

N441 CARE PLAN

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Lakeview College of Nursing

N441: Adult Health III

Professor Potts

2/5/2026

Demographics

Date of Admission 1/29/2026	Client Initials J.I.	Age 68	Biological Gender Female
Race/Ethnicity White	Occupation Retired	Marital Status Divorced	Allergies Codeine, hydrocodone, morphine, penicillin's, sulfa, adhesives/tape, fluorouracil
Code Status Full	Height 152.4cm (5'0")	Weight 67.9kg (149lb 11.1oz)	

Medical History

Past Medical History: Type 2 diabetes mellitus (T2DM), hypertension (HTN), hyperlipidemia (HLD), congestive heart failure (CHF), multiple falls, bilateral subdural hematomas, midline shift, hydrocephalus, respiratory failure, metabolic encephalopathy, depression, urinary tract infection (UTI), supraventricular tachycardia (SVT).

Past Surgical History: Right shoulder arthroplasty, extra ventricular drain (EVD) placement, appendectomy, bilateral carpal tunnel release (CTR), cholecystectomy, hysterectomy, right total knee arthroplasty (TKA).

Family History: Unknown per documentation.

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

Denies tobacco and drug use. Reports not currently utilizing alcohol.

Education: Unknown per documentation.

Living Situation: Owns own home, lives independently.

Assistive devices: None at baseline, prior to recent injuries.

Admission History

Chief Complaint: Multiple falls.

History of Present Illness (HPI)– OLD CARTS

Patient is a 68 y/o female admitted for repeat falls. On 1/13 had reverse TSA for humeral fracture sustained in a fall. D/C to rehab, fell twice in rehab, returned to hospital on 1/14 with metabolic encephalopathy, UTI, and respiratory failure. Client discharged to rehab again on 1/17; sustained an additional x2 falls, resulting in bilateral sub dural hematomas and midline shift. Moved to ICU on 1/21 due to hydrocephalus, EVD placement, and intubation. Date now 1/29, patient has since been extubated and EVD removed. NG tube still in place due to failed swallow study. Is oriented predominately to self, but orientation to place, time, and situation variable. Is unable to discuss aggravating or alleviating factors. Treatment continues to stabilize ICP, and ABG/pH abnormalities subsequent of compound head trauma.

Admission Diagnosis

Primary Diagnosis: Fall (resulting in loss of consciousness and bilateral subdural hematomas)

Secondary Diagnosis (if applicable): Head trauma, altered mental status, and unspecified encephalitis. Recent right reverse total shoulder replacement (1/13).

Pathophysiology

PATHOLOGY

A subdural hematoma is a vascular trauma resulting in the formation of a pocket of blood within the layers of the cerebrum, often as a result of a blunt force impact to the skull (Pierre & Kondamudi, 2023). Effectively, this is a bruise on the brain, where the injurious force causes a vessel to rupture blood out into the cranium. However, unlike other regions of the body, there is a limited occupiable space within the cranium. As such, the addition of such a pocket of blood

loss results in an increase in intracranial pressure (ICP), and the body struggles to metabolize the dead cells in the same way it would in other parts of the body (Capriotti, 2024). Moreover, unlike other regions of the body, the byproducts of such a “clean-up” process leave metabolic waste that when evacuated into the surrounding cerebral tissues also engender neurotoxicity. This is exacerbated by the blood-brain barrier that limits the perfusion of some materials into or out of the cranial vault. The increase of intracranial pressure from this hematoma exerts compression forces onto surrounding tissues, and the pressure and clean-up efforts kick off additional inflammation as a byproduct, resulting in additional swelling, and therefor compounding ICP, in a vicious cycle (Hinkle et al., 2022). Moreover, this impacts the normal maintenance functions of drainage, reabsorption, and transportation of blood, lymph, and cerebral spinal fluid (CSF). Building pressures can also cause a midline-shift, where the central “equator” of the brain is displaced in an asymmetrical fashion across to one side of the skull (Pierre & Kondamudi, 2023). In this client's case, the disruption is further magnified by possessing these forces in both hemispheres of the brain, causing a crushing force of swelling within both sides of the skull. In this client, this resulted in pressure forces occluding the aqueduct system that normally drains excessive fluid content from the cranium. This lead to hydrocephalus – a state of accumulating CSF due to an inability to drain, which further elevated ICP (Chau et al., 2019). As such, it became necessary for her to have an External Ventricular Drain (EVD) surgically applied. This is effectively putting a “tap” on her skull to allow for evacuation of the hematoma, CSF, and other accumulating fluids to bring ICP back down (Chau et al., 2019).

SIGNS AND SYMPTOMS

Manifestations of such a condition can be very evident and serious given the involvement of the brain. Clients will demonstrate altered levels of consciousness, potentially fluctuating between arousal states and orientation. Disorientation to time/place/and situation may vary heavily from moment to moment. Clients may exhibit nausea, vomiting, and headaches in response to increasing ICP (Hinkle et al., 2022). Assessments will demonstrate a range of abnormalities, such as changes in PERLLA and EOM assessments of client's pupillary light accommodation or visual tracking (Thompson, 2022). Clients will also have evident trauma and visible injury to their head when inspected. Cushing's triad is another framework for analyzing clients following head trauma, with criteria including: bradycardia, elevated systolic blood pressure/widening pulse pressure, and abnormal breathing patterns (Hinkle et al., 2022). Clients might report headaches and tinnitus. Physically they may demonstrate discoordination and ataxia when attempting to ambulate, or anything from generalized weakness to very specifically a unilateral flaccidity/paralysis (Thompson, 2022).

DIAGNOSIS

Initial suspicions of impacts incurred from a head trauma may involve the use of assessments and screenings to begin formulating a diagnostic hypothesis. These include the ocular assessments described above, particularly as midline shifts will directly impact visual-motor function (Thompson, 2022). They may also use screenings like the Glasgow Coma Scale (GCS) to make a preliminary determination of the level of impairment in the client from the injury, and monitor for changes throughout their subsequent care. When dealing with an acute head trauma, physicians are often quick to order a CT scan to make visual confirmation on the presence of hematomas, midline shifts, or potential infarcts, among other things (Pierre &

Kondamudi, 2023). For more granular observation, an MRI with contrast dye might be used to further visualize the extent or ongoing nature of a given bleed in the brain. In this client's case, they also utilized an X-ray to rule out complications to her new shoulder replacement from the fall that occurred. The cumulative nature of the clients' repeated falls and head traumas also lead to impacts on the bodies' autonomic ability to regulate homeostatic conditions and systemic regulation over the constituent organs responsible for maintaining it. As such, the client was thrown into an acid-base imbalance, and diagnostically it became necessary to perform arterial blood gas (ABG) analysis at repeat intervals to diagnose and monitor the client's imbalance and select interventions to correct it (Hinkle et al., 2022).

