

N321 Care Plan #2

Lakeview College of Nursing

Delaney Lockard

Demographics (3 points)

Date of Admission 10/5/2019	Patient Initials CR	Age 53 years old	Gender F
Race/Ethnicity Caucasian/White	Occupation Unemployed	Marital Status Widowed	Allergies Penicillin
Code Status Full code	Height 164 cm	Weight 69.3 kg	

Medical History (5 Points)

Past Medical History: CAD, depression, hyperlipidemia, hypertensive cardiovascular disease, MI, neuropathy, diabetes mellitus type 2, hyponatremia, thrombocytosis, asthma

Past Surgical History: Cholecystectomy, placement of coronary artery stents, tubal ligation, trans myocardial revascularization by laser

Family History: History of paternal cardiovascular disease, diabetes mellitus and myocardial infarction; siblings with diabetes mellitus

Social History (tobacco/alcohol/drugs): Former smoker at age 20, quit after 3 years – ½ pack a day – denies alcohol use – denies use of substance

Assistive Devices: gait belt, walker

Living Situation: Patient lives with her son in her home

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): “Oozing” of post-operative wound

History of present Illness (10 points):

Patient presented at the ED by her son on 10/05/19 due to a post-operative wound infection. Patient’s chief complaint was “oozing” of the post-op wound. Patient had a trans

myocardial revascularization procedure performed 2-3 weeks ago at Barnes-Jewish Hospital. This procedure was done by laser in the anterior chest and there were “10 stents” placed through her groin. Patient’s pain and symptoms had been worsening over the three days prior to arrival. The pain and symptoms are described to be constantly present. The wound under her left breast had foul-smelling drainage and the drainage and the drainage was yellow in color. Patient presented with chills but had no fever or cough. Patient says that moving her left arm aggravates the wound site and has no alleviating factors. On a numeric pain scale, the patient states that her pain is an 8 out of 10.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cellulitis

Secondary Diagnosis (if applicable): Post-operative pain

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

Cellulitis is when bacteria enters into the normal skin barriers and then release their toxins into the body’s subcutaneous tissue. The bacteria that commonly causes this infection is *Staphylococcus aureus* (Hinkle, Cheever, and Brunner, 2018). This primarily occurs by the bacteria entering through a crack or a break in the skin. Risk factors of cellulitis include obesity, any type of wound or injury, diabetes mellitus, and lymphedema (MedlinePlus Medical Encyclopedia, 2019). Pertaining to the patient’s secondary diagnosis, acute pain is due to new tissue injury and/or inflammation. Acute means that it can last a few hours or days (Capriotti and Frizzell, 2016). Acute pain usually occurs in things like post-surgery, MI, fractures or appendicitis (Capriotti and Frizzell, 2016).

Signs and symptoms of cellulitis include localized redness, warm to touch, pain, fever, chills and sweating and purulent drainage (Hinkle, Cheever, and Brunner, 2018). The main concern with cellulitis is preventing the infection from furthering and treating the symptoms like pain. Pain is a subjective assessment finding (Capriotti and Frizzell, 2016). When assessing the patient's pain, OLD CARTS mnemonic scale is helpful. This stands for onset of pain, location, duration, characteristics, aggravating/relieving factors and treatment (Capriotti and Frizzell, 2016).

Expected findings of cellulitis would be abnormal CBC (with differential) values such as creatinine, RBCs, hematocrit, hemoglobin, lactic acid, and alkaline phosphatase (Hinkle, Cheever, and Brunner, 2018). Expected vital signs include increased temperature, heightened respiratory rates and hypertension. Expected findings of pain include tachycardia, hypertension, tachypnea, diaphoresis, and anxiety (Capriotti and Frizzell, 2016).

To diagnose cellulitis, the doctor will examine the wound. If there are signs of infection, a fluid sample will be taken as well as various blood tests to confirm an infection is present. Further testing for deeper or nonhealing wounds includes x-ray, ultrasound or a CT scan. In this case, the tunneling of the wound was deep enough to be concerned with spreading, therefore a CT was performed. To diagnose pain, things like the numeric pain scale are useful (Capriotti and Frizzell, 2016).

