N441 CARE PLAN #1

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Lakeview College of Nursing

N441: Adult Health III

Professor Potts

4/13/25

Demographics

Date of Admission	**Client Initials**	**Age**	**Biological Gender**
3/20/25	V.F.	34	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Factory Worker	Single	N/A
Code Status	**Height**	**Weight**	
CPR/Full	4 ft 10 inches	168 lbs.	

Medical History

Past Medical History: Fetal Alcohol Syndrome and Childhood Trauma

Past Surgical History: None

Family History: The patient is adopted and has no family history on file.

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

There is no social history on file, however the adopted mother believes the patient is a casual smoker.

Education: High School Graduate

Living Situation: The patient lives in alone in an apartment.

Assistive devices: None

Admission History

Chief Complaint: Polytrauma- Motor Vehicle vs. Pedestrian Accident

History of Present Illness (HPI)– OLD CARTS

On 3/20/25, at approximately 10 p.m., on the corner of Bradley Street and Mattis Street in Champaign, Illinois, the patient was hit by a motor vehicle while walking to work. The patient's location of the injury was all over the body, with severe trauma to the head. The duration of the illness has been continuous since being struck. The characteristics of the injury included combativeness, agitation, a low Glasgow Coma Scale score, and pupils being uneven and non-

reactive. The associated factors included the patient becoming unconscious, and aggravating factors included any movement by the patient with no relieving factors. The Emergency Medical Technicians performed the emergency treatment, and the timing was constant. The severity of the pain was most likely a 10 out of 10 due to the severity of the accident, but the patient is unable to communicate this due to being unresponsive.

Admission Diagnosis

Primary Diagnosis: Traumatic Brain Injury

Secondary Diagnosis (if applicable):

Pathophysiology

Subdural Hematoma and Subarachnoid Hematoma

As the body's command center, the brain is essential for survival and quality of life. It controls vital bodily systems, permits thought, memory, and emotion, and lets us understand the outside world. Any or all of these can be compromised if there is disruption or injury to the brain.

Intracranial bleeding happens after a head trauma, and the injury to the head is classified depending on where the bleeding is. A subdural hematoma, or SDH, accumulates in the space below the dura mater above the arachnoid membrane (Capriotti, 2023). The subdural space's bridging veins tear and bleed, which causes intracranial bleeding and accumulates and compresses brain tissue (Capriotti, 2023). If brain tissue is compressed by the SDH, it may cause intracranial pressure, neurological damage, or death (Capriotti, 2023).

Tearing of the cerebral and meningeal vessels in the brain's subarachnoid space causes a subarachnoid hemorrhage or SAH (Capriotti, 2023). Traumatic SAH is frequently accompanied by a skull fracture and a cerebral contusion, and intracranial pressure can result from the buildup

of cerebral spinal fluid in the brain (Capriotti, 2023).

The patient was a pedestrian in a pedestrian vs. motor vehicle accident and suffered several injuries, including the head. She was hit at a high rate of speed and had severe head wounds. The Emergency Medical Technicians noticed the signs and symptoms of severe injuries directly to the head and a low Glasgow Coma Scale rating.

The patient was unconscious and unable to let anyone know the extent of her injuries. After confirmation through a CT scan of the head, it was confirmed that the patient suffered several hemorrhages, including the areas of the parietal scalp, left frontal region, left mastoid, and left tentorial leaflet. Several follow-up scans of the head were performed after the initial scan to confirm the diagnosis.

A craniotomy was performed on the patient. A craniotomy is a surgical procedure that removes a portion of the skull to allow for the removal of blood from the brain and to reduce the intracranial pressure caused by the swelling (Hinkle & Cheever, 2022). If a craniotomy had not been performed on the patient, reduced blood flow to the brain would have happened, causing hypoxia and cellular injury (Hinkle & Cheever, 2022).

