N431 Care Plan 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
09/08/19	RC	82 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Married	No known
Code Status	**Height**	**Weight**	
Full Code	5’ 10”	67.6 kg	

Medical History (5 Points)

Past Medical History: Skin cancer, prostate cancer, macular degeneration, hypertension, glaucoma, BPH.

Past Surgical History: No surgical history on file.

Family History: No pertinent family history.

Social History (tobacco/alcohol/drugs): Patient denies smoking, tobacco use, and alcohol use.

Assistive Devices: Patient uses a walker

Living Situation: Patient lived with wife before admission, and will be going to the VA after discharge.

Education Level: Bachelor’s degree

Admission Assessment

Chief Complaint (2 points): Fall

History of present Illness (10 points): Patient is an 82-year-old Caucasian male presented to ED after falling at home on his right elbow. He did not hit his head or lose consciousness. Patient has a large flap laceration on his right elbow and decreased range of motion. Patient is alert and oriented X 3 but has to have help to use the urinal. Patient asked to have help eating his dinner, a meal tray was ordered for him and the nurse fed him. Patient has no other injuries other than his

right elbow. Patient's wife states she can no longer take care of him at home. Patient is waiting on a bed at the VA.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Laceration on right elbow due to fall in patient's home.

Secondary Diagnosis (if applicable): N/A

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

Falls are common in the elderly population, and lacerations can result from falls. Older adults have fragile skin, and skin integrity can be disrupted when they fall. Medline Plus (2019) describes lacerations as wounds that are produced by tearing the soft tissues. The wound is often contaminated with bacteria and debris from the cause of the laceration (Medline Plus, 2019). When an older adult falls, they may fall on objects or the ground, causing the laceration. Signs and symptoms of a laceration are bruising, bleeding, pain, swelling, and skin discoloration (Convenient MD Urgent Care, n.d.). The patient came in with pain, bleeding, and swelling of his right elbow. The expected findings are increased vital signs due to pain. The patient's vital signs upon arrival to the emergency department were increased.

Healthcare providers can order chest x-rays to ensure there are no fractures to the affected area, but there are no diagnostic tests to confirm a laceration. The patient's provider order x-rays of the elbow and chest to ensure there were no fractures. Lab tests can be ordered to support the diagnosis. A complete blood count can be ordered to support the diagnosis of a laceration because there will be blood loss. The patient's red blood cell count, hemoglobin levels, and hematocrit levels were low, indicating blood loss from the laceration. The treatment of a laceration includes irrigating the wound with sterile saline solution, and the injury is closed with

sutures. The patient had sutures on his lacerations on his right elbow.

Pathophysiology References (2) (APA):

Convenient MD Urgent Care. (n.d.). Lacerations and Cuts. Retrieved on September 14, 2019, from https://convenientmd.com/lacerations-and-cuts/

Medline Plus. (2019, September 11). Laceration versus puncture wound. Retrieved on September 14, 2019, from https://medlineplus.gov/ency/imagepages/19616.htm

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	**4.40 - 5.80 10(6)/mcL**	**3.96**	**3.42**	RBC are low due to blood loss from laceration from patient's fall (AACC, 2019).
Hgb	**13.0 - 16.5 g/dL**	**11.5**	**10.3**	Hgb levels are low due to blood loss from laceration from patient's fall (Mayo Clinic, 2018).
Hct	**38.0 - 50.0 %**	**35.5**	**31.3**	Hct levels are low due to recent blood loss from laceration from patient's fall (Mayo Clinic, 2019)
Platelets	**140 - 440 10(3)/mcL**	**370**	**346**	**N/A**
WBC	**4.00 - 12.00 10(3)/mcL**	**11.9**	**11.3**	
Neutrophils	**40.0 - 68.0 %**	**85.0**	**80.2**	Possible side effect of ceftriaxone or possible infection (Jones & Bartlett Learning, 2019).
Lymphocytes	**19.0 - 49.0 %**	**6.6**	**7.7**	Possible side effect of ceftriaxone or possible infection Jones & Bartlett Learning, 2019).
Monocytes	**3.0 - 13.0 %**	**6.9**	**9.2**	**N/A**
Eosinophils	**0.0 - 8.0 %**	**0.9**	**2.6**	**N/A**
Bands	**N/A**	**N/A**	**N/A**	**N/A**

