N431 CARE PLAN # 1

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N441: Adult Health 3

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Demographics

Date of Admission 3/8/2025	**Client Initials** C.G.	**Age** 52	**Biological Gender** Male
Race/Ethnicity white	**Occupation** unknown	**Marital Status** married	**Allergies** Lactose, penicillin
Code Status DNR; intubate	**Height** 6 ft 2 inches	**Weight** 126.1 kg	

Medical History

Past Medical History: diabetes type 11, hyperlipidemia, GERD

Past Surgical History: colonoscopy, upper gastrointestinal endoscopy

Family History: no family history listed within the patient's chart

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): smokes cigarettes, 1 pack per day, unknown for how long due to inability to ask patient; uses alcohol, unknown for how much and how long due to inability to ask patient; no drug usage

Education: unknown education due to inability to ask the patient

Living Situation: at home with wife

Assistive devices: no assistive devices

Admission History

Chief Complaint: headache and altered mental status

History of Present Illness (HPI)– OLD CARTS

The client is unable to be interviewed due to them being intubated. The patient woke up in the middle of the night with the worst headache they have ever had, and then projectile vomited. The patient then went back to sleep and their mental status altered, and the patient's wife had a difficult time having him respond. The patient was also having snoring respirations. The patient's wife called the EMS to take them to Carle emergency department. The patient was then

intubated, and a CT scan showed a large left cerebral hemorrhage along with extremely high blood pressure. This information was found in the ED chart and given to me in the report from my nurse. I was unable to get any extra information or details from the patient.

Admission Diagnosis

Primary Diagnosis: Intracranial hemorrhage

Secondary Diagnosis (if applicable): n/a

Pathophysiology

My patient experienced an intracranial hemorrhage. An intracranial hemorrhage is when there is a bleed in the brain that can occur within the tissue, subarachnoid space, or within the meninges (Capriotti & Frizzell, 2020). This initially occurs when a blood vessel ruptures, and the blood begins to spool within the brain (Capriotti & Frizzell, 2020). This will then raise the intracranial pressure of the patient and cause problems. This will cause damage to the brain cells and tissues. Due to the blood spooling within the brain, inflammatory response occurs which will worsen the effects of the hemorrhage (Capriotti & Frizzell, 2020). The blood flow is reduced which is causing low oxygen to areas of the brain (Capriotti & Frizzell, 2020). With low oxygen and blood perfusion in the brain, this causes problems to the rest of the body.

There are many distinct signs and symptoms of an intracranial hemorrhage. Some of these include a severe headache, vision changes, altered level of consciousness, seizures, vomiting, weakness, numbness, and speech problems (Hinkle & Cheever, 2022). My patient did experience some of these symptoms. My patient woke up in the middle of the night with a severe headache and projectile vomited. The patient then began to lose level of consciousness and become very confused. All of those symptoms are related to an intracranial hemorrhage.

The top diagnostic treatment for an intracranial hemorrhage is a CT scan (Capriotti & Frizzell, 2020). This will show if there is any bleeding within the brain. A patient could also have an MRI scan, or an angiography completed (Capriotti & Frizzell, 2020). My patient was brought to the emergency department and had a CT scan done immediately. This scan showed the intracranial hemorrhage.

My patient was given blood pressure medications and placed on a ventilator. He was unable to breathe on his own and was comatose. The patient's intracranial bleed progressed to quickly for them to be able to be saved. My patient was diagnosed as brain dead around 36 hours after being brought to the hospital. The hospital staff was keeping him alive and his organs and tissues healthy because he was an organ donor.

Pathophysiology References (2) (APA):

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

Hinkle, J. L., & Cheever, K. H. (2022). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
White Blood Cell	18.62	18.71	4-11	The white blood cells are elevated due to inflammation in the brain (Hinkle & Cheever, 2022).
Glucose	266	187	74-100	The glucose is elevated because the patient is diabetic (Hinkle &

				Cheever, 2022). This could be due to a missed dose of medicine or a high carbohydrate meal (Hinkle & Cheever, 2022).
Phosphorus	5.0	4.9	2.5-4.5	The phosphorus can be elevated in a patient with an intracranial hemorrhage due to cellular damage (Hinkle & Cheever, 2022). When cells are damaged, they release phosphorus (Hinkle & Cheever, 2022).
D-Dimer	0.57	2.68	<0.50	D-dime is elevated in a person with a hemorrhage because the body is making clots to help stop the bleeding (Hinkle & Cheever, 2022).
Troponin	n/a	518	0-4	The troponin could be high due to hypoxia to the heart. During an intracranial hemorrhage, less blood is getting to the heart which will cause hypoxia (Hinkle & Cheever, 2022). This will then cause the release of troponins.

