N441 CARE PLAN #1

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N441: Adult Health 3

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March 3rd, 2025

Demographics

Date of Admission	**Client Initials**	**Age**	**Biological Gender**
2/14/2025	A.B	38	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Single	No Known Allergies
Code Status	**Height**	**Weight**	
Full Code	162.6 cm 5’4’’	76.1 kg 167 lbs. 12.3 oz	

Medical History

Past Medical History: Migraine headaches, Hypertension, Drug abuse, Anxiety

Past Surgical History: Tubal ligation

Family History: Heart failure in the father, hypertension and type 2 diabetes in the mother. Grandfather on maternal side passed away from a heart attack.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient and patient’s family deny any tobacco, alcohol, or drug use. Urine drug screen came back positive for amphetamines and benzodiazepines. Patient’s family unaware of the drug use and was at the patient’s bedside the entire day so the nursing student was unable to assess frequency and longevity of use.

Education: High school diploma

Living Situation: The patient lives in Paris, IL with boyfriend and 5 children. Patient has mother, sisters, and aunts who all live nearby.

Assistive devices: This patient does not use any assistive devices.

Admission History

Chief Complaint: Sudden onset of extremely severe headache.

History of Present Illness (HPI)– OLD CARTS

Patient, A.B has some short-term memory loss and is unable to recall the events leading up to her ruptured brain aneurysm. According to the patient's family at bedside, A.B first presented to the emergency department (ED) of Paris Community Hospital on 2/13/25 complaining of a migraine headache. The patient appeared stable and was discharged from the ED on 2/13/25 with migraine medication. The following day on 2/14/25, the patient was washing dishes in the afternoon when she began experiencing a sudden, very severe headache. She was brought back to the ED at Paris Community Hospital by her boyfriend and upon arrival appeared slow moving and slightly stuporous, but was still oriented and able to answer questions. Because the patient does not remember this incident she was unable to describe if anything helped relieve her severe head pain or if certain things made it worse. Due to the patient's sudden "thunderclap" headache and altered mental status compared to the day before, she was given a stat CT which found a subarachnoid hemorrhage near the brainstem. As time went on in the ED, the patient's status continued to deteriorate, her speech became slurred, and she became increasingly difficult to arouse. The decision was made to intubate the patient to maintain an airway and she was given 1.5g of Keppra and started on nicardipine with the goal of keeping her BP less than 160 mmHg. The patient was then transferred to Carle Hospital in Urbana where she was admitted to the ICU.

Admission Diagnosis

Primary Diagnosis: Ruptured brain stem aneurysm with subsequent subarachnoid hemorrhage

Secondary Diagnosis (if applicable): N/A

Pathophysiology

Patient, A.B, suffered from a ruptured brain aneurysm that subsequently led to a subarachnoid hemorrhage. An aneurysm is a weakened area in the wall of an artery (Capriotti,

2020). This weakened area causes a dilated part of the artery that is thin and susceptible to rupturing or clot formation (Capriotti, 2020). Common areas in the body where aneurysms tend to form are the abdominal aortic region and cerebral arteries, this is because these two areas of the body experience higher blood pressures and are more complex in structure (Capriotti, 2020). Aneurysms develop over time due to damage to the lining of the arteries, this is typically caused by atherosclerosis and hypertension (Capriotti, 2020). When plaque builds up on artery walls, they become weaker and consistently high blood pressure further weakens the arterial walls (Capriotti, 2020). As the outpouching of the arterial wall forms this can cause turbulent blood flow in that area that can lead to the development of a clot which can cause a stroke or ischemia depending on where in the body the aneurysm is located. The weakened area of the arterial wall is also susceptible to rupture which is an extremely life-threatening emergency (Capriotti, 2020). In fact, 65% of people who experience the rupture of a cerebral aneurysm die suddenly before reaching a hospital due to hemorrhaging in the brain (Capriotti, 2020).

Risk factors for the development of aneurysms include those ages 60 and older, male gender, atherosclerosis, smoking, hypertension, family history of aneurysms, and connective tissue disorders such as Marfan's or Ehlers-Danlos syndrome (Capriotti, 2020). Many people with an aneurysm do not have any signs or symptoms of the condition until it ruptures (Capriotti, 2020). If the aneurysm is in the thoracic or abdominal region then the person may complain of some abdominal pain, chest pain, shortness of breath, difficulty swallowing and there may even be a pulsating mass that is palpable or a bruit that is able to be auscultated (Hinkle et al., 2021). Signs and symptoms of cerebral aneurysms may include a headache, nausea, vision changes, dizziness, a stiff neck, sensitivity to light, and cranial nerve dysfunction (Hinkle et al., 2021). However, if an aneurysm in the thoracic or abdominal area ruptures, then a patient will have

sudden severe symptoms such as extreme abdominal or back pain, hypotension, tachycardia, difficulty breathing, and loss of consciousness due to blood loss (Hinkle et al., 2021). If a cerebral aneurysm ruptures this results in hemorrhaging in the brain and tell-tale signs of this are symptoms like a sudden, severe, thunderclap headache, confusion, blurred vision, slurred speech, and loss of consciousness (Hinkle et al., 2021). In the case of this patient, she has a history of untreated hypertension and also takes amphetamine drugs which are known to increase blood pressure. These factors put her at increased risk for the development of an aneurysm. The patient had presented to the ED on 2/13/25 with a bad headache and while she has a history of migraines, it could have been the beginning of her brain aneurysm rupturing. The following day she had the classic sign of a subarachnoid hemorrhage with the sudden and severe thunderclap headache. Her speech was also slurred and she became increasingly stuporous and difficult to arouse as the bleeding continued.

Since aneurysms do not typically have signs or symptoms before rupture, most are diagnosed incidentally through imaging for other potential disease processes (Capriotti, 2020). Ultrasonography is the diagnostic test of choice for suspected abdominal aneurysm as an ultrasound can reveal the size and location of the aneurysm (Capriotti, 2020). CTs with the use of contrast can also be used to detect aneurysms and provide detailed information about the size and location of an aneurysm (Capriotti, 2020). Additionally, MRI and angiograms can be used to detect aneurysms (Capriotti, 2020). In the case of patient, A.B, her ruptured aneurysm was initially diagnosed via a CT scan. After being admitted to the ICU she received several follow-up CT scans of the brain and also went to interventional radiology where they performed a cerebral angiogram and they found another aneurysm and were able to coil it. The primary treatment for aneurysms involves preventative measures such as smoking cessation and controlling high blood

pressure (Capriotti, 2020). Once an aneurysm is found, treatment depends on the size and location; if they are small and asymptomatic then providers will typically regularly monitor the aneurysm with imaging such as CTs or MRIs, until it reaches a particular size (Capriotti, 2020). Aneurysms can also be treated by endovascular coiling where a catheter is inserted into the artery in the groin or arm and then a thin wire is threaded into the aneurysm where they coil and fill up the outpouching preventing turbulent blood flow in that area (Capriotti, 2020). Aneurysms can also be "clipped" where a metal piece is placed at the base of the aneurysm to pinch it off and prevent turbulent blood flow (Capriotti, 2020). If an aneurysm ruptures then emergency surgery is done to stop the bleeding and fix the damaged artery while the patient is also given medications to stabilize blood pressure such as vasopressors and fluid and blood products to address blood loss (Capriotti, 2020). In the case of this patient, her cerebral aneurysm ruptured and resulted in a subarachnoid hemorrhage. This was treated by undergoing endovascular coiling where they were able to coil two aneurysms to stop the bleeding. They also placed an external ventricular drain (EVD) to help drain CSF and blood from the brain's ventricles while also monitoring her ICP. She was also being treated with medications such as hypertonic saline to reduce ICP, nimodipine to prevent vasospasm in the brain, fentanyl for pain relief, and blood pressure management medications such as hydralazine. Most subarachnoid hemorrhages are fatal so this patient was extremely lucky.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). Chapter 15: Arterial disorders. In *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed., pp. 329-366). F.A. Davis.