Pathophysiology References (2) (APA):

Capriotti, T. (2023). *Davis advantage for 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.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
WBC	17.57 10^9/L	11.45 10^9/L	5-10 10^9/L	The patient's WBC is high due to the stress of the injury (Pagana, 2021).
Abs Neutrophil	12.84 10^3u/L	9.11 10^3u/L	1.5-7.7 10^3u/L	The patient's Abs Neutrophil is high due to the trauma (Pagana, 2021).
Abs Immature Granulocyte	0.25 10^3u/L	N/A	0-0.00 10^3u/L	The patient's Abs Immature Granulocyte is high so the body can fight off an infection or inflammation from the accident (Pagana, 2021).
PH	7.302	7.457	7.35-7.45	The patient's PH was originally low due to the inefficient oxygen delivery to the patient's tissues (Pagana, 2021).
Lactate	3.76 mmol/L	0.67 mmol/L	0.6-2.2 mmol/L	The patient's lactate is high because of reduced blood flow to the tissues (Pagana, 2021).
COHB	0.1%	0.3%	0.5-1.5%	The patient's COHB is low due to the blood loss (Pagana, 2021).
HC03	18.6 mmol/L	26.3 mmol/L	22-26 mmol/L	The patient's HC03 was originally low due to tissue hypoxia (Pagana, 2021).
BE	-7.2 mmol/L	2.4 mmol/L	-2-2 mmol/L	The patient's BE was low indicating metabolic acidosis (Pagana, 2021).
Glucose	140 mg/dL	128 mg/dL	74-100 mg/dL	The patient's glucose is high due to the stress from the accident (Pagana, 2021).
Chloride	113 mmol/L	108 mmol/L	98-106 mmol/L	The patient's chloride could be high from kidney dysfunction (Pagana, 2021).
CO2	21 mmol/L	25 mmol/L	22-29 mmol/L	The patient's CO2 is low due to poor tissue

				perfusion (Pagana, 2021).
Calcium	8.3 mg/dL	9.6 mg/dL	8.9-10.6 mg/dL	The patient's calcium was originally low due to the blood loss after the trauma (Pagana, 2021).
Albumin	3.3 g/dL	2.8 g/dL	3.4-4.8 g/dL	The patient's albumin is low because of increased vascular permeability from the trauma (Pagana, 2021).
AST	136 u/L	32 u/L	0-35 u/L	The patient's AST was high due to damage of the liver from the accident (Pagana, 2021).
ALT	87 u/L	29 u/L	0-34 u/L	The patient's ALT was high due to the liver being injured (Pagana, 2021).
RBC	3.64 10^6/uL	3.03 10^6/uL	4.10-5.70 10^6/uL	The patient's RBC is low due to blood loss (Pagana, 2021).
HGB	11.9 g/dL	9.5 g/dL	12-16 g/dL	The patient's HGB is low due to blood loss from the accident (Pagana, 2021).
HCT	36.2%	29.8%	37%-47%	The patient's HCT is low due to the blood loss from the accident (Pagana, 2021).
Platelet	287 10^3/uL	452 10^3/uL	140-400 10^3/uL	The patient's platelets are out of range due to the injury (Pagana, 2021).
Blood Urinalysis	Large!	N/A	Negative	The blood urinalysis is positive for blood due to damage to the kidneys or bladder (Pagana, 2021).
Protein Urinalysis	30	N/A	Negative	The patient has protein in the urine due to damage to the kidneys after the accident (Pagana, 2021).
RBC Urinalysis	269 u/L	N/A	0-20 u/L	The patient's RBC urinalysis is high due to an injury to the kidneys, bladder, or urinary tract (Pagana, 2021).
Specific Gravity	1.045	N/A	1.003-1.035	The patient's specific gravity is high possibly due to kidney dysfunction

				(Pagana, 2021).
WBC Urinalysis	31	N/A	0-25 u/L	The WBC urinalysis is high due to the stress or inflammatory response after the accident (Pagana, 2021).

Diagnostic Test & Purpose	**Clients Signs and Symptoms**	**Results**
CT Brain without contrast	The client had significant head injuries from being struck by a motor vehicle.	The results show several injuries including parietal scalp hematomas, parietal fractures, and hemorrhages. The patient also has extensive intracranial and maxillofacial traumatic findings.
CT Cervical Spine	The client had significant injuries all over her body from being struck by a motor vehicle.	The results show no fracture or misalignment.
CT Face	The client had significant head injuries from being struck by a motor vehicle.	The results show bilateral sphenoid sinus fractures with hemorrhage. This CT also showed extensive intracranial and maxillofacial traumatic findings.
CTA Head and Neck	The client had significant head injuries from being struck by a motor vehicle.	Extensive intracranial and maxillofacial traumatic findings. This includes subarachnoid hemorrhage of several areas.
CTA Chest/Abdomen/ Pelvis with contrast	The client had significant injuries all over her body from being struck by a motor vehicle.	The results show acute fractures of the right superior and inferior pubic rami.

