N441 Care Plan

Lakeview College of Nursing

Jason Tegeler

Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
10/27/2019	DB	43	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Factory Worker	Married	Baclofen, gabapentin, penicillin
Code Status	**Height**	**Weight**	
Full code status	177 cm	86.9kg	

Medical History (5 Points)

Past Medical History: The patient has a past medical history of anxiety, bulging lumber disks, multiple sclerosis, depression, and history of suicidal ideation

Past Surgical History: The only past surgical history this patient presented with was hand surgery performed a few years ago.

Family History: The patient's father diagnosed with depression

Social History (tobacco/alcohol/drugs): The patient consumes alcohol in beer and liquor form approximately three to five times per week. He is a former smoker of six years but quit around 30 days ago. The patient denies substance abuse.

Assistive Devices: The patient does not use any assistive devices, including glasses, canes, or walkers.

Living Situation: The patient is married and lives with his wife in Arthur, Illinois. They are having difficulties, and he has sometimes been living in a homeless shelter during the week. The patient has one child but has little contact with her.

Education Level: The patient has some college education but no advanced degree. He is currently employed at Master Brand cabinet making company in Arthur with a full-time position.

Admission Assessment

Chief Complaint (2 points): Possible medication overdose and decreased level of consciousness

History of present Illness (10 points): The patient is a 43-year-old male who arrived in the emergency department by an emergency medical vehicle on 10/27/2019 from a gas station in Arcola. The gas station attendant stated upon arrival at his gas station, and the patient stated to him that he had just taken two weeks of four different medications that night. The four medications were Ampyra, clonazepam, lamotrigine, and Prozac. Upon arrival in the emergency department, the patient's vital signs were a temperature of 36 degrees, a heartrate of 77, respiratory rate of 20, a blood pressure of 132/73, and an oxygen concentration of 96%. The patient was unresponsive, and Keppra gave for seizure activity. The patient intubated and extubated in the ED and sent to the critical care unit to recover.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Overdose on Ampyra, clonazepam, lamotrigine, and Prozac

Secondary Diagnosis (if applicable): The decreased level of consciousness of the patient and unresponsive

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

When a person takes more medicine than medically prescribed, the drug becomes toxic for their body. Whether the drug overdose is intentional or accidental, the person's body cannot metabolize the drug resulting in unintended side effects (Goldberg, 2018). The liver plays an active role in the detoxification of ingested substances and drugs. After the consumption or ingestion of medications, the medication is absorbed in the GI tract and passes into the portal vein. The portal vein transports the substance to the liver, where the detoxification process occurs. The liver's enzymes process the compounds and catalyze the oxidation of many different

organic substances (Capriotti & Frizzell, 2016, p. 702). The process of breaking down the compound is called the first pass of the drug substance. When excess molecules of compounds build-up and can not be broken down into elemental components for receptors to bind to, the level of the compound becomes toxic to the human body. Upon arrival to the ED, the patient's initial liver function tests were elevated due to his liver, trying to metabolize the excessive amounts of drugs in the body. Some signs and symptoms of overdose include hallucinations, confusion, decreased level of consciousness, and anxiety. The patient presented in the ED with a decreased level of consciousness.

Many risk factors can place people at an increased risk of overdose. Some of the risk factors include abusing alcohol and other substances, and some antidepressants cause suicidal ideations that result in patients consuming excessive amounts of their medications. Clients who are prescribed benzodiazepines for seizure disorders can have side effects of suicidal ideations (Clonazepam, n.d.). Patients with past histories of suicide attempts have an increased risk of overdosing on prescription medication. The patient's past medical history includes the use of benzodiazepine, clonazepam, and five suicide attempts.

The provider will order lab tests based on the organ systems that can be harmed by specific drug overdoses. A history and physical exam will lead the provider to narrow evidence of the suspected overdosed drug. Diagnostic tests used to confirm overdoses include a toxicology report, drug screen, urinalysis, and enzyme tests of the liver (Goldberg, 2018). Providers may order gastric lavage to remove unabsorbed drugs in the stomach. The patient has an elevated AST liver function test and incubated to remove undigested drugs remaining in his stomach.

Pathophysiology References (2) (APA):

Capriotti, T. M., & Frizzell, J. P. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. PHILADELPHIA: F A DAVIS.

Clonazepam: Drug Uses, Dosage, Side Effects. (n.d.). Retrieved from https://www.drugs.com/clonazepam.html.

Goldberg, J. (2018). Drug Overdose. Retrieved from https://www.webmd.com/mental-health/addiction/drug-overdose#1.