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-	**133 - 144 mmol/L**	**138**	**N/A**	**N/A**
K+	**3.5 - 5.1 mmol/L**	**4.2**	**N/A**	**N/A**
Cl-	**98 - 107 mmol/L**	**106**	**N/A**	**N/A**
CO2	**21 - 31 mmol/L**	**21**	**N/A**	**N/A**
Glucose	**70 - 99 mg/dL**	**99**	**N/A**	**N/A**
BUN	**7 - 25 mg/dL**	**37**	**N/A**	Patient may be dehydrated due to poor fluid intake or from kidney function slowing (National Kidney Foundation, n.d.).
Creatinine	**0.50 - 1.20 mg/dL**	**1.54**	**N/A**	Patient may be dehydrated (National Kidney Foundation, n.d.).
Albumin	**3.5 - 5.7 g/dL**	**3.5**	**N/A**	**N/A**
Calcium	**8.8 - 10.2 mg/dL**	**8.8**	**N/A**	**N/A**
Mag	**N/A**	**N/A**	**N/A**	**N/A**
Phosphate	**N/A**	**N/A**	**N/A**	**N/A**
Bilirubin	**N/A**	**N/A**	**N/A**	**N/A**
Alk Phos	**34 - 104 U/L**	**82**	**N/A**	**N/A**
AST	**13 - 39 U/L**	**13**	**N/A**	**N/A**
ALT	**7 - 52 U/L**	**10**	**N/A**	**N/A**
Amylase	**N/A**	**N/A**	**N/A**	**N/A**

Lipase	**N/A**	**N/A**	**N/A**	**N/A**
Lactic Acid	**N/A**	**N/A**	**N/A**	**N/A**
Troponin	**N/A**	**N/A**	**N/A**	**N/A**
CK-MB	**N/A**	**N/A**	**N/A**	**N/A**
Total CK	**N/A**	**N/A**	**N/A**	**N/A**

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	**N/A**	**N/A**	**N/A**	**N/A**
PT	**N/A**	**N/A**	**N/A**	**N/A**
PTT	**N/A**	**N/A**	**N/A**	**N/A**
D-Dimer	**N/A**	**N/A**	**N/A**	**N/A**
BNP	**N/A**	**N/A**	**N/A**	**N/A**
HDL	**N/A**	**N/A**	**N/A**	**N/A**
LDL	**N/A**	**N/A**	**N/A**	**N/A**
Cholesterol	**N/A**	**N/A**	**N/A**	**N/A**
Triglycerides	**N/A**	**N/A**	**N/A**	**N/A**
Hgb A1c	**N/A**	**N/A**	**N/A**	**N/A**
TSH	**N/A**	**N/A**	**N/A**	**N/A**

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	**N/A**	**N/A**	**N/A**	**N/A**
pH	**N/A**	**N/A**	**N/A**	**N/A**
Specific Gravity	**N/A**	**N/A**	**N/A**	**N/A**
Glucose	**N/A**	**N/A**	**N/A**	**N/A**
Protein	**N/A**	**N/A**	**N/A**	**N/A**
Ketones	**N/A**	**N/A**	**N/A**	**N/A**
WBC	**N/A**	**N/A**	**N/A**	**N/A**
RBC	**N/A**	**N/A**	**N/A**	**N/A**
Leukoesterase	**N/A**	**N/A**	**N/A**	**N/A**

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	**N/A**	**N/A**	**N/A**	**N/A**
PaO2	**N/A**	**N/A**	**N/A**	**N/A**
PaCO2	**N/A**	**N/A**	**N/A**	**N/A**
HCO3	**N/A**	**N/A**	**N/A**	**N/A**
SaO2	**N/A**	**N/A**	**N/A**	**N/A**