TREATMENT

Managing the care for someone in this condition is highly complex, and as such it should come as no surprise that the client was confined to bed rest on an ICU unit with very frequent neurological assessments being performed. As the medication section of this care plan lays out, the client's complexity also necessitated a profound number of medications, often with some playing a tug of war with one another and having to be titrated to just the right amount (Hinkle et al., 2022). For instance, some medications are responsible for keeping her blood pressure down to prevent re-rupture and re-bleeding of hematomas. Others, however, were utilized to thin the blood in order to prevent clot formation and embolic events. Some medications were employed in preventing seizures from occurring as a result of elevated ICP levels. Likewise, some supplements and fluids were brought to bear to work on addressing her acid-base imbalance. Additionally, this client failed a swallow study and was diagnosed with dysphagia as a result of the brain injury, and therefore to avoid aspiration related complications she was placed on NPO

status and was intubated to be provided NG tube feeding (Capriotti, 2024). Client I & O's will be monitored closely as they overlap with NPO status, kidney function in the presence of so many medications at play, and retained fluid volumes as they relate to blood pressures and quantity within the cranium. As mentioned before, the care for this patient also necessitated a period of EVD drain placement to evacuate accumulated fluid content (Chau et al., 2019). At this time the client is entirely dependent for all cares and resigned to bedrest. But in time, the treatment for the client will become gradually less unstable and medication driven and they will need aggressive rehabilitative efforts from multi-disciplinary therapy services to resolve the functional deficits they have incurred. There is a long road to recovery, and at this time it is unclear how fully they will recover.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for Pathophysiology* (3rd ed.). F. A. Davis Company.

Chau, C. Y., Craven, C. L., & Kolias, A. G. (2019). The evolution of the role of external ventricular drainage in traumatic brain injury. *Journal of Clinical Medicine*, 8(9), 1422.
<https://doi.org/10.3390/jcm8091422>

Hinkle, J., Cheever, K. H., & Overbaugh, K. (Eds.). (2022). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer.

Pierre, L., & Kondamudi, N. P. (2023). Subdural hematoma. StatPearls Publishing.
<https://www.ncbi.nlm.nih.gov/books/NBK532970/>

Thompson, J. (2022). *Essential health assessment* (2nd ed.). F.A. Davis Company.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
pH	-	7.515	7.35 - 7.45	This one I found most curious, given the client is stated to have been in metabolic acidosis. Perhaps, however some combination of the sodium bicarbonate she is receiving, and potentially a form of neurogenic hyperventilation is at play. Or the lab was wrong? Or the Dx was meant to be respiratory alkalosis? This one really stumped me, I was expecting it to be acidic in nature.
pCO ₂	-	22.3 mmHg	35-45 mmHg	This low value would comport with the alkalotic state above. The client is likely hyperventilating to some degree from the neuro trauma and effects of increased ICP.
pO ₂	-	74.7 mmHg	80-100 mmHg	The clients current prolonged immobility may be generating

				<p>some degree of atelectasis.</p> <p>Orders stated Q1h IS, but it wasn't being done, likely because of her AMS.</p> <p>Pneumonia onset would be high on the concern list here.</p>
HCO₃ (Bicarbonate)	-	17.6 mEq/L	21-28 mEq/L	Low bicarbonate once again comports with an *alkolotic* state, with kidneys reducing to compensate.
BE (Base Excess)	-	-3.8 mEq/L	0 +/- 2 mEq/L	Again, a response to an alkalotic state and the bodies attempt to buffer pH.
tHb	-	10.9 g/dL	Female= 12-16 g/dL	The patient has likely had a lot of blood loss from recent traumas, surgeries, and EVD usage.
Glucose	-	123 mg/dL	70 – 99 mg/dL	The patient is a Type 2 diabetic.
Sodium	-	134 mEq/L	136-145 mEq/L	Likely too small a shift to over-assume anything, would want a repeat lab to observe for trends.
CO₂	19 mEq/L	18 mEq/L	23 – 30 mEq/L	Again, another value supporting respiratory alkalosis.

BUN	-	23 mg/dL	10 – 20 mg/dL	Elevated protein breakdown from traumas and surgeries.
Albumin	-	3.0 g/dL	3.5 - 5.0 g/dL	Reduced albumin levels from fluid volume loss, bleeding, recent traumas and surgeries.
AST	-	46 u/L	0 – 35 u/L	Potential stress markers related to the volume of medications the client is taking currently.
ALT	-	104 u/L	4 – 36 u/L	Potential stress markers related to the volume of medications the client is taking currently.
WBC	-	13.41 ×10 ³ /mcL	4 – 12 ×10 ³ /mcL	This would be something to monitor closely. Is this also a stress marker for all her body has gone through, or the sign of an infection to further compound her condition?
Hemoglobin (Hgb)	8.2 g/dL	9.8 g/dL	13 – 16.5 g/dL	The patient has likely had a lot of blood loss from recent traumas, surgeries, and EVD usage.
Hematocrit (Hct)	26.0%	32.2%	38-50%	The patient has likely had a lot of blood loss from recent

				traumas, surgeries, and EVD usage.
MCHC	-	30.4 g/dL	32 – 36 g/dL	
Absolute neutrophils	-	11.56 ($\times 10^9$ /L ³)	1.8 to 7.5 ($\times 10^9$ /L ³)	Neutrophilia as a result of trauma/inflammation/stress.
Absolute lymphocytes	0.62 $\times 10^9$ /L	0.76 $\times 10^9$ /L	1.0 - 4.0 $\times 10^9$ /L	Again, severity of traumas has lead to lymphocytopenia as lymphocytes leave systemic circulation to report to damaged tissues.
Absolute immature granulocytes	-	0.18 $\times 10^9$ /L)	< 0.03 $\times 10^9$ /L)	Representative of a left-shift, suggesting that the bone marrow within the body is working hard to produce new cells to address extensive inflammation from compounding traumas and surgeries.
creatinine	0.53 mg/dL	-	0.7 - 1.3 mg/dL	Potentially atrophy-related due to prolonged immobility and physical deterioration.
magnesium	8.8 mg/dL	-	1.6 - 2.6 mg/dL	This one was also puzzling for me, because its alarmingly high. It is possible it is related to over

				application of laxatives being administered to address immobility related constipation.
RBC	3.00 mc/L	-	4.4 - 5.8 mc/L	The patient has likely had a lot of blood loss from recent traumas, surgeries, and EVD usage.

