N431 Care Plan # 3

Lakeview College of Nursing

Kaity Taylor

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/26/19	RT	58	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Native American	Disabled	Single	Ofloxacin, Penicillin, quinolone, bananas
Code Status	**Height**	**Weight**	
Full	170 cm	64.600 kg	

Medical History (5 Points)

Past Medical History: COPD, antisocial personality disorder, depression, generalized anxiety disorder, hypothyroidism, lung nodules, PTSD, GERD

Past Surgical History: Appendectomy, cataracts, ERCP, cardiac catheterization, cholecystectomy, hysterectomy, breast surgery

Family History: father: alcohol abuse, bipolar, cardiovascular disease, heart attack, HTN
mother: heart failure, HTN, Parkinson's disease

Social History (tobacco/alcohol/drugs): Pt reported being a 3-4 pack per day smoker since she was 13 years old. Patient drinks alcohol regularly. Patient reports daily IV meth use and smokes marijuana multiple times a day.

Assistive Devices: Patient wears glasses or contacts to assist with visual difficulties.

Living Situation: Pt lives at home with her 7 and 20-year-old granddaughters. Pt reported oldest daughter (mother of grandchildren) recently was sentenced to prison.

Education Level: Patient reports having some high school but did not graduate.

Admission Assessment

Chief Complaint (2 points): "Severe headache accompanied with visual disturbances, pain all over my head, and dizziness".

History of present Illness (10 points):.58- year old female with history of COPD, depression, anxiety, and PTSD reported to the emergency department (ED) for complaints of severe headache. Patient reported feeling nauseous, vomiting, and having excruciating head pain for 3-4 days prior to arrival to the ED. Patient reported pain in her frontal sinus that wrapped around to the midline of her skull. Patient rates pain 10/10 on the numeric scale with complaints of photophobia and phonophobia. Patient reports pain to be sharp and constant in nature with occasional relief upon administration of medication.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Migraine

Secondary Diagnosis (if applicable): abnormal intracranial pressure

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

Headaches are also known as cephalalgia and are one of the most complained about difficulties of human nature (Hinkle & Cheever, 2017). Often, a headache is a symptom rather than a disease. A headache can be indicative of some sort of underlying condition such as neurological impairment, muscle tension, stress, or a combination of events (Swearington, 2016). Migraines are a complex system of symptoms and defined as “periodic and recurrent attacks of a severe headaches resulting from hours to days” (Cheever & Hinkle, 2018, p. 2004). Often, the causes of migraines can be determined but occasionally the results are unknown. Typically, clinical manifestations of migraine headaches are severe pain within the head, difficulty listening to loud noises or looking at bright lights, nausea, vertigo, and dizziness (Swearington, 2016). RT came into the emergency department for complaints of vomiting, dizziness, and a severe headache. Diagnostic testing for migraine headaches are physical assessment of the head and neck, neurological examination, CT scan, cerebral angiography, EMG, and MRI scan (Cheever &

Hinkle, 2017). RT underwent a head CT and MRI of the head that were both deemed as unremarkable. The CT scan of RT's head showed no acute hemorrhage, fracture, or evidence of white matter disease. The results of the diagnostic imaging were unable to find the source of the pain and RT then had a lumbar puncture. The lumbar puncture (spinal tap) was able to gather a small amount of cerebral spinal fluid to be analyzed and the results are currently pending. Treatment for migraines often depend on if the migraine is primary or secondary in nature. The number one priority for treatment of migraines is to reduce pain (Swearington, 2016). Treatment can be medications that cause vasoconstriction, inflammation reducers, and pain relivers (Cheever & Hinkle, 2017). In addition, non-pharmalogical measures can be taken such as avoiding possible triggers, relaxation, massage, and avoiding stress. RT had a migraine cocktail that consisted of various pain medications and antiemetics that was prescribed to her in hopes of reducing the pain.