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	**N/A**	**N/A**	**N/A**	**N/A**
Blood Culture	**N/A**	**N/A**	**N/A**	**N/A**
Sputum Culture	**N/A**	**N/A**	**N/A**	**N/A**
Stool Culture	**N/A**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (APA):

AACC. (2019, April 10). Red Blood Cell Count (RBC). Retrieved on September 14, 2019, from https://labtestsonline.org/tests/red-blood-cell-count-rbc#

Jones & Bartlett Learning. (2019). *2019 Nurse's Drug Handbook* (Eighteenth ed.). Burlington, MA: Jones & Bartlett Learning.

Mayo Clinic. (2018, April 7). Low hemoglobin count. Retrieved on September 14, 2019, from https://www.mayoclinic.org/symptoms/low-hemoglobin/basics/causes/sym-20050760

Mayo Clinic. (2019, February 12). Hematocrit test. Retrieved on September 14, 2019, from https://www.mayoclinic.org/tests-procedures/hematocrit/about/pac-20384728

National Kidney Foundation. (n.d.). Understanding Your Lab Values. Retrieved on September 14, 2019, from https://www.kidney.org/atoz/content/understanding-your-lab-values

Diagnostic Imaging

All Other Diagnostic Tests (5 points): X-ray of the elbow minimum 3 views right. Findings include no fracture or dislocation, no bony abnormalities, and no joint abnormalities. Calcification noted in the lateral collateral ligament. Chest x-ray single view portable. Findings include mild hyperinflation and no acute findings.

Diagnostic Test Correlation (5 points): An x-ray of the elbow was ordered because the patient fell on his elbow in his home. The patient did not have fractures, dislocations, bony abnormalities, or joint abnormalities. An x-ray of the chest was ordered possibly due to the fall. The chest x-ray can help the provider determine if the patient fractured any ribs due to the fall (Mayo Clinic, 2018). The patient's provider did not find anything pertinent to the patient's fall.

Diagnostic Test Reference (APA):

Mayo Clinic. (2018, April 26). Chest X-rays. Retrieved from September 14, 2019, from

https://www.mayoclinic.org/tests-procedures/chest-x-rays/about/pac-20393494

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

Home Medications (5 required)

Brand/Generic	amlodipine (Norvasc)	felodipine (Plendil)	hydralazine (Apresoline)	brimonidine (Alphagan)	dorzolamide (Truspot)
Dose	10 mg	place 1 drop in affected eye(s)	5 mg	place 1 drop in affected eye(s)	place 1 drop in affected eye(s)
Frequency	Daily	3 times daily	2 times daily	3 times daily	2 times daily
Route	Oral	Ocular	Oral	Ocular	Ocular
Classification	Antianginal, antihypertensive	Antihypertensive	antihypertensive, vasodilator	Treats elevated intraocular pressure	Treats elevated intraocular pressure
Mechanism of Action	Decreases the intracellular calcium level, inhibiting smooth-muscle cell contractions and relaxing the coronary and vascular smooth muscles.	Slows the movement of extracellular calcium into myocardial and vascular smooth-muscle cells by deforming calcium channels in cell membranes.	It interferes with calcium movement and vascular contraction. increases renin secretion and sodium reabsorption.	Decreases the norepinephrine release at the synaptic junction in the eye.	Inhibits carbonic anhydrase II (CA-II), which is the main CA isoenzyme involved in aqueous humor secretion.
Reason Client Taking	Client taking medication to control hypertensio	Used to treat wide-angle glaucoma	Client taking medication to control hypertensio	Used to treat wide-angle glaucoma	Used to treat wide-angle glaucoma