Previous diagnostic prior to admission (ER, clinic etc.) if pertinent to admission diagnosis	Previous diagnostic results and correlation to client admission	Current Diagnostic Test & Purpose	Clients Signs and Symptoms	Results and correlate to client diagnosis and condition
1/17/26 CT of head w/o contrast	Bilateral acute subdural hematomas with midline shift to left of approximately 5mm.	1/22/26 F/U CT: Head trauma incurred made additional CT appropriate to examine extent of damage. In this care to examine the	Patient exhibiting visible contusions and bruising to exterior of skull. Changes in mental status and orientation observed as well.	In this scenario, the direct cause and effect of fall to trauma observed, as well as resultant changes in cognition, are

		EVD (external ventricular drain) that had been placed to aid in reducing ICP.		quite obvious.
1/17/26 <u>Xray</u> of right shoulder	Right reverse total shoulder arthroplasty remains undamaged by fall.	1/23/26 F/U Xray This time the Xray was performed to confirm accurate placement of the dobhoff NG tube.	With clients altered mental status, limits were imposed on the ability to assess right shoulder with subsequent falls post-arthroplasty. Additionally, such a scan would be a standard of practice to ensure the new shoulder had no been injured in the fall.	It would be critical for further orthopedic intervention to be performed had the client damaged the implantation of the arthroplasty.
-	-	1/22/26 MRI Obstruction of cerebral	Patients subdural hematomas were not reducing to the	Discovering the blockage was critical,

		aqueduct and resulting hydrocephalus.	extent expected, and more swelling was observed in surrounding tissues.	and lead to the brief placement of this drain to help bring swelling down on the brain and improve perfusion.
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Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, A. (2023). *Mosby's diagnostic and laboratory test reference* (6th ed.). Elsevier.

Munakomi S, M Das J, Varacallo M. *Ventriculostomy*. [Updated 2024 Aug 13]. Stat Pearls Publishing; <https://www.ncbi.nlm.nih.gov/books/NBK545317/>

Active Orders

Active Orders	Rationale
Diet: NPO; exceptions for ice chips. Adjust insulin accordingly.	Patient failed swallow test with speech therapy, has dysphagia at this time, concern for aspiration. Insulin must be adjusted based on NPO status & associated NG tube feeds.
Enteral feed orders: Jevity 1.2 cal/ml; pt to receive 1716 calories, 79g protein, 1154 mls	Patient with significant disorientation and swallowing issues. Feeding must be provided

free water from product. Delivered at: 65 mls/hr for 22 total hrs.	via NG tube to prevent complications from aspiration.
Wound care: Regular dressing changes until discharge.	To keep healing injuries free of infection and promote healing.
Neuro checks: Every 2 hours.	This client is in recovery from head trauma, and routine assessments are made to observe for positive or negative changes to her neuro status and orientation.
Activity: strict bedrest until order is discontinued.	Patient has had numerous falls with compounding trauma to her head and body, leaving them very poorly oriented and coordinated in movements. Extremely high fall risk- too high to warrant activity, needs to recover more first.
Urinary catheter- placement and care (external device)	Patient on bedrest, unsafe to mobilize to toilet. Nursing will provide care/cleaning if soiled. External catheter will aid in wicking away urinary moisture.
Cardiac monitoring until order is discontinued.	Patient remains in poor stability; physician wants vitals observed closely.
Elevate head of bed	Due to concerns with intracranial pressure from edema and hydrocephaly, client should not lay flat at this time.

<p>NG/OG tube placement and care; X-ray confirmation. Nasal bridle securement device protocol. Free water flush every 4 hours; Oral Care every 2 hours.</p>	<p>These orders are to establish an NG tube for feedings, confirm accurate placement, and secure device to prevent patient pulling it out. As well as regular flushing to ensure line remains patent. Lastly, because the client is not taking in fluids through their mouth, they need regular oral care to protect the mucous membranes and lips.</p>
<p>Right shoulder sling until discontinued; clean and assess skin twice a day; non-weight bearing precautions.</p>	<p>In one of the clients many recent falls, immediately preceding this admission, the client fracture her right humerus, compromising her shoulder. This required a reverse total shoulder replacement. She is still recovering from this, and should remain non weightbearing and in a sling at this time. Regular skin checks to monitor for skin breakdown or potential infection of surgical site.</p>
<p>Insulin: sliding scale, check AC/HS.</p>	<p>Patient is a diabetic and will need insulin administered according to her current blood glucose levels before every meal and before bed to prevent hyper/hypo glyceemic states.</p>
<p>Intake & output: every shift.</p>	<p>Client to have fluid in and out of her body</p>

	regulated to ensure adequate hydration status and monitor kidney function.
Incentive spirometer ever 1 hour	This was likely part of a bundle of orders pre-programmed. The idea being to prevent pneumonia while admitted. But it was not being followed as it applies poorly to this client in their current state.
Initialize IV access and maintain until discontinued.	The client will need ready access to her vasculature for regular and potentially emergent medications, as well as routine fluids.
Pneumatic compression stockings- bilaterally, at all times in bed until order is discontinued.	This is part of an effort to prevent DVT's/PE's and other clotting events while on strict and prolonged bed rest.
Notify physician if: Temp >101.5. Pulse >120 or <60. Systolic BP >180 or <90. Diastolic BP >100. Urine output <240cc/8 hours. Respiratory rate >32 or <10.	This is so that the physician can be alerted to any significant new instabilities in patient vitals and respond quickly and accordingly.

