N431 Care Plan #1

Lakeview College of Nursing

Breanna Schoonover

Demographics (3 points)

Date of Admission 9/17/19	Patient Initials RB	Age 59	Gender Female
Race/Ethnicity White	Occupation disabled	Marital Status Widower	Allergies Betadine Iodine Nickel Tetracycline
Code Status Full	Height 167.6cm	Weight 86.8kg	

Medical History (5 Points)

Past Medical History:

- Altered in comfort, pain.
- Anxiety
- Chronic Gerd
- Depression
- Increased BMI
- Low Vitamin D level
- Morbid Obesity
- Tobacco Use

Past Surgical History:

- Cesarean Section
- Left Knee
- Lithotripsy
- Right Knee
- T & A
- Tubal Ligation

Family History: No known family history.

Social History (tobacco/alcohol/drugs): Patient states that she does not use any substances. Patient states that she drinks occasionally. However, when asked, she didn't specify how much a day. She also states that she smokes a pack of cigarettes per day.

Assistive Devices: Patient uses a walker at all times. A walker and a gait belt is present at the bedside.

Living Situation: Patient lives in her home, alone, in Charleston Illinois.

Education Level: High school diploma. Education level is appropriate for age.

Admission Assessment

Chief Complaint (2 points): Fractured spine.

History of present Illness (10 points); Patient arrived to the hospital on 9/17 via ambulance after experiencing a fall off a rock. Patient reported that she drank half of a pint of tequila and when she was standing from the rock, her rocker rolled away, resulting in a hard fall. Patient was given pain medication in the ED to comfort her through her pain. On 9/17, day two of her hospital stay, is when I arrived on the clinical site. Patient states that her pain is getting better with the pain medication, but still aggravating her. We are waiting on the rest of her cultures before she can be discharged.

Primary Diagnosis

Primary Diagnosis on Admission (2 points)Fractured spine.

Secondary Diagnosis (if applicable):Acute UTI .

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

A urinary tract infection is an infection of the bladder, the upper urinary tract or the kidney, usually caused by E. Coli, which is a fecal pathogen (Sorenson, Quinn & Klein,

2017). My patient had an infection of the bladder which is also the most common bacterial infection that develops from the ascension of bacteria through the urethra to the bladder. Diabetes Mellitus, obstruction and neurogenic bladder are a few of the common risk factors associated with a UTI(Sorenson, Quinn & Klein, 2017). My patient came to the ER from a fall she had, associated with some confusion and back pain. Other clinical manifestations consist of dysuria, urgency and frequency. UTI's can also be asymptomatic, which is typically not treated unless the patient is at high risk or pregnant. A urinalysis was completed on my patient and is typically done in this situation to rule out bacteriuria. Another test that can be obtained is a urine culture but isn't usually done unless the patients has recurring symptoms or if it is a complicated case of cystitis. Cystitis is usually cured with antibiotics such as nitrofurantoin, trimethoprim-sulfamethoxazole or Fosfomycin. Another recommendation to drink cranberry juice but contraindicated in interstitial cystitis. (Sorenson, Quinn & Klein, 2017)

Pathophysiology References (2) (APA):

Sorenson, M., Quinn, L., Klein, D. ***Pathophysiology: Concepts of Human Disease*****. New York, NY. Pearson. 2017.**

Hinkle, J., Cheever, K. (2018) ***Brunner and Suddarth's Textbook of Medical-Surgical Nursing*****. (14th ed.) Philadelphia, Pa: Wolters Kluwer.**

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	4.49	4.62	
Hgb	11.3-15.2	13.5	13.8	
Hct	33.2-45.3	40.7	42.0	
Platelets	149-493	267	260	
WBC	4.0-11.7	9.4	13.1	wbc increase in situations where an infection is present (Hinkle&Cheever, 2018)
Neutrophils	45.3-79	56.7	89.0	A change in neutophils is normal when there is a rise in wbc d/t infection (Hinkle&Cheever, 2018)
Lymphocytes	11.8-45.9	29.1	8.8	A change in lymphocytes and monocytes correlate with the rise in WBC d/t infection (Hinkle&Cheever, 2018)
Monocytes	4.4-12.0	6.3	1.6	A change in lymphocytes and monocytes correlate with the rise in WBC d/t infection (Hinkle&Cheever, 2018)
Eosinophils	0.0-6.3	6.3	NA	
Bands	NA	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	142	140	
K+	2.5-5.1	4.1	4.6	
Cl-	98-107	107	107	
CO2	22-29	27	28	