Treatment for cellulitis can be treated via outpatient care with oral antibiotic therapy. If severe, antibiotics will be administered via IV infusion (Hinkle, Cheever, and Brunner, 2018). Medications like ceftriaxone sodium and vancomycin hydrochloride can be used as antibiotics to treat cellulitis. In some cases, surgery may be needed to clean out a wound to prevent further spread of cellulitis. Untreated cellulitis can become life-threatening. When treating pain, the

doctor can prescribe nonopioid or opioid analgesics, depending on the severity of the patient's pain. This includes medications like morphine sulfate (opioid), and acetaminophen (Tylenol).

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. Philadelphia: PA. Davis Company.

Hinkle, J. L., Cheever, K. H., & Brunner, L. S. (2018). *Brunner & Suddarths textbook of medical-surgical nursing*. Philadelphia: Wolters Kluwer.

MedlinePlus Medical Encyclopedia. (2019, October 2). Retrieved October 21, 2019, from <https://medlineplus.gov/ency/article/000855.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 (10/05/19)	Today's Value (10/06/19)	Reason for Abnormal Value
RBC	4.5-6	3.68	3.53	Due to blood loss via post-op. wound

				opening
Hgb	14-16	11.3	10.8	Due to blood loss via post-op. wound opening
Hct	35-47	33.3	32.1	Due to blood loss via post-op. wound opening
Platelets	150-400	467	430	Due to thrombocytosis
WBC	4500-11000	11.7	11.8	Due to presence of post-operative infection
Neutrophils	45-75%	50.1	63.9	
Lymphocytes	20-40%	37.5	22.8	
Monocytes	1-10%	10.5	11.5	
Eosinophils	< 7%	1.4	1.2	
Bands		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 (10/05/19)	Today's Value (10/06/19)	Reason For Abnormal
Na-	135-145	135	138	
K+	3.5-5	4.1	3.7	
Cl-	97-107	96	102	
CO2	20-30	29	27	
Glucose	70-110	190	117 (taken on 10/07/19 during shift)	Due to patient's diabetes mellitus type 2
BUN	10-20	15	19	
Creatinine	0.6-1.3	0.61	1.74	Due to diabetes mellitus type 2
Albumin	3.5-5.2	3.9	3.48	

Calcium	8.6-10.2	10	8.8	
Mag		N/A		
Phosphate		N/A		
Bilirubin	0.1-1.2	1.8	1.2	Due to patient's blood loss and low RBCs
Alk Phos	30-120	254	245	Due to patient's CAD and hypertensive cardiovascular disease
AST	10-30	33	32	Due to patient's medication atorvastatin
ALT	10-40	42	31	Due to patient's medication atorvastatin
Amylase		N/A		
Lipase		N/A		
Lactic Acid	0.5-1	1.8	N/A	Due to patient's post-op. infection

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 (10/5/19)	Today's Value (10/06/19)	Reason for Abnormal
INR	2-4	1.04	N/A	Due to impaired liver function and loss of blood
PT	9.6-11.8	13.8	N/A	Due to impaired liver function and loss of blood/infection
PTT	30-40	30.2	N/A	Due to impaired liver function and loss of blood/infection
D-Dimer		N/A		
BNP		N/A		
HDL		N/A		
LDL		N/A		

Cholesterol		N/A		
Triglycerides		N/A		
Hgb A1c		N/A		
TSH		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		
pH		N/A		
Specific Gravity		N/A		
Glucose		N/A		
Protein		N/A		
Ketones		N/A		
WBC		N/A		
RBC		N/A		
Leukoesterase		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 (10/05/19)	Today's Value (10/06/19)	Explanation of Findings
Urine Culture		N/A		
Blood Culture	Negative	Negative	N/A	

Sputum Culture		N/A		
Wound culture	Negative	N/A	In progress	

Wound cultures test for anaerobic and aerobic bacteria of the wound. Anaerobic bacteria is bacteria that cannot grow in the presence of oxygen and aerobic bacteria is such that can grow with exposure to oxygen. Anaerobic bacteria are present in deeper wounds; in this case, the patient has a post-operative wound.

