N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
8/26/19	JH	80yr	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Widowed	Penicillin
Code Status	**Height**	**Weight**	
Full Code	157.4 cm	67.400kg	

Medical History (5 Points)

Past Medical History:

- Coronary artery disease, CVA, Atherosclerosis in lower extremities, HTN, GERD, Hyperlipidemia, Arthritis, Myofascial Pain

Past Surgical History:

- Lymphadenectomy due to breast cancer (Lift limb restriction)

Family History:

- Mother had breast cancer
- Father also passed of cancer

Social History (tobacco/alcohol/drugs):

- Patient quit smoking in 1975 and denies any use of alcohol. Patient also denies use of any other substances

Assistive Devices:

- Patient uses a cane to ambulate and move around her house

Living Situation:

- Patient lives alone at home. Patient also performs self care of ADLs

Education Level:

- Patient passed high school and went to college for one month but decided it was not for her and she took up a job.

Admission Assessment

Chief Complaint (2 points): Right lower extremity pain

History of present Illness (10 points):.

Patient is an 80yr old female that had presented to Dr. Green's office complaining of pain in the right lower extremity. Patient stated that the pain has been going on for "quite some time" over a period of six months. She does not recall where the pain had started at but states it is in both legs but the right lower extremity is unbearable. Patient has been taking pain medications at home per patient statement. Patient was limiting mobility to prevent pain from occurring. Aggravating factors included walking and putting pressure on leg. Patient stated that resting reduced her pain but it was constant.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Right Lower Femoral Artery Occlusion

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points):

Imagine having a sharp stabbing pain in your leg all the time. A numbing feeling that

won’t go away even if you walk or exercise the limb. That is how having a blockage in your femoral artery is. This patient that I took care of had an occlusion of the right femoral artery and she had to have a FemPop procedure done. This procedure is when doctors go into the femoral artery opening blockages that are causing the leg pain. The signs and symptoms that are associated with this include swelling in the affected leg that won’t go down and even tenderness along the veins of the leg. This patient that I had had similar signs and symptoms which included increased leg swelling and pain that would persist even when at rest. The cause of this is due to plaque buildup in the artery of the legs that has to be bypassed by this procedure. It is performed to bypass the blocked portion of the main artery in the leg using a piece of another blood vessel(Stanford Healthcare., 2019). The pathophysiology behind this is quite simple. The human body breaks down the molecules that are consumed and then are absorbed into the bloodstream. The body uses them to make ATP for energy and gets rid of the ones that are not needed, but with the excess some gets left behind in the bloodstream and over time can build up as plaque in the artery. When too much builds up it starts to occlude the strength of blood which in turn slows down and causes a clot. This clot is what causes low perfusion into the lower extremities. This patient also had the indications from this pathophysiology. The patient had labs drawn in order to monitor for electrolytes before performing surgery and she had all normal labs. There was an elevation in the BUN and creatinine due to patient not having adequate hydration but that was the only significant lab. This surgery does not require specific labs. The only treatment that can occur for an occluded femoral artery is the surgery that was mentioned earlier. But just like any procedure, catheterization can cause complications.

Catheterization (even with a 6F catheter) can cause complications, both vascular access complications and complications from closure of the arteriotomy incision(Hamel, W. J., 2009). Thankfully this patient did not have any complications during her procedure and will make a full recovery.

Pathophysiology References (2) (APA):

S. H. (2019). Femoral Popliteal Bypass (Fem-Pop Bypass). Retrieved from https://stanfordhealthcare.org/medical-treatments/f/femoral-popliteal-bypass.html

Hamel, W. J. (2009, February 1). Femoral Artery Closure After Cardiac Catheterization. Retrieved from http://ccn.aacnjournals.org/content/29/1/39

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.80-5.41**	**NA**	**2.76**	Patient had to have surgery and as it goes with any surgery there was blood loss. It takes the bone marrow 7 days to make new red blood cells which will then improve the RBC count in the body(RN Medical surgical nursing, 2016)
Hgb	**11.3-15.2**	**NA**	**8.3**	Directly related with the surgery and reduction of RBC is the reduction of hemoglobin and hematocrit.. When there is blood loss the patient would have low Hgb and Hct. Monitor the patient for adverse effects pertaining to anemia(RN Pharmacology for Nursing, 2016)