Glucose	**70-99**	**89**	**126**	**Many factors can cause an increase in glucose. Glucose tends to rise when a patient is in a stressful situation or in pain. (Hinkle&Cheever, 2018)**
BUN	**6-20**	**15**	**14**	
Creatinine	**0.5-0.9**	**0.68**	**0.65**	
Albumin	**3.5-5.2**	**3.8**	**NA**	
Calcium	**8.6-10.4**	**8.8**	**9.2**	
Mag	**1.6-2.4**	**NA**	**NA**	
Phosphate	**2.5-4.5**	**NA**	**NA**	
Bilirubin	**0.3-1**	**0.3**	**NA**	
Alk Phos	**35-105**	**56**	**NA**	
AST	**0-32**	**16**	**NA**	
ALT	**0-33**	**11**	**NA**	
Amylase	**50-150**	**NA**	**NA**	
Lipase	**10-160**	**NA**	**NA**	
Lactic Acid	**0-150**	**NA**	**NA**	
Troponin	**0.5-2.4**	**NA**	**NA**	
CK-MB	**0.0-0.04**	**NA**	**NA**	
Total CK	**20-100**	**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	Value on	Today's	Reason for Abnormal

	Range	Admission	Value	
INR	**0.86-1.14**	**NA**	**NA**	
PT	**11.9-15**	**NA**	**NA**	
PTT	**22.6-35.3**	**NA**	**NA**	
D-Dimer	**0.00-0.62**	**NA**	**NA**	
BNP	**0.5-30**	**NA**	**NA**	
HDL	**>60**	**NA**	**NA**	
LDL	**<100**	**NA**	**NA**	
Cholesterol	**<200**	**NA**	**NA**	
Triglycerides	**0-150**	**NA**	**NA**	
Hgb A1c	**4-5.6%**	**NA**	**NA**	
TSH	**0.4-4.0**	**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**	**yellow, Clear**	**NA**	
pH	**5.0-8.0**	**6.0**	**NA**	
Specific Gravity	**1.005-1.034**	**1.008**	**NA**	
Glucose	**Normal**	**Normal**	**NA**	
Protein	**Negative**	**Negative**	**NA**	
Ketones	**Negative**	**Negative**	**NA**	
WBC	**<5**	**<1**	**NA**	
RBC	**0-3**		**NA**	
Leukoesterase	**Negative**	**Negative**	**NA**	

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	80-100 mmhg	NA	NA	
PaCO2	35-45mmhg	NA	NA	
HCO3	21-28mEq/L	NA	NA	
SaO2	60-75	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	Negative	>100,000cfu/ml	NA	Gram negative bacillI. Findings indicate that the patient is positive for a UTI. (Hinkle&Cheever, 2018)
Blood Culture	Negative	NA	NA	
Sputum Culture	Negative	NA	NA	
Stool Culture	Negative	NA	NA	

Lab Correlations Reference (APA):**Hinkle, J., Cheever, K. (2018)** ***Brunner and Suddarth's Textbook of Medical-Surgical Nursing*****. (14th ed.) Philadelphia, Pa: Wolters Kluwer.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points): A CT was done on my patient upon my patients arrival to the emergency department. : A CT Scan is a combination of multiple x/ray images taken of different angle on/around a patient's body. A computerized tomography is

used to show cross sectional images of bones, blood vessels and soft tissue inside the body.

A CT scan without (Sorenson, Quinn & Klein, 2017).

A CT with contrast of the abdomen and pelvis: showing a fracture in her spine.

A CT W/O contrast of the brain and head: no acute abnormalities

Maxillofacial w/o contrast- no abnormalities

Diagnostic Test Reference (APA):

Sorenson, M., Quinn, L., Klein, D. ***Pathophysiology: Concepts of Human Disease*****. New York, NY. Pearson. 2017.**

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

Home Medications (5 required)

