advanced stage and requires more aggressive treatments even after pinpointing and treating the initial cause of impairment (Mayoclinic.org, 2024).

The kidneys are utilized by the body to filter waste from the body including blood and fluid and excreted as urine. If the kidneys are not functioning correctly this waste may build up and affect not only the kidneys but other systems as well. CKD is often a manifestation of another illnesses including diabetes, HTN, glomerulonephritis, interstitial nephritis, polycystic kidney disease, obstruction of the urinary tract, vesicoureteral reflux, frequent kidney infections, and kidney stones. Signs and symptoms include nausea, vomiting, loss of appetite, fatigue, sleep disturbances, changes in urination, muscle cramps, edema, change in mental status, skin changes, HTN, SOB, chest pain, and fluid retention (Mayoclinic.org, 2024).

CKD can affect multiple organ systems negatively affecting the patient by placing them at risk for HTN, pulmonary edema, heart disease, hyperkalemia, anemia, weakened bone strength, decreased sex drive, CNS damage, immune response vulnerability, pericarditis, and

irreversible kidney damage. Once CKD has led to irreversible kidney damage the patient is now dependent on hemodialysis to assist in the filtering of the patient's blood or utilizing a kidney transplant. Dialysis is the artificial filtering of the body's blood through a dialyzer at a rate of 200-400 mL/minute. The patient will have a surgical procedure placing a fistula in their arm to utilize this filtration process during hemodialysis. This process removes the excess fluid and solutes from the blood and cleanses the blood with a sterile solution then returns the blood back into the body through the cephalic vein. Imbalances are corrected during this process and BUN, electrolyte, albumin, creatinine are returned to normal values (Capriotti & Frizzell, 2020).

Education is key for the patient they should be aware of risk factors of CKD including HTN, diabetes, cardiovascular disease, smoking obesity, family history, older age, medications that damage the kidney, abnormal structure of the kidney, and having African American or Asian American decent (Capriotti & Frizzell, 2020).

The primary diagnosis was established for this patient due to the admission diagnosis of noncompliance with dialysis related to the patient's diagnosis of CKD. The patient's signs and symptoms upon admission of SOB, chest pain, abdominal pain, and nausea are all signs and symptoms related to CKD. The treatment for the patient's symptoms included continuous cardiac monitoring, administration of continuous oxygen via nasal canula set a 6 L., dietician consultation, social worker consultation, medication to treat and prevent nausea, AMB-IR biopsy drainage for ascites, breathing treatments, medication regimen, MRSA related contact isolation, and hemodialysis ordered for 3 times a week.

The patient also has been educated on the process of hemodialysis and kidney transplantation because of the possibility that the patient may be a candidate in the future for a transplant procedure and will need a basic understanding. The patient should also understand the

importance of not being compliant with hemodialysis treatments and what the result could be from missing dialysis appointments.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed.). F.A. Davis Company.

Mayo Clinic Staff. (2024). *Chronic Kidney Disease*. Mayoclinic.org. https://www.mayoclinic.org/diseases-conditions/chronic-kidney-disease/symptoms-causes.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Creatinine	29.61 mg/dL	7.55 mg/dL	0.70-1.30 mg/dL	Elevated creatinine can be related to kidney dysfunction related to the patient's chronic kidney disease diagnosis.
Albumin	3.6 g/dL	2.7 g/dL	3.4-4.8 g/dL	Decreased levels of albumin can be related to kidney dysfunction related to chronic kidney disease.
Calcium	6.3 mg/dL	7.0 mg/dL	8.9-10.6 mg/dL	Decreased levels of calcium can be related to

				thyroid function related to the patient's hyperparathyroidism diagnosis.
RBC	2.50 10^3/uL	2.31 10^3/uL	4.10-5.70 10^3/uL	Decreased RBC levels can be related to the patient's anemia diagnosis.
HGB	7.4 g/dL	6.8 g/dL	12.0-18.0 g/dL	Decreased HGB occurs when RBC levels are decreased, and this can be related to the patient's anemia diagnosis.
MCHC	32.6 g/dL	30.1 g/dL	32.0-36.0 g/dL	Decreased MCHC levels can be related to the patient's anemia diagnosis.
RDW	22.5 %	21.1 %	12.0-15.0 %	Elevated RDW levels can be related to the patient's anemia diagnosis.
RDW-SD	76.1 FL	75.4 FL	36.7 – 46.1 FL	Elevated RDW-SD levels can be related to the patient's anemia diagnosis.

Platelet	139 10^3/uL	126 10^3/uL	140-400 10^3/uL	Decreased platelet count can be related to the patient's anemia and chronic kidney disease diagnosis.
Absolute Lymph	0.72 10^3/uL	0.51 10^3/uL	1.00-4.90 10^3/uL	Decreased levels of absolute lymph can be a result of the use of corticosteroids. The patient is currently prescribed fluticasone propionate (Flonase).
Troponin	67 ng/mL	58 ng/mL	0-0.04 ng/ml	Increased troponin levels can be related to an emergent cardiac situation. Increased troponin can also be related to the patient's chronic kidney disease diagnosis.