Diagnostic Test & Purpose	**Clients Signs and Symptoms**	**Results**
CT Brain	This was completed on the patient due to their mental status change, neuro deficit, and acute, stroke suspicion.	1. Acute hemorrhage in the left cerebellar hemisphere crossing into the right cerebral hemisphere measuring 3.5 cm by 5.5 cm 2.Mild hydrocephalus
XR chest	This was completed to check the	Endotracheal tube in

	placement of the endotracheal tube.	place Bibasilar atelectasis
XR KUB	This test was completed to check the NG tube placement.	NG tube with tip in mid body of the stomach
CT chest/abdomen/pelvis	This test was completed for organ donation purposes.	

Diagnostic Test Reference (1) (APA):

Hinkle, J. L., & Cheever, K. H. (2022). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

Active Orders

Active Orders	Rationale
Turns q 2	The patient has this order because they are bedrest. If the patient is getting turned from side to side, it will decrease the risk of skin breakdown and pressure injuries
Oral care q 2	The patient is intubated and needs oral care often to help prevent pneumonia and bacteria. The patient's mouth is also dry so it will help moisten it.
Npo	The patient is placed under NPO because they are currently on a ventilator and sedated.
Vitals q 1	Vital signs are an important order for every patient. It will help monitor if there are any drastic changes that are happening.
I and O q 1	Intake and output are very important for this patient, especially output. The patient will only be receiving an input of whatever fluids the doctor ordered, but output is important because it allows the nurse to know if the kidneys are perfusing and doing their job (Hinkle & Cheever, 2022).
SCD	The patient has SCD as an order to prevent blood clots from forming. The patient is bedrest, so they are not moving around.
Catheter care	Catheter care is ordered once per shift. This

	will help cleanse the site to avoid any infection.
Blood sugar q 4	The patient has diabetes, so it is important to monitor their sugars to know when to give or hold insulin.

Medications

Home Medications (Must List ALL)

Medication	Reason for taking
atorvastatin	The patient is taking this medication to help with their lipid levels. The patient has a history of hyperlipidemia (Jones & Bartlett Learning, 2022).
duloxetine	The patient is taking this medication due to depression (Jones & Bartlett Learning, 2022).
lisinopril	The client is taking this medication to help lower their blood pressure (Jones & Bartlett Learning, 2022).
Insulin pen needle	The patient takes insulin to help manage and control their diabetes.
metformin	The patient is taking this to help manage their diabetes (Jones & Bartlett Learning, 2022).
pantoprazole	The patient is taking this medication to help with heart burn and acid reflux. The patient has a history of GERD (Jones & Bartlett Learning, 2022).

Hospital Medications (Must List ALL)

Brand/Generic	Rocephin/ ceftriaxone	famotidine/ Pepcid	insulin glargine/Lantus	insulin lispro/Humalog	norepinephrine/ Levophed
Classification	Cephalosporin Antibiotics	Histamine H2-Receptor Inhibitors	Long-acting Insulin	Short-acting Insulin	Adrenergic agonist
Reason Client Taking	The patient's white blood cell count was elevated so the provider ordered an antibiotic. This is a	Their history of GERD is the reason that they are taking this medication (Jones & Bartlett	The client is taking this medication to help with their diabetes.	The client is taking this medication to help with their diabetes.	The client is taking this to raise their blood pressure (Jones & Bartlett Learning, 2022).