Hinkle, J. L., Cheever, K. H., & Overbaugh, K. J. (2021). Chapter 26: Assessment and management of patients with vascular disorders and problems of peripheral circulation. In *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed., pp. 838-841). Wolters Kluwer.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
PO2	**177.6 mmHg**	**105.9 mmHg**	80-100mmHg (Carle Foundation Hospital, n.d.)	This lab is an indirect measurement of O2 in arterial blood (Pagana et al., 2023 p. 104). The likely reason that this patient's PO2 was elevated was the fact that had been intubated and on a ventilator at the time of the lab draws. Because ventilators deliver a higher concentration of oxygen to the lungs this can cause an increase in PO2 because more oxygen is getting into the blood stream (Pagana et al., 2023 p. 108). As the patient became more stable her PO2 levels began to trend back down to the normal range.
BE	**-2.3 mmol/L**	**3.5 mmol/L**	-2.0-2.0 mmol/L	This lab is measurement of all the anions in the body and can help determine if a patient is in metabolic acidosis or alkalosis (Pagana et al., 2023 p. 105). Originally this patient had a negative BE meaning that she was in metabolic acidosis. It is likely that she became acidic due to her subarachnoid hemorrhage which causes a build up of lactate in the body. She later had a positive BE meaning she was in metabolic alkalosis (Pagana et al., 2023 p. 105). This excess of base was likely due to the fact that this patient had had an OG

			(Carle Foundation Hospital, n.d.)	tube in place when the lab was drawn and OG feedings and suction can cause metabolic alkalosis due to the loss of gastric acids. Furthermore, this patient is taking famotidine which decreases the production of gastric acids and creates a more alkalotic state.
Urine Drug Screen	**Positive**	N/A	Negative (Carle Foundation Hospital, n.d.)	This patient was found to have amphetamines and benzodiazepines in her system. According to the report given by the night shift nurse this patient uses meth with her boyfriend. It is unknown how frequently this occurs or for how long it has been going on.
Blood Glucose	**121 mg/dL**	**117 mg/dL**	74-100 mg/dL (Carle Foundation Hospital, n.d.)	There are many things that can cause an increase in blood glucose levels such as corticosteroid therapy, acute stress, and enteral tube feedings (Pagana et al., 2023 p. 453). This patient is of course under a great deal of acute stress from her ruptured aneurysm and was receiving enteral tube feeds through an OG.
BUN	**5 mg/dL**	11 mg/dL	7-19 mg/dL (Carle Foundation Hospital, n.d.)	Several things can cause a lower BUN level such as liver, failure, malnutrition, malabsorption, low protein diet, overhydration, and pregnancy (Pagana et al., 2023 p. 151). Considering this patient's background and other lab values it is likely arrived to ED malnourished and was not consuming a diet high in protein, vitamins, and minerals which could account for her low BUN level on admission.
Creatinine	**0.54 mg/dL**	**0.43 mg/dL**	0.55-1.02 mg/dL	Decreased muscle mass and debilitation can cause a lower

			(Carle Foundation Hospital, n.d.)	creatinine level (Pagana et al., 2023 p. 297). This patient very suddenly became seriously weak and debilitated following the rupture of her aneurysm and this may have caused her decreased creatinine levels.
Potassium	**3.3 mmol/L**	3.9 mmol/L	3.5-5.1 mmol/L (Carle Foundation Hospital, n.d.)	Many things can cause low potassium in a person such as deficient dietary intake, malnutrition, GI disorders, surgery, trauma, certain medications and more (Pagana et al., 2023 p. 708). This patient suffered a very traumatic brain bleed after the rupture of her aneurysm which could have affected her potassium levels and she may also have had a poor dietary intake of the supplement.
Calcium	**8.7 mg/dL**	**8.1 mg/dL**	8.9-10.6 mg/dL (Carle Foundation Hospital, n.d.)	Several things can contribute to a low calcium level such as alkalosis, low albumin, vitamin D deficiency, low dietary intake, and alcohol consumption (Pagana et al., 2023 p. 181). This patient's calcium levels are likely low because she currently has some base excess causing metabolic alkalosis, she also has a low albumin level and it is very likely prior to admission she had a low dietary intake of calcium.
WBC	**14.37** $10^3/uL$	10.24 $10^3/uL$	4.0-11.0 $10^3/uL$	Infection, stress, and inflammation can cause an increase in white blood cell count (Pagana et al., 2023, p. 949). This patient's body has been under a great deal of stress since the rupture of her brain aneurysm and subsequent subarachnoid hemorrhage. She has also been spiking fevers and

			(Carle Foundation Hospital, n.d.)	both blood and respiratory cultures found staph bacteria indicating she has an infection as well. All of this combined caused a high WBC count, but after stabilizing and being on medications such as meropenem and vancomycin her WBC has gone down to within the normal range.
Hgb	**10.2 g/dL**	**7.9 g/dL**	11.0-16.0 g/dL (Carle Foundation Hospital, n.d.)	Decreased hemoglobin can be caused by things such as anemia and hemorrhage (Pagana et al., 2023 p. 480). This patient suffered a subarachnoid hemorrhage resulting in blood loss and given her background and MCV and MCH values it is also possible she is anemic.
Hct	**32.3%**	**25.9%**	34%-47% (Carle Foundation Hospital, n.d.)	Decreased hematocrit can be caused by the same reason as decreased hemoglobin from things like anemia and hemorrhage (Pagana et al., 2023 p. 478). This patient suffered a subarachnoid hemorrhage resulting in blood loss and given her background and MCV and MCH values it is also possible she is anemic.
MCV	**75.3 fL**	**76.6 fL**	80.0-100.0 fL (Carle Foundation Hospital, n.d.)	MCV measures the average size of a single RBC; decreased levels of MCV can be caused by anemia due to chronic illness or iron deficiency anemia (Pagana et al., 2023 p. 754). Iron deficiency anemia is not uncommon in women of menstruating age; it is likely this patient has some iron deficiency anemia that had not been previously diagnosed.
MCH	**23.8 pg**	**23.4 pg**	26.0-33.0 pg	MCH measures the amount of hemoglobin in an RBC; MCH can be decreased due to anemia as well (Pagana et al., 2023 p.

			(Carle Foundation Hospital, n.d.)	754). As stated above, it is likely that this patient is mildly anemic and just had not been diagnosed prior to this hospital stay.
Absolute Neutrophil	**12.25** $10^3/uL$	6.95 $10^3/uL$	1.6-7.7 $10^3/uL$ (Carle Foundation Hospital, n.d.)	Acute bacterial infections, stress, inflammation, and trauma stimulate neutrophil production (Pagana et al., 2023 p. 947). This patient was found to have staph bacteria in her blood and respiratory cultures and she also suffered a great deal of trauma, stress, and inflammation from her subarachnoid hemorrhage and subsequent EVD placement.
HCO3	22.8 mmol/L	**27. 8 mmol/L**	22.0-26.0 mmol/L (Carle Foundation Hospital, n.d.)	Increased HCO3 can occur when a person is in a metabolic alkalotic state, it can also be caused by gastric suctioning, COPD, and aldosteronism (Pagana et al., 2023 p. 107). As mentioned previously, this patient is in a metabolic alkalotic state likely from her OG feedings and gastric suction.
Total Protein	7.3 g/dL	**5.7 g/dL**	6.0-8.0 g/dL (Carle Foundation Hospital, n.d.)	Decreased total protein can be caused by malnutrition, malabsorption, and blood loss (Pagana et al., 2023 p. 728). This patient suffered a subarachnoid hemorrhage resulting in blood loss and based off of her other RBC indices she may be malnourished and not eating a diet high in vitamins and minerals at home.
Albumin	3.9 g/dL	**2.4 g/dL**	3.5-5.0 g/dL (Carle Foundation Hospital, n.d.)	Albumin makes up about 60% of total protein and decreased albumin can be caused by malnutrition and infections (Pagana et al., 2023 p. 728). This patient was found to have a bacterial infection in her blood and is also likely mildly malnourished.

AST	21 U/L	**63 U/L**	9-43 U/L (Carle Foundation Hospital, n.d.)	Increased AST levels are often caused by drug induced liver injuries, hepatitis, alcohol use, skeletal muscle trauma, stress, or recent convulsions (Pagana et al., 2023 p. 121). This patient suffered a very traumatic injury and her body is currently under a great deal of stress. This bodily stress combined with the fact that she is taking a great number of medications could be the cause of her increased liver labs since the liver is where many drugs are metabolized.
ALT	10 U/L	**96 U/L**	0-34 U/L (Carle Foundation Hospital, n.d.)	Increased ALT levels are often caused by cirrhosis, hepatoxic drugs, hepatitis, MI, pancreatitis, and stress/trauma to striated muscle (Pagana et al., 2023 p. 17). This patient suffered a very traumatic injury and her body is currently under a great deal of stress. This bodily stress combined with the fact that she is taking a great number of medications could be the cause of her increased liver labs since the liver is where many drugs are metabolized.
RBC	4.29 $10^6/uL$	**3.38** $10^6/uL$	3.5-5.2 $10^6/uL$ (Carle Foundation Hospital, n.d.)	Decreased RBC count can be due to anemia, hemolysis, hemorrhage, over hydration, bone marrow failure, and more (Pagana et al., 2023 p. 750). This patient suffered a brain bleed causing a loss of blood and it is also likely that she is mildly anemic.
MCHC	31.6 g/dL	**30.5 g/dL**	31-35 g/dL (Carle	MCHC is the average concentration of hemoglobin in a single RBC; MCHC can be decreased when a person has iron deficiency anemia (Pagana et al., 2023 p. 754). Based on this patient's other RBC indices

			Foundation Hospital, n.d.)	it is likely she has some mild anemia.