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7th ed.). Philadelphia, PA: F.A. Davis Company

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT of chest with contrast

Diagnostic Test Correlation (5 points): The reason for the CT was ordered was because of her post-operative wound infection and its purulent drainage. CT scans are useful because they provide imaging of a number of things, in this case being infection. This diagnostic test can also allow the doctor to see if any infection has spread to other organs and/or bones. Because of this patient's 5.5 cm tunneling of her incision on the anterior chest, this would be vital to viewing if the infection spread to her ribs.

Diagnostic Test Reference (APA):

Ady, J., & Fong, Y. (2014, December). *Imaging for infection: from visualization of inflammation to visualization of microbes*. Retrieved October 21, 2019, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4268555/>.

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

Home Medications (5 required)

Brand/Generic	acetaminophen (Tylenol)	albuterol (Proventil)	aspirin	atorvastatin (Lipitor)	gabapentin (Gralise)
Dose	325 mg tablet x 2 = 650 mg	90 mcg	81 mg tablet	40 mg tablets	300 mg capsule
Frequency	Q4H, PRN	Q4H PRN 2 puffs	QD	QD	TID
Route	PO	PO	PO	PO	PO
Classification	Antipyretic, nonopioid analgesic	Bronchodilator	Anti-inflammatory, antiplatelet, antipyretic, nonopioid analgesic	Antihyperlipidemic, HMG-CoA reductase inhibitor	Anticonvulsant
Mechanism of Action	Inhibits cyclooxygenase, then blocking prostaglandin production and tampering with pain impulse generation in the peripheral NS.	Attaches to beta 2 receptors on the bronchial cell membranes to convert ATP to cAMP and in the end, the bronchial smooth muscle-cells are relaxed and inhibits histamine release	Blocks the prostaglandin synthesis and therefore gets rid of swelling and pain; inhibits platelet aggregation; acts on the heat regulating center	Reduces cholesterol in plasma and lipoprotein levels – increases liver cells to increase uptake and breakdown	This is structurally like our body's GABA, which inhibits the rapid firing of neurons that cause seizures – it also prevents heightened responses to painful stimuli and pain-related reactions and in turn relieves neuralgia
Reason Client Taking	Tx Pain	Tx Asthma	Tx Thrombocytosis, hypertension,	Tx Hyperlipidemia	Tx neuropathy

			coronary disease		
Contraindications (2)	Severe hepatic impairment, severe liver disease	Hypersensitivity to albuterol	Asthma, bleeding problems	Active hepatic disease, breastfeeding	Hypersensitivity to gabapentin
Side Effects/Adverse Reactions (2)	Hypotension, abdominal pain	Anxiety, angina	Hearing loss, bronchospasm	Abnormal dreams, arrhythmias	Agitation, abnormal vision
Nursing Considerations (2)	Use cautiously in patients with alcoholism, monitor patient's liver function on long-term therapy	Use cautiously in patients with issues like cardiac disorders, diabetes mellitus, or hypertension – can worsen; monitor serum potassium levels	Don't crush time-release tablets, ask about tinnitus	Expect to measure lipid levels every 2-4 weeks, monitor diabetic patients	Know that you can mix these capsules into applesauce, pudding or water; give this two hours or more after antacid

Hospital Medications (5 required)

Brand/Generic	ceftriaxone sodium (Rocephin)	insulin detemir (Levemir)	Hydrocodone bitartrate and acetaminophen (Norco)	morphine sulfate	vancomycin hydrochloride (Vancomycin)
Dose	1000 mg – 200 mL/hr	0.28 mL	5 mg/325 mg	2 mg/mL	1.5 g/over 90 minutes
Frequency	QD	HS	Q4H, PRN	Q2H, PRN	QD
Route	IV piggyback	SubQ	PO	IV push	IV piggyback
Classification	Antibiotic	Long-acting human insulins	Analgesic	Analgesic	Antibiotic