Pathophysiology References (2) (APA): Swearingen, P. L. (2016). *All-in-One Nursing Care Planning 4th Edition.* St. Louis, Missouri: Elsevier

Cheever, K., & Hinkle, J. (2017). *Brunner's & Suddarth's Textbook of Medical-Surgical Nursing*. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins

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	4.2-6.1	4.38	4.81	
Hgb	12-18	13.2	13.6	
Hct	37-52	38.9%	42%	
Platelets	150-400	182	166	
WBC	4000-10000	7.3 x 10^3	5.9 x 10 ^3	

Neutrophils	45-75%	73.2%	70.0%	
Lymphocytes	20-40%	28.4%	25.2%	
Monocytes	4-12.0%	6.6%	12%	
Eosinophils	0.0-6.3%	1.2%	1.7%	
Bands	<3%	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-	135-145	141	141	
K+	3.5-5.0	3.8	3.6	
Cl-	96-106	101	101	
CO2	20-29	25	26	
Glucose	70-110	127	89	Pt came into hospital in the evening and had ate prior with no instruction to fast (Cheever & Hinkle, 2017).
BUN	6-20	16	17	
Creatinine	0.8-1.2	0.59	0.71	Patient reports NSAID use during bouts of headaches and it is known that NSAIDS can reduce creatinine levels (Cheever & Hinkle, 2017). In addition, patient is chronic meth user which can be harmful to kidneys.
Albumin	3.5-5.5	4.2	4.1	
Calcium	8.5-10.2	9.5	9.3	
Mag	1.3-2.1	n/a	n/a	
Phosphate	3.0-4.5	n/a	n/a	

Bilirubin	0.3-1	n/a	n/a	
Alk Phos	30-120	55	n/a	
AST	10-40	18	n/a	
ALT	0-33	73	n/a	Chronic drug and alcohol abuse can lead to increased liver function tests (Cheever & Hinkle, 2017).
Amylase	**23-85**	n/a	n/a	
Lipase	**0-160**	24	n/a	
Lactic Acid	**0.5-2.4**	n/a	n/a	
Troponin	**less than 0.04**	n/a	n/a	
CK-MB	**3-5%**	n/a	n/a	
Total CK	**3-25**	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	**0.8-1.14 (2-3 on warfarin)**	n/a	0.96	
PT	**11-15.5 seconds**	n/a	13.0	
PTT	**30-40 seconds**	n/a	n/a	
D-Dimer	**less than 2**	n/a	n/a	
BNP	**less than 100**	n/a	n/a	
HDL	**greater than 40**	n/a	n/a	
LDL	**less than 100**	n/a	n/a	

Cholesterol	**less than 200**	n/a	n/a	
Triglycerides	**less than 150**	n/a	n/a	
Hgb A1c	**4-5.6% (if diabetic less than 7%)**	n/a	n/a	
TSH	**0.4-4**	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	clear and yellow	n/a	n/a although upon inspection was clear and yellow	
pH	5.0-8.0	5.0	7.0	
Specific Gravity	1.005-1.035	1.013	1.006	
Glucose	normal	n/a	n/a	
Protein	negative	n/a	n/a	
Ketones	negative	n/a	n/a	
WBC	less than 5	n/a	n/a	
RBC	0-3	n/a	n/a	
Leukoesterase	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	7.41	n/a	
PaO2	75-100	87.8	n/a	
PaCO2	35-45	41.6	n/a	

HCO3	22-28	23.2	n/a	
SaO2	95-100%	98%	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	n/a	n/a	
Blood Culture	negative	n/a	n/a	
Sputum Culture	negative	n/a	n/a	
Stool Culture	negative	n/a	n/a	

Lab Correlations Reference (APA): Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology Introductory Concepts and Clinical Perspectives*. Philadelphia, PA: F.A. Davis Company.

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): RT had lumbar puncture and results are pending to investigate possible cause of uncontrolled headaches. MRI w/o contrast of the head was completed and marked unremarkable. CT of the head w/o contrast was complete showing no hemorrhage, fracture, or white matter disease and otherwise unremarkable.

Diagnostic Test Correlation (5 points): Pt diagnostic testing procedures were all deemed to be within normal limits with no suspected cause for headaches/migraines. Pending results of lumbar

puncture. Diagnostic testing measures to not only determine cause for headaches but also to rule out more serious conditions such as hemorrhage or tumor.