		No other findings on the chest or abdomen.
CT Thoracic Spine	The client had significant injuries all over her body from being struck by a motor vehicle.	The results show compression fractures of the anterior superior L2 and L3 and acute fracture of the left L4-L5 transverse processes.
CT Lumbar	The client had significant injuries all over her body from being struck by a motor vehicle.	These findings are the same as the thoracic findings.
XR Elbow Right	The patient was struck by a motor vehicle and the extent of the injuries were unclear, so this x-ray was necessary to see the damage.	The results show no fracture or misalignment.
XR Knee left	The patient was struck by a motor vehicle and the extent of the injuries were unclear, so this x-ray was necessary to see the damage.	The results show no fracture or misalignment.
XR Knee Right	The patient was struck by a motor vehicle and the extent of the injuries were unclear, so this x-ray was necessary to see the damage.	The results show no fracture or misalignment.

Diagnostic Test Reference (1) (APA):

Pagana, K., Pagana, T., & Pagana, T. (2021). *Mosby's® diagnostic and laboratory test reference* (15th ed.). Elsevier Inc.

Active Orders

Active Orders	Rationale

Sinus Precautions	The patient had a craniotomy therefore sinus precautions are to reduce any intracranial pressure.
Restraint- Non-Violent/Non-Self-Destructive	This order is necessary for mitts, so the patient does not pull out her IV's or endotracheal tube.
Admit (Admit/PRN Pain Medication Substitution Protocol)	This order is the admit protocol and allow for the administration of PRN pain medications.
Activity- Increase Activity as Tolerated	This order is to allow the patient to increase activity as tolerated to regain strength.
Elevate Head of Bed to 45 Degrees	This order is to keep the bed at 45 degrees to reduce intracranial pressure.
Diet: NPO	The patient cannot eat any food by mouth due to the accident. This is an order for nothing per oral.
Enteral Feeding Order	This order is to allow for enteral feedings which is necessary since the patient is nothing per oral.
Neuro Check Q2H	This order is to make sure the patient is receiving neuro checks every two hours due to the brain injury.
Pupillometer Check Q2H	This order is to make sure the patient's pupils are not showing any irregular signs from the brain injury.
Free Water Flush Q4H	This order is to add water in the enteral feeding to maintain the tube patency.
Vital Signs Q1H	This order is necessary to keep an eye on any changes in vital signs.
Assess CAM-ICU Q12H	This an assessment necessary to see if the patient has any change in confusion or the level of consciousness has changed.
Cardiac Monitoring	This order is necessary to monitor the patient's cardiac activity for any abnormalities.
Keep SBP between 90 and 140	This order is to keep the systolic blood pressure between 90-140 to make sure the pressure in the arteries stays normal.
Assess CPOT or Patient Self-Reported Pain Q2H	The patient cannot report their own pain so the nurse must use the CPOT scale and determine the level.
Follow Attached Algorithm for Titration and Weaning	This order enables the nurse to titrate and wean the patient for medications based on the patient's condition.
Delirium: Daytime Interventions- As appropriate, lights on and window blinds open	This order is necessary to keep the patient on a normal schedule of morning and nights.