Mechanism of Action	Interferes with the bacterial cell wall synthesis by interfering with the production of peptidoglycan, which makes the cell protective – without this the bacterial cells die	Insulin promotes storage and encourages breakdown of things like glucose, fat and amino acids – lowers glucose concentration by starting the uptake of glucose in muscle and adipose tissue – also involved in regulation of protein metabolism	Binds to opioid receptors and activates them at the site, producing the effect of pain relief	Binds with and starts opioid receptors in the brain/spinal cord and produces analgesia and euphoria	Inhibits bacterial RNA along with cell wall synthesis – causing cell wall lysis and death of bacterial cell
Reason Client Taking	Tx cellulitis	Tx diabetes mellitus type 2	Tx open wound pain	Tx open wound pain	Tx cellulitis
Contraindications (2)	Calcium-containing IV solutions, IV administration of ceftriaxone containing lidocaine	Hypersensitivity to insulin, hepatic disease	Acute or severe bronchial asthma, significant respiratory depression	Acute or severe bronchial asthma, hypersensitivity to montelukast sodium	hypersensitivity to corn, hypersensitivity to vancomycin
Side Effects/Adverse Reactions (2)	Chills/fever, abdominal cramps	Hypoglycemia, upper respiratory tract infection	Anxiety, dehydration	Amnesia, bradycardia	Hypotension, dyspnea
Nursing Considerations (2)	Use cautiously in patients allergic to penicillin, never give at the same time as calcium-containing infusions	Roll the vial between hands (do not shake), don't use if precipitate is present	Don't administer to patients with impaired consciousness, don't administer to patients who are or may be pregnant	Use caution when administered to patients with hypoxia, store at room temperature	Infuse over at least 1 hour/1 gram, check BUN and creatinine serum levels during therapy

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook* (18th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient appeared to be in and out of sleep while lying in her bed. She appears anxious and tired with an A&O x 4. Patient is in pain but not in distress. Overall appearance x 3.</p>
<p>INTEGUMENTARY (2 points): Skin color: Normal for ethnic Character: dry, warm to touch, pink Temperature: 36.6 C Turgor: Good Rashes: None Bruises: L & R arm Wounds: incision wound on anterior chest, inferior to L. breast Braden Score: 19 Drains present: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: wound vac</p>	<p>Patient is Caucasian and presents with a fair complexion. Skin is warm to dry and warm to touch. The skin turgor and its elasticity tg66tis normal with no tenting present or abnormal textures. No rashes present. Bruises are present on the left and right peripheral arm due to old IV sites. There is an incision wound on the anterior chest, inferior to the left breast. Drain is present; a wound vac was applied on 10/07/19.</p> <p>Braden scale: 19</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Patient’s head is midline with no deviations. Ears show no abnormal drainage; the tympanic membrane is visible and pearly grey. Hair is a grey color, longer length, and balding in the center. PEERLA is noted. Nose shows the turbinates equal bilaterally. Oral mucosa is pink and moist with no abnormalities. Patient uses glasses. Upper row of teeth is decayed with pre-molars missing bilaterally.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: 3+ Capillary refill: < 3 seconds 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: N/A</p>	<p>Patient is not currently on telemetry. Heart sounds auscultated and S1 and S2 sounds noted. No murmur present. Dorsalis pedis pulses graded at 3+ and present bilaterally Capillary refill was < 3 seconds. Patient does not currently have edema. No signs of neck vein distention.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>No accessory muscle use when breathing. Patient denies SOB. Anterior lungs were auscultated</p>