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
2/14/25 Chest x-ray: An x-ray uses radiation to create images of the body's bones and it can show bone fractures and soft tissue swelling as well as verify placement of devices like ET, NG, and OG tubes (Pagana et al., 2023). This test was performed on this patient to verify the placement of the endotracheal tube providers had to insert in order to maintain her airway.	This patient was suffering from a ruptured brain aneurysm and subsequent subarachnoid hemorrhage. This was causing her level of consciousness to decrease, her speech was slurred and she was becoming increasingly lethargic and difficult to arouse. Therefore, the decision was made to intubate the patient with an ET tube to maintain a patent airway.	The chest x-ray showed that the ET tube was correctly placed a few centimeters above the carina. The patient's lungs also showed no signs of acute cardiac or pulmonary disease.
2/14/25 Electrocardiograph (ECG): An ECG is a graphic representation of the electrical impulses of the heart and can show irregular electrical activity occurring in the cardiac cycle (Pagana et al., 2023). This test was performed on the patient in the ED to rule out a heart attack and help identify if any life threatening dysrhythmias were present.	The patient presented to the ED with a decreased level of consciousness and became difficult to arouse. Therefore, the providers wanted maintain continuous cardiac monitoring and obtain an ECG to help identify if the patient was possibly having a heart attack or any life threatening dysrhythmias that could be contributing to her decreased LOC.	The results of this ECG were insignificant. It showed the patient was in normal sinus rhythm and was not having any dysrhythmias or heart blocks.
2/14/25 Computed Tomography (CT) of the head and neck with contrast: A CT is a type of x-ray that can be used with or without contrast and it involves taking several tomographic x-rays of an area in multiple layers which results in a 3D image; hence, these images are more detailed than a regular x-ray (Pagana et al., 2023). This imaging test was performed specifically on the	The patient present to the ED with a severe, sudden onset, "thunderclap" headache. Such a severe headache such as that is one of the primary symptoms of a hemorrhage in the brain. She also had a decreased level of consciousness and slurred speech which are also signs of a blockage in the brain due to things like a stroke, tumor, or bleeding. Therefore, the providers wanted to get a CT as soon as possible to determine what was causing her	The results of this CT showed a 3 mm sized aneurysm at the basilar tip of the brain as well as a 1.5 mm aneurysm of the left supraclinoid internal carotid artery with evidence of a subarachnoid hemorrhage.

patient's head and neck to visualize if there were any abnormalities such as bleeding, aneurysms, fractures, tumors, or infarcts.	neurological symptoms.	
2/15/25 CT of brain w/o contrast: As mentioned above a CT of the brain can show detailed images that can reveal abnormalities such as bleeding, swelling, aneurysms, and infarcts. This patient underwent a repeat CT to confirm findings on the previous scan.	The day prior the patient was found to have two aneurysms that results in a subarachnoid hemorrhage. The patient remained sedated and ventilated and needed a repeat CT to assess how her condition was progressing.	The results of this CT found that the patient had increased cerebral edema as well as an increased amount of subarachnoid hemorrhage volume and intraventricular blood.
2/15/25 Interventional radiology, cervical cerebral CT angiography: A CT angiography is a specialized type of CT that involves the injection of a special dye that enhances visualization of blood vessels and tissues. When used in the head, a CTA can detect things like cerebral aneurysms, carotid dissections, strokes and more (Pagana et al., 2023). This patient went to interventional radiology to have her aneurysms better assessed and then coiled to block off the aneurysms and prevent further bleeding and possible clotting.	The previous CT scans showed increased cerebral edema and bleeding. Therefore, the patient needed to undergo this CTA procedure to better visualize where exactly her aneurysms were and the providers were then able to perform endovascular coiling of the aneurysms to stop bleeding from the aneurysms and prevent further rupture.	Through the increased visualization of the 2 aneurysms at the basilar tip of the brain as well as the left supraclinoid internal carotid artery with the CTA, the providers were able to successfully provide endovascular coiling to block off the aneurysms. They gained access through the right femoral artery with a size 6 French guiding catheter.
2/16/25 CT of brain w/o contrast: The purpose of this CT was as another follow up CT from the one on 2/15 after the aneurysms were coiled and an EVD was placed.	A follow up CT was necessary to evaluate if this patient's condition was worsening or improving. She remained sedated and intubated at this point.	Results of this CT showed that the subarachnoid and hemorrhage had now stabilized with a slight decrease in ventricular swelling. Placement of the EVD shunt also appeared stable.
2/16/25 Echocardiography: An echocardiograph is a type of ultrasound procedure that can be used to evaluate the structure and function of the heart. It can be used to diagnose pericardial	This test was performed because the patient had gone through the very traumatic experience of a ruptured brain aneurysm and having to be intubated and mechanically ventilated. All of this	There were no significant findings from the echo. There were no signs of acute myocardial disease or damage.

effusions, valvular heart disease, infarctions, and other myocardial abnormalities (Pagana et al., 2023).	stress can be very hard on the heart and she also has a history of methamphetamine use which can damage the heart as well.	
2/17/25 CT of brain w/o contrast: This patient underwent another repeat CT to again check the progress of her subarachnoid hemorrhage and coiled aneurysms. A CT allows providers to check for increased bleeding, swelling, the development of any new aneurysms and the placement of her EVD.	The patient had been responding well to her endovascular coiling and EVD placement. It was still important for providers to take follow-up CT scans to check on the progression of her healing and ensure there was not an increase in bleeding or swelling.	Results of this CT showed that the hemorrhaging had remained stabilized and that there was decreasing swelling of the brain. The coiled aneurysms appeared stable as well as the placement of the EVD.
2/18/25 Chest x-ray: As mentioned previously a chest x-ray visualized the chest cavity and can confirm placement of devices like ET, NG, and OG tubes.	This patient had an orogastric tube placed to provide enteral feeding and it is necessary to confirm placement of the OG tube at the stomach and that it did not accidentally get placed at the lungs which would cause aspiration.	The x-ray confirmed that OG tube was correctly placed with the end of it in the stomach.
2/18/25 Blood Culture: Blood cultures are obtained to detect if there are any bacteria or other pathogens in the blood stream (Pagana et al., 2023). The specimen is than cultured and analyzed to determine what specific bacteria may be present.	This patient began having fevers on 2/17/25 as well as an increased WBC count which prompted providers to check for possible infection.	Results of the blood culture found staphylococcus species present in the blood.
2/20/25 Respiratory Culture: Sputum cultures are obtained to determine if there are any bacteria or other pathogens present in a patient (Pagana et al., 2023). The gathered specimen is stained to see whether it has gram positive or negative bacteria and then further analyzed as to what species of bacteria is present. It is important to wait for cultures to come back before starting	The patient continued to be febrile with an increased WBC count and was still on the ventilator at this time so providers also did a sputum culture to assess for any possible respiratory infections that could be causing her fevers and increased WBCs.	Results of the sputum culture found staphylococcus aureus bacteria present.

antibiotics so that the appropriate antibiotic can be administered and antibiotic resistance can be avoided.		
2/21/25 Chest x-ray: A chest x-ray provides a visualization of the heart and lungs and can detect inflammation or fluid build up in these areas.	This patient continued to have fevers, increased respiratory secretions and had both blood and sputum cultures positive for staph bacteria. This prompted providers to want an additional chest x-ray to check the status of her lungs and heart to see if there was any evidence of pulmonary infection.	The chest x-ray results showed only minor pleural effusions with no evidence of significant cardiopulmonary compromise or infiltrates.

Lab/Diagnostic Test Reference (1) (APA):

Carle Foundation Hospital (n.d.). *Normal lab values reference ranges*. Epic Systems.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's Diagnostic and Laboratory Test Reference* (16th ed.). Elsevier.

Active Orders

Active Orders	Rationale
NPO Diet- except meds with small sips	The patient had her OG tube and ET tube removed the morning of 2/23/25. She passed her RN bedside swallow screen so she may have some oral medications by mouth with small sips of water. However, she must be evaluated by speech therapy to do an official swallow examination before she can receive any food or drink by mouth. This is to ensure that she does not choke or aspirate on anything.
Q2 Neuro Assessments	This patient had a ruptured brain aneurysm and now has an EVD in place; therefore, it is incredibly important to do frequent and routine neuro assessments so that if there are any changes in her neurological status it is promptly caught and addressed.
Q2 Pupilometer Check; Notify physician if 1.5mm change from baseline or if NPi difference is >0.7	This goes along with her neuro assessment. The pupilometer assess the size and reactivity of her pupils. Any significant changes in pupil size or reactivity would indicate that there is a possible serious change that occurred in the brain that would need immediate intervention.