Brand/Generic	**Tylenol/ Acetaminophen**	**zofran/ Ondanseteron**	**Ativan/ Lorazapam**	**Centrum/ Multivitamin**	**Trazodone**
Dose	**1000mg**	**4mg**	**2mg**	**1 tablet**	**300 mg/ 3 tablets**
Frequency	**Q6H**	**Q6H**	**DAILY**	**DAILY**	**HS**
Route	**PO**	**IV**	**PO**	**PO**	**PO**
Classification	**Non-opioid analgesics, antipyretic**	**Blocks serotonin receptors**	**Anti-anxiety Benzodia**	**nutrition deficiency - vitamins**	**Anti-depressant**

			zepine		
Mechanism of Action	**Blocks prostaglandin production, interfering with pain generation in thePNS.**	**Prevents Nausea and Vomiting.**	**Potentiates the effect of GABA by binding to specific receptors .**	**Contains fat soluble vitamins that maintain nutrition balance**	**alters the effects of serotonin in the CNS**
Reason Client Taking	**Pain**	**Sickness from the pain medication**	**To treat anxiety**	**prevents vitamin deficiencies**	**Depression**
Contraindications (2)	**Severe active liver disease. Severe hepatic impairment**	**Prolonged QT intervals Hypersensitivity to ondansetron**	**Acute angle-closure glaucoma Hypersensitivity to lorazepam**	**Hypersensitivity to the medication. Avoid taking if any know alcohol intolerance**	**Hypersensitivity to the medication. Concurrent use of MAOIs**
Side Effects/Adverse Reactions (2)	**abdominal pain Hemolytic anemia**	**Agitation Anxiety**	**Chest pain Amnesia**	**Allergic reaction urine discoloration**	**Suicidal thoughts Drowsiness**
Nursing Considerations (2)	**Be sure to use cautiously in patient with hemolytic impairment. Be aware of alcohol use, because it is also important to be cautious in patients who are alcoholics.**	**Monitor Electrolytes Monitor for serotonin syndrome-chills, confusion & diaphoresis**	**Monitor patients' vitals-RR Be aware that there is an increased risk of suicide.**	**monitor nutrition balance Document any abnormal nutrition findings**	**Use cautiously in suicidal behavior . Be aware that in increase the risk of suicide attempt**

Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Take vital signs prior to administering medication. Prior to starting on medication, obtain a liver enzyme test.**	**obtain baseline vitals**	**obtain baseline vitals**	**assess for signs of nutritional deficiency**	**Monitor signs and symptoms of depression prior to administration. Be sure to educate client on risks of medication prior to administering .**
Client Teaching needs (2)	**Educate patient not to exceed the daily limit. Educate patient that she should not drink any alcohol while taking this medication.**	**Seek medical attention STAT if symptoms/ adverse effects are worsening. Monitor for signs and symptoms of hypersensitivity**	**Teach patient to take medication as prescribed** **Teach patient to take with or right after meals**	**Take medication every day Take with or without meals**	**Education patient to take the medication as prescribed. Administer with or immediately after meals.**

Hospital Medications (5 required)

Brand/Generic	**Norco/ Hydrocodone-acetaminophen**	**Cipro/ Ciprofloxacin**	**Pepcid /Famotidine**	**Toradol /Sprix**	**Phenergan/ histantil**
Dose	**1 tablet**	**500mg/ 1 tablet**	**20mg/ 1 tablet**	**30 mg**	**12.5 mg**
Frequency	**Q8H**	**BID**	**Q12H**	**q6H**	**Q4H**

Route	**PO**	**PO**	**PO**	**IV**	**IM**
Classification	**opioid analgesic**	**First Generation cephalosporin, Antibiotic**	**Antiulcer agents , h2 antagonists**	**NSAID**	
Mechanism of Action	**Binds to opiate receptors in the CNS**	**Destroy bacteria cell wall**	**Inhibits h2 receptors**	**Inhibits prostaglandins synthesis**	**Blocks the effects of histamines**
Reason Client Taking	**Pain**	**Treatment of skin/ skin structure infection**	**infection**	**Pain**	**Diminished nausea and vomiting**
Contraindications (2)	**Hypersensitivity to medication Significant respiratory distress**	**Hypersensitivity to cephalexin Hypersensitive to other cephalosporins**	**Hypersensitivity to medication**	**Hypersensitivity to medication Alcohol intolerance**	**Hypersensitivity to medication Cardiovascular disease**
Side Effects/Adverse Reactions (2)	**Confusion Dizziness**	**Edema Hearing Loss**	**Arrhythmias Constipation**	**Drowsiness GI Bleeding**	**NMS Confusion**
Nursing Considerations (2)	**Use cautiously in patients taking MAOIs Use cautiously in patients taking antidepressants**	**Assess BM: C Diff. Assess BUN & Creatinine levels**	**Use cautiously in renal impairment Administer with meals**	**Use cautiously in heart failure**	**Supervise closely to prevent injury Administer deep.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**assess BP, Pulse and rr prior to administration**	**Obtain normal baseline of vitals**	**Obtain an EKG**	**Obtain vitals, (BP).**	**Obtain baseline vitals**
Client Teaching needs (2)	**Monitor vitals Assess bowel sounds**	**Report watery/bloody stools to provider**	**Take medication as directed. May cause**	**Take medication with meals Stand**	**Take medication with meals Change**