Delirium: Nighttime Interventions- Minimize noise, dim lights to create a sleeping atmosphere	This order is necessary to keep the patient on a normal schedule of morning and nights.
Delirium: Assess for Delirium using CAM/CAM-ICU every 12 hours and with any acute mental status change	The patient as a brain injury so regular assessments for delirium are necessary for prevention of the pulling of any tubes.
Delirium: Assess for the Continuing Need for Lines, Tubes, Restraints Daily	The patient should be assessed for the continuance of all lines and tubes because it is one less line or tube the patient could pull out during a delirium episode.
Urinary Catheter Placement and Care-External Catheter	The patient has an external catheter; therefore, placement and care of the catheter is necessary.
NG/OG Tube Placement and Care	The patient has an O/G tube, and this order is needed to properly take care of it.
Intake & Output Q2H	This order is to monitor the patient's intake and output to make sure it matches.
Wound Care/Dressing Change	This order is for caring for the craniotomy wound and any other wounds the patient has.
Oral Care Q2H	This order is to perform oral care on the patient every 2 hours to help prevent infections.
Pneumatic Compression Stockings-Bilateral	This order is necessary to prevent blood clots since the patient is immobile.
Initiate Hospital Basic Care	This order is to follow the hospital basic care protocol.
Titrate Pain Medications to Achieve Goal CPOT </=2	This order is to keep the patient's pain under control and also to help with agitation.
Initiate Hospital CCU 1000 ICU Mobility Protocol	This is the basic hospital protocol care for the ICU needed for this patient.
High Risk-Patient is High Risk for DVT/PE	The patient is immobile; therefore, she needs to be monitored closely for DVT/PE.
Pharmacological Prophylaxis Contraindicated or Patient Currently on Therapeutic Coagulation	The patient is currently on Heparin so this order is to allow for the nurse to determine if it is still appropriate or other measures can be used to prevent blood clots.
Notify Physician if SBP>140, HR>130 <50, Temperature >39C or <36C, RR >30 <8, Urine Output <60 q2H	This order is to notify the physician if the patient's vital signs or RR changes for the worst so they can intervene.
No Central/Arterial Access Through Right Femoral Artery	This order is most likely due to the patient being on heparin and has a high risk of bleeding.
Notify Intensivist if the patient has any of the following findings: GCS </=12 or down 3 points from initial pupillometer changes, decreased LOC	This order is to watch the patient's Glasgow Coma scale and report any changes so it can be addressed immediately.

Notify Neurosurgery (Pupilometer) Change in pupil sizes	This order is to notify neurosurgery for pupil changes which could mean increased intracranial pressure.
Delirium: Notify Provider: Increased Agitation Despite Treatment	This order is necessary if the patient's delirium status changes so it can be addressed right away.
Oxygen Therapy per Respiratory Protocol	This order is necessary to provide oxygen therapy per protocol.

Medications

Home Medications (Must List ALL)

Medication	Reason for taking
The patient currently does not take any medications at home.	

Hospital Medications (Must List ALL)

Brand/ Generic	Seroquel/ quetiapine fumarate (NDH, 2023)	Pepcid/ Famotidine (NDH, 2023)	Keppra/ levetiracetam (NDH, 2023)	Heparin Sodium Injection/ heparin sodium (NDH, 2023)	Merrem I.V./meropenem (NDH, 2023)	Fentora /fentanyl citrate (NDH, 2023)
Classification	Pharm Class: Dibenzothiazepine Therapeutic Class: Antipsychotic (NDH, 2023)	Pharm Class: Histamine-2 blocker Therapeutic Class: Antiulcer agent (NDH, 2023)	Pharm Class: Pyrrolidine derivative Therapeutic Class: Anticonvulsant (NDH, 2023)	Pharm Class: Anticoagulant Therapeutic Class: Anticoagulant (NDH, 2023)	Pharm Class: Carbapenem Therapeutic Class: Antibiotic (NDH, 2023)	Pharm Class: Opioid Therapeutic Class: Opioid analgesic (NDH, 2023)
Reason Client Taking	The patient is taking this medication to reduce any episodes of delirium and to keep the patient calm (NDH, 2023).	The patient is taking this to prevent ulcers and or GERD (NDH, 2023).	The patient is taking this so she does not have seizures (NDH, 2023).	The patient is taking this to prevent blood clots (NDH, 2023).	The patient is taking this to treat and prevent any infection (NDH, 2023).	The patient is taking this for pain and to assist with sedation (NDH, 2023).
List two teaching needs for the medication pertinent to the client	When the patient becomes alert, she should rise slowly due to hypotension and educate the patient that the medication can cause drowsiness (NDH, 2023).	This medication can be taken with or without food, and take this medication at bedtime (NDH, 2023).	The patient may have mental and behavioral changes while on this medication and aggression and irritability are possible (NDH, 2023).	The patient should understand that heparin cannot be taken orally, and they have an increased risk of bleeding while on this medication (NDH, 2023).	The patient should report difficulty breathing immediately and if they have any skin changes such as blisters (NDH, 2023).	The patient should not take this drug longer than needed due to the risk of dependency and do not stop taking this drug abruptly because of withdrawal symptoms (NDH, 2023).
Key nursing assessment(s) prior to administration	The patient should be monitored for tardive dyskinesia and the patient's blood glucose should be monitored for hyperglycemia (NDH, 2023).	This medication can be dangerous with patients who have phenylketonuria, and the patient should be monitored for bronchospasms (NDH, 2023).	Monitor the patient for any seizure activity and do not stop the drug abruptly because it may increase seizure activity (NDH, 2023).	Monitor the patient's hematocrit, and platelet counts regularly, and bleeding is a major adverse effect of heparin (NDH,	Monitor the patient for C-Diff while on this medication and stop the drug immediately if there is a sign of anaphylaxis (NDH, 2023).	The nurse should be aware that the lowest dose for pain control should be given and to monitor the patient's