Hct	**33.2-45.3%**	**NA**	**24.7**	Directly related with the surgery and reduction of RBC is the reduction of hemoglobin and hematocrit.. When there is blood loss the patient would have low Hgb and Hct. Monitor the patient for adverse effects pertaining to anemia(RN Pharmacology for Nursing, 2016)
Platelets	**149-493 K**	**NA**	**160**	
WBC	**4-11.7 K**	**NA**	**8.1**	
Neutrophils	**45.3-79**	**NA**	**78.3**	
Lymphocytes	**11.8-45.9**	**NA**	**12.6**	
Monocytes	**4.4-12.0**	**NA**	**8.7**	
Eosinophils	**0.0-6.3**	**NA**	**0.1**	
Bands	**<1**	**NA**	**NA**	

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**135-145**	**NA**	**139**	
K+	**3.5-5.1**	**NA**	**4.4**	
Cl-	**98-107**	**NA**	**106**	
CO2	**22-29**	**NA**	**24**	

Glucose	**70-99**	**NA**	**112**	Illness or stress can trigger hyperglycemia because hormones produced to combat illness or stress can also cause your blood sugar to rise(Mayo Clinic, 2018)
BUN	**6-20**	**NA**	**27**	Patient had an increased BUN due to not taking in enough fluid.
Creatinine	**0.5-0.9**	**NA**	**1.33**	The creatine being increased is a sign of acute kidney injury that could cause further complications if not corrected(RN Adult medical surgical nursing, 2016)
Albumin	**3.5-5.2**	**NA**	**NA**	
Calcium	**8.6-10.4**	**NA**	**8.4**	
Mag	**1.6-2.4**	**NA**	**NA**	
Phosphate	**0.8-1.5**	**NA**	**NA**	
Bilirubin	**0.1-1.2**	**NA**	**NA**	
Alk Phos	**35-105**	**NA**	**NA**	
AST	**0-32**	**NA**	**NA**	
ALT	**0-33**	**NA**	**NA**	
Amylase	**30-125**	**NA**	**NA**	
Lipase	**10-150**	**NA**	**NA**	
Lactic Acid	**0.5-1**	**NA**	**NA**	

Troponin	**<0.06**	**NA**	**NA**	
CK-MB	**0-4.30**	**NA**	**NA**	
Total CK	**22-198**	**NA**	**NA**	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**0.8-1.1**	**NA**	**NA**	
PT	**11-13.5**	**NA**	**NA**	
PTT	**30-40**	**NA**	**NA**	
D-Dimer	**<0.5**	**NA**	**NA**	
BNP	**<100**	**NA**	**NA**	
HDL		**NA**	**NA**	
LDL		**NA**	**NA**	
Cholesterol		**NA**	**NA**	
Triglycerides		**NA**	**NA**	
Hgb A1c		**NA**	**NA**	

TSH		**NA**	**NA**	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Yellow, Clear**	**NA**	**Straw**	
pH	**5.0-8.0**	**NA**	**8.0**	
Specific Gravity	**1.005-1.034**	**NA**	**1.013**	
Glucose	**Normal**	**NA**	**Normal**	
Protein	**Negative-Normal**	**NA**	**negative**	
Ketones	**Negative**	**NA**	**negative**	
WBC	**<5**	**NA**	**negative**	
RBC	**0-3**	**NA**	**negative**	
Leukoesterase	**Negative**	**NA**	**negative**	

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35-7.45**	**NA**	**NA**	
PaO2	**75-100**	**NA**	**NA**	
PaCO2	**35-45**	**NA**	**NA**	
HCO3	**18-22**	**NA**	**NA**	
SaO2	**95-100**	**NA**	**NA**	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**NEG**	**NA**	**NA**	
Blood Culture	**NEG**	**NA**	**NA**	
Sputum Culture	**NEG**	**NA**	**NA**	
Stool Culture	**NEG**	**NA**	**NA**	

Lab Correlations Reference (APA):

RN Adult medical surgical nursing Ed. 10.0

RN Adult medical surgical nursing. (2016) Retrieved March 20, 2019

RN Pharmacology for nursing Ed. 7.0

RN Pharmacology for nursing. (2016) Retrieved March 20, 2019

Mayo Clinic. (2018, November 3). Hyperglycemia in diabetes Symptoms and causes. Retrieved from https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Today the only diagnostic test that was performed on this patient was a doppler ultrasound test. This was done to check for pulses in the lower extremities

after the surgery. Previously, I did not see any other test that was performed.