<p>Breath Sounds: Location, character</p>	<p>anteriorly. Lungs sound clear with no presence of crackles. Patient doesn't use oxygen at home.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: consistent carbohydrates Current Diet: consistent carbohydrates Height: 164 cm Weight: 69.3 kg Auscultation Bowel sounds: Active Last BM: 10/06/19 Palpation: Pain, Mass etc.: soft, non-tender Inspection: Distention: rounded Incisions: inferior to left breast Scars: none Drains: wound vac present Wounds: post-operative wound on anterior chest, inferior to left breast Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Patient's current diet is consistent carbohydrates at home and in the hospital. She denies the use of alcohol. Upon auscultation, bowel sounds are active in all four quadrants. Last BM was on 10/06/19. Patient does not have pain upon palpation. Abdomen is round and distended. There is an incision inferior to her left breast with a wound vac present. This is due to the post-operative wound present. No masses present. No ostomy, nasogastric or PEG tubes present. Patient also denies rapid or current weight loss.</p>
<p>GENITOURINARY (2 Points): 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: Size:</p>	<p>Patient requires assistant with a gait belt and walker to and from the bathroom. No dialysis or catheter. Urine is yellow and hazy; there was 40 mL voided in my shift. Patient says she feels no pain, hesitancy or urgency upon urination. Patient is on I's and O's.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: walker, gait belt 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: 70 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Patient shows no sign of neurovascular deficit. Patient exhibits active range of motion bilaterally, but pain-inducing for her post-operative wound inferior to her left breast. Patient has a Morse fall risk score of 70, making her at risk for falls. Patient requires some assistance when standing. Patient uses walker and gait belt. She also needs minimal ADL assistance.</p>

<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Patient has been in and out of sleep in her hospital bed. She appears tired. A&O x 4 and LOC x 3. Patient speaks English well. Patient speaks at a slower pace. Patient MAEW for current age and situation. PERLA is present upon assessment.</p>
<p>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):</p>	<p>Patient states that she “enjoys walking, yard work, and making crafts.” Her developmental level is noted to be normal. Patient states that she is of the Baptist religion. Patient appears to have family support by her four brothers and lives with her son. Patient is unemployed.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
07:28	70 bpm	104/58	13	36.6 C	97% RA
11:28	80 bpm	104/67	16	36.6 C	98% RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
08:14	Numeric pain scale	L. breast	8	Consistent	Administered morphine 2 mg/mL
14:14	Numeric pain scale	L. breast	10	Sharp, consistent	Administered morphine 2 mg/mL

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g Location of IV: peripheral R. hand Date on IV: 10/07/19 Patency of IV: Catheter patent Signs of erythema, drainage, etc.: No sign of erythema, phlebitis, infiltration or drainage IV dressing assessment: IV dressing is clean, dry and intact	Sodium Chloride 0.9% IV solution 1000 mL – 75 mL/hr

Intake and Output (2 points)

Intake (in mL) (10/06/19)	Output (in mL) (10/06/19)
900 mL	1801 mL

Nursing Care**Summary of Care (2 points)**

Overview of care: Patient has been in the hospital receiving care since 10/05/19. She came to the ED presenting with a post-operative infection that was “oozing.” During my shift, I assessed her vitals once and pain once. A head-to-toe assessment was performed. HPI, PMH and PSH were noted as well. Patient complained of pain during primary application of a wound vac but morphine administration was the nursing intervention.

Procedures/testing done: During my shift there was no testing done. A wound vac was applied as prescribed by the physician.

Complaints/Issues: Patient complained of her pain being 10/10 during the set up of her wound vac. This is due to the precise measurements needed for the primary application of the wound vac. Patient had no other complaints during my shift.

Vital signs (stable/unstable): Patient's vital signs appeared to be normal and stable upon both assessments.

Tolerating diet, activity, etc.: Patient's diet is consistent carbohydrates at home and in the hospital. Patient ate 50% of her lunch that was provided. She tolerates ambulation to the bathroom with a walker and gait belt with minimal assistance.

Physician notifications: The physician was notified about applying a wound vac and he put in an order for one to be applied.