Foley catheter placement	It is necessary to closely monitor and track urine output on this patient to ensure her kidneys are functioning properly, especially considering they are having to give her many different IV fluids. This helps the nurse track that the patient's output is matching her intake.
Q1 EVD assessment with hourly drainage and ICP check; Notify physician if EVD output is > 30 cc/hr, if ICP > 20, if there is no drainage for 2 hours, or if there are significant changes in neuro status.	It is crucial to frequently monitor the drainage from the EVD and the patients ICP hourly. Drainage should be clear to light pinkish in color, if it becomes red this indicates that there is a new bleed occurring. Too much drainage due to improper positioning can cause damage to the brain as well like collapsed ventricles. The nurse must ensure that the EVD stays level in order to drain properly as well as assess the insertion site for any redness and swelling. Lastly, it is incredibly important to monitor ICP as increased ICP is a sign that the patient's status is becoming unstable and could lead to strokes, herniation, seizures, and even death.
Q4 Oral care	This patient is no longer ventilated so her oral care can be changed to Q4 hours. It must still remain at Q4 hours because she is NPO so it is important to prevent the build up of secretions in the mouth that can harbor bacteria and cause infection.
Q4 Blood glucose; Notify physician if BG <60 or >200	This patient is currently NPO so it is important to make sure that her blood glucose levels do not drop too low.
Q1 Intake and Output	This patient has both an EVD drain and a foley catheter in place so it is extremely important to closely monitor the output of these drains to ensure they are draining properly and that her output matches all of the fluids she is taking in. She is also on several IV fluids and medications so it is important to know exactly how much fluid is going into her body so that again the providers can be sure that her kidneys are functioning properly to excrete the fluids as well.
Continuous cardiac monitoring	All ICU patients should be on continuous cardiac monitoring so that any changes in cardiac rhythm can be quickly detected. This patient was bradycardic at times but returned to normal sinus rhythm.
Continuous pulse oximetry	All ICU patients should be on continuous pulse oximetry. This is particularly important for this patient because she was extubated the morning of 2/23/25 so it is crucial to ensure that her oxygen saturation remains within the normal range after

	coming off of the ventilator that was providing oxygen for her. She is currently on 2L nasal cannula.
Keep head of bed elevated 30 degrees	It is important to maintain the head of the bed at 30 degrees not only to facilitate ease of breathing, but also to keep her EVD shunt level and draining properly.
Initiate electrolyte replacement order set if morning magnesium is < 1.6, GFR or CrCl > 30 mls/min, or potassium is <3.6	Closely monitoring of electrolyte balance and kidney function is crucial in ICU patients. Imbalances in electrolytes can indicate poor kidney function and even lead to deadly cardiac dysrhythmias. Therefore, it is important to closely monitor electrolyte levels and provide replacement therapy promptly when necessary.
Q2 Turns	This patient is currently bed bound and very weak so she is unable to effectively turn her self on her own. She should be turned routinely with the use of pillow supports to help prevent skin break down and pressure injuries.
Bilateral pneumatic compression stockings	This patient is bed bound and unable to effectively move her legs. Therefore, SCDs are important for promoting good blood flow through the legs and are used prophylactically to prevent DVTs from lack of movement.
CHG bath daily	This patient a PICC in her right arm and an arterial line in her left arm, therefore it is extremely important to ensure these insertion sites stay clean and free of pathogens as any bacteria would have a direct line to get into the blood stream. Chlorhexidine gluconate is a strong antiseptic that helps prevent infection.
Notify physician for SPB > 140, HR >130 or <50, Temp >39C or <36C, RR >30 or <8, and UO <30ml/hr	It is important to notify the physician of severely abnormal vital signs such as these as they likely indicate a serious problem in the patient that requires immediate intervention.

Medications

Home Medications (Must List ALL)

Medication	Reason for taking
Unknown blood pressure medication- patient unable to remember what she was prescribed, but states she does not take the medication.	This patient was prescribed an unknown blood pressure medication to control her hypertension, but she does not take the medication.

Hospital Medications (Must List ALL)

Brand/Generic	Sodium Chloride with Potassium Chloride Solution (0.9% NaCl with KCl 40 mEq)	Tylenol (acetaminophen)	Bacitracin (bacitracin topical ointment)	Dulcolax (Bisacodyl)	Buffered Hypertonic Saline Solution (3% sodium chloride/sodium acetate)	ReadyPrep CHG cloths (2% chlorhexidine gluconate)
Classification	**Pharmacological Class:** Electrolyte solution **Therapeutic Class:** Electrolyte replacement and hydration solutional (National Institutes of Health, 2022)	**Pharmacological Class:** Non-salicylate para-aminophenol derivative **Therapeutic Class:** antipyretic, nonopioid analgesic. (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** cyclic polypeptide antibiotic **Therapeutic Class:** Antibiotic (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** stimulant laxative **Therapeutic Class:** laxative (Cerner Multum, 2025a)	**Pharmacological Class:** hypertonic saline electrolyte solution **Therapeutic Class:** electrolyte and fluid replenisher (Holden et al., 2021)	**Pharmacological Class:** broad spectrum anti-microbial **Therapeutic Class:** topical antiseptic (Cerner Multum, 2025b)
Reason Client Taking	This patient is currently NPO so this IV fluid helps provide necessary fluid volume and the addition of potassium is helping to correct the low potassium level she had upon admission. Proper replacement of sodium and potassium is crucial for good muscle and nerve functioning (National Institutes of Health, 2022).	This medication is being given PRN to address temperatures over 100.4F. This patient has been experiencing some fevers due to an infection with staph bacteria.	This ointment is being applied prophylactically to prevent infections around her PICC and arterial line (Jones & Bartlett Learning, 2023). Infections acquired through central lines such as a PICC can become very serious and deadly quickly due to their proximity to the heart.	This medication is being given PRN for constipation and to help promote good bowel movements since this patient is bed bound and also receiving opioid analgesics (Cerner Multum, 2025a).	This fluid replacement solution is often given to patients with brain injuries to help prevent increased ICP and treat cerebral edema. The addition of sodium acetate helps to buffer the solution and prevent chloride build up. This patient suffered a subarachnoid hemorrhage which resulted in cerebral edema and intracranial swelling which this medication helps to control (Holden et al., 2021).	This patient has a central line and therefore must have a CHG bath every day. This is done prophylactically to help prevent infection as CHG is more effective at killing bacteria than soap and water alone. As mentioned previously, central line infections are very serious and can be potentially fatal, so maintaining clean skin is crucial (Cerner Multum, 2025b).
List two teaching needs for the medication pertinent to the client	-If the patient is able, the nurse should educate them to report any signs of hyperkalemia such as numbness and tingling in the extremities. -If the patient is able they should also report any	-Do not drink alcohol while taking this medication -Notify the provider if there are signs of hepatotoxicity such as bleeding, easy bruising, or overall malaise (Jones & Bartlett	-While this is typically done by the nurse in an ICU setting, if the patient wishes to self-administer this medication they should	-Stop using this medication if stools become very loose and frequent. -Notify the physician if there are any signs of blood in the stool (Cerner	-The nurse should teach the patient things to avoid doing that can increase ICP such as coughing forcefully or straining forcefully to have a BM. -The nurse should also teach the	-The cloth is meant for external use only so avoid the eyes and vaginal areas. -Use once daily as prescribed by the physician (Cerner Multum,

	symptoms of fluid overload such as increased work of breathing or noticeable swelling in the extremities (National Institutes of Health, 2022).	Learning, 2023).	be taught to only use a finger-tip sized amount and apply a thin layer. -Only apply this medication 1-3 times a day as prescribed by the physician (Jones & Bartlett Learning, 2023).	Multum, 2025a).	patient to report any physical symptoms of increasing ICP such as a headache, blurred vision, or nausea/vomiting (Holden et al., 2021).	2025b).
Key nursing assessment(s) prior to administration	The nurse should closely monitor electrolyte labs prior to administration to ensure that sodium and potassium levels are not too high before administration. Careful attention to ECGs should also be given as low potassium levels as well as high potassium levels can cause harmful cardiac dysrhythmia. The nurse should also assess the patient for signs of fluid over load such as edema or pulmonary congestion, especially when giving multiple IV fluids (National Institutes of Health, 2022).	According to provider orders, the nurse should assess the patient's temperature prior to administration and it should exceed 100.4F. The nurse should also assess the patients liver labs prior to administration and be sure not to exceed the daily maximum dose of 3g in 24 hours (Jones & Bartlett Learning, 2023).	The nurse should assess this patient's IV lines for any signs of infection such as redness or swelling. The nurse should also check with the patient for any allergies to similar medications such as neomycin prior to applying this ointment (Jones & Bartlett Learning, 2023).	The nurse should keep track of how frequently the patient is having bowel movements as well as the character of the bowel movement prior to administration . If a bowel obstruction is suspected do NOT administer this medication (Cerner Multum, 2025a).	The nurse should routinely monitor the patient's ICP to ensure that the medication is working therapeutically. Frequent neuro assessments should also be done to assess for any subtle changes in patient condition. Serum sodium levels should also be watched closely to prevent hypernatremia (Holden et al., 2021).	The nurse should closely monitor central line sites such as this patient's PICC as well as her arterial line for any signs of infection such as redness, swelling, or purulent discharge. Temperature and WBC count should also be closely monitored daily. The nurse should use one cloth for each extremity as well as one for the trunk and one for the back to ensure the entire body is well cleansed (Cerner Multum, 2025b).
Brand/Generic	**Insta-Glucose (dextrose 40%)**	**Cardizem (diltiazem)**	**Zantac (famotidine)**	**Actiq (fentanyl)**	**Vancocin (vancomycin)**	**Heparin Sodium Injection (heparin)**
Classification	**Pharmacological Class:** anti-hypoglycemic **Therapeutic Class:** glucose elevating agent	**Pharmacological Class:** calcium channel blocker **Therapeutic Class:** antianginal, antiarrhythmic, antihypertensive (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** histamine 2-blocker **Therapeutic Class:** antiulcer agent (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** opioid **Therapeutic Class:** opioid analgesic (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** glycopeptide **Therapeutic Class:** antibiotic (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** anticoagulant **Therapeutic Class:** anticoagulant (Jones & Bartlett Learning, 2023).
Reason Client Taking	In case of	This medication	This patient	This	This patient was	This patient is