	n		n		
Contraindications (2)	Aliskiren therapy in patients with diabetes or renal impairment and hypersensitivity to amlodipine or its components.	Hypersensitivity to felodipine and hypersensitivity to felodipine's components.	Coronary artery disease and mitral valve disease.	Orthostatic hypertension and numbness in the hands or feet.	Ocular infection and corneal abrasion.
Side Effects/Adverse Reactions (2)	Constipation, dyspnea, weight loss, fatigue	Dry eyes and irritation	Angina, edema, tachycardia, fever, and dyspnea.	Blurred vision, dry eyes, and irritation	Blurred vision, dry eyes, and irritation
Nursing Considerations (2)	Monitor blood pressure while adjusting the dosage. Assess the patient frequently for chest pain when increasing the dose of amlodipine.	May cause severe hypotension with syncope. Grapefruit juice affects bioavailability of felodipine.	Give tablets with food to increase bioavailability. Check patient's blood pressure when changing positions and watch for signs of orthostatic hypotension.	Administer other eye drop medications at least 5 minutes apart. Do not touch container tip to eye or eyelid.	Administer other eye drop medications at least 5 minutes apart. Do not use if the solution changes color.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess renal and liver function labs.	Monitor blood pressure and pulse.	Check patient's blood pressure and pulse.	Check patient's blood pressure and pulse.	Check patient's blood pressure and pulse.
Client Teaching needs (2)	Suggest taking amlodipine with food to reduce GI	Instruct patient to keep felodipine away from	Instruct patient to take tablets with food. Advise	Have eyesight checked regularly and notify	Instruct patient to administer other ocular

	upset. Tell patient to take missed dose as soon as remembered and next dose in 24 hours.	light. Advise patient to avoid grapefruit juice during therapy.	patient to change positions slowly.	provider. Instruct patient to put pressure on the inner corner of the eye.	medications at least 5 minutes apart. Advise patient to notify provider if they experience adverse side effects of this medication.

Hospital Medications (5 required)

Brand/Generic	amlodipine (norvasc)	ceftriaxone(rocephin)	enoxaparin (lovenox)	acetaminophen (Tylenol)	timolol (Timoptic)
Dose	10 mg	1 g	40 mg	650 mg	1 drop both eyes
Frequency	Daily	Every 24 hours	Daily	Every 4 hours as needed	Twice daily
Route	Oral	IV	Sub-q injection	Oral	Ocular
Classification	Antianginal, antihypertensive	Antibiotic	Antithrombolytic	Nonopioid analgesic, antipyretic	Beta blocker
Mechanism of Action	Decreases the intracellular calcium level, inhibiting smooth-mus	Interferes with bacterial cell wall synthesis by inhibiting cross-linkin	Enoxaparin rapidly binds with antithrombin III and inactivates clotting	Inhibition of central prostaglandin synthesis elevates the pain threshold.	Blocks alpha1 and beta2 receptors in vascular smooth

	cle cell contractions and relaxing the coronary and vascular smooth muscles.	g of peptidoglycan strands. Peptidoglycan makes the cell membrane rigid and protective. Without it, bacterial cells rupture and die.	factors. Without thrombin, fibrinogen can't convert to fibrin and clots can't form.	Reduces fever by inhibiting release of prostaglandins in the CNS as well as endogenous pyrogens at the hypothalamic thermoregulator center.	muscles and beta1 receptors in the heart.
Reason Client Taking	Client taking medication to control hypertension	Used to prevent infection of client's laceration.	To prevent blood clots from forming.	Client takes this for pain as needed	Used to treat glaucoma
Contraindications (2)	Aliskiren therapy in patients with diabetes or renal impairment and hypersensitivity to amlodipine or its components.	Calcium-containing IV solutions and hypersensitivity to ceftriaxone.	Active major bleeding and history of heparin-induced thrombocytopenia (HIT).	Active/severe hepatic disease and hypersensitivity to product	Asthma and COPD
Side Effects/Adverse Reactions (2)	Constipation, dyspnea, weight loss, fatigue	Fever, chills, leukopenia, neutropenia, dyspnea.	Confusion, hyperlipidemia, epistaxis, hemorrhage, pulmonary edema or embolism	Headache, nausea, vomiting, insomnia, agitation	Diplopia, dry eyes, and irritation.
Nursing Considerations (2)	Monitor blood pressure	Protect powder from light.	Test stool for occult blood, as	Monitor renal function and	Monitor for impaired