Diagnostic Test & Purpose	**Clients Signs and Symptoms**	**Results**

ECG 12 lead is utilized to measure how fast/slow the heart is beating and to assist in finding the cause of chest pain and shortness of breath being experienced by the patient (Capriotti & Frizzell, 2020).	Chest pain, shortness of breath, and client's cardiac history. The patient has a history of chronic chest pain, CAD, HF with reduced ejection fraction, and HTN.	Normal sinus rhythm, t-wave normal, possible inferior infarct, prolonged QT, and abnormal ECG.
IR US paracentesis is utilized to drain a collected pocket of fluid within the abdomen. An ultrasound is often utilized prior to assisting in locating the fluid (Capriotti & Frizzell, 2020).	Ascites a build up of fluid located within the patient's abdomen. This could be related to not following a strict cardiac diet and consuming excessive amounts of sodium.	Removal of 4 L of dark straw fluid collected with no complications noted.

Diagnostic Test Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed.). F.A. Davis Company.

Active Orders

Active Orders	Rationale

Cardiac monitoring 24 hours until discontinued.	The patient reported chest pain on arrival at the ED and has an extensive cardiac history that is necessary to be monitored.
Consult a dietician.	The patient is non-compliant with a cardiac diet at home and requires a consultation with the dietician while admitted into the hospital. Education will also be provided for the patient's continued cardiac diet at home.
Hemodialysis ordered weekly M/W/F.	Hemodialysis is ordered related to the patient's previous hemodialysis orders and non-compliance reported.
Consult Social worker.	The social worker is beneficial to assist the client with obtaining transportation assistance. The client requires transportation assistance to maintain his ability to attend dialysis and other medical appointments.
Consult nephrology	A nephrology consult is related to the patient's diagnosis of chronic kidney disease and noncompliance of hemodialysis.
Isolation contact ordered regarding MRSA diagnosis.	The patient's MRSA diagnosis requires contact isolation when entering the patient's room.
AMB-IR biopsy drainage requested related to	The order for drainage is related to the

ascites.	patient's ascites located within the abdomen. Removal is not only required for comfort but also to obtain a sample for testing.
Consult gastroenterology related to recurring anemia.	Gastroenterology assists in the treatment of the patient's recurring anemia.
Code status attempt CPR/Full Treatment.	Each patient requires a code status to determine what treatment the hospital staff can perform if a patient codes while admitted. This patient requires all life saving measures including CPR.
Administration of Blood once.	The patient requires a blood transfusion related to anemia.

Medications

Home Medications (Must List ALL)

Brand/ Generic	Albuterol HFA	pantoprazole (Protonix)	iron sucrose (Venofer)	Calcitriol (Rocaltrol)	carvedilol (Coreg)	Diphenhydramine (Benadryl)
Classification	Pharmacologic Class: Adrenergic. Therapeutic class: Bronchodilator (Nurse's Drug Handbook, 2023).	Pharmacologic Class: Proton pump inhibitor. Therapeutic class: Antiulcer (Nurse's Drug	Pharmacologic Class: Iron mineral. Therapeutic class: Hematinic (Nurse's Drug Handbook	Pharmacologic Class: Vitamin D analogue. Therapeutic class: Anti hypocalemic (Nurse's	Pharmacologic Class: nonselective beta blocker and alpha-1 blocker. Therapeutic class: Antihypertensive, heart	Pharmacologic Class: Antihistamine. Therapeutic class: Antianaphylactic adjunct, antidyskinet

		Handbook, 2023).	, 2023).	Drug Handbook, 2023).	failure treatment adjunct (Nurse's Drug Handbook, 2023).	ic, antiemetic, antihistamine, antitussive, antivertigo, sedative-hypnotic (Nurse's Drug Handbook, 2023).
Reason Client Taking	Shortness of breath.	Prevention of heartburn.	Anemia	Treatment of hypocalcemia related to dialysis.	Treatment of hypertension.	Itching
List two teaching needs for the medication pertinent to the client	Educate the patient on the importance of washing the mouthpiece of the inhaler once a week with water and allowing it to dry before replacing the devices cap (Nurse's Drug Handbook, 2023). Educate the patient to wait one minute between each inhalation (Nurse's Drug Handbook, 2023).	Educate the patient to notify the PCP immediately if a decrease in urine or if blood in the urine occurs (Nurse's Drug Handbook, 2023). Educate the patient to provide a listing of over the counter or herbal medications to the provider before	Educate the patient to report signs of an allergic reaction including rash, swelling, light headedness, breathing issues, and itching Drug Handbook, 2023). Educate the patient about s/s of iron overload including abnormal bleeding,	Educate the patient not to take other forms of vitamin D while utilizing this medication (Nurse's Drug Handbook, 2023). Educate the patient to take a missed dose as soon as possible (Nurse's Drug Handbook, 2023).	Educate the patient that this medication should be taken with food (Nurse's Drug Handbook, 2023). Educate the patient that this medication may cause dizziness, light headedness, and orthostatic hypotension and that precautions when standing from a	Educate the patient to only take the ordered dose (Nurse's Drug Handbook, 2023). Educate the patient that this medication should be taken with food (Nurse's Drug Handbook, 2023).