	hypoglycemic emergency for blood sugar less than 60 (Mayo Clinic, 2024).	is being given PRN to help control systolic blood pressures over 200 (Jones & Bartlett Learning, 2023).	was on a ventilator and is now NPO so this medication is being given prophylactically to reduce HCL in the stomach and prevent peptic ulcers (Jones & Bartlett Learning, 2023).	medication was originally being given as adjunct to the sedatives this patient was on while being ventilated. It is now being used to address pain associated with coming off of mechanical ventilation and treatment of her ruptured aneurysm as this medication should not be abruptly stopped (Jones & Bartlett Learning, 2023).	febrile for several days and found to have staphylococcus bacteria present in both blood and sputum cultures. Vancomycin is a strong antibiotic that is effective at treating staph bacteria, particularly ones that are resistant to other antimicrobial medications (Jones & Bartlett Learning, 2023).	currently bed bound and now that her brain bleed is under control it is important to prevent and DVTs from forming due to her immobility so heparin is being given to prevent the development of clots (Jones & Bartlett Learning, 2023).
List two teaching needs for the medication pertinent to the client	-This medication is used in emergency situations only. -To use this medication twist the top off and squeeze the entire contents into the mouth and swallow (Mayo Clinic, 2024).	-Patients should report any symptoms such as difficulty breathing, dizziness, palpitations, or rash. -The patient should be taught to change positions slowly after this medication is given in case of hypotension which could result in falls (Jones & Bartlett Learning, 2023).	- Patients should not take this medication alongside other stomach acid reducing drugs. -Take this medication in the morning and do not take more than once a day (Jones & Bartlett Learning, 2023).	- The patient should be educated that it is best to taper off of this medication rather than suddenly stop it's use to prevent the return of severe pain, especially since this patient had been on this medication for several days due to her being on the ventilator. -The patient should be taught to inform the nurse if she starts to feel unwanted side effects such as confusion, changes in vision, or tremors (Jones & Bartlett Learning, 2023).	-The nurse should education the patient about the importance of completing the full course of antibiotics in order to effectively treat the infection and prevent antibiotic resistance. -Notify the nurse or provider if persistent or severe diarrhea develops or if they notice any changes in their hearing (Jones & Bartlett Learning, 2023).	-While it is the nurse who is administering this medication, the patient should still be included on education as to the importance of rotating injection sites in the abdomen and to help keep track of rotating sites. -The patient should be taught to inform the nurse if they notice any unusual bleeding like blood in the stool or urine or any easy bruising (Jones & Bartlett Learning, 2023).
Key nursing assessment(s) prior to administration	The nurse should assess the client's blood sugar and assess ability of	The nurse should closely monitor blood pressure prior to	The nurse should closely monitor	The nurse must perform a thorough respiratory	This medication has been known to cause severe skin reactions in	The nurse should know that bleeding is a major

	the client to swallow before giving this medication (Mayo Clinic, 2024).	administration and ensure that the patient is on a cardiac monitor so that the nurse can monitor the ECG for possible dysrhythmias (Jones & Bartlett Learning, 2023).	kidney and liver labs as dysfunction with these organs may require dosage adjustments for this medication. The nurse should also assess for side effects such as dizziness and headache (Jones & Bartlett Learning, 2023).	assessment before and after administering this medication as it is a strong respiratory depressant. The nurse should also be aware that fentanyl taken alongside other medications that increase serotonin in the brain, such as the quetiapine that this patient is also prescribed, can cause serotonin syndrome. Therefore, the nurse should watch for symptoms like agitation, tachycardia, and sweating (Jones & Bartlett Learning, 2023).	patients and therefore the nurse should closely monitor the skin for any signs of rash or blistering. Additionally, the nurse should closely monitor blood vancomycin levels for peaks and troughs. The nurse should also closely monitor the patient's stools because of the risk of developing C-diff (Jones & Bartlett Learning, 2023).	adverse effect of heparin and should therefore take precautions to prevent bleeding such as using a soft-bristled toothbrush and avoiding unnecessary injections. The nurse should closely monitor for any signs of bleeding such as blood in the urine or stool. Lastly, the nurse should be aware that heparin-induced thrombocytopenia can occur so it is important to check platelet values daily (Jones & Bartlett Learning, 2023).
Brand/Generic	**Apresoline (hydralazine)**	**Humalog (insulin lispro)**	**Combivent (ipratropium albuterol)**	**Trandate (labetalol)**	**SulfaMag (magnesium sulfate)**	**Merrem (meropenem)**
Classification	**Pharmacological Class:** vasodilator **Therapeutic Class:** antihypertensive (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** human insulin analog **Therapeutic Class:** Antidiabetic (U.S. National Library of Medicine, 2021)	**Pharmacological Class:** anticholinergic, adrenergic **Therapeutic Class:** bronchodilator (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** non-cardio selective beta blocker/ alpha 1 blocker **Therapeutic Class:** antihypertensive	**Pharmacological Class:** mineral **Therapeutic Class:** electrolyte replacement (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** carbapenem **Therapeutic Class:** antibiotic (Jones & Bartlett Learning, 2023).
Reason Client Taking	This medication is being given PRN for systolic blood pressures over 200 mmHg as this patient has a history of untreated hypertension (Jones & Bartlett Learning, 2023).	This medication is being given PRN for blood glucose levels over 160. This patient does not have a history of diabetes, but she was receiving enteral nutrition and that combined with the stress her body is under can	This medication is being given PRN for any dyspnea or shortness of breath since this patient was recently extubated and her lungs are still recovering (Jones &	This medication is being given PRN for a systolic blood pressure higher than 200 mmHg.	This medication is being given because this patient suffered a subarachnoid hemorrhage. Magnesium sulfate serves as a neuroprotective agent and is often used for patients with subarachnoid hemorrhage	This antibiotic is being given because it is effective in treating the staphylococcus bacteria that was found in this patient's blood and sputum cultures (Jones & Bartlett

		cause increases in blood sugar levels.	Bartlett Learning, 2023).		where it can help prevent neuromuscular excitability and mitigate the effects of vasospasm (Jones & Bartlett Learning, 2023).	Learning, 2023).
List two teaching needs for the medication pertinent to the client	-Change positions slowly as this medication can cause hypotension and dizziness. -Report any feelings of numbness or tingling in the limbs as this may be an indication that other antihypertensive medications should be used (Jones & Bartlett Learning, 2023).	-Blood sugar level should be assessed prior to administering this medication. -Rotate injection sites to maintain skin integrity (U.S. National Library of Medicine, 2021).	-Rinse mouth out with water after each use to minimize throat dryness and irritation. -This is not a rescue medication and should not be used for acute bronchospasm (Jones & Bartlett Learning, 2023).	-To minimize the effects of orthostatic hypotension, the patient should slowly change positions in bed. -Scalp tingling may occur in early treatment, but should subside (Jones & Bartlett Learning, 2023).	-This medication may cause patients to feel flushed and sluggish, this is expected. -Notify the provider right away if experiencing any difficulty breathing (Jones & Bartlett Learning, 2023).	-Report to the nurse immediately if any symptoms such as a rash or sore mouth develop. -Report severe diarrhea or diarrhea that lasts longer than 3 days (Jones & Bartlett Learning, 2023).
Key nursing assessment(s) prior to administration	The nurse should always assess the patient's blood pressure and heart rate before giving this medication to ensure they do not cause severe hypotension.	The nurse should assess blood glucose level prior to administering this medication and know that this medication should be given before meals via sliding scale (U.S. National Library of Medicine, 2021).	The nurse should assess heart rate and rhythm prior to administration as this medication can cause tachycardia and atrial fibrillation (Jones & Bartlett Learning, 2023).	The nurse should always assess the patient's blood pressure and heart rate prior to administration to prevent hypotension (Jones & Bartlett Learning, 2023).	The nurse should closely monitor the patient for signs of magnesium toxicity such as bradycardia, depressed DTRs, hypotension, respiratory depression and oliguria. The nurse should also routinely monitor serum magnesium levels (Jones & Bartlett Learning, 2023).	The nurse should ensure that cultures were obtained and analyzed prior to administering this medication. The nurse should also watch closely for hypersensitivity reactions and pay close attention to patient stools due to the risk of developing C. diff (Jones & Bartlett Learning, 2023).
Brand/Generic	**Robaxin (methocarbamol)**	**Senokot (sennosides)**	**Bactroban (mupirocin)**	**Nimotop (nimodipine)**	**Oxycontin (oxycodone)**	**Seroquel (quetiapine)**
Classification	**Pharmacological Class:** carbamate derivative **Therapeutic Class:** skeletal muscle relaxant (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** senna glycoside **Therapeutic Class:** laxative (U.S. National Library of Medicine, 2024)	**Pharmacological Class:** antibacterial **Therapeutic Class:** antibacterial ointment (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** calcium channel blocker **Therapeutic Class:** anti-hypertensive (Das & Zito, 2024)	**Pharmacological Class:** Opioid **Therapeutic Class:** Opioid analgesic (Jones & Bartlett Learning, 2023).	**Pharmacological Class:** dibenzo thiazepine **Therapeutic Class:** antipsychotic (Jones & Bartlett Learning, 2023).
Reason Client Taking	To help relieve any muscle discomfort from	To avoid constipation caused by opioid	This is being applied to the patient's	This medication is being used to	This medication is prescribed PRN for severe pain.	This medication is given PRN to