	while adjusting the dosage. Assess the patient frequently for chest pain when increasing the dose of amlodipine.	Monitor for signs of superinfection, such as cough or sputum changes, diarrhea, fever, malaise, and pain.	ordered. Keep protamine sulfate nearby in case of accidental overdose.	urine for albumin and blood. Monitor renal function in patients on long term therapy.	circulation in elderly patients. Expect varied drug effectiveness in elderly patients.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess renal and liver function labs.	Assess CBC, hematocrit, AST, and ALT labs.	Check serum potassium level.	Assessing patient's liver functions labs	Monitor blood pressure
Client Teaching needs (2)	Suggest taking amlodipine with food to reduce GI upset. Tell patient to take missed dose as soon as remembered and next dose in 24 hours.	Advise patient to report any hypersensitivity reactions. Tell patient to report evidence of blood dyscrasia or superinfection to provider.	Advise patient to notify provider for adverse reactions, especially bleeding. Instruct the patient of the importance of attending the follow-up appointments.	Tell patients that tablets may be crushed or swallowed whole. Caution patient not to exceed the recommended dosage.	Instruct client or client's family how to apply the eye drops correctly. Instruct client to report irritation or diplopia.

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurse's Drug Handbook* (Eighteenth ed.). Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient awake and sitting in the chair. He is alert and oriented X 3. Patient does not appear to be in acute distress. Patient speaks English well. Patient does not MAEW and strength is greater in his legs. Patient shows no signs of neurological deficit.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Patient's skin is pink, dry, and intact. The patient's temperature at 1101 was 97.6 F. Patient's skin tents, but this is expected with elderly patients. No rashes noted. Bruising and lacerations on right forearm and elbow. Wound is pink and closed with stitches. Braden Score is 16. No drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical. Trachea is midline without deviation. Thyroid is not palpable, no noted nodules. Carotid pulses are palpable and strong. No lymphadenopathy in the head or neck is noted. Right pupil is slightly larger than the left pupil. Tympanic membrane is visible and pearly grey bilaterally. No visible drainage in ears. Nose has no deviation, turbinates pink and moist bilaterally. Oral mucosa is pink and moist. Patient has dentures.
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:**	Clear S1 and S2 sounds present and no gallops or murmurs present. Regular cardiac rate and rhythm. Pulses are palpable throughout. Capillary refill was 4 seconds possibly due to dehydration. No JVD noted and no presence of edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Breath sounds are clear to auscultation bilaterally. Respirations are unlabored with regular pattern and depth. Patient does not appear to be in respiratory distress.

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:**	Patient's diet at home is regular, he will eat what his wife makes him. His current diet is regular. Patient's height is 5' 10'' and weight is 67.6 kg or 148.7 lbs. Bowel sounds are hyperactive in all four quadrants upon auscultation. Last BM was 9/10. Patient denies pain upon palpation, no masses or organomegaly noted. No distention, incisions, scars, drains, or wounds present. Patient does not have an ostomy, nasogastric tube, or feeding 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:**	Patient is incontient. No dialysis or catheter. Patient's urine was dark yellow in color. Patient has 2 occurrences of immeasurable urine output. Patient denies pain with urination. No lesions, nodules, or swelling noted.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient's strength is greater in his legs. Patient has a decreased ROM due to recent fall. Patient uses a walker and needs assistance to walk around. Patient needs help to walk and sit. Patient is a fall risk due to weakness and recent fall. Fall score is 70. Nursing technician reports a decrease in activity and mobility. Patient is not independent.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐**	Patient does not MAEW. Patient is weak. Patient's right pupil is slightly larger than the left pupil. Patient's legs are stronger than his arms,

Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	possibly due to pain from the fall and the laceration. Patient is alert and oriented X3. Patient speaks quietly, but his speech is not impaired. Patient slept most of the shift.
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 is well developed for his age. Patient has support from his wife and family. Patient's wife was in his room throughout the day and expressed concern about him, in a caring manner. Patient has strong support from family.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0740	**57**	**130/49**	**18**	**97.8 F**	**96**
1101	**65**	**183/70**	**18**	**97.6 F**	**98**

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0740	**0/10**	**N/A**	**N/A**	**N/A**	**None**
1101	**0/10**	**N/A**	**N/A**	**N/A**	**None**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV: Right arm**	Patient has a continuous infusion of 0.9% normal saline at a rate of 100 mL/hr.