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	4.28-5.56	5.06	4.88	n/a
Hgb	13.0-17.0	14.2	13.6	n/a
Hct	38.1-48.9%	41.4	43.0	n/a
Platelets	149-393 k	320	322	n/a
WBC	4-11.7 k	25.4	12.7	An increase in white blood cells can indicate all types of infection related to an inflammatory or infectious response. The patient also has WBC in his urinalysis, which indicates a UTI infection (Van Leeuwen & Bladh, 2015, p. 459).
Neutrophils	45.3-79	70.1	84.9	An increase in neutrophils can result by an inflammatory condition and physiological stress (Van Leeuwen & Bladh, 2015, p. 460).
Lymphocytes	11.8-45.9	17.3	7.5	A decrease in lymphocytes can result in toxic chemical exposure. The patient consumed two weeks of four different types of medication, causing a toxic environment (Van Leeuwen & Bladh, 2015, p. 461).
Monocytes	4.4-12.0	7.4	6.5	n/a
Eosinophils	0.0-6.3	n/a	0.7	n/a

Bands	Less than 10	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-	136-145	141	144	n/a
K+	3.5-5.0	3.5	4.1	n/a
Cl-	98-107	108	113	Metabolic acidosis and hyperventilation can cause the exchange of intracellular chloride replaced by bicarbonate. The patient's body was compensating for metabolizing two weeks of medication resulting in a metabolic state (Van Leeuwen & Bladh, 2015, p. 348)
CO2	22-29	24	23	n/a
Glucose	74-109	188	87	Increases in glucose levels can result in acute stress reactions. Hyperglycemia stimulated by the release of catecholamines and glucagon. The patient's body was going through an acute stress reaction when he consumed his two weeks of a medication regime.
BUN	7-25	15	8	n/a
Creatinine	0.7-1.2	0.95	1.06	n/a
Albumin	3.5-5.2	4.0	4.0	n/a
Calcium	8.6-10.3	9.0	8.8	n/a
Mag	1.6-2.4	2.0	2.3	n/a
Phosphate	2.5-4.5	n/a	n/a	n/a

Bilirubin	0.3-1.0	0.4	0.5	n/a
Alk Phos	40-130	98	102	n/a
AST	0-40	106	15	Elevated AST levels are an indicator of cellular damage in the liver. The patient ingested a two-week regime of medication, and the liver is becoming damaged, trying to metabolize the drugs (Van Leeuwen & Bladh, 2015 p. 165).
ALT	0-41	16	32	n/a
Amylase	23-85	n/a	n/a	n/a
Lipase	13-60	n/a	n/a	n/a
Lactic Acid	0.5-2.0	1.8	n/a	n/a
Troponin	0-0.03	0.010	n/a	n/a
CK-MB	3-5%	2.38%	n/a	n/a
Total CK	20-200	139	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	0.86-1.14	n/a	n/a	n/a
PT	11.9-15.0	n/a	n/a	n/a
PTT	25-35 seconds	n/a	n/a	n/a
D-Dimer	Less than 0.5	n/a	n/a	n/a
BNP	0.5-30	n/a	n/a	n/a
HDL	Greater than 40	n/a	n/a	n/a

LDL	Less than 130	n/a	n/a	n/a
Cholesterol	Less than 200 mg/dL	n/a	n/a	n/a
Triglycerides	Less than 150 mg/dL	n/a	n/a	n/a
Hgb A1c	4-5.6%	n/a	n/a	n/a
TSH	0.3-5	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	Yellow & clear	Amber & cloudy	Yellow & cloudy	According to the website rxlist.com, 2019, Ampyra can cause urine to look cloudy and have an amber color. The patient is taking Ampyra for his MS (Ampyra, 2019).
pH	5.0-8.0	5.0	n/a	n/a
Specific Gravity	1.005-1.034	1.018	n/a	n/a
Glucose	Normal	Normal	n/a	n/a
Protein	Negative	Negative	n/a	n/a
Ketones	Negative	Trace	n/a	
WBC	Less than 5	10	n/a	An increase in white blood cells in the urine can be indicative of an infection in the urinary tract (Van Leeuwen & Bladh, 2015).
RBC	0-3	1	n/a	n/a
Leukoesterase	Negative	Negative	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	7.35-7.45	7.36	n/a	n/a
PaO2	80-100	321.0	n/a	Increased levels of PaO2 can result in hyperventilation. The patient has been suffering from anxiety, and his body may be compensating for respiratory distress from the polypharmacy overdose (Van Leeuwen & Bladh, 2015 p. 257).
PaCO2	35-45	39.5	n/a	n/a
HCO3	22-26	22.2	n/a	n/a
SaO2	95-100	99.0	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	Negative	Negative	n/a	n/a
Blood Culture	Negative	n/a	n/a	n/a
Sputum Culture	Negative	n/a	n/a	n/a
Stool Culture	Negative	n/a	n/a	n/a

Lab Correlations Reference (APA):

Ampyra (Dalfampridine Extended-Release Tablets): Side Effects, Interactions, Warning, Dosage & Uses. (2019, July 10). Retrieved from https://www.rxlist.com/ampyra-drug.htm.