Diagnostic Test Correlation (5 points):

The doppler uses ultrasound technology to search for the blood pressure of a pulse and creates a loud sound to indicate there is a pulse. Normal test results indicate that you have no narrowing or blockages in your arteries. It also means that the blood pressure in your arteries is normal(Pietrangelo, A., 2018)

Diagnostic Test Reference (APA):

Pietrangelo, A. (2018, September 29). Doppler Ultrasound Exam Of Arm Or Leg: Purpose, Results, And More. Retrieved from https://www.healthline.com/health/doppler-ultrasound-exam-of-an-arm-or-leg#results

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Clopidogrel/ Plavix	Furosemide/ Lasix	Atorvastatin/ Lipitor	Bisoprolol/ Zebeta	Losartan/ Cozaar
Dose	75mg/1tab	20mg/1tab	20mg/1tab	5mg/1tab	25mg/1tab
Frequency	Daily	Daily	Daily	Daily	Daily
Route	PO	PO	PO	PO	PO
Classification	Anticoagulant	Loop Diuretic	Antihyperlipidemic	Beta blocker	Antihypertensive
Mechanism of Action	Blocks the activity of cyclooxygenase the enzyme	Inhibits sodium and water reabsorption in the loop	Reduces plasma cholesterol and lipoprotein	Inhibits stimulation of beta 1 receptors sites, located	Blocks binding of angiotensin II to receptor

	needed for prostaglandin synthesis (2018 Nurses drug handbook, 2017)	of henle and increases urine formation.	levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on the liver cells.	mainly in the heart, resulting in decreased cardiac excitability, cardiac output and oxygen demand	sites in many tissues, including adrenal glands and vascular smooth muscle.
Reason Client Taking	-Patient is taking this as a blood thinner.	Patient is taking this to lower the edema in his leg and to help the kidneys excrete more toxins through urine.	Patient has a history of high cholesterol and is taking this to control it.	To bring down high blood pressure	To reduce the risk of stroke in patients with hypertension
Contraindications (2)	-Hemophilia -Peptic Ulcer Disease	-Hypersensitivity -Anuria	-Active hepatic disease -Breastfeeding women	-Acute HF -Cardiogenic Shock	-Renal failure patients -hypersensitivity
Side Effects/Adverse Reactions (2)	-Tinnitus -Bronchospasm	-Dizziness -Jaundice	-Amnesia -Glaucoma	-hallucinations -orthostatic hypotension	-Malaise -Nasal congestion
Nursing Considerations (2)	-Do not give more than the recommended dose. -Ask about tinnitus	-Use cautiously in patients with electrolyte imbalances (2018 Nurses drug handbook, 2017)	-Know it can be used with colestipol for additive effects -Expect liver function tests to be performed before starting this	-Use cautiously in patients that have major cardiac surgery planned. -If patient in HF develops bradycardia, expect to	-Beware in patients that have renal artery stenosis -Know that in some people losartan is

			medication.	lower the dose.	best given in 2 separate doses
Key Nursing Assessment(s) Prior to Administration	Nurse should assess is the patient on another blood thinner? Assess labs for PT/PTT levels	The patient's electrolytes would have to be checked in order to prevent sodium or potassium from being depleted.	Patients that are taking this medication should also be monitored for hypotension due to the adverse effect of lowering blood pressure by this drug	Assess the patient for high triglyceride levels due to beta blockers causing an increase in these levels	The nurse would have to watch the patient's labs in order to check for kidney function.
Client Teaching needs (2)	-Advise patient to keep away from children. -Advise the patient to put it in a location that would make it easy to recognize the medication.	-Instruct the patient to take at the same time each day. -Advise clients to measure weight and decrease sodium intake.	-Tell patient to take drugs at the same time each day. -Advise patients with diabetes to monitor blood sugar very closely.	-Instruct client to take same time of day -Notify provider if pulse falls below 60bpm	-Instruct client to avoid salt substitutes because they may increase potassium in blood -Tell female client to tell provider if they get pregnant