Hospital Medications (Must List ALL)

Brand/Generic	Humalog/ insulin lispro	Sodium bicarbonat e	Symmetrel / amantadin e	Norvasc/ amlodipine	Lipitor/ atorvastati n
Dose, frequency,	1-20 units	650mg	100mg	5mg tablet	10mg tab

route	per sliding scale, subcutaneously (subQ), Q4h	tablet, via nasogastric tube (NGT), daily	capsule (NGT) twice daily (BID)	(NGT) daily (QD)	(NGT) QD
Classification (Pharmacological and therapeutic and action of the drug)	<p>Pharmacological class: Rapid-acting Insulin</p> <p>Therapeutic class: Antidiabetic</p>	<p>Pharmacological class: Alkalinizing agent.</p> <p>Therapeutic class: Antacid; electrolyte.</p>	<p>Pharmacological class: Dopamine agonist</p> <p>Therapeutic class: Anti-Parkinson agent/mood stabilizer</p>	<p>Pharmacological class: Calcium channel blocker</p> <p>Therapeutic class: antihypertensive</p>	<p>Pharmacological class: HMG-CoA reductase inhibitor</p> <p>Therapeutic class: Antihyperlipidemic</p>
Reason Client Taking	To control her blood glucose levels, as she is a T2 diabetic.	Used as a buffer to control acid levels and elevate pH levels. Which was part of what is confusing me with her pH or which acid/base condition she actually has.	I suspect this was related to both her clinical psychological depression, and general CNS depression at this time.	Improves vascular perfusion via vasodilation and cardiac function modification .	To manage lipid content in blood stream to reduce potential for plaque formation in blood vessels which may contribute to events of MI or CVA.

<p>Two contraindications (pertinent to the client)</p>	<p>1. Hypoglycemia. 2. Hypokalemia.</p>	<p>1. Metabolic or respiratory alkalosis. 2. Severe sodium imbalances (hyper or hypo).</p>	<p>1. Concurrent use of antipsychotics. 2. Renal impairment.</p>	<p>1. Hypotension 2. Hepatic impairment.</p>	<p>1. Hepatic impairment 2. Hemorrhages and/or active bleeds.</p>
<p>Two side effects or adverse effects (Pertinent to the client)</p>	<p>1. Induced hypoglycemia. 2. Lipodystrophy.</p>	<p>1. May induce metabolic alkalosis. 2. Fluid overload & edema.</p>	<p>1. May worsen disorientation or sleep/wake cycles in ICU patients. 2. May cause mottling of the skin which can appear as DVT.</p>	<p>1. peripheral edema. 2. May exacerbate disorientation and cause orthostatic hypotension further risking additional patient falls (once off bedrest again).</p>	<p>1. May result in AKI or kidney failure. 2. May result in rhabdomyolysis.</p>
<p>List two teaching needs for the medication pertinent to the client</p>	<p>1. Monitor for hypoglycemia; educate on S/S. 2. Rotate injection sites.</p>	<p>N/A, patient will not be receiving this after discharge, and should only be administered by the nurse.</p>	<p>1. You could explain that this medication, while normally for Parkinsons, is used to help improve arousal and help wake the patients cognition. 2. Report</p>	<p>1. Daily weights, monitor LE swelling. 2. Perform good oral hygiene secondary to gingival hyperplasia.</p>	<p>1. Report muscle pain or weakness. 2. Report discoloration of urine (dark).</p>

			purple rash on legs if observed.		
Two Key nursing assessment(s) prior to administration	<p>1. Insulin should be timed with Jevity NG tube feeds for this client.</p> <p>2. Verify blood glucose levels before administering feeds + insulin.</p>	<p>1. Monitor sodium levels.</p> <p>2. Monitor ABG's.</p>	<p>1. Oral mucosa – this will cause dry mouth, and the client already possesses oral care concerns as related to NPO + NG tube feed status.</p> <p>2. Blurred vision. The client is already having visual/ocular dysfunction, and this may compound that.</p>	<p>1. Monitor oral cavity for potential gingival hyperplasia.</p> <p>2. Monitor heart rate and blood pressure.</p>	<p>1. Monitor kidney and liver function.</p> <p>2. Monitor blood glucose in diabetic patients.</p>
Brand/Generic	Zetia/ ezetimibe	Heparin	Keppra/ levetiracetam	Levaquin/ levofloxacin	Zestril/ lisinopril
Dose, frequency, route	10mg tablet (NGT) QD	5000 units/ml subQ Q8h	500mg tab (NGT) BID	750mg in Dextrose 5% in water (D5W) 150ml, run at 199ml/hr IV piggy back (IVPB) QD	40mg tablet (NGT) QD
Classification	Pharmacolo	Pharmacol	Pharmacol	Pharmacolo	Pharmacol

(Pharmacological and therapeutic and action of the drug)	Pharmacological class: Cholesterol absorption inhibitor Therapeutic class: anti-lipemic	Pharmacological class: Anticoagulant Therapeutic class: Anticoagulant	Pharmacological class: pyrrolidine derivative Therapeutic class: anticonvulsant	Pharmacological class: Fluoroquinolone Therapeutic class: Antibiotic	Pharmacological class: ACE inhibitor Therapeutic class: Antihypertensive
Reason Client Taking	Lowers cholesterol levels.	DVT prophylaxis.	Seizure prophylaxis due to potential for seizure activity from head traumas.	Client has had numerous recent invasive surgeries.	Reduction of blood pressure to minimize renewed bleeding or increased ICP.
Two contraindications (pertinent to the client)	1. Hepatic impairment. 2. History of gallstones.	1. Active and uncontrolled bleeding. 2. Low H & H levels.	1. Depression and other psychiatric issues. 2. Kidney dysfunction.	1. Electrolyte imbalances. 2. Bradycardia or prolonged QT interval, or when taken concurrently with meds that can cause these.	1. Renal dysfunction. 2. Hypotension.
Two side effects or adverse effects (Pertinent to the client)	1. arthralgia. 2. further elevates ALT/AST	1. Uncontrollable bleeding.	1. Somnolence. 2.	1. Can lower seizure threshold. 2. Can	1. Hyperkalemia. 2. Persistent