Van Leeuwen, A. M., & Bladh, M. L. (2015). *Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (5 ed.). Philadelphia, PA: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X-ray

Chest x-rays are used to evaluate the placement and position of an endotracheal tube, feeding tubes, chest tubes, and known or suspected pulmonary disorders (Van Leeuwen & Bladh, 2015 p. 341-342). The patient arrived in the ED unresponsive with assumed polypharmacy overdose. The patient required an ET tube for incubation and needed a chest x-ray to verify placement and position. The chest x-ray revealed lungs clear and ET tube tip 5.6 cm above the carina overlying distal stomach. A second chest x-ray performed after the ET tube was removed revealed lungs clear.

EEG

EEGs are used to assess the electrical activity in the brain, helping to diagnose brain injury, infection, bleeding, and death (Van Leeuwen & Bladh, 2015 p.646). The patient was unresponsive upon arriving at the ED. An EEG scan on 10/27/2019 and results showed abnormal cerebral diffuse dysfunction affecting the entire brain, excessive Beta activity. The test revealed there were no persistent asymmetries, lateralling abnormalities, nor epileptiform discontinued.

EKG

EKGs or ECGs are commonly used to evaluate the electrical conduction generated by the heart during the cardiac cycle (Van Leeuwen & Bladh, 2015, p.640). Upon arrival to the ED on October 17, 2019, the patient was nonresponsive and required a 12 lead EKG to assess his electrical conductivity of heart. The test came back with a prolonged QT wave and sinus bradycardia. After being released to the CCU, the patient was on continuous telemetry with every shift reporting and recording his EKG activities. An EKG performed while in clinical, and the results showed a normal sinus rhythm with PR interval at 0.16, QT interval at 0.36, and the QRS interval at 0.08, all within normal ranges.

Diagnostic Test Correlation (5 points):

Diagnostic Test Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2015). *Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (5 ed.). Philadelphia, PA: F.A. Davis Company.

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

Home Medications (5 required)

Brand/Generic	Aleve/ naproxen	Ampyra/ dalfampridine	Klonopin/ clonazepam	Lamictal/ lamotrigine	Prozac/ Fluoxetine HCL
Dose	440mg	10mg	15mg	75mg	20mg
Frequency	Q8hrs.	BID	BID	BID	Daily
Route	PO	PO	PO	PO	PO
Classification	NSAID	Potassium channel blocker	Anticonvulsant	Anticonvulsant/ Phenyl triazine	Antidepressant SSRI
Mechanism of Action	Inhibits prostaglandin synthesis to produce anti-inflammatory, analgesic, and antipyretic effects (Comerford, 2018, p.1054).	Broad-spectrum potassium channel blocker that increases conduction of action potentials in demyelinated axons through inhibition of potassium channels (Rxlist.com)	Acts by facilitating effects of the inhibitory neurotransmitter GABA (Comerford, 2018, p. 359).	It inhibits the release of glutamate and aspartate in the brain (Comerford, 2018, p. 865).	It inhibits CNS neuronal uptake of serotonin (Comerford, 2018, p. 658).
Reason Client Taking	To manage pain	To treat multiple sclerosis	To manage the patient's anxiety level	To help reduce the effects of Ampyra	The patient has a history of depression
Contraindications (2)	Patients with aspirin-sensitive asthma Patients with GI	Patients with severe kidney disease. Patients with a	Patients with chronic respiratory disease Patients with open-angle	Patients with renal, hepatic, or cardiac impairments Patients	Patients with a history of diabetes mellitus, seizures,