		taking this medication (Nurse's Drug Handbook, 2023).	fatigue, and sedation (Nurse's Drug Handbook, 2023).		lying down position will need to be taken (Nurse's Drug Handbook, 2023).	
Key nursing assessment(s) prior to administration	Assess the patient's vitals and be aware of an increased heart rate or blood pressure before administration of the medication because albuterol can increase the patient's HR and BP (Nurse's Drug Handbook, 2023). Monitoring of the patient's potassium levels is important in prevention of hypokalemia related diagnosis from albuterol use (Capriotti & Frizzell, 2020).	Assess the patient's urine output and bowel movements for abnormal consistency, bleeding, or an inadequate amount produced (Nurse's Drug Handbook, 2023). Magnesium and calcium lab results are monitored prior to administration of this medication (Capriotti & Frizzell,	Confirm with the patient if they have experienced previous reactions to iron products previously (Nurse's Drug Handbook, 2023).	Assess for skin lesions, preexisting liver conditions, serum calcium levels, magnesium levels, alkaline phosphate levels, and radiology related to bone conditions to assist in the determination of the patients baseline status prior to the administration of the medication (Nurse's Drug Handbook, 2023).	Assess the patient's vitals and auscultate heart sounds before administering the medication (Nurse's Drug Handbook, 2023).	Assess allergies, lung sounds, sleep patterns, cough, and lung sounds (Nurse's Drug Handbook, 2023).

		2020).				
Brand/ Generic	nitroglycerin (Nitrostat)	naloxone hydrochloride (Narcan)	methoxy polyethylene glycol-epoetin beta (Mircera)	fluticasone propionate (Flonase)	folic Acid (Folvite)	promethazine hydrochloride (Prometheg an)
Classification	Pharmacologic Class: Nitrate. Therapeutic class: Antianginal, vasodilator (Nurse's Drug Handbook, 2023).	Pharmacologic Class: Opioid antagonist. Therapeutic class: Antidote (Nurse's Drug Handbook, 2023).	Pharmacologic Class: Erythropoietin. Therapeutic class: Antianemia (Nurse's Drug Handbook, 2023).	Pharmacologic Class: Corticosteroid. Therapeutic class: Antiasthmatic, anti-inflammatory (Nurse's Drug Handbook, 2023).	Pharmacologic Class: Vitamins (Nurse's Drug Handbook, 2023).	Pharmacologic Class: Phenothiazine. Therapeutic class: Antihistamine (Nurse's Drug Handbook, 2023).
Reason Client Taking	Treatment of acute angina.	Opioid induced respiratory depression.	Treatment of anemia.	Management of nasal congestion.	Management of vitamin deficiency related to anemia**.**	Nausea.
List two teaching needs for the medication pertinent to the client	Educate the patient to contact PCP if they experience blurred vision, dizziness or severe headache (Nurse's Drug Handbook, 2023). Educate patient on s/s of angina	Educate the patient on the s/s of opioid induced respiratory depression (Nurse's Drug Handbook, 2023). Educate the patient and family on	Educate the patient on administering the drug properly and disposing of needles properly (Nurse's Drug Handbook, 2023).	Educate the patient to wait at least 1 minute between each inhalation (Nurse's Drug Handbook, 2023). Educate the patient rinse	Educate the patient on the importance of eating a folate rich food diet and provide a listing of the items included within the diet (Nurse's Drug Handbook,	Educate the patient to avoid excessive sunlight exposure (Nurse's Drug Handbook, 2023). Educate the patient to contact PCC before utilizing