Diagnostic Test Reference (APA): Cheever, K., & Hinkle, J. (Eds). (2017). *Brunner's & Suddarth's Textbook of Medical-Surgical Nursing*. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins

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

Home Medications (5 required)

Brand/Generic	(Levothyroxine) Synthroid	Albuterol (Salbutamol)	Ascorbic Acid (Vitamin C)	(Omeprazole) Prilosec	Diphenhydramine (Benadryl)
Dose	200 mcg	500 mg	250 mg	20 mg	25 mg
Frequency	Daily	BID	Daily	Daily	PRN Q 6 hrs
Route	PO	Inhalant	PO	PO	PO
Classification	Synthetic thyroxine	Bronchodilator	Vitamin/ Organic Compound	Proton pump inhibitor/anti ulcer	antihistamine
Mechanism of Action	Replaces endogenous thyroid hormone (Frandsen, G., & Pennington, 2018).	relaxing the smooth muscles of the airways. It activates the beta2-adrenergic receptors in the lungs, which begins a cascade of **actions** that result in bronchodilat	acts as a coenzyme that is needed to synthesize and use certain amino acids (Frandsen, G., & Pennington, 2018).	Interferes with gastric secretion production (Frandsen, G., & Pennington, 2018).	Binds to central and peripheral H1 receptors competing with histamine for these sites and preventing it from reaching action site (Frandsen

		ion (Frandsen, G., & Pennington, 2018).			, G., & Penningto n, 2018).
Reason Client Taking	Thyroid replacement therapy d/t dx of hypothyroidi sm	Treat patient for symptoms of COPD	Low levels of vitamin C that is not obtained from diet	Decrease symptoms of GERD	PRN antiemeti c
Contraindications (2)	Acute MI, uncorrected adrenal insufficiency	Patients taking beta blockers and hypokalemia	Hemochrom atosis or patients with kidney disease/kidn ey stones	Current rilpivirine therapy and hypersensitiv ity to PPI	Hepatic impairme nt and sever active liver disease
Side Effects/Adverse Reactions (2)	Insomnia and weight gain	Nervousness and muscle cramps	Blood in urine and weight loss	Psychotic disturbance and vitamin b12 deficiency	Drowsine ss and epigastric distress
Nursing Considerations (2)	Administer prior to breakfast and expect pt to undergo thyroid function tests often during therapy	Monitor serum potassium levels and be aware of drug tolerance after prolonged use	Ask patient what other vitamins or herbal supplements she is taking prior to administrati on and administer same time every day	Give before meals preferable in the morning and be prepared to monitor for macrocytic anemia	May produce false negative results and expect to give parentally if oral is not suggested
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess thyroid levels often	Monitor potassium levels	Gather information on patient's herbal supplements as may cause severe interactions	Monitor for increased GERD symptoms/ul cer/bleeding	LOC
Client Teaching needs (2)	Instruct pt this drug most likely	Shake canister before use	Drink plenty of fluids with taking	Tell pt to take the drug before meals	May cause drowsines

	will need to be taken for life and take before breakfast to increase chance of absorption	and rinse out mouth after use to prevent oral thrush	this medication and do not crush/chew/ break tablet	to increase chance of absorption and avoid alcohol	s. Do not operate heavy machinery or drive any form of vehicle.

Hospital Medications (5 required)

Brand/Generic	Enoxaparin (Lovenox)	Magnesium hydroxide (Milk of Magnesia)	Ketorolac (Toradol)	Metoclopramide (Reglan)	Acetaminophen (Ofirmev)
Dose	40 mg	30 mL	0.5 mL	10 mg	1000 mg/100 ml
Frequency	Daily	QID PRN	Q 6 hrs PRN	Q6H PRN	Q6 hrs PRN
Route	Subq	PO	IV Push	IV Push	IV piggyback injection
Classification	Anticoagulant	antacid	NSAID	Benzamide antiemetic	antipyretic
Mechanism of Action	Binds with antithrombin inactivation of the coagulation enzymes (Frandsen, G., & Pennington, 2018).	Neutralizes stomach acid (Frandsen, G., & Pennington, 2018).	Possesses potent analgesic activity (Frandsen, G., & Pennington, 2018).	Antagonizes central dopamine receptors (Frandsen, G., & Pennington, 2018).	Antipyretic and analgesic activity (Frandsen, G., & Pennington, 2018).
Reason Client Taking	Coagulation prevention	Heartburn/upset stomach nausea	PRN for pain due to headache/migraine	Nausea and vomiting episodes	Pain management and fever reducer
Contraindications (2)	Renal impairment and people dx with hx	Kidney disease or impacted stool	Pt with liver disease or coagulation disorders	Pheochromocytoma and Parkinson's disease	Liver and renal impairments