	disorders, hepatic disease, or history of peptic ulcers	history of seizure activity.	glaucoma	diagnosed with acute manic or mixed episodes of bipolar disorder	mania, or hepatic, renal, or CV disease Patients who have not stopped taking MAOIs within 14 days
Side Effects/Adverse Reactions (2)	Tinnitus Peptic ulceration	Bladder pain Bloody or cloudy urine	Leukopenia thrombocytopenia	Suicidal ideation Irritability	Weight loss anxiety
Nursing Considerations (2)	Monitor CBC and renal and hepatic function Monitor patient for neurological effects	Monitor creatinine clearance Monitor for blood in the urine	Monitor the patient for changes in behavior Monitor CBC and LFTs	Monitor for changes in behavior and thoughts of suicide Monitor patient for headache, fever, neck stiffness, nausea	Monitor weight and I&Os Monitor for behavior changes and record them
Key Nursing Assessment(s) Prior to Administration	Assess PT/INR time Assess for abdominal pain or discomfort	Establish a baseline for creatinine clearance for renal function Assess for bladder or kidney pain	Obtain baseline for CBC and LFT levels Assess patient for suicidal thoughts or behaviors	Assess patient's behavior and ask if any thoughts of harming themselves Assess for drug interactions, including acetaminophen.	Assess medications already taking (MAOIs, SSRIs, TCAs) Assess for thoughts of harming themselves
Client Teaching needs (2)	Take the drug with food to lower GI effects	If a dose missed, do not double up on medication	Do not stop taking abruptly Avoid hazardous activities until	Report headache, fever, neck stiffness immediately	The drug can cause dizziness; avoid driving

	Teach s&s of bleeding, blood in vomit, urine, or stool. Notify provider if any of these occur.	Inform the patient that seizure activity is a possible risk. Notify the provider if seizure activity occurs.	drug CNS effects are known	to provider Do not stop taking abruptly; will have to be weaned off slowly.	while under the influence of effects It may take four weeks or longer for full effects.

Hospital Medications (5 required)

Brand/Generic	Rocephin/ ceftriaxone	Lovenox/ enoxaparin	Pepcid/ famotidine	Keppra/ levetiracetam	Offirmev/ acetaminophen
Dose	200 mg	40 mg=0.4ml	20mg/2ml	750mg/75ml	1000 mg/100 ml
Frequency	Q24hrs.	Daily	BID	BID	Q6hrs. PRN
Route	IV piggyback	SubQ	IV push	IV piggyback	IV piggyback
Classification	Antibiotic Third-generation cephalosporin	Antithrombotic Low molecular weight heparin	Antiulcer drug/H2-receptor antagonist	Anticonvulsant/ pyrrolidine derivative	Analgesic Nonopioid
Mechanism of Action	Inhibits cell-wall synthesis, promoting osmotic instability: usually bactericidal	Accelerates formation of antithrombin III-thrombin complex and deactivates thrombin, preventing the	Completely inhibits the action of histamine on the H2-receptor sites of parietal cells,	It inhibits simultaneous neuronal firing that leads to seizure activity (Comerford,	Inhibits prostaglandin production and interfering with pain receptors

	(Comerford, 2018, p.310).	conversion of fibrinogen to fibrin (Comerford, 2018, p.530).	decreasing gastric acid secretion (Comerford, 2018, p.618)	2018, p.882).	(Comerford , 2018, p.68).
Reason Client Taking	The patient exhibited signs of a UTI infection. Urine culture was positive.	Prophylactic treatment to prevent DVT formation	To prevent and treat heartburn. To prevent stress ulcers from forming as well.	The patient was taking and overdosed on Ampyra. One adverse effect of Ampyra is seizure activity. The patient has a history of seizure activity.	To manage pain
Contraindications (2)	Patients with hypersensitivity to penicillin. Patients with a history of renal insufficiency	Patients with hypersensitivity to heparin, or pork products; Patients with active major bleeding.	Hypersensitivity to drug Patients with renal or hepatic impairment.	Patients with a history of psychiatric symptoms Patients with hypersensitivity to the drug	Patients with severe hepatic impairment Patients with severe active liver disease
Side Effects/Adverse Reactions (2)	Leukopenia diarrhea	Thrombocytopenia hemorrhage	Dizziness constipation	Leukopenia dizziness	Oliguria tachycardia
Nursing Considerations (2)	Monitor patients for superinfection, diarrhea, and anemia. Monitor patient's labs-CBC w/diff.-WBC and platelet count	Regularly inspect the patient for bleeding. Don't try to expel the air bubble from the prefilled syringe.	Monitor creatinine and BUN for renal dysfunction Monitor for blood loss in emesis or stool.	Monitor patients for dizziness; place patient on fall risk precautions. Monitor for seizure activities.	Monitor IV site for redness and swelling Program infusion pump to give over a 5-10-minute interval
Key Nursing Assessment(s) Prior to Administratio	Establish a baseline for PT/INR value.	Monitor Lab values-platelet counts. Establish a	Assess patient for abdominal pain	Obtain a baseline CBC w./diff. to establish	Ensure proper dosing-bottle is in 100