	pectoris and how to utilize this medication properly by following the instructions (Nurse's Drug Handbook, 2023).	how to administer the medication and to contact 911 once administered (Nurse's Drug Handbook, 2023).	Educate the patient on the importance of compliance with this medication dose regimen and appointments regarding this medication (Nurse's Drug Handbook, 2023).	mouth after each use of the inhaler (Nurse's Drug Handbook, 2023).	2023). Educate the patient to contact the PCP if the following occurs because the dose may need to be lowered. Nausea, loss of appetite, stomach pain, trouble concentrating or sleeping, excessive bloating, confusion, mood changes like depression, or impaired judgment (Nurse's Drug Handbook, 2023).	OTC medications with this medication (Nurse's Drug Handbook, 2023).
Key nursing assessment(s) prior to administration	Check vital signs and LOC before each dose (Nurse's Drug Handbook, 2023).	Assess the patient to ensure they are experiencing an overdose and not sedation. S/S of overdose include	Assess the patient's iron levels and vitals specifically the patients blood pressure before administration	Assess the patient's vitals and note the baseline to measure the medications effectiveness	Assess the patient for Skin lesions, color, and adventitious sounds. Also confirm lab work including CBC, Hgb,	Assess the patient's history of sedation and CNS depression effect before administering this medication (Nurse's

		faint pulse, slow breathing or no breathing, blue or gray in color, deep snore or gurgle, and pale or clammy skin (Nurse's Drug Handbook, 2023).	(Nurse's Drug Handbook, 2023).	(Nurse's Drug Handbook, 2023).	Hct, serum folate levels, serum vitamin B12 levels, Schilling test (Nurse's Drug Handbook, 2023).	Drug Handbook, 2023).
Brand/ Generic	rosuvastatin calcium (Crestor)	sevelamer carbonate (Renvela)	venlafaxine hydrochloride (Effexor XR)	Benzocaine (Orajel)	octreotide microspheres (Sandostatin)	sennosides (Ex-lax)
Classification	Pharmacologic: HMG-CoA reductase inhibitor. Therapeutic: Antilipemic (Nurse's Drug Handbook, 2023).	Pharmacologic: Polymeric phosphate binder. Therapeutic: Phosphate binder (Nurse's Drug Handbook, 2023).	Pharmacologic: SSNRI Therapeutic: Antidepressant (Nurse's Drug Handbook, 2023).	Pharmacologic: Topical anesthetic (Drugs.com, 2024).	Pharmacologic: Somatostatin and somatostatin analogs (Drugs.com, 2024).	Pharmacologic: Laxatives (Drugs.com, 2024).
Reason Client Taking	Treatment of hyperlipidemia.	Phosphate levels related to chronic kidney	Treatment of depression and anxiety.	Gum and tooth pain.	Regulation of blood sugar.	Treatment of constipation.

		disease and dialysis.				
List two teaching needs for the medication pertinent to the client	Encourage the patient to follow a low fat/ low cholesterol diet (Nurse's Drug Handbook, 2023). Educate patient that utilizes antacids to wait 2 hours after taking this medication to use antacids (Nurse's Drug Handbook, 2023).	Educate the patient to take all other medications 1 hour before or 3 hours after taking this medication (Nurse's Drug Handbook, 2023). Educate the patient to take this medication with meals (Nurse's Drug Handbook, 2023).	Educate the patient on the importance of taking this medication as ordered and not stopping this medication abruptly (Nurse's Drug Handbook, 2023). Educate the patient's family to monitor the patient for suicidal tendencies while taking this medication (Nurse's Drug Handbook, 2023).	Educate the patient to contact PCP if the patient has a history of asthma, bronchitis, emphysema, breathing disorders, smoking, or heart disease (Drugs.com, 2024). Educate the patient to avoid eating or drinking for 1 hour after medication administration (Drugs.com, 2024).	Educate the patient to throw injection pen away after 28 days (Drugs.com, 2024). Educate the patient to contact the PCP if a dose is missed (Drugs.com, 2024).	Educate the patient not to take other medications within two hours of taking this medication (Drugs.com, 2024). Educate the patient not to take two doses at the same time if a dose is missed (Drugs.com, 2024).
Key nursing assessment(s) prior to administration	Assess the patient's LDL and HDL results. Assess the patient for hypercholesterolemia (Nurse's Drug	Assess the patient for constipation and confirm last bowel movement (Nurse's	Assess the patient for baseline for future comparison. Also evaluate the	Assess the patient's mouth for bleeding, open sores, or drainage (Drugs.co	Assess the patient's blood sugar, vitals, and thyroid related labs (Drugs.com	Assess the patient for constipation and confirm last bowel movement.

	Handbook, 2023).	Drug Handbook, 2023).	patient's lab results to ensure renal and hepatic function (Nurse's Drug Handbook, 2023).	m, 2024).	, 2024).	