Hospital Medications (5 required)

Brand/Generic	Enoxaparin/ Lovenox	Pantoprazole /Protonix	Ranitidine/ Zantac	Pramipexole /	Acetamino phen/

				Mirapex	Tylenol
Dose	0.3ml	10ml	300mg/2caps	0.25mg	500mg
Frequency	At bedtime (HS)	Daily	Daily	Daily	PRN
Route	SubQ	IV Push	PO	PO	PO
Classification	Antithrombotic	Proton Pump Inhibitor	H2 Blockers	Dopamine antagonists	Antipyretic and Nonopioid analgesic
Mechanism of Action	Potentiates the action of antithrombin III a coagulation inhibitor. By binding with this the enoxaparin rapidly binds with and inactivates factors	Interferes with gastric acid secretion by inhibiting the H+,K+, ATP enzyme system in gastric cells	Works to interfere and block the gastric acid that is already present by inhibiting enzymes in gastric cells	Works with the chemical receptors in the brain to decrease the effects of parkinsons	Inhibits the enzyme cyclooxygenase blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.
Reason Client Taking	To prevent nosocomial thrombus formation	To prevent gastric stomach ulcers while in hospital	To stop a flare up of acid reflux	To treat parkinson's disease	Patient is taking this for pain
Contraindications (2)	-Major bleeding -hypersensitivity	-Hypersensitivity -Rabeprazole sodium	-hypersensitivity -Patients on ketoconazole	-hypersensitivity - patients taking haloperidol	-Severe hepatic impairment -Hypersensitivity
Side Effects/Adverse Reactions (2)	-Edema -Nausea/ Vomiting	-Fatigue -Hypertonia	-confusion -agitation	- drowsiness -nausea	-Hepatotoxicity -Pancytopenia

Nursing Considerations (2)	-Use cautiously in patients that have had heparin induced thrombocytopenia -Be aware that drug is not recommended in patients with prosthetic heart valves.	-Ensure the continuity of gastric acid suppression during transition from oral to IV -Know that PPIs should not be given longer than necessary.	-Ensure that the patient has relief of gastric acid production. - Nurses should know that an increased dose could make the stomach more alkalotic which would also be toxic.	-Use cautiously in patients that are are shallow breathers. -Use cautiously in patients who are working out increasingly	-Use cautiously in patients with renal impairment. -Monitor renal function
Key Nursing Assessment(s) Prior to Administration	Assess the patients PTT before injection. Also assess the patient for bruises or bleeding indicating an adverse effect of lovenox	Assess the patient for any cardiac dysrhythmia prior to administration.	Assess the LOC before administration because if a patient has ulcers, this medication could affect them in the bloodstream.	Assess renal function in patients prior to admission	Monitor the patient for liver dysfunction because tylenol can cause it to be worse
Client Teaching needs (2)	-Advise client to notify provider if bleeding occurs -Emphasize the importance of follow ups with provider	Tell patients to expect relief of symptoms within 2 weeks. -Instruct patient to notify prescriber if diarrhea.	-Do not take more than recommended dose per day. -Take to provider if they experience any sort of dizziness and confusion	-Do not drive while taking this medication. -Increase your fluid intake -Do not work out rigorously while on this drug.	-Tell patient that tablets may be crushed or swallowed whole. -Caution patient to not exceed dosage limit.

Medications Reference (APA): *2018 nurses drug handbook*. (2017). Burlington: Jones &

Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is AxO4 and is not currently in any distress. Patient is sitting in reclining chair sleeping
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** 21 **Drains present: Y☐ N ☐** **Type:**	Patient is a white male and has proper color. They have no skin breaks or any other skin conditions. Patients braden score is a 21. The patient is also free from any drains. Some bruises were present on the lower extremities but most were related to the blood thinner being given
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The head was free from skin breaks and was in good condition. The ears have a possibility for skin breakdown but currently are not red and are free from breakdown. Eyes were equal, round, reactive to light and accommodation. Nose was moist due to use of humidification.
CARDIOVASCULAR (2 points): **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:**	Patient has normal S1 and S2 heart sounds were auscultated at the mitral valve. A heart strip was read and interpreted. Normal sinus rhythm was noted. Patient also had good peripheral pulses and were graded to be 3+. The dorsalis pedis were the pulses graded. Patient had good cap refill which was 1-2 seconds and was not cyanotic. Patient had a good oxygen saturation but is at risk for that lowering. There was no JVD present. No edema was present.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Lung sounds were auscultated in all lobes and they were diminished in the right lower lobe. Patient was on Room Air. No use of accessory