	levels.	2. Thrombocytopenia.	Behavioral changes.	exacerbate delirium or cause agitation.	dry coughing. Particularly as pertaining to increasing ICP forces with coughing fits.
List two teaching needs for the medication pertinent to the client	<p>1. Report muscle pain or weakness.</p> <p>2. Report discoloration of urine (dark).</p>	<p>1. Discuss with dentist before any dental work due to bleeding risks.</p> <p>2. Report discoloration of urine (blood).</p>	<p>1. Discuss any behavioral changes or concerns with physician.</p> <p>2. Do not skip doses, even one missed dose potentiates seizure and increased ICP.</p>	<p>1. Report and ankle pain or swelling due to potential for Achilles tendon rupture.</p> <p>2. Be aware of increased light sensitivity to skin. Keep skin from UV exposure.</p>	<p>1. Report chronic cough to physician.</p> <p>2. Any swelling of the lips/tongue/throat - report to the emergency department immediately.</p>
Two Key nursing assessment(s) prior to administration	<p>1. Monitor liver enzymes.</p> <p>2. To the degree possible with patient cognition, monitor them for muscle pain that may be suggestive of potential rhabdomyolysis.</p>	<p>1. Monitor client H & H, as well as platelets.</p> <p>2. Thorough nursing assessments for ruling out new onset bleeds, particularly in this client's case of subdural</p>	<p>1. Monitor GCS scores, as this may impact them negatively.</p> <p>2. Monitor kidney function labs.</p>	<p>1. Monitor heart rate and rhythm.</p> <p>2. Monitor electrolytes.</p>	<p>1. Monitor BP.</p> <p>2. Monitor renal labs and electrolytes.</p>

		hematomas.			
Brand/Generic	Protonix/ pantoprazol e	MiraLAX/ polyethylen e glycol	Seroquel/ quetiapine	Senokot/ sennosides- docusate sodium	Zoloft/ sertraline
Dose, frequency, route	40mg oral suspension (NGT) QD before breakfast	17g (NGT) BID	50mg tablet (NGT) at bedtime	8.6-50mg tablet, x2 tablets, (NGT) BID	100mg tablet (NGT) QD
Classification (Pharmacological and therapeutic and action of the drug	Pharmacolo gical class: Proton pump inhibitor (PPI) Therapeutic class: Anti-ulcer agent (GI specific)	Pharmacol ogical class: Osmotic Laxative. Therapeuti c class: Laxative.	Pharmacol ogical class: Atypical antipsychot ic. Therapeuti c class: Antipsycho tic; mood stabilizer.	Pharmacolo gical class: Stool softener Therapeutic class: Laxative	Pharmacol ogical class: Selective serotonin reuptake inhibitor (SSRI) Therapeuti c class: Antianxiety , antidepress ant, anti- OCD, anti- panic, anti-

					PTSD, anti-premenstrual dysphoric.
Reason Client Taking	To control stomach acid and minimize associated discomfort or dyspepsia. Particularly in setting of NG tube placement where additional acid imbalances may occur.	To alleviate constipation from immobility.	Assumption is patient has been prescribed to treat her documented depression.	To alleviate constipation from immobility.	Assumption is patient has been prescribed to treat her documented depression.
Two contraindications (pertinent to the client)	<ol style="list-style-type: none"> 1. Hypocalcemia. 2. Hypersensitivity to PPI's. 	<ol style="list-style-type: none"> 1. Severe GI upset. 2. Suspected bowel obstruction. 	1. Severe CNS depression.	<ol style="list-style-type: none"> 1. Nausea and vomiting. 2. Nothing else applicable for this patient. 	<ol style="list-style-type: none"> 1. Bradycardia or lengthened QT segments, or if taking concurrently with other medications that have this effect. 2. Hypokalemia or hypomagnesemia.
Two side effects or adverse effects (Pertinent to the	<ol style="list-style-type: none"> 1. Hyperglycemia. 	<ol style="list-style-type: none"> 1. Bloating, cramping, flatulence. 	1. Somnolence/sedation.	<ol style="list-style-type: none"> 1. Diarrhea. 2. 	<ol style="list-style-type: none"> 1. Hyponatremia.

client)	2. GI inflammation .	2. Electrolyte imbalance.	2. Orthostatic Hypotension.	Abdominal cramping and/or GI upset.	2. Increased bleeding risk.
List two teaching needs for the medication pertinent to the client	<p>1. Report changes in bowel habits.</p> <p>2. Report bleeding/clotting issues.</p>	<p>1. Avoid long term use.</p> <p>2. Report severe abdominal pain or diarrhea.</p>	<p>1. Be aware of sedation effect, do not operate vehicles/machinery.</p> <p>2. Do not get out of bed without assistance as this potentiates a fall.</p>	<p>1. Take with plenty of fluids to aid in effect.</p> <p>2. Report any rectal bleeding.</p>	<p>1. Note that this medication can take several weeks of consistent usage to take effect.</p> <p>2. Go to the ED for any shivery/sudden high fever/or muscle stiffness due to potential for serotonin syndrome.</p>
Two Key nursing assessment(s) prior to administration	<p>1. Monitor electrolyte levels.</p> <p>2. Monitor PT or INR if taking any anticoagulants.</p>	<p>1. Monitor fluids.</p> <p>2. Monitor electrolytes.</p>	<p>1. Monitor EKG/cardiac waveforms for QT interval length.</p> <p>2. Monitor glucose and lipid levels.</p>	<p>1. Perform abdominal assessments.</p> <p>2. Monitor client bowel movements.</p>	<p>1. Monitor sodium levels and for signs of SIADH onset.</p> <p>2. Monitor for signs of symptoms of bleeding.</p>
Brand/Generic	Thiamine (vitamin B1, supplement)	Topamax/topiramate	Tylenol/acetaminophen	Folic acid	Apresoline/hydralazine
Dose, frequency, route	100mg tablet (NGT) QD	200mg tablet (NGT) at bedtime	500mg tablet (NGT) Q6H or	400mcg tablet (NGT) QD	10mg IV push Q10min PRN for

			PRN for mild Pn		systolic blood pressure (SBP) of >140 (hold if <90)
Classification (Pharmacological and therapeutic and action of the drug)	Pharmacological class: Water-soluble B-complex vitamin. Therapeutic class: Nutritional supplement/vitamin.	Pharmacological class: Anticonvulsant. Therapeutic class: Antiepileptic; migraine prophylactic.	Pharmacological class: Non salicylate, para-aminophenol derivative Therapeutic class: Antipyretic, nonopioid analgesic	Pharmacological class: water-soluble vitamin. Therapeutic class: Antianemic.	Pharmacological class: Direct-acting peripheral vasodilator. Therapeutic class: Antihypertensive.
Reason Client Taking	Aids in the stabilization of neuro and metabolic functions.	Seizure prophylaxis.	Pain control.	Likely to stimulate erythropoiesis to aid in production of red blood cells following significant bleeding related losses and as supported by low levels on lab work.	To reduce blood pressure to prevent new bleed formation or increased ICP.