				2023).		respiratory status closely (NDH, 2023).
Brand/ Generic	MiraLAX/ polyethylene glycol (NDH, 2023)	Senokot/sennosides-docusate sodium (NDH, 2023)				
Classification	Pharm Class: Laxative Therapeutic Class: Stimulant Laxative (NDH, 2023)	Pharm Class: Laxative Therapeutic Class: Stimulant Laxative (NDH, 2023)				
Reason Client Taking	The patient is taking this to keep her bowels moving and stools soft (NDH, 2023).	The patient is taking this to keep her bowels moving and stools soft (NDH, 2023).				
List two teaching needs for the medication pertinent to the client	The patient should not take this if she has rectal bleeding, or the patient should not take this if they become alert and nauseous (NDH, 2023).	The patient should not take this if she has rectal bleeding, or the patient should not take this if they become alert and nauseous (NDH, 2023).				
Key nursing assessment(s) prior to administration	If the patient has excessive soft bowel movements this medication may not be needed.	If the patient has excessive soft bowel movements this medication may not be needed.				

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Keppra/levetiracetam	This medication was chosen	1. This medication can make

	because of the patient's head injury and craniotomy. It is needed so the patient does not have any seizures.	the patient angry and since the patient is in the critical care unit with many tubes and I.V.'s it is important to monitor (NDH, 2023). 2. This medication can make the patient aggressive which must be monitored due to the setting of the patient (NDH, 2023).
2. heparin	This medication was chosen because the patient is unable to move around and is at a high risk for blood clots.	1. Heparin can cause fast breathing or wheezing. This is important because the patient has an endotracheal tube (NDH, 2023). 2. This medication can cause bleeding that won't stop which is important to monitor because of the patient's critical care status (NDH, 2023).
3. meropenem	This medication was chosen because it is an antibiotic that treats a wide range of infections, and the patient needs this to ward off any infection while in the critical care unit.	1. This medication can cause a fast, weak pulse. This is important while monitoring the patient in the critical care unit (NDH, 2023). 2. This medication can cause confusion. This correlates to the patient because she has a traumatic brain injury which already causes confusion (NDH, 2023).

Medications Reference (1) (APA)

2023 nurse's drug handbook (22nd ed.). (2023). Jones & Bartlett Learning.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** Not alert **Orientation:** Not oriented	The patient is A/O X 0 and is intubated but appears to be resting comfortably. She is non-verbal and does not open her eyes. She appears to