	of UC			patients should be cautious with this medication	
Side Effects/Adverse Reactions (2)	Epistaxis and hematuria	Hairy tongue and diarrhea	Abdominal pain and dry mouth	Drowsiness and tremors	Acute liver failure and Steven Johnson syndrome
Nursing Considerations (2)	Use cautiously in alcoholics and rotate injection sites	May be mixed with water or milk and monitor calcium levels	Ask patient what OTC (herbal/vitamin) supplements that are taking and monitor for rash/skin peeling indicative of Steven Johnson syndrome	Monitor for tardive dyskinesia and administer 30 minutes to 1 hr before eating	Use oral swab for potential dry mouth side effects and monitor for skin rashes
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor coagulation factors	Monitor electrolyte specifically calcium and monitor kidney function tests	Liver function tests	Assess for extrapyramidal symptoms	Liver function tests
Client Teaching needs (2)	Explain cannot be taken orally and explain hair loss may occur	Shake well before use and avoid use of other antacids	Avoid drinking alcohol (may increase bleeding) and monitor for blood in the stool	Do not drive or operative heavy machines report signs of extrapyramidal symptoms	Follow dosing directions accurately and may cause liver impairment

Medications Reference (APA): Frandsen, G., & Pennington, S.S. (2018). *Abrams clinical drug therapy: Rationales for nursing practice.* Philadelphia: Wolters Kluwer Health.

Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2017). *Davis's Drug Guide for Nurses* (15 ed.). Philadelphia, PA: F.A. Davis Company.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient was pleasant and cooperative during all interactions. Alert and oriented x4. Patient was able to have developmentally appropriate conversations with all healthcare team members.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 23** **Drains present: Y☐ N ☐X** **Type:** n/a	Upon assessment, patient's skin was pink, warm, and dry with no evidence of abnormal rashes, bruises, or wounds. Patient's Braden score was 23. Patient did not have any drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's eyes and ears were equally symmetrical with no evidence of abnormalities. Patient's nose was midline with no NG tube placement present. Patient's hair was evenly dispersed and dark brown in color. Patient wears glasses and sometimes contacts to assist with visual impairments related to difficulty seeing far away. Pt reported sometimes her glasses aggravate her headaches and she takes them off.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐X** **Edema Y ☐ N** X☐ **Location of Edema: n/a**	Patient is currently not on cardiac monitors or telemetry. Heart sounds were assessed at the aortic, pulmonic, tricuspid, and mitral valves and all appeared within normal limits. Pulses were deemed 2+ at radial and pedal locations and present at valve locations. Heart sounds were normal sinus rhythm upon auscultation. Capillary refill was approximately 2-3 seconds. No signs of edema or neck vein distention was noted. During vital sign assessment collection, pt was within normal limits for blood pressure and heart rate.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N** X☐	No accessory muscle use was observed during assessment. Patient did not report any shortness

Breath Sounds: Location, character	of breath or difficulty breathing. Lung sounds were present and clear bilaterally in all 5 lobes. Patient denies use of oxygen at home.
GASTROINTESTINAL (2 points): **Diet at home:** Regular **Current Diet:** Regular **Height:** 170 cm **Weight:** 64.600 kg **Auscultation Bowel sounds:** **Last BM:** 10/27/19 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N** X☐ **Nasogastric: Y ☐ N ☐X** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐X** **Type:**	Patient is currently on regular diet similar to her diet when she is at home. Bowel sounds were assessed and heard in all 4 quadrants. Patient's last bowel movement was earlier this morning on 10/27/19. Pt reported loose stool upon elimination. Over the past few days prior to being admitted to the hospital, patient said she was experiencing vomiting and diarrhea. No ostomy, NG, or feeding tubes were present.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N** X☐ **Dialysis: Y ☐ N** X☐ **Inspection of genitals:** **Catheter: Y ☐ N ☐X** **Type:** **Size:**	Patient is independent with voiding and does not have a catheter. Patient did not report urgency, burning, or pain upon urination. Pt's urine is clear and yellow in nature. Pt was not on strict I&O so no amount was collected or noted.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐X** **Fall Risk: Y ☐ N**X☐ **Fall Score:** 35 **Activity/Mobility Status: Independent** **Independent (up ad lib) X☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Morse fall risk score of 35. Patient is not a fall risk and does not require any assistive devices upon ambulation. Patient is independent for all activities of daily living. Pt has full range of motion in all extremities.