	being bed bound and also to help the patient relax which facilitates better ICP control (Jones & Bartlett Learning, 2023).	medications she is taking and lack of mobility (U.S. National Library of Medicine, 2024).	nares to decolonize them from staph bacteria (Jones & Bartlett Learning, 2023).	manage vasospasms and reduce cerebral infarction in the brain following this patients' subarachnoid hemorrhage (Das & Zito, 2024).		treat delirium and agitation which can occur with ICU patients (Jones & Bartlett Learning, 2023).
List two teaching needs for the medication pertinent to the client	-This medication is best taken with food to avoid stomach upset/nausea. -This medication can cause the urine to have a brownish tinge, this is expected (Jones & Bartlett Learning, 2023).	-Take this medication with a full glass of water. -This medication takes about 8 hours to work so taking in the morning or bedtime is best (U.S. National Library of Medicine, 2024).	-Only use this medication twice a day as prescribed by the physician. -Notify the nurse if any nasal irritation occurs (Jones & Bartlett Learning, 2023).	-Report side effects such as headache or heart palpitations. -The nurse should teach the importance of taking this medication routinely every 4 hours to prevent vasospasms which reduce blood flow to the brain and can cause neuro deficits (Das & Zito, 2024).	-Take this medication with food and try to take with the same amount of food each time to maintain a consistent blood level. -Do not take this medication alongside other opioids as it can cause severe respiratory depression (Jones & Bartlett Learning, 2023).	-This medication can cause dizziness and/or drowsiness. -Notify the physician right away if experiencing symptoms such as muscle rigidity, excessive sweating, or heart palpitations (Jones & Bartlett Learning, 2023).
Key nursing assessment(s) prior to administration	This medication can cause bradycardia and hypotension so the nurse should obtain a set of vital signs prior to administration (Jones & Bartlett Learning, 2023).	The nurse should monitor bowel movements prior to administration and withhold the medication if the patient begins having very loose stools (U.S. National Library of Medicine, 2024).	The nurse should inspect the nares of the patient prior to administration to look for any lesions or irritation. The nurse should also check to see if the patient has had any allergic reaction to topical antibiotics in the past (Jones & Bartlett Learning, 2023).	The nurse should assess the patient's blood pressure and heart rate prior to administration as this medication can cause hypotension or dysrhythmias. The nurse should also perform frequent neuro checks to ensure the medication is working therapeuticall y (Das & Zito, 2024).	Prior to administration the nurse should check the last time the patient had any opioid medications to avoid causing severe respiratory depression. The nurse should also perform a thorough respiratory assessment to prior to administration (Jones & Bartlett Learning, 2023).	Prior to administration the nurse should ensure that the patient is well hydrated as this medication can cause dehydration. The nurse should also monitor the patient's blood pressure prior to administration to avoid causing hypotension and the nurse should ensure fall precautions are in place (Jones & Bartlett Learning, 2023).
Brand/Generic	**Sodium Chloride Tablets**	**Thiamine (vitamin B1)**				
Classification	**Pharmacological Class:** N/A **Therapeutic**	**Pharmacological Class:** N/A **Therapeutic**				

	Class: N/A	**Class:** N/A				
Reason Client Taking	As adjunct treatment with the 3% saline IV solution to manage her ICP.	To prevent thiamine deficiency and ensure proper metabolic and nervous system functioning (Jones & Bartlett Learning, 2023).				
List two teaching needs for the medication pertinent to the client	N/A	N/A				
Key nursing assessment(s) prior to administration	N/A	N/A				

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Nimodipine	This medication was chosen and highly prioritized because blood products in the brain from a subarachnoid hemorrhage can irritate the walls of arteries in the brain and can vasospasms. These vasospasms interfere with blood and oxygen flow to the brain and can cause further brain damage such as strokes, coma, and even death (Das & Zito, 2024). Nimodipine has been found very effective at preventing these vasospasms after a subarachnoid hemorrhage and the physician stressed the importance of its timely administration every 4 hours to keep this patient safe and stable.	**1.** One common side effect of this medication is a headache. This would be very important to pay attention to for this patient because a headache could also be caused by a more serious problem such as increasing ICP or one re-bleeding of one of her aneurysms. Therefore, the nurse would want to assess the patient for the presence of a headache to differentiate if the cause is a side effect of nimodipine or something more serious (Das & Zito, 2024). **2.** This medication can also cause palpitations and heart rate irregularities(Das & Zito, 2024) . This patient has already had a fair amount of heart rate variability becoming bradycardic at times and tachycardic other times. It would be very

		important to closely monitor this patients' cardiac monitor after administering this medication to ensure it does not trigger any dangerous dysrhythmias.
2. 3% sodium chloride/sodium acetate hypertonic saline solution	This medication was prioritized because this patient suffered a subarachnoid hemorrhage which resulted in cerebral edema and intracranial swelling. When this increased intracranial pressure and swelling occurs it restricts blood flow to the brain and damages brain tissue which can cause serious neuro deficits or even death (Holden et al., 2021). Hypertonic solutions such as 3% saline are effective at decreasing ICP and cerebral swelling by drawing water and fluids out of the brain (Holden et al., 2021). It is extremely important to control ICP after an event such as a subarachnoid hemorrhage to prevent further brain damage from occurring.	**1.** For some individuals this medication can cause a rise in body temperature and development of a fever (Holden et al., 2021). This patient was already struggling with spiking fevers due to a staph infection; therefore, it would be important to make sure that this medication was not also contributing to fevers as fevers can cause increases to ICP. **2.** This patient is receiving a number of different IV fluids along with 3% saline so it would be important to monitor for the side effect of fluid overload which can cause symptoms such as edema, dyspnea, increased BP and HR (Holden et al., 2021).
3. Vancomycin	This medication was also prioritized because this patient was becoming febrile for several days and was found to have staphylococcus bacteria in both blood and sputum cultures. If infections such as this are not promptly addressed a patient can quickly become septic and go into shock which is extremely life threatening. Vancomycin is a very strong antibiotic that is effective against staphylococcus bacteria	**1.** One side effect that this medication can cause, especially when given in larger doses is C.diff associated diarrhea (Jones & Bartlett Learning, 2023). This patient is already experiencing loose stools, likely related to the OG tube feeds she was receiving, but it would be very important to continue to monitor the patient's bowel movements and watch for very watery and foul smelling stools.

	(Jones & Bartlett Learning, 2023).	**2.** This medication can also cause thrombocytopenia (Jones & Bartlett Learning, 2023). This patient is also already receiving heparin injections which can also cause thrombocytopenia. Therefore, this patient should definitely be on bleeding precautions and the nurse should closely assess platelet count and look for any signs of bleeding such as blood in the urine or stool or the development of petechiae.

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Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** awake, lethargic **Orientation:** x4 **Distress:** moderate **Overall appearance:** clean-kept, tired, calm **Infection Control precautions:** none **Client Complaints or Concerns:** back pain, gas pains, anxious	Upon assessment this patient was alert and oriented to person, place, time and situation. However, the patient is unable to recall the exact events leading to her hospitalization though she understands she "hurt her head". The patient was calm and cooperative, but was in moderate distress stating that she had lower back pain as well as gas pains, and was "worried about falling asleep". Patient's overall appearance was clean and well kept, but very tired looking. Patient is not currently on any isolation precautions.
VITAL SIGNS: **Temp:** 99.3°F **Resp rate:** 18 **Pulse:** 83 **B/P:** 151/69 (this is within current BP goal range) **Oxygen:** 96% **Delivery Method:** 2L NC	During shift, the patient's vital signs were stable. Temperature was taken orally and patient is still struggling with elevated temperatures, though they are trending down from previous days. Respirations were even and slightly tachypneic at times, likely due to patient anxiety and pain. Pulse was regular and BP was obtained from left upper arm in the supine position. Patient has history of elevated blood pressure with current blood pressure goal of SBP 140-160. Patient was extubated early 2/23/25 and is tolerating it well with an O2 saturation at 96% on 2L nasal cannula at this time.
PAIN ASSESSMENT: **Time:** 15:45 **Scale:** Numeric Rating Pain Scale **Location:** lower back and stomach **Severity:** 8/10, severe	This patient was struggling with severe lower back and abdominal pain rated an 8/10. She stated that she "cannot get comfortable" and that her lower back hurts "so bad from laying here". She also had complaints of intense "gas pains" in