Distress: None **Overall appearance:** Typical of an ICU patient **Infection Control precautions:** Standard **Client Complaints or Concerns:** None	be in no distress and her overall appearance is typical of an ICU patient. The patient is under standard precautions and cannot voice her complaints or concerns at this time.
VITAL SIGNS: **Temp:** 100.4 degrees Fahrenheit **Resp rate:** 24 **Pulse:** 74 **B/P:** 108/68 **Oxygen:** 40% **Delivery Method:** ET Tube	The patient's vital signs are out of the normal range with the blood pressure being slightly low, high respirations, and an above normal temperature.
PAIN ASSESSMENT: **Time:** 0800 **Scale:** CPOT **Location:** N/A **Severity:** 0 **Characteristics:** N/A **Interventions:** N/A	The patient is non-verbal in the Intensive Care Unit; therefore, the pain level was taken using the Critical Care Pain Observation Tool which equaled to a zero. There were no facial expressions, body movements, muscle tension, or signs of agitation.
IV ASSESSMENT: **Size of IV:(** 2)- 18 Gauge and (1)- 20 Gauge **Location of IV:** anterior left antecubital left upper arm, and anterior right wrist **Date on IV:** 3/30 **Patency of IV:** Flushed without difficulty **Signs of erythema, drainage, etc.:** **IV dressing assessment:** Transparent, clean, dry, and intact **Fluid Type/Rate or Saline Lock:** N/A	The patient has 3 IV''s. -Peripheral 18 Gauge Anterior left antecubital -Peripheral 18 Gauge Left upper arm -Peripheral 20 Gauge Anterior right wrist
INTEGUMENTARY: **Skin color:** Appropriate for ethnicity **Character:** Normal **Temperature:** Warm and dry **Turgor:** No tenting **Rashes:** No **Bruises:** Yes- several **Wounds:** Yes. **Braden Score:** 12 **Drains present:** **Y**☐ **N** ☒ **Type:**	The patient has notable bruising on many areas of her body including her legs, feet, and abdomen. There is a large incision with staples on the left side of her head which is where the craniotomy was performed. This wound has no redness or areas of concern.
HEENT: **Head/Neck:** Large incision from craniotomy surgery **Ears:** Normal **Eyes:** PERRLA	The patient's head has the surgery scar from the craniotomy surgery. Pupillometer checks are done frequently, and they are within normal range.

Nose: Normal **Teeth:** Normal	
CARDIOVASCULAR: **Heart sounds:** Normal **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** Normal **Peripheral Pulses:** Normal **Capillary refill:** Less than 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:** N/A	Normal sinus rhythm with are no gallops, rubs, or murmurs coming from S1 or S2. The patient has a telemetry monitor.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** Normal	The respiration rate and pattern are above normal range. The patient has an endotracheal tube airway with mechanical ventilation at 40%.
GASTROINTESTINAL: **Diet at home:** Normal **Current Diet:** NPO **Is Client Tolerating Diet?** Yes **Height:** 4 ft. 10 inches **Weight:** 168 lbs. **Auscultation Bowel sounds:** **Last BM:** 3/29 **Palpation: Pain, Mass etc.:** Patient is unable to communicate if she has any pain. **Inspection:** **Distention:** None **Incisions:** None **Scars:** None **Drains:** None **Wounds:** None **Ostomy: Y ☐ N ☒** **Nasal gastric: Y ☐ N ☐ Other** **Size:** It is an oral gastric 18 French **Feeding tubes/PEG tube Y ☒ N ☐** **Type:** Oral Gastric No Peg	The patient's abdomen is soft and non-distended in all four quadrants. She has an oral gastric feeding tube that was placed on 3/21/25.
GENITOURINARY: **Color:** Dark **Character:** Concentrated **Quantity of urine:** 425 mL **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒**	The patient has very dark and concentrated urine.

Inspection of genitals: Normal **Catheter: Y** ☒ **N** ☐ **Type:** External Urinary Catheter **Size:**	
Intake (in mLs) 558 mL **Output (in mLs) 425** mL	Net output = 130 mL
MUSCULOSKELETAL: **Neurovascular status:** Poor **ROM:** Unable **Supportive devices:** N/A **Strength:** Unable **ADL Assistance: Y**☒ **N** ☐ **Fall Risk: Y** ☒ **N**☐ **Fall Score:** 23 **Activity/Mobility Status:** **Activity Tolerance:** None currently **Independent (up ad lib)** No **Needs assistance with equipment** Yes **Needs support to stand and walk** Unable to stand and walk	The musculoskeletal system is unable to be assessed. The patient is unconscious and intubated.
NEUROLOGICAL: **MAEW: Y** ☐ **N**☒ **PERLA: Y** ☒ **N**☐ **Strength Equal: Y** ☐ **N** ☐ Unable to assess **if no - Legs** ☐ **Arms** ☐ **Both** ☐ **Orientation:** Altered level of consciousness **Mental Status:** Not alert **Speech:** None **Sensory:** None **LOC:** Unconscious	The patient is withdrawn with no signs of arousing. She has an altered LOC, but her pupils are now reactive. The patient's Glasgow Coma Scale rating is a 7.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** Petting her cats **Developmental level:** 10 -12 years old **Religion & what it means to pt.:** Christian **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient's mother was interviewed and advised me that the patient is on the development level of a 10–12-year-old and her usual coping method is to pet her cats, but the patient does get angry and loud when expressing her emotions. Her mother stated that the patient is Christian and knows God is watching over her. She also noted that the patient has a huge family, but they live in Cincinnati, Ohio.