Future plans for patient: Discharging this week, follow-up appointments on MWF for wound vac upkeep

Discharge Planning (2 points)

Discharge location: Home with son

Home health needs (if applicable): Follow instructions on medications

Equipment needs (if applicable): wound vac

Follow up plan: Patient will have follow-up appointments to reassess her wound and change the dressing when needed (MWF)

Education needs: Patient should be educated on the importance of healing a wound. She should be educated on the new medications that she is taking. Client education needs to be provided about wound vacs and the upkeep of them. She also needs to increase her PO intake.

Nursing Diagnosis (15 points)

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 	Rational <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Intervention (2 per dx)	Evaluation <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk of infection related to post-operative wound as evidence by chief complaint of “oozing” and purulent drainage that was yellow and foul-smelling	To prevent further infection or sepsis pertaining to the patient	<ol style="list-style-type: none"> 1. Note color, character and odor of all drainage. Report significant findings. 2. Change dressing as prescribed, using a sterile technique. 	Patient was compliant with the dressing change. She was in pain, so the nursing intervention performed was administering 2 mg/mL of morphine sulfate. Patient seemed to be more relaxed after administration.
2. Acute pain related to post-operative wound infection as evidence by a numeric pain scale rating of 10.	To reduce the pain to a tolerable level within 1-2 hours.	<ol style="list-style-type: none"> 1. Accept the patient’s report of pain and plan interventions based on this report. 2. As prescribed, administer opioid analgesics (e.g. morphine) for pain of greater severity. 	Patient reported a 10 out of 10 on the numeric pain scale. The nursing intervention that was chosen was to administer morphine sulfate 2 mg/mL to treat the patient’s pain. Patient responded well to the medication.
3. Wound care education related to the wound vac applied as evidence by the post-operative wound	To decrease the time needed for the healing process.	<ol style="list-style-type: none"> 1. Teach the patient or significant other the prescribed wound care procedure, if indicated following 	Patient was educated on the upkeep of the wound vac that was applied. She was compliant on the discharge planning of getting the dressing changed on Mondays, Wednesdays, and Fridays. Patient

infection.		discharge. 2. When a drain is used, maintain its patency, prevent kinking, and secure the tubing to prevent the drain from becoming dislodged.	understands the need to bring the wound vac with her and the importance of keeping the tubing in the proper position.
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Other References (APA):

Swearingen, P. L. (2016). All-in-one care planning resource: medical-surgical, pediatric, maternity; psychiatric nursing care plans. Philadelphia, PA: Elsevier/Mosby.

Concept Map (20 Points):

Subjective Data

Chills and pain have been increasing in severity over the past couple days but was not accompanied by a fever.
Patient stated that her wound was “oozing” with purulent drainage with a foul odor and it was yellow in color.

Nursing Diagnosis/Outcomes

Risk of infection / prevention

-Outcome: The patient's infection does not spread as evidence by a decrease in purulent drainage and normal CBC with differential levels.

Treatment of acute pain

-Outcome: The patient responds well to the administration of morphine sulfate as evidence by a decreased score on the numeric pain scale.

Wound care education

-Outcome: The patient understands the importance of the upkeep of her wound vac as evidence by her compliance with her discharge planning and follow-up appointments.

Objective Data

-Patient was not febrile upon admission
-VS during my shift were not abnormal for the patient.
-CBC with differential shows decreased levels of RBC, Hgb, Hct. It also shows an increase in BUN, creatinine, and lactic acid.

Patient Information

C.R. is a 53-year-old female with a history of CAD, depression, hyperlipidemia, hypertensive cardiovascular disease, MI, neuropathy, DM type 2, hyponatremia, thrombocytosis and asthma. Pertinent past surgical history includes cholecystectomy, placement of cardiac stents and trans-myocardial revascularization.

Nursing Interventions

Hydrocodone-acetaminophen, Rocephin and Vancomycin administration.

Monitor VS and report any significant findings

Assess patient's pain often

Monitor for signs of pressure ulcers

Monitor RBC, Hgb and Hct levels along with lactic acid.

Administer morphine PRN severe pain.

Speaking in a therapeutic manner to the patient.

Educating the patient on wound vac care and discharge planning.

Be sure to explain all interventions, diagnostics, and medications.