Hospital Medications (Must List ALL)

Brand/ Generic	Calcium Carbonate (Tums)	guaifenesin (Mucinex)	acetaminophen (Tylenol)	heparin sodium (Heparin injection)	oxygen systemic (Oxygen)	carbamide peroxide (Debrox)
Classification	Pharmacologic: Calcium salts Therapeutic: Antacid (Nurse's Drug Handbook, 2023).	Pharmacologic Class: Expectorant. Therapeutic class: Expectorant (Drugs.com, 2024).	Pharmacologic: No salicylate, para-aminophenol derivative. Therapeutic: Antipyretic, nonopioid analgesic (Nurse's Drug Handbook, 2023).	Pharmacologic Class: Anticoagulant. Therapeutic class: Anticoagulant (Nurse's Drug Handbook, 2023).	Pharmacologic: Medical gas (Drugs.com, 2024).	Pharmacologic: Astringents (Drugs.com, 2024).
Reason Client Taking	Reflux symptoms.	Cough and chest congestion.	Pain management.	Prevention of blood clots. Utilized as	Shortness of breath and hypoxia.	Cerumen Removal.

				a lock solution to assist with maintaining patency of venous catheter during dialysis.		
List two teaching needs for the medication pertinent to the client	Ensure the patient is educated that the tablets should be chewed completely before swallowing the tablet (Nurse's Drug Handbook, 2023). Educate the patient on the importance of utilizing this medication within 1 to 2 hours after meals (Nurse's Drug Handbook, 2023).	Educate the client to refrain from eating or drinking for at least thirty minutes following the ingestion of the medication (Drugs.com, 2024). Educate the patient on the importance of increasing their fluid intake while utilizing this medication and how it will assist in loosening mucus and clear congestion (Drugs.com, 2024).	Educate the patient not to exceed the daily recommender amount of acetaminophen because of the risk of liver damage (Nurse's Drug Handbook, 2023). Educate the patient on the signs and symptoms of hepatotoxicity including bleeding, bruising, and malaise (Nurse's	Educate the patient on the use of Heparin and aspirin together and that it can increase the risk of bleeding (Nurse's Drug Handbook, 2023). Educate the patient on the importance of refraining from daily activities that may cause bleeding to occur. Suggest that the patient utilize a soft toothbrush and brush gently.	Educate the patient to follow the provider's instructions to utilize 6 L. of oxygen continuously 24 hours a day. Educate the patient about the dangers of smoking while utilizing oxygen.	Educate the patient to tilt their head sideways and instill 5–10 drops of the solution into the ear (Drugs.com, 2024). Educate the patient to keep the solution in ear the canal for several minutes by tilting the head (Drugs.com, 2024).

			Drug Handbook, 2023).	Encourage the patient to use an electric razor to avoid razor cuts that could lead to uncontrolled bleeding may occur with this use of this medication (Nurse's Drug Handbook, 2023).		
Key nursing assessment(s) prior to administration	Serum calcium levels monitored frequently to ensure calcium levels are within a safe range (Nurse's Drug Handbook, 2023). Therapeutic response of the patient should be monitore	Assess the patient's current cough and expectorants, vitals, and any respiratory depression before administering the medication (Drugs.com, 2024).	Assess the patient's total daily intake of acetaminophen including over the counter medications that contain acetaminophen to ensure the safe daily dosage is not exceeded (Nurse's Drug Handbook, 2023).	Assess the patient for any abnormal bleeding and address the bleeding immediately (Nurse's Drug Handbook, 2023). Monitoring of PTT lab results is the test used when heparin is being utilized (Capriotti & Frizzell, 2020).	Assess the patient's oxygen level and if the patient is experiencing respiratory depression/SOB.	Assess the ear for any bleeding or discharge before administering medication.

	d by assessing the patient for a negative Troussea u's sign and Chvostek 's sign (Nurse's Drug Handboo k, 2023).		Monitori ng of the patient's electrolyt es, ALT, AST, bilirubin, creatinine , glucose, PT, and PTT lab results to assist in the preventio n of liver associate d injuries (Capriotti & Frizzell, 2020).			
Brand/ Generic	epoetin alfa (Procrit)	hydralazin e hydrochlor ide (Apresolin e)	ondansetr on (Zofran)	prochlorpe razine (Compro)	melatonin (Melatonin)	
Classific ation	Pharmaco logic Class: Recombi nant human erythropo ietin (Drugs.co m, 2024).	Pharmacol ogic Class: Vasodilato r. Therapeuti c Class: Antihypert ensives (Nurse's Drug Handbook, 2023).	Pharmaco logic Class: Selective serotonin receptor antagonis t. Therapeu tic Class: Antiemeti c (Nurse's Drug Handboo k, 2023).	Pharmacol ogic Class: Piperazine and phenothia zine. Therapeuti c Class: Antiemeti c (Nurse's Drug Handbook , 2023).	Pharmacologic Class: electrolytes, Miscellaneous, Nutraceutical products (Drugs.com, 2024).	
Reason Client	Treatmen t of	Treatment of	Nausea preventio	Control nausea.	Insomnia prevention.	