Date on IV: 9/8/19 **Patency of IV: Appears patent, stable, and flushes easily** **Signs of erythema, drainage, etc.: No signs of erythema, drainage, or swelling at the insertion site** **IV dressing assessment: Clean, dry, intact**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
960 mL	**Patient is incontient, 2 occurrences of immeasurable urine output.**

Nursing Care

Summary of Care (2 points)

Overview of care: I helped the patient sit up in the chair to eat breakfast. The nursing technician and I ordered his breakfast for him. Before his breakfast came, the wound care nurse came in to change his dressing on his right elbow. He only ate one or two bites of his breakfast and when he was finished, he wanted to be put back into bed to sleep. I woke the patient up to give him his medication and to take vital signs. The patient's wife

Procedures/testing done: No procedures were done during the day.

Complaints/Issues: Patient wanted to sleep throughout the day.

Vital signs (stable/unstable): The patient's vital signs were stable throughout the day, he has high blood pressure, but it was stable for him.

Tolerating diet, activity, etc.: Patient did not want to sit up in the chair. He wanted to lie in bed immediately after breakfast. Patient ate one or two bites of his breakfast and about half of his milkshake.

Physician notifications: No physician notifications for the day.

Future plans for patient: Patient is waiting on a bed at the VA.

Discharge Planning (2 points)

Discharge location: Patient will be discharged to the VA.

Home health needs (if applicable): N/A

Equipment needs (if applicable): Patient will need to use a walker after discharge.

Follow up plan: Patient will follow up with his provider if there are signs of infection around the injury.

Education needs: Patient and patient's wife will need education on fall prevention, rehabilitation, medication administration and adverse effects, and follow up appointments with the provider.