		Complete full course of medication.	**dizziness or drowsiness**	**slowly when rising d/t orthostatic hypotension**	**positions slowly.**

Medications Reference (APA):

Lab Reference (APA Format): Jones & Bartlett Learning. Nurse's Drug Handbook. (2018)

n.a. n.a.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress: No distress noted** **Overall appearance:**	**Patient is a&O4. Upon arrival, patient is up and talking in bed. She is aware of person, place, time and situation.** **Overall appearance is appropriate for age. With no signs of any distress.**
INTEGUMENTARY (2 points): **Skin color:Normal for ethnicity** **Character:PWD** **Temperature:Normal** **Turgor: Normal skin turgor** **Rashes: No rashes noted** **Bruises: Four bruises located.**	**Patient is caucasion, with normal skin color for ethnicity. Skin is PWD. Patient has a couple bruises due to her fall. One bruise is located in on her back . A couple other bruises are located on her arms and leg, due to her fall.**

Wounds:None noted. **Braden Score:20** **Drains present: Y☐ N ☐** **Type:na**	
HEENT (1 point): **Head/Neck:Trachea is midline** **Ears: No drainage , pearly gray membrane.** **Eyes: No glasses** **Nose: No deviated Septum** **Teeth: No dentures**	**PERRLA noted. Head is midline, with no deviations. Hair is brown in color. No deviated septum noted. Patient has not dentures and no glasses.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: +4, bounding** **Capillary refill: less than 3 seconds** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	**Heart sounds auscultated. no abnormal heart sounds heard, noted s1 and s2 heart sounds. Radial and pedal pulses felt bilaterally, rated at a 4+ bilaterally. Capillary refill was less than 3 seconds.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**No accessory muscle use noted. Trachea is midline with no deviations.** **Breath sounds were clear to auscultation bilaterally. No adventitious lung sounds. Patient is on room air.**
GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current Diet Regular** **Height: 167.6** **Weight:86.8** **Auscultation Bowel sounds: active** **Last BM: 9/16** **Palpation: Pain, Mass etc.:No pain, masses, etc on palpitation** **Inspection: No abnormalties noted** **Distention:NA** **Incisions:NA** **Scars:NA** **Drains: NA** **Wounds:NA** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐**	**Patient is not on any special diet at home. She is on a regular diet while at the hospital. Bowel sounds auscultated and active in all quadrants. patient denies any pain upon palpation. Flat abdomen with no distention. Last bowel movement was on 9/16, patient states, the day prior to arriving at the hospital.**

Type:	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**No catheter present. No noted genital abnormalities. Urine is yellow-clear. Patient states there is not burning upon urination.**
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☐**	**Active ROM, bilaterally in upper and lower extremities. Patient is up at lib, with her walker that is present at bedside. A walker is used on a daily basis.**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient shows no signs of neurological damage or deficit. She is fully aware of her surroundings and demonstrates a dull level of consciousness. .
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 states that she talks to her friend on the phone as much as she can to help her cope. Developmental level is appropriate for her age Presbyterian Patient lives by herself at home in charleston. She states that is can become lonely at times which is why she enjoys talking to her friend on the phone. .

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1100	**95**	**134/88**	**16**	**36.3**	**96%**
1500	**90**	**123/89**	**20**	**36.3**	**99%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1100	**numeric**	**back**	**9**	**sharp pain**	**Gave pain meds.**
1500	**numeric**	**back**	**9**	**Sharp pain**	**Pain meds due soon.**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g **Location of IV: Left AC** **Date on IV: 9/17** **Patency of IV: patent, flushes well** **Signs of erythema, drainage, etc.: no abnormal signs.** **IV dressing assessment: No drainage present on dressing. Dry.**	Saline Lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1950 ml	**1350ml**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient is waiting for her cultures to come back. Possible discharge by tomorrow if the cultures come back normal. We are controlling her back pain and keeping her comfortable throughout the day.