Taking	anemia related to CKD.	hypertension.	n.			
List two teaching needs for the medication pertinent to the client	Educate the patient about S/S of blood clots (Drugs.com, 2024). Educate the patient to contact the provider if they experience heart attack or stroke related symptoms (Drugs.com, 2024).	Educate the patient to take this medication without food (Nurse's Drug Handbook, 2023). Educate the patient to change positions slowly especially in the morning (Nurse's Drug Handbook, 2023).	Educate the patient to report signs of a rash formation immediately (Nurse's Drug Handbook, 2023). Educate the patient cardiac adverse reactions and to report them to the PCP immediately (Nurse's Drug Handbook, 2023).	Educate the patient to sit or stand slowly from lying position to minimize the effects of orthostatic hypotension (Nurse's Drug Handbook, 2023). Educate the patient to contact the PCP about restlessness or involuntary movements (Nurse's Drug Handbook, 2023).	Educate the patient about avoiding operation of machinery for at least 4 hours after taking the medication (Drugs.com, 2024). Educate the patient to avoid caffeinated drinks when taking this mediation (Drugs.com, 2024).	
Key nursing assessment(s) prior to administration	Assess the patient's vitals and potassium levels. (Drugs.com, 2024).	Assess blood pressure, pulse rate, and weight (Drugs.com, 2024).	Assess for electrolyte imbalances (Nurse's Drug Handbook, 2023).	Assess the patient's vitals and for any sign of CNS depression (Nurse's Drug Handbook	Assess the patients blood pressure and hold if patient is experiencing hypotension (Drugs.com, 2024).	

				, 2023).		

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. oxygen systemic (Oxygen)	Assists in the prevention of Shortness of breath and hypoxia.	**1.** Over oxygenation can lead to severe chest pain. **2.** Over oxygenation can lead to difficulty breathing.
2. epoetin alfa (Procrit)	Because it is vital in the treatment of anemia related to CKD.	**1.** Change in heart rate causing tachycardia or bradycardia. **2.** Change in breathing pattern and shortness of breath.
3. hydralazine hydrochloride (Apresoline)	This medication is vital in the treatment of hypertension.	**1.** Experiencing fast pounding or irregular heartbeat or pulse. **2.** Experiencing chest pain or discomfort.

Medications Reference (1) (APA)

Capriotti, T., & Frizzell, J. P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed.). F.A. Davis Company.

Drugs.com staff. (2024). *Acetaminophen.* Drugs.com. https://www.drugs.com/druginteractions/acetaminophen-with-proair-hafa-11-0-109-2464.html.

Drugs.com staff. (2024). *Carbamide Peroxide.* Drugs.com. https://www.drugs.com/monograph/carbamide-peroxide-eent.html.

Drugs.com staff. (2024). *Epoetin alfa.* Drugs.com. https://www.drugs.com/mtm/epoetin-alfa.html.

Drugs.com Staff. (2024). *Guaifenesin.* Drugs.com. https://www.drugs.com/guaifenesin.html.

Drugs.com Staff. (2024). *Octreotide*. Drugs.com. https://www.drugs.com/octreotide-oral-injection.html.

Drugs.com. (2024). *Oxygen*. Drugs.com. https://www.drugs.com/international/oxygen.html

Drugs.com Staff. (2024). *Orajel.* Drugs.com. https://www.drugs.com/orajel.html

Drugs.com Staff. (2024). *Sennosides.* Drugs.com. https://www.drugs.com/cdi/sennosides-chewable-tablets.html.

Learning, J. & B. (2022). *Nurse's Drug Handbook 2023*. Jones & Bartlett Learning.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:** **Infection Control precautions:** **Client Complaints or Concerns:**	The patient is alert and oriented x4 to person, place, and time. The patient is well groomed, coherent, and no acute distress. MRSA/contact precautions. Patient denies any complaints or concerns.
VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:**	Temp: 97.9 Resp rate: 16 Pulse: 58 B/P: 140/76 O2: 100% with nasal cannula @ 6 L.

Oxygen: **Delivery Method:**	
PAIN ASSESSMENT: **Time:** **Scale:** **Location:** **Severity:** **Characteristics:** **Interventions:**	The patient denies pain and rates his pain a 0 out of 10 on a numeric pain scale. No interventions were performed 9/22/24 at 10:30.
IV ASSESSMENT: **Size of IV:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **Fluid Type/Rate or Saline Lock:**	The patient's 20 G peripheral IV is in the lower proximal right forearm and was placed 9/17/24. No signs of swelling, redness, or pain. IV site cool while flushing with normal saline. No signs of drainage. Dressing is clean and dry. No fluid utilized at this time. Saline lock in place for IV site.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin is pink, dry, and warm with no jaundice, bruising, wounds, damage, or rashes present. Skin turgor 3+. Braden score noted as 18 mild risks. No drain present. An incision is noted on the URQ of the abdomen related to the paracentesis performed 9/20/24. Continued monitoring of the incision area is noted related to the 4 L. of dark straw-colored fluid that was collected during aspiration. HD catheter tunneled double (central venous catheter) noted 8/11/23. AV fistula left arm 10/15/19.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head and neck are symmetrical, trachea is midline without deviation, thyroid is not palpable, no nodules noted. Bilateral carotid pulses palpable 2+. Eyes symmetrical bilaterally, sclera white, cornea clear, conjunctiva pink, no drainage. PERRLA bilaterally. Ears are symmetrical bilaterally with no visible or palpable deformities, lumps, or lesions. Bilateral frontal sinuses are nontender to palpation, septum is midline, turbinate noted as moist and pink bilaterally and no visible bleeding, drainage, or polyps noted. Oral mucosa moist/pink teeth are intact with no signs of missing or damaged teeth on the top or bottom. Uvula is midline and tonsils moist/pink. .