ET Tube: **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	muscles to breathe. Patient did not have an ET Tube
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Patients diet at home is consistent of regular foods. Patient is currently on a heart healthy diet. Patient is a widow so there is no one at home to cook for her, so she cares for self. Patient is 157.4cm in height and 167.400kg in weight Patients last BM was on the 25th Bowel sounds were present in all four quadrants There are no ostomy or drains present. Patient also did not have an NG tube.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	Patients urine was of straw color and was an output of 55ml. Patient stated no pain with urination and was not on dialysis. Patient did have a catheter and genitals were free from erythema or bleeding. Patient had a 14 french catheter, and no CAUTI prevention measures were taken due to catheter being taken out per order.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:**	Patient was active and had full ROM due to her performing active exercises. Patient did use a cane to help with her ambulation. Patient currently needs ADL assistance due to being a fall risk. Patient currently has been free of falls

ADL Assistance: Y☐ N ☐ **Fall Risk: Y ☐ N☐** **Fall Score: 35** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	for the past 3 months. Patient does however have an IV Pole and AxO times 4. Patients current fall score is 35.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: AxO4** **Mental Status: Alert** **Speech: Normal** **Sensory: Normal** **LOC: AxO4**	The patient was able to move all extremities well and had one leg in rest. The patient's eyes were equal, round, reactive to light and accommodation. Patient had equal strength and was oriented to location, time, setting and situation.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient was asked about coping methods and she stated that she doesn't have any due to not feeling lonely. Patients developmental level is that of an adult but has only gone to school until high school. Patient is of christian faith. Patient states she has no family.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	**68**	**98/59**	**16**	**36.6**	**100%**
1100	**72**	**102/64**	**16**	**36.6**	**100%**

Vital Sign Trends/Correlation:

The patient's vital signs were within normal range both times they were taken. The patients blood pressure was taken manually due to the patients blood pressure cuff not taking correctly via monitor.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	**Numerical**	**None**	**0/10**	**None due to no pain**	**None needed**
1100	**Numerical**	**Leg**	**3/10**	**Achy pain**	**Position change was done**

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Patient had 18g Location is in the right AC Date on IV was 8/26/19 IV flushes and was used for medications Patients dressing is free from debris and erythema
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	Arterial line was present in the patient There was no size on this line but it was in the right radial artery. This was inserted in the OR on 8/25/19 This line works and no signs of erythema or drainage were noted. The line was then taken out so no CLABSI prevention was needed.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
Patient had an intake of 240ml with breakfast	**Patient had an output of 55ml with the catheter being in place before it was taken out.**

Nursing Care

Summary of Care (2 points)

Overview of care: Patients care was done smoothly. Morning medications were passed quickly and then patient was assessed and sat up into the recliner chair. Patient stayed in the chair for 2 hours and was comfortable. There was no report of pain earlier in the morning but later in the day patient did report pain on a numerical scale of 3/10. The patient declined pain medications and so she was repositioned and was comfortable after that.

Procedures/testing done: Patient did have the doppler ultrasound done on her to assess for venous blood in the lower extremities

Complaints/Issues: Patient complained once in the shift about pain but was quickly taken care of to help minimize pain. The rest of the time she was sleeping

Vital signs (stable/unstable): Vital signs were stable on the patient

Tolerating diet, activity, etc.: Patient did tolerate activity and diet but preferred to sleep for most of the time.

Physician notifications: Physician was into see the patient and did not put in notes until after I left the facility.

Future plans for patient: Patient has a high probability for discharge tomorrow and no other plans are noted in cerner for her.

Discharge Planning (2 points)

Discharge location: Patient is to be discharged to home

Home health needs (if applicable): Patient will have a wound care nurse come to her home and look to see if she is healing as well as expected.