<p>Two contraindications (pertinent to the client)</p>	<p>1. Severe renal impairment. 2. Hypotension.</p>	<p>1. Acid-Base balance complications. 2. Renal impairment.</p>	<p>1. Liver dysfunction. 2. Excessive concurrent use with other potentially nephrotoxic medications.</p>	<p>1. Concurrent use with other anticonvulsants may lead to disruption of therapeutic levels. 2. Must rule out B12 deficiency before use.</p>	<p>1. Tachycardia. 2. Hypotension.</p>
<p>Two side effects or adverse effects (Pertinent to the client)</p>	<p>1. May cause anaphylactic reaction (rare). 2. May cause hypotension.</p>	<p>1. Cognitive slowing. 2. Oligohidrosis and hypothermia.</p>	<p>1. Hypotension. 2. Hemolytic Anemia.</p>	<p>1. CNS function alterations such as confusion, irritability, or sleep disturbances. 2. May induce bronchospasms.</p>	<p>1. Can cause tachycardia, rhythm irregularity, and palpitations. 2. Headaches and orthostatic hypotension.</p>
<p>List two teaching needs for the medication pertinent to the client</p>	<p>1. Explain that this can be taken to aid in improving cognition improvement in this scenario. 2. Teaching point can be that once client has resumed full diet, grains</p>	<p>1. Increase hydration to prevent kidney stone formation while taking this medication. 2. This medication can cause “brain fog”.</p>	<p>1. Standard formulation can be crushed, but not extended release formulations. Do not exceed recommended daily dosages. 2. Monitor for signs of</p>	<p>1. May stain urine a bright yellow, but this is normal and benign. 2. Teaching point – this medication assists in improving her blood counts.</p>	<p>1. Immediately report any new or abnormal headaches as it may be a sign of increasing ICP. 2. May cause elevated heart rate/palpitations</p>

	and lean meats can help provide this naturally.		bleeding.		ions.
Two Key nursing assessment(s) prior to administration	1. Thiamine demand increases with high carb intake. Consult w/ dietician and physician regarding Jevity feeds, thiamine, and insulin combination. 2. Monitor GCS/orientation level, which should improve with thiamine.	1. Monitor ABG's. 2. Regular neuro checks.	1. Monitor liver labs. 2. Monitor kidney labs.	1. Monitor CBC labs. 2. Auscultate for adventitious lung sounds.	1. Monitor ICP and blood pressures. 2. Monitor heart rate and rhythm.
Brand/Generic	Trandate/ labetalol	Zofran/ ondansetron	Duoneb/ ipratropium- albuterol	Aldactone/ spironolactone	
Dose, frequency, route	10mg IV push Q15min PRN for SBO >140 (hold if <90)	4mg IV push, QD as needed for nausea & vomiting (N/V)	0.5-2.5 mg/ml nebulizer solution, 3mL inhalation, Q6h	25mg tablet (NGT) QD	
Classification (Pharmacological and therapeutic and action of the drug)	Pharmacological class: Selective alpha-1	Pharmacological class: Selective serotonin receptor antagonist.	Pharmacological class: Ipratropium	Pharmacological class: Potassium-sparing	

	<p>blocker and non-selective beta-adrenergic blocker.</p> <p>Therapeutic class: Antihypertensive.</p>	<p>Therapeutic class: Antiemetic</p>	<p>(anticholinergic), Albuterol (Selective beta-2 adrenergic agonist).</p> <p>Therapeutic class: Bronchodilator.</p>	<p>diuretic.</p> <p>Therapeutic class: Antihypertensive & diuretic.</p>	
Reason Client Taking	To reduce blood pressure to prevent new bleed formation or increased ICP.	To address nausea.	To improve airway patency and subsequent oxygenation.	To control hypertension and reduce fluid volume.	
Two contraindications (pertinent to the client)	<p>1. Conditions or medications resulting in bronchospasm, or other forms of respiratory distress.</p> <p>2. Bradycardia or conditions</p>	<p>1. Elongated QT interval, or concurrent use with drugs resulting in them.</p> <p>2. Severe liver dysfunction or suspected</p>	<p>1. Existing tachycardia or arrhythmias.</p> <p>2. Existing hypokalemia.</p>	<p>1. Hyperkalemia.</p> <p>2. Renal impairment.</p>	

	of heart block.	bowel obstruction.			
Two side effects or adverse effects (Pertinent to the client)	<p>1. Masks hypoglycemia.</p> <p>2. Orthostatic hypotension and dizziness.</p>	<p>1. Hypotension.</p> <p>2. Pruritus.</p>	<p>1. May generate tachycardia or arrhythmias.</p> <p>2. May cause hypokalemia.</p>	<p>1. May generate hyperkalemic states.</p> <p>2. May induce hyponatremia, which could lead to increased cerebral edema and ICP.</p>	
List two teaching needs for the medication pertinent to the client	<p>1. Monitor blood glucose closely as this medication may suppress some normally felt symptoms of hypoglycemia.</p> <p>2. change positions slowly as this medication causes orthostatic hypotension.</p>	<p>1. Report sudden changes in vision.</p> <p>2. Report sudden chest pain or tightness.</p>	<p>1. May cause “shaky” or “jittery” feeling for a while after administration.</p> <p>2. Rinse out mouth immediately after use to prevent oral thrush.</p>	<p>1. Avoid potassium-rich foods like bananas or oranges.</p> <p>2. Avoid salt-substitutes that may be hiding potassium in them.</p>	
Two Key nursing assessment(s) prior to administration	<p>1. Monitor heart rate and rhythm.</p> <p>2. Monitor respiratory status.</p>	<p>1. Monitor electrolyte levels.</p> <p>2. Monitor client behavior for signs or</p>	<p>1. Monitor heart rate and rhythm.</p> <p>2. Monitor potassium levels.</p>	<p>1. Monitor electrolyte levels.</p> <p>2. Monitor blood pressure, as well as</p>	

		symptoms of serotonin syndrome.		intake & output.	
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Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Keppra (levetiracetam) & Topamax (topiramate)	I chose both for their seizure prophylaxis due to the high risk for seizure the client has and how devastating it could potentially be if one occurred.	1. Somnolence. 2. Behavioral changes.
2. Trandate (labetalol)	This and the other anti-hypertensives the client are on are critical to preventing a “re-bleed” and increasing ICP.	1. Masks hypoglycemia. 2. Orthostatic hypotension and dizziness.
3. Heparin/Lovenox	While somewhat contradictory to my selection above, I also feel the blood thinner is also critical. Moreover, the careful titration of the right amount is profoundly critical. The client is at a heightened risk for	1. Uncontrollable bleeding. 2. Thrombocytopenia

	throwing a clot due to all the bleed events, numerous medications and traumas in play.	
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Medications Reference (1) (APA)