n	Establish if the patient has any known allergies to cephalosporins or penicillin.	baseline for coagulation therapy. Assess for PT/INR time. Protamine sulfate ready in case of overdose.	Obtain baseline for kidney function with BUN and creatinine lab values.	RBC, WBC, and neutrophil counts, the drug may decrease values. Assess patient's LOC and A&O	ml, but dosing is 1000mg per bottle. Assess patient for pain, location, description and intensity.
Client Teaching needs (2)	Instruct the patient to report discomfort at the IV site. Notify staff of diarrhea or loose stools.	Teach patients to avoid OTC drugs containing aspirin or other salicylates unless ordered by the provider. Consult provider before initiating herbal therapy.	Limit the use of prescription drugs to no longer than eight weeks, unless ordered by the provider. Report abdominal pain, blood in stools or vomit, black tarry stools, or coffee-ground emesis	Ambulate slowly to avoid falling. Do not stop taking drugs suddenly; the patient will wean off slowly.	Notify the provider if a rash appears immediately. Teach the patient to avoid alcohol while using the drug. Limit drug to 2g/day or less.200

Medications Reference (APA):

Ampyra (Dalfampridine Extended-Release Tablets): Side Effects, Interactions, Warning, Dosage & Uses. (2019, July 10). Retrieved from https://www.rxlist.com/ampyra-drug.htm.

Comerford, K. C. (2018). *Nursing 2018 drug handbook*. Philadelphia: Wolters Kluwer.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and oriented times four. The patient appears to be a little confused and tired but not in distress.
INTEGUMENTARY (2 points): **Skin color: pink** **Character: dry, intact** **Temperature: warm** **Turgor: loose** **Rashes: n/a** **Bruises: n/a** **Wounds: n/a** **Braden Score: 21** **Drains present: Y☐ N ☒** **Type:**	The patient is a white/Caucasian identifying himself as a male. Skin is pink in color, dry, warm, and intact. Skin turgor is loose but no rashes, bruising, or wounds. The patient has a tattoo on his left upper arm, but no open or bleeding wounds or abrasions. A Braden score of 21 assessed for the skin. There are no drains present for this patient.
HEENT (1 point): **Head/Neck: Normocephalic** **Ears: symmetrical** **Eyes: PERRLA** **Nose: No deviation present** **Teeth: Zero missing**	The patient's head is normocephalic and is midline concerning the torso with no deviated trachea or neck. Ears are symmetrical, bilaterally, and are equal in size. PERRLA present for eyes. The nose is vertically midline with no deviated septum. The nasal cavity is moist with no inflamed turbinates bilaterally. The patient's mouth is moist, pink, with all teeth intact. No dentures or implants present.
CARDIOVASCULAR (2 points): **Heart sounds: S1, S2** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): RR** **Peripheral Pulses: 2+** **Capillary refill: less than 3 sec** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	The patient's cardiac rhythm was normal sinus rhythm, as evidenced by the telemetry strip. Upon auscultation of heart, hear S1 and S2 noted with no murmur heard. Peripheral pulses assessed pedal and radial pulses graded at 2+ bilaterally. Capillary refill time on left index finger and right metatarsal less than three seconds. No neck vein distention or edema present for this patient.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒**	No accessory muscles used during inspiration or expiration with regards to this patient. The

Breath Sounds: Location, character **ET Tube: NO** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	trachea is midline, with no deviations present. The patient denies shortness of breath. Anterior and posterior lung sounds clear upon auscultation. No advantageous lungs sound, including stridor, wheezes or crackles heard bilaterally both anterior and posterior. The patient's oxygen saturation remained above 98% on room air throughout clinical. The patient did not require an ET tube during clinical rotation.
GASTROINTESTINAL (2 points): **Diet at home: regular** **Current Diet: NPO** **Height: 177cm** **Weight: 86.9kg** **Auscultation bowel sounds:** **Last BM: 10/28/2019** **Palpation: Pain, Mass etc.:** **Inspection: all four quadrants** **Distention: slight** **Incisions: n/a** **Scars: n/a** **Drains: n/a** **Wounds: n/a** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	The patient has been nothing by mouth (NPO) diet since arriving at the ED on 10/27/2019. The patient's normal diet at home is regular. The patient's abdomen upon inspection is round and slightly distended. Auscultation of the patient's abdomen resulted in active bowel sounds heard in all four quadrants and were active. Upon percussing and palpation, the patient presented with no pain, tenderness, or masses noted. The patient's last bowel movement was 10/28/2019, with a normal amount and color present. The patient has no incisions, scars, wounds, or drains present in the abdominal area.
GENITOURINARY (2 Points): **Color: yellow** **Character: light haze** **Quantity of urine: 250ml** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: yes** **Catheter: Y ☒ N ☒** **Type: Foley** **Size: 14 french** **CAUTI prevention measures:** **Catheter care ordered Q12 hrs.**	The patient had voided 250 ml of yellow, light haze color urine into Foley catheter. Catheter care performed on the patient before discontinuing the Foley catheter at 0900. Perineal area cleaned and inspected with no abnormalities noted. The patient did not urinate after Foley catheter was removed to assess if pain presents during urination. The patient was placed on antibiotics for UTI before Foley catheter insertion.

MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 45** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	The patient has an active range of motion with no supportive devices necessary for ambulation. The patient's strength rated at five over five with active ROM. The patient is a fall risk due to medication regime and decreased level of consciousness. A Morse Fall risk assessment performed and scored a 45 with minimal risk of falling. No assistance needed for activities of daily living, but patient is assigned up with one assist.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation: times four** **Mental Status:** **Speech: appropriate** **Sensory:** **LOC: Glasgow scale=15**	The patient can move all extremities well with equal strength bilaterally, both upper and lower extremities. The patient is alert and oriented times four. Glasgow coma scale assessed at 15. The patient's speech, English, is clean, non-slurred, and appropriate. The patient shows no signs of neurological damage or deficit.
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):**	The patient utilizes his Christian religion to cope with stress. The patient is actively participating in Christian lead marriage counseling. The patient did receive some college credits but did not finish acquiring his associate degree. He currently is employed at Master Brand cabinet-making facility in Arthur, Il. The patient is married, but current circumstances are unknown due to issues in the marriage. The patient does have one child but was reluctant to discuss situation.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0738	84	132/73	24	36	99
1200	95	124/68	18	37	96

Vital Sign Trends/Correlation:

The patient's vital signs remained stable during the clinical shift. The patient received Offimev analgesic around 0800 for pain resulting in lowered blood pressure and respiratory rate, suggesting pain was relieved**.**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0738	Numeric	Generalized	7 out of 10	Dull, aching pain	Offimev to relieve pain
1200	Numeric	n/a	0 out of 10 Absent of pain	n/a	n/a

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22 gauge **Location of IV:** right forearm **The date on IV:** 10/28/2019 **Patency of IV:** patent as evidenced by flushing IV with 10ml of normal saline **Signs of erythema, drainage, etc**.: No signs of drainage, erythema or unusual drainage **IV dressing assessment:** dry and intact derma bond transparent dressing	Normal Saline 0.9% at a rate of 100ml/hr.
Other Lines (PICC, Port, central line, etc.)	
Type: n/a **Size: n/a** **Location: n/a** **Date of insertion: n/a** **Patency: n/a** **Signs of erythema, drainage, etc.: n/a** **Dressing assessment: n/a** **Date on dressing: n/a**	

CUROS caps in place: Y ☐ N ☐ **CLABSI prevention measures: n/a**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
406.56 ml IV fluids	600 ml Foley Catheter which was d/c at 0900

Nursing Care

Summary of Care (2 points)

Overview of care: Vital signs assessed every four hours. Catheter care performed at 0900 and discontinued Foley catheter at that time. The patient received Offimev analgesic at 0800 along with famotidine to reduce stomach acid.

Procedures/testing done: CT scheduled for today

Complaints/Issues: The patient complained of pain around 0738. The patient received Offimev to relieve pain issues.

Vital signs (stable/unstable): Vital signs stable throughout clinical.

Tolerating diet, activity, etc.: The patient's current dietary status was NPO. The patient did not ambulate out of bed during clinical. The patient was able to change positions throughout the day in bed.

Physician notifications: Provider notified that psychiatric evaluation completed and the Foley catheter removed.

Future plans for patient: A CT scan scheduled for today. The patient possibly moved to the behavioral health wing of hospital for further evaluations.

Discharge Planning (2 points)

Discharge location: Patient to be discharged home to Arthur to live with his wife.

Home health needs (if applicable): n/a

Equipment needs (if applicable): n/a

Follow up plan: The patient will require stress counseling upon discharge, maybe in an outpatient setting, to include AA and group therapy sessions. The patient should have labs reviewed by PCP, including CBC and serum levels monitored for electrolytes, medications, and renal function.