Procedures/testing done: No testing was done throughout the day while I was giving care.

Complaints/Issues: Patient complains of pain in her back. We are controlling this pain with norco.

Vital signs (stable/unstable): Vitals have been stable throughout the day.

Tolerating diet, activity, etc.: Patient is tolerating her diet well.

Physician notifications: Possible discharge tomorrow, once cultures are reviewed.

Future plans for patient: Patient will reside in her home in charleston. She will be sent home with pain medications to help with her back pain. She will have a check up appointment with her primary next week to be sure the pain is being resolved.

Discharge Planning (2 points)

Discharge location: Charleston, Illinois.

Home health needs (if applicable): NA

Equipment needs (if applicable): Patient has her walker that she will use daily.

Follow up plan: Check-up appointment next week with her primary.

Education needs: Education on when to take her medication. Signs and symptoms to be on the lookout for in association with her medications.

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

Nursing Diagnosis	**Rational**	**Intervention (2 per dx)**	**Evaluation**
● Include full nursing diagnosis with	● Explain why the nursing		● How did the patient/family respond

“related to” and “as evidenced by” components	diagnosis was chosen		to the nurse’s actions? ● Client response, status of goals and outcomes, modifications to plan.
At risk for falls related to weakness, dizziness, unsteady gait or impaired balance as evidence by patient’s orthostatic hypotension (Swearingen, 2016, page 252).	**This was chosen because my patient was at a very high fall risk due to her fracture.**	**1.Assist patient when she needs to get out of bed with a gait belt 2.Have patients call light within reach; therefore, if she needs to get up right away we can be right in and decrease her chances of falling.**	**Client was able to maintain a safe environment with no falls throughout the day.**
Impaired comfort related to disease process and injury as evidence by (Swearingen, 2016, page 39).	**I chose this because my patient seemed to be very uncomfortable and not able to sleep due to her pain.**	**1. Use specific method of reporting pain using description, severity and location. 2.Assess vitals every 4 hours. These are specific indicator of pain.**	**Client was able to feel comfort in her pain when medication was given.**
Disturbed sleeping patterns related to patient’s pain and environmental factors as evidence by only getting 4-6 hours of sleep a night (Swearingen, 2016, page 73).	**I chose this because my patient had stated that she has not had a full good night of rest since she has been to the hospital.**	**1.Monitor the patient’s activity level. Irritability is a common sign of being tired, and a nap can be encouraged unless it is later in the day. 2Provide pain medication or a medication that could help achieving sleep.**	**We promoted sleep as much as we could. The client stated that she is well rested, just ready to go home.**

Deficient knowledge related to unfamiliarity with type of measure done to prevent and manage complications as evidence by confusion upon asking her questions (Swearingen, 2016, page 14).	**I chose this because my patient seemed to be confused at times when talking about her diagnosis and medication.**	**1.Evaluate the patient's understanding of information provided.** **2. Communicate with the patient and request feedback as it will show how much she understands.**	**Patient was thankful in the education provided, due to a better understanding of what was going on and what side effects to look for.**

Other References (APA): Hinkle, J., Cheever, K. (2018) ***Brunner and Suddarth's Textbook of Medical-Surgical Nursing*****. (14th ed.) Philadelphia, Pa: Wolters Kluwer.**

Subjective Data

Nursing Diagnosis/Outcomes

Nursing Interventions

Objective Data

Patient Information

Patient reports complaints of back pain
Patient denies any pain or burning with urination, also stating that she had no idea she was experiencing any signs and symptoms of a UTI

Patient should be able to amulate with her walk with little to no pain on 9/18.
Patient should report that her pain is at a minimal level with all of the medication therapy by the time she goes home.
Patient should be well educated on what medications to take and how often to take them before she is discharged.
Patient should be aware of any and all side effects to look for with her medications before discharge.

Vitals were performed Q4H- NO ABNORMAL findings
A physical assessment was performed- lungs and heart were listened to with no adventitious

Patient is a 59 year old patient who arrived to the ED on 9/17 d/t a fall from a rock while slightly intoxicated. Results indicated a

oBTAIN VITALS Q4H.
Monitor for any signs or symptoms of side effects in association with her medications.
Document any abnormal findings with vitals, reports of pain,
Be sure to maintain the client in a safe environment, being sure to have her walker in reach at all times.

ling sounds and no abnormal heart sounds noted.

spine along with an acute UTI