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:**	Clear S1 and S2 without murmurs, gallops, or rubs noted. Normal rate and rhythm noted. Brachial and radial pulses strong and steady 2 +, capillary refill 3+, no sign of vein distention noted. No edema present.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Normal rate and pattern of respirations, respiratory rate 58 bpm, respirations symmetrical and non-labored, lung sounds clear throughout anterior and posterior bilaterally, no wheezes, crackles, or rhonchi noted. Chest rises and falls evenly. No accessory muscle use or distress noted. Patient denies experiencing SOB or pain when breathing currently or within the last 24 hours. Patient reports that he utilizes 6 L. of oxygen provided via nasal canula continuously when at home and currently during his admittance to the hospital. Baseline noted between 96-100 with use of O2 at 6 L.
GASTROINTESTINAL: **Diet at home:** **Current Diet:** **Is Client Tolerating 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:**	The patient reports that he does not limit his diet at home regardless of the cardiac diet his PCP has suggested he follow. His current diet while at the hp consists of a cardiac diet which is related to his cardiac history. The patient's height is 5'6" and weight 166 lbs. 7.2 oz. Bowel sounds normal and active in all 4 quadrants and the client reports last BM as 9/22/24 at 08:00. Patient reports no pain, bleeding, or change in bowel movements. Abdomen is soft with no tenderness or pain reported in all 4 quadrants upon palpation. No distention, scars, drains, enlargements, masses, abnormalities, or wounds noted on abdomen. No ostomy, nasogastric, or feeding tube noted. An incision is noted on the URQ of the abdomen related to the paracentesis performed 9/20/24. Continued monitoring of the incision area is noted related to the 4 L. of dark straw-colored fluid that was collected during aspiration.

GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☒ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine is clear and yellow in color. The patient had a total of 130 mL of urine output during the shift, and the patient's last urination was 9/22/24 at 02:00. The patient's intake was 1400 mL during the shift. The patient reports that urine output is usually minimal because of decreased kidney function. The patient denies any pain experienced with urination currently. Dialysis is scheduled three times weekly. No inspection of genitals performed. No catheter present.
Intake (in mLs) **Output (in mLs)**	Intake: 1000 mL. Output: 100 mL.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Activity Tolerance:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	The patient does not exhibit any deficit in his neurovascular status. All extremities have full range of motion (ROM). Hand grips and pedal push and pulls demonstrate patient's normal and are equal strength. Supportive devices utilized at this time include a walker, gait belt, and a one-person standby assist related to the patient's cardiovascular diagnosis. ADL assistance for walking and transfers as a standby assist during the patient's HP admittance related to the patient's cardiovascular diagnosis and fall risk status. The fall risk is noted as yes. The patient's fall score is 65 and the patient is considered a high fall risk.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient is able to MAEW in all extremities. PERLA noted bilaterally, Equal strength in arms and legs noted bilaterally. The patient is oriented x 4 to person, place, situation, and time. Normal cognition noted. Speech is clear. Sensory normal. LOC alert.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:**	The patient states his coping methods consist of "keeping on pushing through as best I can". The patient states his developmental level is appropriate for his age and "he can read and

Personal/Family Data (Think about home environment, family structure, and available family support):	write independently". The patient can make fully informed decisions for himself at home and at the HP. Patient reports he would rather not report his religious beliefs. The patient reports that his support system consists of his brother while at home where he lives independently. The patient reports that he is a single and that he lives with his brother which assists him with transportation and other needs when he can.

Discharge Planning

Discharge location: The patient is scheduled to discharge to home independently today or tomorrow. The patient lives independently with his brother in the same home.

Home health needs: The patient will need a support system, oxygen/tubing, and transportation assistance provided through insurance when discharged to home. The patient will need a safety care plan when discharged along with education of health care needs and the importance of compliance to be utilized at home before final discharge from the hospital.

Equipment needs: Equipment needed to provide a safe environment for the patient when returning home includes proper education and equipment necessary for oxygen distribution. The patient may require temporary use of a walker and the removal of any environmental factors that may affect the patient's safety if he is still required to be a fall risk upon discharge.