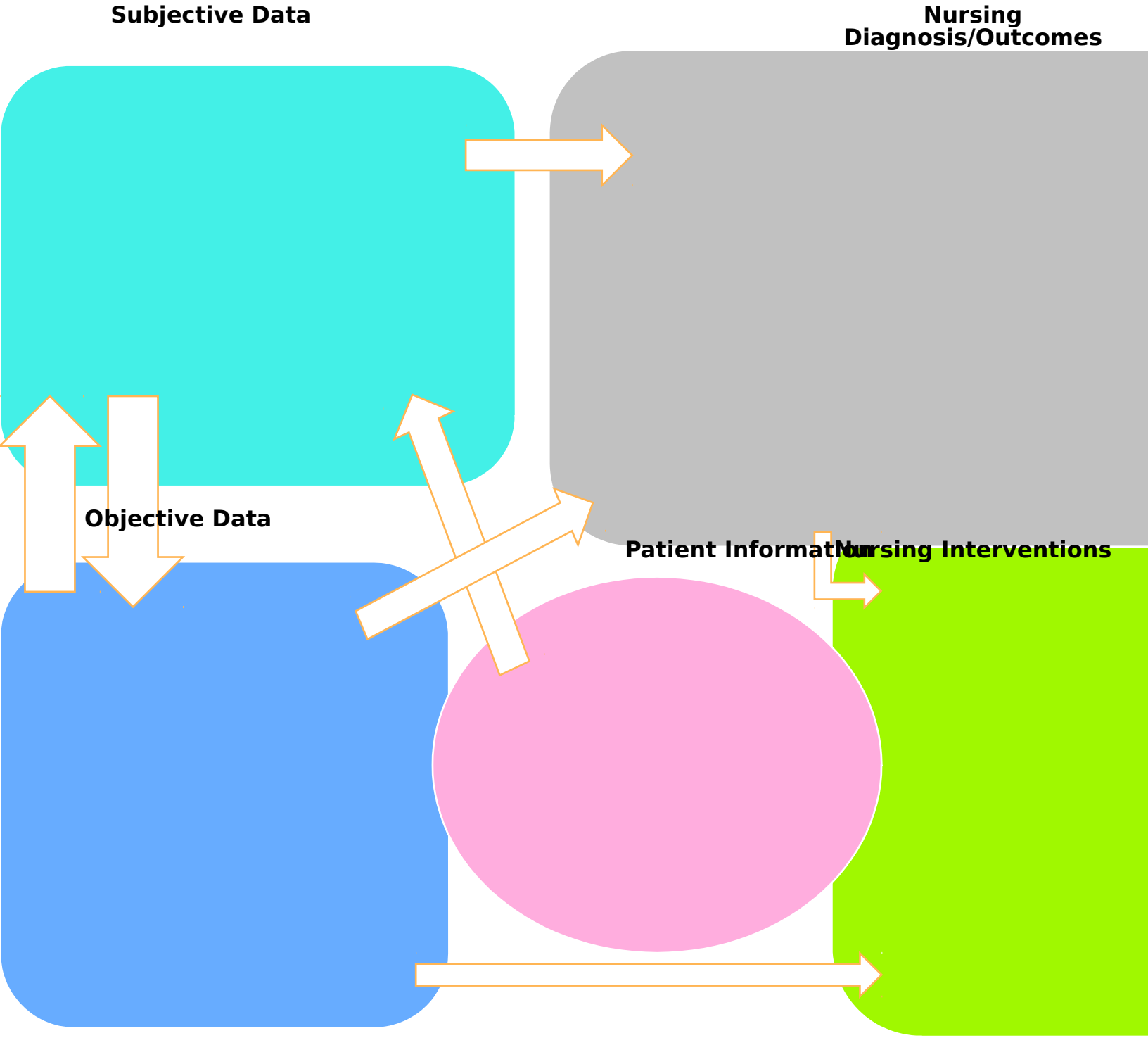
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Failure to thrive related to the impact of the fall and chronic disease as evidenced by difficulty in performing self-care needs.	**Patient has a decrease in activities of daily living.**	**1. Support the patient and encourage independence.** **2. Help clients to participate in activities.**	**The patient did not want to sit in the chair or walk down the hall. The client slept most of the day. The goal was not met.**
2. Risk for bleeding related to laceration on right elbow as	**Patient's dressing on his elbow had bloody discharge when the nurse**	**1. Dressing changes as needed.** **2. Monitor hematocrit and**	**The patient's wife stated she will notify the provider if she sees blood from the patient's injury. The goal was**

evidenced by bloody drainage at the incision site.	**changed the dressing.**	**hemoglobin levels.**	**met.**
3. Risk for infection related to laceration on right elbow as evidenced by increased neutrophils.	**Infection may occur if the patient does not take care of the injury from the fall.**	**1. Change the patient's dressing when soiled.** **2. Assess for signs of infection frequently.**	**The patient's wife is aware of the signs of infection and stated she will notify the provider if she sees any signs. Patient's dressing was changed at 0830. The goal was met.**
4. Activity intolerance related to glaucoma as evidenced by excessive sleeping and not eating meals.	**Patient's wife stated the patient was not acting like himself. Patient wanted to sleep throughout the day and did not eat his breakfast in the morning.**	**1. Encourage patient to do activities independently** **2. Provide adequate nutrition to increase ability to perform ADL.**	**Breakfast was provided to the patient, and he at one or two bites of food. Patient stated he could not eat the rest of his breakfast. The patient was given the choice to sit in the chair and walk down the hall, but he refused. The goal was not met.**

Other References (APA):

Concept Map (20 Points):


Subjective Data
Nursing
Diagnosis/Outcomes
Objective Data
Patient Information
Nursing Interventions