NEUROLOGICAL (2 points): **MAEW: Y** X☐ **N**☐ **PERLA: Y** X☐ **N**☐ **Strength Equal: Y** X☐ **N** ☐ **if no - Legs** ☐ **Arms** ☐ **Both** ☐ **Orientation:** A&O x4 **Mental Status:** Normal **Speech:** English/WNL **Sensory:** WNL **LOC:** awake and oriented	Patient was alert and oriented x 4 during duration of shift. Patient was pleasant and answered all questions appropriately. Patient spoke English with Native American background and speech was within normal limits. Strength was equal bilaterally in all extremities. No signs of any neurological impairments during assessment.
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 disabled and enjoys spending time around her house with her grandchildren. Patient is tearful when discussing her oldest daughter being sent to prison and she is left to care for her 7 and 20-year-old granddaughters. Patient reports being depressed and having anxiety that is increased with her constant headaches. Patient was alert and oriented x4 during all assessments. Patient reports using methamphetamine to give her the energy she needs to get through the day.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	88	123/72	18	37.0 C	92% (COPD)
1100	96	119/78	18	36.1 C	92% (COPD)

Vital Sign Trends: Overall patient's vital signs remained within normal limits. Patient's pain would diminish after medication was administered which helped to keep her vital signs steady.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1200	Numeric	Head pain	10/10	Constant with no alleviation.	IV migraine cocktail was administered
1540	Numeric	Head pain	8/10	Constant headache pain increasing upon exertion	It was not time for next dose of migraine cocktail, so patient was given Tylenol

					and the lights were turned off to promote relaxation and rest.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22 g **Location of IV:** Right forearm **Date on IV:** 10/26/19 **Patency of IV:** Patent and dry flushed without difficulty **Signs of erythema, drainage, etc.:** No evidence of draining, infiltration, or erythema **IV dressing assessment:** IV was patent and dry with clean dressing dated 10/26/19	Saline lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Patient ate 75% of her lunch that consisted of chicken, mashed potatoes, and green beans. Patient had 60 oz of water. Patient had normal saline flowing at 125mL/hr from a 600 mL bag.	0 mL was reported during shift d/t pt being independent with voiding.

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was pleasant and cooperative throughout all interactions. Throughout stay, patient's vital signs remained steady and within normal limits. Physical head to toe assessment was performed at 1200 and documented accordingly. Migraine cocktail was

administered, and patient reported slight alleviation and was encouraged to rest. Currently, results of lumbar puncture are pending.

Procedures/testing done: Upon arrival to ED, patient had CT and MRI of the head that were within normal limits and otherwise marked as unremarkable. No procedures during shift. Pt is awaiting results of lumbar puncture to determine possible cause of extreme headaches/migraines.

Complaints/Issues: Patient was in quite a bit of pain from headache that was constant and sharp in nature. Patient reported pain 10/10 on the numeric scale that decreased to 8/10 after migraine cocktail was administered.

Vital signs (stable/unstable): Pt vitals remained steady throughout shift. Pt did not report any SOB, palpitations, HA, or chest pain.

Tolerating diet, activity, etc.: Pt is currently on regular diet with no alterations required. Patient had chicken, mashed potatoes, and green beans for lunch with water to drink.

Physician notifications: Hospitalist came in and informed the patient of her pending results of the lumbar puncture.

Future plans for patient: Pt is remaining in the hospital for observation and results of lumbar puncture are pending.

Discharge Planning (2 points)

Discharge location: Pt will return home with granddaughters.

Home health needs (if applicable): n/a due to pending results of lumbar puncture.