Nursing Drug Handbook. (2024). *Nurses Drug Handbook* (2024 ed.). Wolters Kluwer.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: Alertness: Orientation: Distress: Overall appearance: Infection Control precautions: NO Client Complaints or Concerns: None	Alerted and oriented x2, poorly groomed, no signs of distress. Patient is sedate in affect, sleeping most of the day, denies pain, rating 0/10. Overall appearance is calm & cooperative.
VITAL SIGNS: Temp: Resp rate: Pulse: B/P: Oxygen: Delivery Method:	98.9* farenheit 18 breathes per minute 69 beats per minute 119/62 blood pressure 85 mean arterial pressure 93% SPO2 on room air
PAIN ASSESSMENT: Time: Scale: Location: Severity: Characteristics: Interventions:	Patient reports 0/10 pain throughout shift, whenever inquired.
IV ASSESSMENT: Size of IV:	The patient had an 18 gauge IV on dorsum of left

<p>Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment: Fluid Type/Rate or Saline Lock:</p>	<p>hand, originally placed on 1/25/26. Remains patent, but currently capped and not running anything. No noted drainage, erythema, infiltration, or phlebitis. The dressing intact and dry.</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Skin color is normal for client ethnicity. Skin warm and dry upon palpation. No rashes or lesions. Some ecchymosis was observed on bilateral upper extremities in several patches along humerus and forearms associated with recent falls, as well as a contusion sustained to the left forearm. Normal quantity, distribution, and texture of hair over body for patients' gender and age. Nails without clubbing or cyanosis. Skin turgor within normal bounds. Scalp has been partially shaved due to EVD drain placements that have since been removed and stitched shut to control extent of subdural hematoma, and bruising around these sites is still visible, but without sign of infection or weeping.</p> <p>Braden score: 12 No drains present.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Patients' head and neck are symmetrical; the trachea is midline without deviation. Thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and 2+. No Lymphadenopathy in the head or neck is noted.</p> <p>Eyes: Bilateral sclera white, bilateral cornea slightly cloudy in appearance, bilateral conjunctiva pink, no visible drainage from eyes.</p>

Bilateral lids are moist and pink without lesions or discharge noted. PERRLA bilaterally, red light reflex present bilaterally, Rosenbaum 14/14, Snellen 20/20, EOMs intact bilaterally. However, Patient has limited upward gaze at this time and demonstrates a left eyelid ptosis.

Ears: Bilateral auricles- no visible or palpable deformities, lumps, or lesions.

Nose: Septum is midline, turbinate's are moist and pink bilaterally and no visible bleeding or polyps. Bilateral frontal sinuses are nontender to palpation.

Throat: Posterior pharynx and tonsils are moist and pink without exudate noted. Tonsils at 25%.

Uvula is midline; soft palate rises and falls symmetrically. Hard palate intact. Oral mucosa overall is moist and pink without lesions noted.

Teeth- Some dentition is missing. Gums healthy, moist, and pink.

<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Clear S1 and S2. PMI palpable at 5th intercostal space at MCL. Normal rate and rhythm. All extremities are pink, warm, dry, and symmetrical. Pulses 2+ throughout bilaterally. Capillary refill less than 3 seconds - fingers and toes, bilaterally. No edema inspected or palpated in upper extremities. Epitrochlear lymph nodes are nonpalpable bilaterally. Homan's signs negative bilaterally. No neck vein distention.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Patient does not evidence any accessory muscle use or respiratory distress at this time. No wheezing, crackles, or ronchi upon auscultation of bilateral lung fields left to right, both anterior & posterior. Normal rate/rhythm/pattern of respirations. Symmetrical chest movement anterior to posterior and left to right with breathing.</p>
<p>GASTROINTESTINAL: Diet at home: Current Diet: Is Client Tolerating Diet? Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention:</p>	<p>Patient with normoactive bowel sounds upon auscultation of all four abdominal quadrants. No sensitivity to palpation. Patient on a NG tube-feed diet of Jevity solution at this time and unable to report her baseline diet. Documentation shows last full bowel movement was 1/29/26, and was</p>

<p>Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Size: 12 Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>noted to have been normal in quality/color/characteristics.</p> <p>12 French NG tube in place, patent, and secured via nasal bridal device.</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: External - Female Size: N/A</p>	<p>The patient is on strict bed rest for recovery and safety. Urine output is normal in quantity, frequency, smell, and color remains modestly yellow from intake deficit at this time. Collected by female external catheter device. No observed discomfort or pain with urination.</p> <p>Female external catheter present. Genitals were not observed. Not on dialysis.</p>
<p>Intake (in mLs)</p> <p>Output (in mLs)</p>	<p>680 ml in via IV.</p> <p>1650 ml out via external catheter collection chamber.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 39 Activity/Mobility Status: Activity Tolerance: Independent (up ad lib)</p>	<p>Difficulties experienced checking Pt strength and RoM due to her current condition and limitations. Grip strength is diminished, client weak generally at this time, dependent for all mobilization. Left upper extremity stronger of the two at this time due to ongoing healing from right TSA. Pt is beginning to demonstrate onset of bilateral food drop, with tight calf musculature and positional deformity of feet when in neutral. Is wearing posey boots on both feet, but frequently kicks the</p>

<p>Needs assistance with equipment Needs support to stand and walk</p>	<p>right one off, and requiring pillows to position LE's into neutral.</p> <p>Prior to January, the client was independent for mobility without an assistive device. Prior to these most recent falls the client was ambulating at rehab with a single point cane on the left due to the right arm being in a sling.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input checked="" type="checkbox"/> Arms <input checked="" type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Patient is currently A&Ox2. Consistently oriented to self, and that she "had multiple falls". Intermittently oriented to year and month. Consistently disoriented to place until informed. Is able to follow simple commands within her current physical ability. Speech is sluggish and mumbled but mostly appropriate. Is now able to open eyes volitionally, with light accommodation, but lacks ability to perform an upward gaze. Denies numbness, tingling, or sensation impairments.</p>
<p>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):</p>	<p>At this time the patient is unable to provide insight into aspects of her psychosocial or cultural background. The patient has had no visitors during this shift. Documentation on these aspects is very limited.</p> <p>Psychosocial developmental level: 65 y/o+ = Integrity vs despair; Virtue developed = Wisdom.</p>

Discharge Planning

Discharge location: Documentation notes that the patient has a daughter who intends to bring the client to her home with services for continued recovery. This is understandably due to their

apprehension with further inpatient rehab due to how many falls occurred inexcusably on their watch, leading to client's current condition.