Characteristics: dull, achy **Interventions:** pain medication, repositioning	her abdomen and felt bloated. To address this patient's pain fentanyl is being given at 100mcg/hr and she was repositioned with pillows to better support her back.
IV ASSESSMENT: **Size of IV:** 3Fr triple lumen PICC; 20G; 18G **Location of IV:** right upper arm; left radial; left AC **Date on IV:** 2/15/25, 2/15/25, 2/20/25 **Patency of IV:** intake, patent **Signs of erythema, drainage, etc.:** none **IV dressing assessment:** clean, dry, intact **Fluid Type/Rate or Saline Lock:** NSKCl continuous infusion 75ml/hr (proximal), fentanyl 10ml/hr (medial), 3% saline continuous infusion 50ml/hr (distal) in PICC; vancomycin 166.7 ml/hr & meropenem 33.3 ml/hr in left radial arterial line; left AC saline locked	This patient has several IV lines including a 3Fr triple lumen PICC in her right upper arm. This line was placed 2/15 and is patent with NSKCl, fentanyl, and 3% saline running. She also has an 20G arterial line that was placed 2/15 on the radial side of her left arm and this is being used for her antibiotics vancomycin and meropenem. The 18G in her left AC was placed on 2/20 is currently saline locked. All IV sites are clean, dry, intact, and patent with good flow. There are no sides of redness, irritation, or infiltration. There is slight bruising around the IV sites.
INTEGUMENTARY: **Skin color:** pale, appropriate for ethnicity **Character:** dry, intact **Temperature:** warm **Turgor:** no tenting **Rashes:** none **Bruises:** yes **Wounds:** yes **Braden Score:** 15, mild **Drains present:** **Y☒** **N ☐** **Type:** EVD, Foley catheter	This patient's skin was pale and appropriate for her ethnicity. Skin was warm to the touch, dry and intact with the exception of IV sites, staples on her head from EVD placement, and a vascular incision puncture at the right groin. Skin turgor was good with no tenting. Normal quantity, distribution, and texture of hair for gender. This patient had no rashes or open lesions. Slight mottling was noted on both legs from the thighs down to the feet. There was mild bruising around all 3 IV insertion areas, but appear to be healing well. This patient has a surgical incision from her EVD placement, but the incision is well approximated with the use of staples and no drainage is present. Dressing on wound is clean, dry, and intact. Patient does complain of itching at incision site at times. This patient also has a vascular incision puncture at the right femoral artery from interventional radiology procedure. Mild bruising around puncture site, but dressing is clean, dry, and intact. Drains present on this patient include her EVD and foley catheter. Both are patent and draining appropriately. Overall Braden score for this patient is 15, indicating mild risk for pressure injury. Patient on Q2 turns and able to adjust self in bed okay.

HEENT: **Head/Neck:** surgical incision right side with EVD **Ears:** WDL **Eyes:** WDL **Nose:** WDL **Teeth:** missing/damaged	**Head:** Patient's head was normal in size and shape for age. Surgical incision on right side is well approximated and closed with the use of staples. Dressing on top is clean, dry, and intact. EVD drain present and working appropriately. Trachea was midline without deviation. Carotid pulse was palpable and 2+ with no lymphedema noted. **Eyes:** Sclera were white bilaterally with clear corneas. Conjunctiva was pink and moist with no signs of drainage. PERRLA bilaterally and EOMS intact bilaterally. At 1400 right pupil was 2.8mm in size and left 3.1mm. No concerning changes in pupil size/reactivity. Patient denies use of glasses. **Ears:** No visible deformities, lesions, or drainage noted. Hearing intact. **Nose:** Septum was midline and mucous membranes pink. No drainage noted and sinuses nontender. **Teeth:** Oral mucosa pink and moist. Tongue and uvula midline with hard palate intact. Patient complains of sore throat from having had an ET tube. Dentition appeared somewhat unhealthy with a few missing and chipped teeth. Speech was muffled, soft, and raspy due to recent extubating.
CARDIOVASCULAR: **Heart sounds:** clear, regular **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** NSR **Peripheral Pulses:**+2 upper, +1 lower **Capillary refill:** <3 bilaterally. **Neck Vein Distention:** **Y** ☐ **N** ☒ **Edema Y** ☐ **N** ☒ **Location of Edema:** N/A	Patient's S1 and S2 sounds were clear with an overall regular rate and rhythm. No signs of murmurs, gallops, or rubs and no S3 or S4 sounds present. The apical pulse was palpable at the 5th intercostal space and left midclavicular line. Peripheral pulses at left and right radial sites were even and 2+. Peripheral pulses at dorsalis pedis were even, but 1+ bilaterally. No edema or jugular vein distension noted. Capillary refill less than 3 seconds bilaterally in fingers and toes.
RESPIRATORY: **Accessory muscle use:** **Y**☐ **N** ☒ **Breath Sounds: Location, character**	Generally, this patient had a normal rate and pattern of respirations. She was extubated the morning of 2/23/25 and was tolerating it well. She became tachypneic at times likely due to her pain and anxiety, but breathing did not appear labored. Patient has infrequent, raspy cough related to extubating with occasional small amounts of clear secretions. Upon auscultation lung sounds were clear with no crackles present, but diminished bases bilaterally. Patient encouraged to do deep breathing. Patient is currently on 2L nasal cannula with an oxygen

	saturation sitting around 95-97%; it is anticipated she will move to room air shortly.
GASTROINTESTINAL: **Diet at home:** regular **Current Diet:** NPO **Is Client Tolerating Diet?** yes **Height:** 5' 4" **Weight:** 167lbs **Auscultation Bowel sounds:** normoactive **Last BM:** 2/23/25 **Palpation: Pain, Mass etc.:** **Inspection:** X **Distention:** mild **Incisions:** none **Scars:** yes **Drains:** no **Wounds:** no **Ostomy:** **Y** ☐ **N** ☒ **Nasogastric:** **Y** ☐ **N** ☒ **Size:** **Feeding tubes/PEG tube** **Y** ☐ **N** ☒ **Type:**	This patient eats a regular diet at home, but is currently NPO. She had been receiving enteral feedings through an OG tube, but this was removed early 2/23/25. Patient must wait to be seen by speech to do swallow screens before advancing diet. Patient did pass RN beside swallow screen and can take medications with small sips of water until she can be officially evaluated by speech. Patient bowel sounds are normoactive. Patient had been complaining of gas pains and mild abdominal bloating was noticed, but there are not concerns of constipation or obstruction as patient has had 3 loose bowel movements on 2/23/25. There were no rashes, bruises or wounds present on the abdomen, but very small scarring from a tubal ligation surgery.
GENITOURINARY: **Color:** pale yellow **Character:** clear **Quantity of urine:** 1,275ml **Pain with urination:** **Y** ☐ **N** ☒ **Dialysis:** **Y** ☐ **N** ☒ **Inspection of genitals:** WDL **Catheter:** **Y** ☒ **N** ☐ **Type:** Foley **Size:** 16 Fr	Patient currently has a foley catheter in place that is draining well. Patient is producing large amount of clear, yellow urine without difficulty. 1,275ml of urine noted for shift. This is expected due to quantity of IV fluids patient is receiving. Kidneys appear to be functioning well. Foley and peri-care performed with no signs of irritation.
Intake (in mLs) **Output (in mLs)**	**Intake for 12-hour shift:** -0.9% NaCl with KCl 75ml/hr continuous infusion (900ml) -3% NaCl/sodium acetate continuous infusion 50ml/hr (600ml) -fentanyl continuous infusion 10ml/hr (120ml) -magnesium sulfate 50ml -meropenem 100ml -vancomycin 250ml **TOTAL: 2,020 ml** **Output for 12-hour shift:** -EVD drainage: 48ml

	-Urine: 1,275ml **TOTAL: 1,323ml**
MUSCULOSKELETAL: **Neurovascular status:** cap refill <3 seconds **ROM:** PROM **Supportive devices:** none **Strength:** weak **ADL Assistance:** **Y☒ N ☐** **Fall Risk:** **Y ☒ N☐** **Fall Score:** 22, high **Activity/Mobility Status:** bedbound **Activity Tolerance:** low **Independent (up ad lib)** no **Needs assistance with equipment** N/A **Needs support to stand and walk** N/A	All extremities have full range of motion, but RN must assist with moving extremities. Hand grips were equal bilaterally, but weak. Pedal pushes and pulls were also weak, but equal bilaterally. Overall strength is weak and diminished. Patient is able to follow commands and move purposefully when asked. Patient is able to adjust herself in bed slightly, but needs assistance to turn from side to side and move up in the bed. Patient needs assistance with all activities of daily living such as oral care, bathing, and changing. Patient is very lethargic and has low activity tolerance. Patient is currently bedbound, but will likely need assistive devices as she progresses. Patient is a high fall risk and has appropriate fall precautions in place.
NEUROLOGICAL: **MAEW:** **Y ☐ N☒** **PERLA:** **Y ☒ N☐** **Strength Equal:** **Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** x4 **Mental Status:** awake, lethargic **Speech:** muffled, soft, raspy **Sensory:** WDL **LOC:** awake, lethargic, GCS 15	This patient is alert and oriented to person, place, time, and situation. She understands that she is in the hospital due to a brain bleed, but is unable to recall the events leading up to her being admitted into the ICU. Patient is too weak to move extremities well independently, but has full range of motion with assistance. Patient strength is equal bilaterally though is weak overall. Neuro checks have been good and patient is able to follow commands and answer questions appropriately, but is very lethargic. Patient was recently extubated so her voice is muffled, soft, and raspy, but speech is coherent. Current GCS is 15. Patient appears to have normal cognition and developmental level for age. Patient denies any numbness and tingling in the extremities and has no complaints of a headache.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** family, drug use **Developmental level:** Intimacy vs. Isolation **Religion & what it means to pt.:** N/A **Personal/Family Data (Think about home environment, family structure, and available family support):** Lives with boyfriend and 5 kids. Has additional family in the area.	This patient is very anxious about her current state of health. She prefers to have her sister, mother, or aunt at her beside at all times and has expressed she is scared to go to sleep for fear of not waking up. The patient has been accepting of all medications and has verbalized an understanding of the importance of not touching her EVD and keeping her head as still as possible. Patient was found to have amphetamines and benzodiazepines in her system upon arrival to the ED, which shows she

	may have a substance abuse problem and is struggling to cope with stressors in her life. Patient made no mention of religious affiliation. Patient lives in Paris, IL with her boyfriend and 5 young kids. She has expressed how much she misses her children and is worried about them seeing her. Her family also lives nearby and has been at her bedside at all times providing support.