	preventative measure to avoid any infection (Jones & Bartlett Learning, 2022).	Learning, 2022).			
List two teaching needs for the medication pertinent to the client	1.The whole antibiotic needs to be administered and finished. 2. Watch for diarrhea because clostridium difficile is an adverse effect. (Jones & Bartlett Learning, 2022).	1. This medication should only be used for a short time only. 2. If a patient misses a dose, they should take it as soon as possible. (Jones & Bartlett Learning, 2022).	1. This shot is subcutaneous and should be rotated each time it is given. 2. This is typically just given once in the morning because it is long-lasting insulin. (Jones & Bartlett Learning, 2022).	1. The patient should be aware of signs and symptoms of hyper/hypoglycemia. 2. This medication should be given before meals and is on a sliding scale. (Jones & Bartlett Learning, 2022).	1. This medication interacts with some antidepressants, so the patient needs to be careful with his depression medication. 2. This medication should not be stopped abruptly because it can cause a fast drop in blood pressure. (Jones & Bartlett Learning, 2022).
Key nursing assessment(s) prior to administration	If the antibiotic is going through the IV, it is important to flush the IV before giving it to make sure that it is going into the veins. (Jones & Bartlett Learning, 2022).	Give this medication before eating to help with heartburn and acid reflux. (Jones & Bartlett Learning, 2022).	Check the patient's blood sugar. (Jones & Bartlett Learning, 2022).	Check the patient's blood sugar. (Jones & Bartlett Learning, 2022).	The nurse needs to check the patient's blood pressure before giving this medication. If the blood pressure is within the normal range, it could cause hypertension. (Jones & Bartlett Learning, 2022).

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. norepinephrine	I chose this medication because it is very important. If the blood pressure gets too low, the body will not be getting enough oxygen, causing hypoxia (Jones &	1. hypertension 2. decreased urine output (Jones & Bartlett Learning, 2022)

	Bartlett Learning, 2022).	
2. Insulin lispro	This medication is also very important. This is a fast-acting insulin, so the patient gets this right before their meals, so they do not have hyperglycemia after eating.	1. hypoglycemia 2. fluid retention (Jones & Bartlett Learning, 2022)
3. Insulin glargine	This medication is also important because it helps the body maintain blood sugar levels throughout the day. Without this, the patient can also experience hyperglycemia.	1. hypoglycemia 2. Hypokalemia (Jones & Bartlett Learning, 2022)

Medications Reference (1) (APA)

Jones & Bartlett Learning. (2022). 2023 Nurse's drug handbook (22nd ed.). 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 a/o times 0; the patient is intubated and shows no signs of distress; patient's overall appearance looks normal for age; standard precautions; no concerns
VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:** **Oxygen:** **Delivery Method:**	Temperature 36.7 Respiration 14 Pulse 74 Blood Pressure 100/56 Oxygen 100% -ventilator
PAIN ASSESSMENT: **Time**: **Scale**: **Location**: **Severity**: **Characteristics**: **Interventions**:	There was no pain assessment done on the patient since they are brain dead and cannot feel any pain within their body.

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 has 4 IVs; 16 in right hand; 18 in left hand; 18 in left forearm; 18 in right AC; all of the IVs were placed on the 8th and are open, flush well, and has good blood return; no abnormal signs or concerns; dressing is dry and intact; lactated ringer is going in left hand at 75 ml/hr; rest of the IVs are saline locked
INTEGUMENTARY: **Skin color**: **Character**: **Temperature:** **Turgor**: **Rashes**: **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient's skin is color is normal for ethnicity; warm to touch, turgor is normal; no signs of rashes, bruises, or wounds; skin is dry and intact Braden Score: 8 No drains present
HEENT: **Head/Neck**: **Ears:** **Eyes:** **Nose:** **Teeth**:	Patient is immobile; head, neck within normal limits; patient does not respond to sound; ears are free of abnormalities; patient is not PERRLA and cannot open their eyes; patient has no abnormalities with teeth or nose .
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**:	S1 and S2 auscultated; peripheral pulses +2; cap refill less than 3 seconds; no neck vein distention; no edema
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	No accessory muscle use; wheezes heard bilaterally on lower lobes of lungs
GASTROINTESTINAL: **Diet at home:** **Current Diet**: **Is Client Tolerating Diet?** **Height**: **Weight:**	Regular diet at home; NPO currently; client is tolerating diet; 6' 2"; 126.1 kg.; bowel sounds active in all four quadrants; last BM on the 8th; no abnormalities with palpation or inspection; no ostomy; the patient has a nasogastric tube; no feeding tube