Equipment needs (if applicable): Patient will still use a cane to walk and perform ADLs

at home.

Follow up plan: Patient will follow up with Dr. Greens office if there are any complications at home. Patient will also come to see Dr. Green to have her left leg worked on as well due to her having poor circulation.

Education needs: Patient will have to be educated about discharge and care for her incision while staying at home. An education print out will be provided to the patient before discharge and instructions will be verbally reviewed.

Nursing Diagnosis (15 points)
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	**Rational** ● Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Patient is at risk for infection related to having an open incision as	This was chosen due to the patient having an open area leading to an entry point for harmful bacteria.	1. Patient will be infection free for the remainder of her stay 2. Patient will be	Patient remained infection free for the time of care at the facility. Patient was given clear instructions on how to care for her incision. Goals were met

evidenced by incision being close to genitals		able to state two ways to keep bacteria from entering incision	for this patient.
2. Risk for falls related to inability to walk without assistance as evidenced by patient needing cane and assistive personnel	Patient is unable to walk without gait belt, cane, and one CNA by the side.	**1.** Patient will be able to demonstrate ability to ambulate 50ft in the first three hours of shift. **2.** Patient will perform shower by self once assisted to the restroom by assistive personnel	Patients goals were met! Patient was able to perform both of these tasks but fall risk is still initiated due to use of cane.
3. Risk for injury related to venous stasis as evidenced by rest ordered after surgery	The patient was put on a fall risk due to having surgery	**1.** Patient will remain injury free for the remainder of my shift. **2**. Patient will ambulate at least 100 feet to have an increase in mobility before the end of my shift.	The patient was free from injury the duration of my shift and the patient was great at being standby assist. The patient did not walk a total of 100feet but did walk around the room to help increase activity.
4. At risk for deficient knowledge related to unfamiliarity with changing dressing at home	Patient will be discharged home and will need to know how to change self dressings on days that home health is not visiting	1. Patient will be given an alternate learning method. 2. Patient will be able to repeat back the time needed to wash hands before dressing changes	The goal was met for this patient and patient was given a print out on how to change dressings at home while also being shown at the hospital. Patient was able to repeat back and know 20 seconds as the recommended time to wash hands for.
5. Risk for deficient fluid volume related to active loss as evidenced by elevated BUN	Patient had a high BUN and that is one reason they should be more closely monitored.	**1.** Patient will be able to have normal labs by the next morning's blood draw. **2.** Patients weight	Patients lab came back normal and the patient's weight was monitored in the morning. Patient did not have significant weight gain.

		will be monitored to check for significant weight gain.	

Other References (APA):

Concept Map (20 Points):

Subjective Data

- Patient stated that pain has been going on for “quite some time” when asked about duration of pain
- Patient responded with “0” on a 0/10 scale for pain after surgery

Objective Data

- Patients BUN was elevated indicating kidney function being affected by the surgery medications.
- Patient had a low RBC, hct and hgb due to surgery causing a small drop in blood count.

Nursing Diagnosis/Outcomes

Patient is at risk for infection related to having an open incision a close to genitals
Patient remained infection free for the remainder of the stay at th discharge.
Risk for falls related to inability to walk without assistance as evi cane and assistive personnel
Patient was not able to ambulate too far but was able to move aro personnel.
Risk for injury related to venous stasis as evidenced by rest order
Patient remained free from DVT blood clots
At risk for deficient knowledge related to unfamiliarity with char
Patient was taught about dressing changes at home and was given perform them to help guide her care.
Risk for deficient fluid volume related to active loss as evidenced
Patient was able to

Patient Information

Patient is an 80yr old female that had presented to Dr. Green’s office complaining of pain in the right lower extremity. Patient stated that the pain has been going on for “quite some time” over a period of six months. She does not recall where the pain had started at but states it is in both legs but the right lower extremity is unbearable. Patient has been taking pain medications at home per patient statement. Patient was limiting mobility to prevent pain from occurring. Aggravating factors included walking and putting pressure on leg. Patient stated that resting reduced her pain but it was constant

Nursing Interventions

- Monitor the patient's labs AKI due to patient having a
- Monitor the patient's vital infection.
- Monitor patients intake ar dehydration.