Discharge Planning

Discharge location: This patient does not currently have a discharge date set, but has been progressing remarkably well. The patient hopes to discharge to home support from her boyfriend and family, though she may need to be placed at a rehabilitation center or skilled nursing facility for a while depending on how her recovery continues to progress.

Home health needs: This patient will likely continue to need help with activities of daily living such as dressing, bathing, meal preparation, mobility support and more until she gains more strength back.

Equipment needs: This patient is currently bedbound and needs the support of supplemental oxygen via nasal cannula. It can be anticipated that as this patient progresses she will need mobility devices such as slide boards, gait belts, walkers, etc.

Follow up plan: This patient was recently extubated and is tolerating it well, but is still following up with respiratory therapy to continue to monitor her status and wean her off of the nasal cannula to room air. She is also waiting to be seen by speech to have a swallow assessment to be sure she can advance her diet without risk of aspiration. As she continues to improve she will be expected to work with OT and PT to help her gain her strength back and manage any neuro deficits caused by her subarachnoid hemorrhage. Though, incredibly, this patient appears free of any major deficits.

Education needs: This patient should receive reinforced education about the importance of her EVD and not moving her head around quickly so that the drain is not disrupted. She should also be taught things to avoid doing so that her ICP doesn't increase such as coughing forcefully or straining to have a bowel movement. She should also be provided education from her physician and healthcare team about what to expect as she progresses and how long it may take to get her strength back and fully heal. Additionally, because of her history of drug use, she would likely benefit from speaking to a therapist or counselor to help her find positive coping mechanisms and pain management strategies. Lastly, this patient has a history of high blood pressure but was not taking her prescribed medication. She should be taught the importance of taking her blood pressure medication every day and incorporating other lifestyle changes such as a reduced sodium diet and increased exercise to help lower her blood pressure and avoid the development of further aneurysms and related cardiovascular problems.

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. Risk for ineffective	While "risk for" diagnoses	Patient will experience	**1.** Perform hourly checks	The patient was very

	cerebral tissue perfusion related to subarachnoid hemorrhage as evidenced by need for nimodipine and 3% saline to manage ICP and use of EVD to collect drainage and monitor ICP (Phelps, 2023).	are not typically prioritized first, this particular diagnosis was chosen as a number one priority because this patient's number one concern is maintaining a normal ICP and preventing any cerebral swelling or re-bleeding. This is currently being managed with medications to prevent vasospasms and draw fluid off of the brain, but this patient is still at high risk for increased ICP and compromised cerebral perfusion. This is very dangerous because if cerebral perfusion is ineffective this can lead to a stroke which can cause huge neuro deficits or even death. Therefore, this	adequate cerebral perfusion as evidenced by an ICP under 20 and no changes in neurological status the duration of her time in the ICU (Phelps, 2023).	of the drainage in the EVD and check patient ICP. **2.** Perform hourly neurological checks including assessing level of consciousness, muscle strength and equality, sensation, and size and reactivity of pupils.	compliant with these interventions. She verbalized an understanding of the importance of check her neurological status hourly and was compliant with the use of a pupilometer. She also was very good about using the call light when she wanted to reposition her head so that the EVD could be leveled each time.

	diagnosis was prioritized first because while impaired physical mobility and pain are also important problems this patient faces, the number one concern of the healthcare team is to ensure that this patient's cerebral blood flow is maintained.			
2. Impaired physical mobility related to physical deconditioning as evidenced by rupture of a brain aneurysm leading to a subarachnoid hemorrhage and patient bedbound, unable to move extremities well without assistance and overall musculoskeletal weakness (Phelps, 2023).	This nursing diagnosis was chosen because this patient is currently very lethargic and weak following her surgery to address her ruptured brain aneurysm. Upon assessment her overall strength was very weak and she struggles to turn her self in bed or move her extremities by herself. She is currently bedbound and requires a great deal of	Patient will demonstrate improved muscle strength and maintain joint range of motion prior to discharge from the ICU (Phelps, 2023).	**1.**Perform passive range of motion to all joints at least once every shift to promote strength and prevent deformity (Phelps, 2023). **2.**Turn and position patient every 2 hours and properly support joints in a functional position to prevent skin breakdown and musculoskeletal deformity (Phelps, 2023).	The patient was very tolerant of PROM performed by the nurse in the morning. Family was at bedside and stated that they also understood the importance of PROM and would assist with this intervention as well. Q2 turns were also routinely done and pillows were placed to elevate

	assistance to do any ADLs. Being this weak puts her at risk for additional health concerns such as contractures, pressure injuries, atelectasis, and more which could quickly cause this patient's status to deteriorate.			pressure points. Patient stated she appreciated being turned and it helped alleviate some of her back pain.
3. Acute pain related to physical injury and immobility as evidenced by patient verbally rating pain an 8/10, facial grimacing, and occasionally tachypnea (Phelps, 2023).	This diagnosis was chosen because the patient rated her pain an 8/10 which is considered severe pain. She was very uncomfortable and had lower back pain as well as gas pains. Pain causes increased stress and anxiety in a patient which could lead to more serious problems such as rises in blood pressure, heart rate, and increase ICP which would be very dangerous for this patient.	Patient will express decreased pain that is considered tolerable within a reasonable time after interventions (Phelps, 2023).	**1.** Provide pain control medication as prescribed by the physician and re-evaluate effectiveness (Phelps, 2023). **2.**Perform comfort measures to promote relaxation such as a warm bath and position changes (Phelps, 2023).	The patient tolerated these interventions well. She had a fentanyl infusion running and the nurse was able to speak with the provider about adjusting the dose slightly to help manage this patient's pain. This patient was also provided with a warm bed bath and pillows were used to better support her back. After these interventions the patient stated that she

				was still uncomfortable, but that the pain was manageable at a 4/10.
4. Fear/ powerlessness related to unfamiliar environment, anxiety, and physical immobility as evidenced by patient stating that they are scared to fall asleep for fear of not waking up and becoming tearful as she was assisted in cleaning up after a bowel movement (Phelps, 2023).	This diagnosis was chosen because the patient was clearly very anxious and fearful about her current health condition. She appeared scared to move in bed and wanted family at the bedside at all times. She verbally expressed that she was scared to fall asleep because she felt she might not wake up. She also felt very embarrassed that she needed so much support because of her weakness. Fear like this can be very detrimental to a patient and cause increases in blood pressure, heart rate, and even difficulty breathing. It is	Patient will effectively communicate fears and feelings of powerlessness associated with her present situation and identify coping mechanisms that would help ease her anxiety by the end of the shift (Phelps, 2023).	**1.** Encourage the patient to express her feelings and concerns and use open ended questions to better understand her fears (Phelps, 2023). **2.** Provide as many opportunities as possible for the patient to make decisions about their care and provide positive encouragement for participation in care (Phelps, 2023).	The patient tolerated these interventions well. At first she would only speak with her family members about her anxiety, but through supportive, open-ended questions the nurse was able to assess why the patient was scared to go to sleep and provide extra reassurance of how well she was being looked after. The patient was also included in as much decision making as possible regarding her care such as if she wanted ice packs for pain, the lights on or off, and allowing her

	important to address fear and anxiety like this so that the patient is able to stay calm and heal more effectively.			sister to move the recliner right next to the bed. This helped her feel like she had a little bit more control over her situation.
5. Risk prone health behaviors related to inadequate education and life stressors as evidenced by non-compliance with hypertension medications and drug abuse (Phelps, 2023).	This diagnosis was chosen and prioritized last because the patient's risk prone behaviors are a problem outside of the hospital and played a role in what led to the development and rupture of her brain aneurysm. Upon admission to the hospital she was found to have amphetamines and benzodiazepines in her system and she also has a history of high blood pressure, but was not taking her medication. These types of health behaviors put her at a very high risk to	Patient will express understanding of the importance of taking her blood pressure medications and be able to identify healthy coping mechanisms prior to discharge (Phelps, 2023).	**1.** Encourage patient to express feelings in a safe, private environment and promote discussion of previous coping mechanisms (Phelps, 2023). **2.** Begin teaching about medication compliance and how to properly take medications at home (Phelps, 2023).	Due to the acuity of this patient's current condition, during this shift time was not specifically spent educating the patient on blood pressure medications or her drug use. However, the nurse did discuss with the patient that she is in a safe environment and encouraged her to tell us about ways we can help her cope such as turning on some music she might like or bringing in a chaplain to speak with. The patient appeared to

	experience another serious cardiovascular event and therefore proper education and counseling should be provided to address these risky behaviors.			appreciate this.

Other References (APA):

Phelps, L. L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.