Home health needs: In order to facilitate discharge to daughters home, the client needs a full suite of home-services, including nursing, PT/OT/ST.

Equipment needs: Likely a robust set of needs that the daughter will need to consult with therapy services and case management to secure, such as an appropriate assistive device, and daughter will likely want ways to facilitate 24/7 monitoring of the patient in case their orientation remains an issue. Daughters' home layout is unknown, so unclear what barriers to entry/exit exist.

Follow up plan: The extent of the patient's injuries and recovery suggests the client will need follow ups with multi-disciplinary therapy services for ongoing rehabilitation, and with a neurologist.

Education needs: Clients shifting cognition makes this a moving target at present. Certainly, significant measures need to be taken to prevent any additional fall events.

Nursing Process

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Outcome Goal (1 per dx)	Interventions (2 per goal)	Evaluation of interventions

<p>1. Risk for Adult Falls</p> <p>as related to client's recent traumas and as supported by patient's recent fall and diminished orientation (Phelps, 2023).</p>	<p>The patient is 65+ and her functional capacity remains diminished from baseline due to recent traumas. Avoiding repeat fall is a major concern at this time.</p>	<p>Patient to remain free of additional falls during acute stay in hospital (Phelps, 2023).</p>	<p>1. Once client is off of bedrest;</p> <p>Utilize chair alarms, educate on call light, label client as a x1 assist for all transfers, update whiteboard and apply fall risk wrist band on client (Phelps, 2023).</p> <p>2. Perform</p> <p>occasional orthostatics (or delegate task) to provide regular feedback on</p>	<p>At present, this patient has all appropriate standard fall risk measures in place and is on bedrest until further improvement is noted.</p>
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			<p>patient's current safety with transfers vs blood pressure drops (Phelps, 2023 p.187)</p>	
<p>2. Risk for Excessive Bleeding as related to numerous traumatic injuries; and as supported by lab work related to clotting factors and current hemodynamic-altering medications (Phelps, 2023).</p>	<p>At this time, the patient is taking numerous hemodynamic altering medications that potentiate risks for re-bleed events. Their H&H is also low.</p>	<p>Normalize H&H levels(Phelps, 2023). Patient to demonstrate better lab work (Phelps, 2023).</p>	<p>1. Monitor client for signs and symptoms of bleeding (Phelps, 2023). 2 . Monitor client bleeding/wounds, wean off blood thinners when able (Phelps, 2023).</p>	<p>This clients continues to be in a very precarious state and will continue to require these medications at this time. However, it should be the goal to reduce some of these medications as progress is demonstrated.</p>

<p>3. At risk for impaired skin integrity, as related to immobility and independence impairments, as evidenced by weight bearing restrictions and pain with movement (Phelps, 2023).</p>	<p>The patients lack of mobility, and significant pain with doing so, engender a decreased ability to independently reposition to avoid skin breakdown during prolonged bedrest.</p>	<p>Patient will remain free of avoidable skin breakdown (Phelps, 2023).</p>	<p>1. “Help patient into a comfortable position and use pillows to splint or support painful areas as appropriate <i>to reduce muscle tension or spasm and to redistribute pressure on body parts</i> (Phelps, 2023).”</p> <p>2. “Perform prescribed treatment regimen for client skin (bathing, linen changes, regular checks for blanchability or redness – particularly areas where brace touches skin); monitor progress. Report favorable and adverse responses to treatment regimen <i>to maintain or modify current therapies, as needed</i></p>	<p>At this time, patient remains free of skin breakdown, but will need routine care and observation to make sure dependent skin around surgical sites and pressure points in particular do not result in skin breakdown.</p>
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			(Phelps, 2023).”	
<p>4. Impaired Gas Exchange, as related to ventilation-perfusion mismatch secondary to trauma, medications in play, and potential bronchospasm (Phelps, 2023).</p>	<p>The clients acid-base imbalance further destabilizes her condition and alters her recovery. Correcting ABG values, and subsequently pH, will be important to promoting a full recovery.</p>	<p>Patient will demonstrate normalized pH and ABG values (Phelps, 2023).</p>	<p>1. Assess and record pulmonary status every 4 hours or more frequently if patient’s condition is unstable. Poor pulmonary status may result in hypoxemia (Phelps, 2023).</p> <p>2. Perform bronchial hygiene, as ordered, including coughing, percussion, postural drainage, and suctioning. These measures promote drainage and keep airways clear (Phelps, 2023).</p>	<p>At this time the client continues to demonstrate documented reports of metabolic acidosis, and lab values support respiratory alkalosis. The fact that both of these are in play demonstrates that the client is still very unstable in this regard and is swinging between extremes.</p>
<p>5. Acute pain, as related to multi-trauma injuries and surgical interventions (Phelps, 2023).</p>	<p>At this time the patients pain reports on a verbal 0-10 numerical scale are dubious reliable due to altered mental status. Given the extent of bodily impact, it is</p>	<p>Patient will report that pain is adequately managed, and reports will be accurate and reliable (Phelps,</p>	<p>1. “Using a pain flowchart, record the time of medication administration and results of pain assessment every hour until the next dose to monitor the therapy’s</p>	<p>At this time the patient is able to rest through these injuries with the aid of medications and due to decreased overall alertness. However, pain will undoubtedly become a factor as cognition</p>

	likely a mercy she is not more aware of her body at this time. One should assume that as cognition improves, awareness of significant pain will being to play a significant factor.	2023).	effectiveness (Phelps, 2023).” 2. “Help patient into a comfortable position and use pillows to splint or support painful areas as appropriate <i>to reduce muscle tension or spasm and to redistribute pressure on body parts</i> (Phelps, 2023).”	improves, and documentation notes they have allergies to opioid medications, so treating their pain will be complicated by this.
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Other References (APA):

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