Education needs: The Patient would benefit from stress coping techniques. The patient would benefit from education on alcoholism and programs like AA.

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 "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

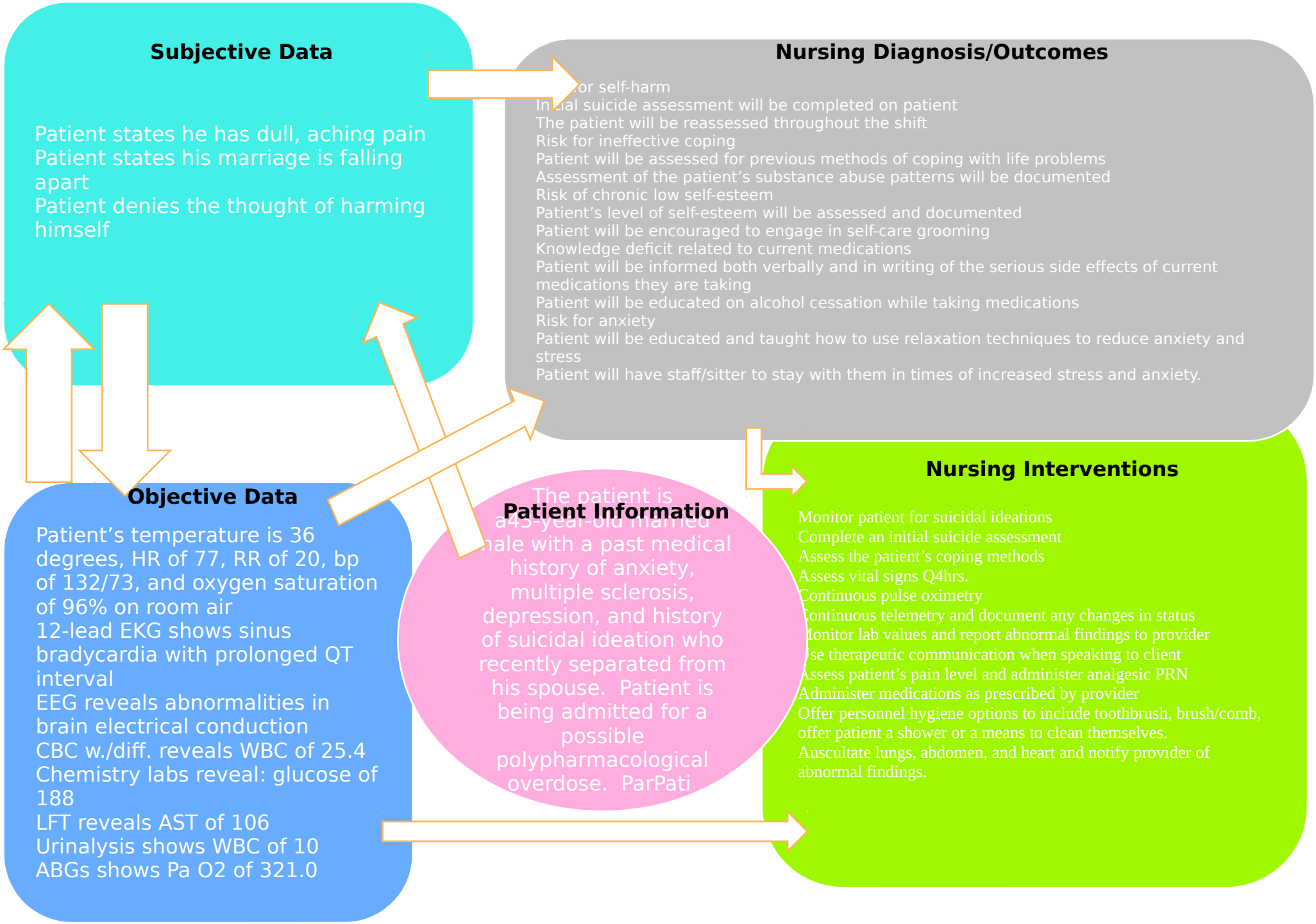
1. The risk for self- harm related to suicidal ideations and overdosing on medication, as evidenced by recent admission to the ED.	This nursing diagnosis chosen because the patient had five previous attempts at ending his own life.	1. Complete an initial suicide assessment 2. Reassess for suicidality, especially during times of change	The goal partially met. With the help of the nurse I followed, we asked him if he was thinking about harming himself. He avoided the question at first, so we asked him an hour later if he had thought about harming himself. He denied having ideas of harming himself.
2. The risk for ineffective coping related to inadequate support for client and previous attempts of suicide	This nursing diagnosis chosen because the patient stated that when he feels overwhelmed, he likes to have a few beers and watch pornography	1. Assess the patient's previous methods of coping with life problems. 2. Determine the use of substances (alcohol, other drugs, smoking, and eating patterns).	The goal partially met. I assessed the patient's previous methods of coping with life. He stated that drinking was one of the ways he coped. The patient uses pornography and alcohol to self-relieve stress and copes with anxiety.
3. Risk of chronic low self-esteem related to repeated negative reinforcement of self-appraisal as evidenced	This nursing diagnosis chosen because the client showed a sign of low self-esteem. I had asked him what positive things about your life, and he stated that taking two	1. Assess the patient's level of self-esteem 2. Encourage the patient to engage in self-care grooming	Goal not met. I had asked the patient if he wanted to get cleaned up and take a shower. The client denied wanting to get cleaned up and just went back to sleep.