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:**	
GENITOURINARY: **Color**: **Character**: **Quantity of urine**: **Pain with urination: Y ☐ N ☐** **Dialysis**: **Y ☐ N ☐** **Inspection of genitals**: **Catheter**: **Y ☐ N ☐** **Type:** **Size:**	Urine is yellow; clear; >30 ml/hr; no signs of pain is shown with urinating; patient's genitals are free of any abnormalities; patient has a 14 french indwelling urinary catheter
Intake (in mLs) **Output (in mLs)**	1000 mL 620 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**	Patient neurovascular status is within normal limits; patient cannot move own body due to being on a ventilator; no supportive devices; strength 0; patient cannot do any activities of daily living; patient is a fall risk; bedrest is the activity fall score- 45

NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation**: **Mental Status**: **Speech**: **Sensory**: **LOC:**	Patient is not MAEW; patient is not PERLA; strength is 0 on both sides; not oriented; patient is intubated; no speech, sensory; patient has no LOC
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level**: **Religion & what it means to pt.**: **Personal/Family Data (Think about home environment, family structure, and available family support)**:	The patient was intubated so I could not ask about coping methods or consider the developmental level. The patient had a note in their chart that the family wanted a pastor to come and pray with them for support. This makes me assume that they could be religious and praying could possibly be a coping method. The patient had lots of family members present. The family has a stable, supportive, and safe structure.

Discharge Planning

Discharge location: patient is not getting discharged, patient passed away

Home health needs: n/a

Equipment needs: n/a

Follow up plan: n/a

Education needs: educate the family on support groups and counseling if needed

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"	**Rationale** • Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per dx)**	**Interventions (2 per goal)**	**Evaluation of interventions**

components • Listed in order by priority – highest priority to lowest priority pertinent to this client				
1. Impaired gas exchange related to no brain activity as evidenced by failed brain-dead test and being on a ventilator (Phelps, 2023).	I chose this nursing diagnosis because I thought it was the most important. If the patient cannot exchange gas on their own, then they will not be able to live.	Keep patient breathing on ventilator without until it is time for surgery for the organ donation.	**1.** Monitor the ventilator settings to detect any changes that need to be made (Phelps, 2023). **2.** Check the patient's vital signs every hour.	The interventions helped the patient to maintain adequate gas exchange.
2. Poor airway clearance related to presence of thick secretions as evidenced by the bronchoscopy (Phelps, 2023).	I chose this nursing diagnosis because with all the extra secretions, it will make it hard for the patient to breathe.	Clear the secretions in the lungs to make them healthy before the surgery for the organ donation.	**1.** Complete oral care and swabbing every two hours on the patient (Phelps, 2023). **2.** Help assist whoever is completing the bronchoscopy on the patient (Phelps, 2023).	The patient was cleared of a majority of their thick secretions.
3. Low cerebral tissue perfusion is related to increased intracranial pressure as evidenced by no pupillary response (Phelps, 2023).	I chose this nursing diagnosis because the low cerebral tissue perfusion is causing poor circulation, which is important.	Increase the tissue perfusion in the body within 24 hours to restore circulation .	**1.** Palpate peripheral pulses of the patient every 2 hours to check for perfusion. **2**. Complete neurovascular assessments on the patient	The patient's tissue perfusion throughout the body was good and the pulses were all +2.

			every 2 hours.	
4. Impaired mobility related to neurologic changes from the stroke as evidenced by the patient being unable to move their extremities (Phelps, 2023).	I chose this nursing diagnosis because if the patient cannot move then worse symptoms can occur such as skin breakdown or pulmonary embolisms.	Have the patient not go stiff in their extremities up until the surgery.	**1.** Complete passive range of motion on the patient's extremities every two hours. **2.** Rotate the patient on each side every 2 hours.	The patient's interventions were completed, and the patient's extremities never became stiff.
5. Decreased sensory perception related to damage to the temporal lobes as evidenced by patients unresponsive to any stimuli (Phelps, 2023).	I chose this nursing diagnosis because the patient has poor sensory perception so it is important to make sure no harm is done since the patient will likely not be able to feel it.	To not damage the patient and be aware of injury that could occur before their organ donation surgery since the patient can not feel anything.	1. Prevent any heavy or shop objects from hitting the patient. 2. Prevent extreme warm or cold temperatures from being on the patient.	The patient's body was free of harm by avoiding any dangerous outcomes.

Other References (APA):

Phelps, L. (2023). Nursing Diagnosis Reference Manual. (12th ed.) Wolters Kluwer.