Discharge Planning

Discharge location: The patient's family has plans to have the patient discharged to a medical facility in Cincinnati, Ohio as soon as she is medically able.

Home health needs: Home health care needs are unable to be determined at this time.

Equipment needs: Equipment needs are unable to be determined at this time.

Follow up plan: If this patient is discharged an extensive follow-up plan will be needed but this is unable to be determined at this time.

Education needs: The patient's family will need to be educated on all medications, therapies, and future needs of the patient but this is unable to be determined at this time.

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

priority to lowest priority pertinent to this client				
1. Ineffective airway clearance related to the effects of the endotracheal tube as evidenced by the inability to clear secretions (Phelps, 2023).	This nursing diagnosis was chosen because when going back to the ABCs of nursing, airway is priority number one. The patient must have a clear airway to breathe correctly.	The patient will not have adventitious sounds or crackles heard upon auscultation (Phelps, 2023).	**1.**Assess respirations of the patient continuously (Phelps, 2023). **2.**Assess the lung sounds of the patient continuously (Phelps, 2023).	The patient's airway remained clear and free of secretions during my clinical hours.
2. Risk for aspiration related to the patient's endotracheal tube as evidenced by the patient's reduced level of consciousness (Phelps, 2023).	This nursing diagnosis was chosen because aspiration can lead to many other issues such as pneumonia, infection, or death.	The patient will not experience aspiration.	**1.** Perform suctioning as necessary (Phelps, 2023). 2.Keep the head of the bed elevated after a feeding (Phelps, 2023).	The patient did not aspirate and remained free of pneumonia, infection, and death during my clinical hours.
3. Impaired gas exchange related to a foreign body of the endotracheal tube in the patient's throat as evidenced by the patient's abnormal blood PH level (Phelps, 2023).	This nursing diagnosis was chosen because if the patient's PH is not in range, it can affect vital organs due to low oxygen delivery.	The patient will have an oxygen saturation of greater than 90%.	**1.**Maintain a patent airway by providing frequent suctioning (Phelps, 2023). **2**.Reposition the patient frequently to encourage maximum lung expansion (Phelps, 2023).	The patient's PH remained within normal range during my clinical hours.
4. Impaired physical mobility related to the patient's physical	This nursing diagnosis was chosen because prolonged immobility can	The patient will remain free of contractures and ulcers	**1.**Provide adaptive equipment related to the patient's	The patient did not have any muscle contractions or ulcers during

	deconditioning as evidenced by the decreased level of consciousness and the strength of the patient (Phelps, 2023).	lead to many other issues such as muscle atrophy or blood clots.	due to the impaired physical mobility (Phelps, 2023).	capabilities (Phelps, 2023). **2.**Provide passive ROM as ordered (Phelps, 2023).	my clinical hours.
5.	Impaired skin integrity related to decreased physical mobility as evidenced by the patient's immobility and level of consciousness (Phelps, 2023).	This nursing diagnosis was chosen because the patient can develop pressure ulcers due to her lack of mobility.	The patient skin's integrity will remain intact.	**1.**Position the patient so all the bony prominences are protected (Phelps, 2023). 2**.** Use cushions to alleviate pressure on areas that are prone to impaired skin integrity (Phelps, 2023).	The patient's skin remained free of any pressure ulcers during my clinical hours.

Other References (APA):

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