by three divorces where his ex-wives stated he was the fault the marriage failed.	weeks of medication and I still can't end it.	activities.	
4. Knowledge deficit related to current medications, as evidenced by not knowing the adverse effects of his medications	The patient stated he was still having suicidal thoughts even though he was on an antidepressant to deal with suicidal ideations.	1. Inform the patient both verbally and in writing of the serious side effects that occur while taking his medications. 2. Reinforce not to consume alcohol while taking his medications.	The goal partially met. The patient's goals not met due to the time restraints of an eight-hour clinical. I did speak to him about some of his medications, but nothing was written down.
5. The risk for anxiety related to lack of knowledge regarding cause and treatment, as evidenced by not knowing how to cope with stress.	This nursing diagnosis chosen because the patient stated that he would get anxious and nervous and not know how to deal with stress.	1. Teach relaxation techniques like deep breathing exercises, progressive relaxation, and focused imagery. 2. Stay with the patient during increased stress periods. Use short, simple directions.	Goal not met. The patient could not focus on the tasks at hand. He kept relating to the past two days, how he didn't know how he got to the hospital.

Other References (APA):

Swearingen, P. L. (2016). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, psychiatric nursing care plans*. St. Louis, MO: Elsevier/Mosby.

Concept Map (20 Points):


Subjective Data
Patient states he has dull, aching pain
Patient states his marriage is falling apart
Patient denies the thought of harming himself
Nursing Diagnosis/Outcomes
or self-harm
Initial suicide assessment will be completed on patient
The patient will be reassessed throughout the shift
Risk for ineffective coping
Patient will be assessed for previous methods of coping with life problems
Assessment of the patient's substance abuse patterns will be documented
Risk of chronic low self-esteem
Patient's level of self-esteem will be assessed and documented
Patient will be encouraged to engage in self-care grooming
Knowledge deficit related to current medications
Patient will be informed both verbally and in writing of the serious side effects of current medications they are taking
Patient will be educated on alcohol cessation while taking medications
Risk for anxiety
Patient will be educated and taught how to use relaxation techniques to reduce anxiety and stress
Patient will have staff/sitter to stay with them in times of increased stress and anxiety.
Objective Data
Patient's temperature is 36 degrees, HR of 77, RR of 20, bp of 132/73, and oxygen saturation of 96% on room air
12-lead EKG shows sinus bradycardia with prolonged QT interval
EEG reveals abnormalities in brain electrical conduction
CBC w./diff. reveals WBC of 25.4
Chemistry labs reveal: glucose of 188
LFT reveals AST of 106
Urinalysis shows WBC of 10
ABGs shows Pa O2 of 321.0
Patient Information
The patient is a43-year-old married male with a past medical history of anxiety, multiple sclerosis, depression, and history of suicidal ideation who recently separated from his spouse. Patient is being admitted for a possible polypharmacological overdose. ParPati
Nursing Interventions
Monitor patient for suicidal ideations
Complete an initial suicide assessment
Assess the patient's coping methods
Assess vital signs Q4hrs.
Continuous pulse oximetry
Continuous telemetry and document any changes in status
Monitor lab values and report abnormal findings to provider
Use therapeutic communication when speaking to client
Assess patient's pain level and administer analgesic PRN
Administer medications as prescribed by provider
Offer personnel hygiene options to include toothbrush, brush/comb, offer patient a shower or a means to clean themselves.
Auscultate lungs, abdomen, and heart and notify provider of abnormal findings.