Follow up plan: A follow-up plan to return home independently has been determined currently. A follow up plan may include the patient's discharge plan, future procedures related to the patient's current hospitalization, and future appointments with location, date, and time noted.

Education needs: The patient will need to be provided with education focused on a safety plan related to the importance of being compliant with the dialysis order, uncontrolled HTN, complications related to COPD and emphysema, medication administration, fall

prevention, and environmental safety within the patient's home. The patient should be aware of signs and symptoms that can alert the patient to the possible occurrence of kidney failure, respiratory failure, uncontrolled HTN, and COPD exacerbation. The patient should also be made aware of the process they can follow to prevent the occurrence from happening, for example utilizing 6 L. of continuous oxygen via nasal canula and completing dialysis weekly as ordered by the physician.

Nursing Process
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	**Outcome Goal (1 per dx)**	**Interventions (2 per goal)**	**Evaluation of interventions**
1. Impaired gas exchange related to ineffective breathing pattern as evidenced by shortness of breath (Phelps, 2023).	The patient reports experiencing shortness of breath that worsens with exertion. The patient has a history of acute and chronic respiratory failure with hypoxia.	Patient will maintain adequate ventilation and have clear breath sounds on auscultation before the patient is discharged (Phelps, 2023).	**1.**Administer and monitor oxygen therapy as ordered (Phelps, 2023). **2.** Record intake and output to monitor patient's fluid status (Phelps, 2023).	The patient was provided with 6 L. of continuous oxygen and O2 status was monitored frequently. Intake and output monitored and recorded in EPIC.
2. Deficient	The patient	Patient will	**1.** Negotiate	The patient was

knowledge related to inadequate commitment to learning as evidenced by non-participation in dialysis treatment (Phelps, 2023).	reports that noncompliance with participation in dialysis treatment has been an ongoing issue. The patient reports that recently he has not attended dialysis treatments for three weeks. Knowledge deficient and transportation are reported as contributing factors to the patient's noncompliance.	state intention to make needed changes in lifestyle by attending dialysis at the scheduled times weekly and utilize provided transportation during education provided by hospital staff (Phelps, 2023).	with patient to develop goals for learning. Encourage patient in planning meaningful goals and encourage the patient to follow through (Phelps, 2023). **2.**Provide patient with resources needed to obtain transportation and follow up after discharge (Phelps, 2023).	provided education and encouraged to create meaningful goals to be compliant with dialysis treatments. The social worker was contacted and resources and information for transportation based on insurance and financial status were requested to be reviewed with the patient before discharge.
3. Decreased cardiac output related to uncontrolled HTN as evidenced by chest pain (Phelps, 2023).	The patient reports experiencing chest pain and reports that his HTN diagnosis is not controlled.	Patient will understand the importance of maintaining a proper cardiac diet, mediation regimen, prescribed activity level while in the hospital and once returning home (Phelps, 2023).	**1.** Weigh patient daily before breakfast to detect fluid retention (Phelps, 2023). **2**.Maintain dietary restrictions as ordered including a cardiac diet, fluid restriction, and recording the patient's intake and output (Phelps, 2023).	The patient's weight was obtained before breakfast and charted. The patient was assisted with ordering breakfast, lunch, and dinner while observing the ordered cardiac diet. The patient's fluids have been restricted and recorded.

4. Fatigue related to a decreased level of HGB as evidenced by decreased physical exertion (Phelps, 2023).	The patient reports experiencing fatigue and decreased physical exertion. The patient has a history of anemia.	The patient will employ measures to prevent or modify fatigue (Phelps, 2023). The patient will utilize a blood transfusion, and prescribed medications.	**1.** Conserve energy through rest, planning, and setting priorities to prevent fatigue (Phelps, 2023). **2.** Encourage patient to eat foods rich in iron and minerals (Phelps, 2023).	The patient has been provided education to encourage energy conservation and assisted throughout the day with ADLs to assist in the prevention of fatigue. The patient has been proved a listing of foods rich in iron and minerals that will assist with the prevention of fatigue related to an anemia diagnosis.
5. Decreased activity tolerance related to inadequate oxygenation as evidenced by shortness of breath on exertion (Phelps, 2023).	The patient reports experiencing shortness of breath that worsens with exertion. The patient has a history of emphysema and respiratory failure.	The patient will perform self-care activities at tolerance level throughout the day and the need to increase activity level gradually (Phelps, 2023).	1. Support and encourage activity to patient's level of tolerance to assist with building the patient's independence (Phelps, 2023). 2. Provide emotional support and encouragement to improve the patient's self confidence to assist patient with the motivation to perform	The patient was provided encouragement to perform ADLs at his tolerance level. The patient was provided encouragement to perform ADLs independently.

			ADL's independently (Phelps, 2023).	

Other References (APA):

Phelps, L. L. (2023). *Nursing diagnosis reference manual*. Wolters Kluwer.