Equipment needs (if applicable): n/a

Follow up plan: n/a due to pending results of lumbar puncture.

Education needs: Pt has had education involving ways to alleviate headache pain such as relaxation techniques, follow up care, and non-stimulating environments.

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. Acute pain related to headache as evidenced by photophobia and phonophobia	Patient is suffering from severe pain in her frontal sinus radiating to the middle of her head that is unable to be relieved	1. Assess characteristics of pain (quality, characteristics, location, onset) 2. Encourage periods of rest	Goal partially met- Patient reports pain on numeric scale 10/10 with occasional relief of 8/10 after migraine cocktail is given. Patient was encouraged to relax, and techniques were promoted (lights off, non-stimulating environment)
2. Activity intolerance related to severe head pain as evidenced by staying in bed and not ambulating	Patient reports pain becomes worse upon exertion and does not want to ambulate except when using the restroom.	1. Promote balance between ambulation and rest periods 2. Encourage patient to ambulate to avoid development of DVT	Goal partially met- patient does not want to get out of bed unless absolutely necessary but understands the risks. Patient walked in the hallway after medication administration. Continues to find balance of activity and rest.
3. Risk for infection related to lumbar puncture as evidenced by redness and drainage	Patient underwent rf lumbar puncture earlier this morning and is at an increased risk for infection	1. Ensure frequent assessment checks for signs of infection (redness, swelling, drainage) 2. Frequent hand hygiene	Partially Met- patient does not have any signs of infection at this time but results are still pending, and time is critical. Patient was taught not to mess with puncture site and is adhering to directions positively.
4. Constipation related to increased pain	Often, pain medications cause	1. Encourage fluid intake of at least	Goal Met- patient reported loose stool this morning

medications as evidenced by difficulty passing stool	constipation and the patient is on several pain medications due to an attempt to reduce headache.	2500 mL/day 2. Administer stool softeners (MiraLAX, Milk of Magnesia)	after her Milk of Magnesia was administered. Additionally, patient has been drinking fluids often to promote motility.

Other References (APA): Swearingen, P. L. (2016). *All-In-One Nursing Care Planning Resource* (4 ed.). St. Louis, Missouri: ELSEVIER**.**

Concept Map (20 Points):

Subjective Data

- Headache
- Vomit
- Diarrhea
- Dizziness
- Photophobia
- Phonophobia
- Visual disturbances

Nursing Diagnosis/Outcomes

1. Acute pain related to headache as evidenced by photophobia and phonophobia
- Patient reports pain on numeric scale 10/10 with occasional relief of 8/10 after migraine cocktail is given. Patient was encouraged to relax, and techniques were promoted (lights off, non-stimulating environment)
2. Activity intolerance related to severe head pain as evidenced by staying in bed and not ambulating
- patient does not want to get out of bed unless absolutely necessary but understands the risks. Patient walked in the hallway after medication administration. Continues to find balance of activity and rest.
3. Risk for infection related to lumbar puncture as evidenced by redness and drainage
- patient does not have any signs of infection at this time but results are still pending, and time is critical. Patient was taught not to mess with puncture site and is adhering to directions positively.
4. Constipation related to increased pain medications as evidenced by difficulty passing stool
- patient reported loose stool this morning after her Milk of Magnesia was administered. Additionally, patient has been drinking fluids often to promote motility.

Objective Data

- CT of head
  - Unremarkable
  - No hemorrhage, fractures, white matter disease
- RF Lumbar puncture
  - Results pending
- MRI of head
  - Unremarkable

Patient Information

58-year-old female with history of anxiety, PTSD, depression, and GERD presented to emergency department for complaints of severe headache, vomiting, and dizziness. Patient was admitted to the hospital as an inpatient.

Nursing Interventions

1. Assess characteristics of pain (quality, characteristics, location, onset)

2. Encourage periods of rest

3. Promote balance between ambulation and rest periods

4. Encourage patient to ambulate to avoid development of DVT

5. Ensure frequent assessment checks for signs of infection (redness, swelling, drainage)

6. Frequent hand hygiene

7. Encourage fluid intake of at least 2500 mL/day

8. Administer stool softeners (MiraLAX, Milk of Magnesia)