N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
1-20-2020	C.P.	71	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Married	Clarithromycin, doxycycline, moxifloxacin, gabapentin, prednisone, adhesive bandage, biaxin, latex
Code Status	**Height**	**Weight**	
Full	165.1 cm	95.9 kg	

Medical History (5 Points)

Past Medical History: chronic back pain, chronic bilateral swimmers ear, depression, diverticulosis, fall risk, hematuria, endometrial cancer, hypertension, hypercholesterolemia, hypertensive cardiovascular disease, numbness and tingling in foot, occlusion of left iliac artery, otitis media recurrent, tobacco use

Past Surgical History: lower limb angiogram, cystoscopy, hysterectomy

Family History: mom: congestive heart disease, uncle: diabetes, grandpa: bladder cancer

Social History (tobacco/alcohol/drugs): patient reports no use of alcohol or drugs. Sh is a smoker and has smoked 1-2 packs each day for 50 years.

Assistive Devices: Patient wears glasses.

Living Situation: Patient lives at home with her husband.

Education Level: Patient has a highschool education.

Admission Assessment

Chief Complaint (2 points): Right femoral to left femoral artery bypass surgery

History of present Illness (10 points): The patient came in for femoral to femoral artery bypass surgery. After a previous angiogram she was started on plavix, but stopped the medication the day before surgery. The patient stated that the Plavix relieved her pain she was feeling at night. The patient is also taking aspirin for a blood thinner. The patient was complaining of some lower extremity pain and also her chronic back pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Occlusion of the left iliac artery

Secondary Diagnosis (if applicable): N/A

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

Occlusion of the iliac artery can also be known as aortoiliac occlusive disease. This is the blockage of the iliac arteries along with the aorta and the main blood vessels in a patient's body. "The iliac arteries are the branches that your aorta divides into around the level of the belly button to provide blood to your legs and the organs in your pelvis" (Vallabhaneni). When a blockage happens the most common cause would be a build up of plaque in the arteries. Plaque is a grouping of fat, calcium, cholesterol, and different substances that float around in the blood (Atherosclerosis). Over a period of time the plaque will become hard and cause a narrowing in your arteries making the blood harder to pass through.

Even though the most common cause of aortoiliac disease is atherosclerosis, it can be caused by other factors. Conditions such as Takayasu's arteries for example, can cause an inflammation in the arteries causing them to become blocked. Direct radiation to the pelvic can also cause this disease by increasing the inflammation in the arterial wall.

Risk factors of this disease can include high cholesterol, high blood pressure, smoking, diabetes, being overweight or obese, not exercising enough, having an unhealthy diet, a family history, an inactive lifestyle, or radiation to the pelvis (Aortoiliac Occlusive Disease). My patient has a health history of high cholesterol and high blood pressure. She also has been a smoker for over 50 years smoking 1-2 packs per day.

Symptoms for aortoiliac occlusive disease can be absent or the patient may experience some fatigue, pain, or cramping. When the disease is in the early stages the fatigue, pain, and cramping will be felt in the butt, thighs, and calves. The more severe the disease gets; the patient will feel these symptoms while walking short distances. The more

sever the disease becomes the more painful the legs will feel. The patient will begin to experience "pain at rest in your feet and toes, coldness and numbness in your legs, sores or wounds on your legs, and feet, and even gangrene or the death of tissue in your feet" (Vallabhaneni). My patient was complaining of the numbness in her legs beginning to worsen. With pain the vital signs would show a rapid heart rate and an increase in BP and respirations. My patient's respirations were increased, but not due to her being in pain. She also has a history or hypertension.

Diagnostic tests for a patient with aortoiliac occlusive disease would be an ABI, duplex ultrasound, CT angiogram, MR angiogram, or a catheter-directed angiogram. My patients ABI showed a mildly decreased right ABI with severely decreased left ABI suggesting occlusion of the left iliac artery.

Treatment for this disease would first be risk factor modification. The patient should stop smoking, control their cholesterol and high blood pressure, manage diabetes, and exercise regularly (Vallabhaneni). My patients have been encouraged to stop smoking. She stated that she wants to stop but keeps putting it off. She is also on medications such as metoprolol and atorvastatin to help reduce her BP and cholesterol. Surgical treatment would be a surgical bypass. My patient received a femoral to femoral artery bypass surgery.

Pathophysiology References (2) (APA):

VALLABHANENI, R. A. G. H. U. V. E. E. R. (n.d.). Aortoiliac Occlusive Disease. Retrieved January 24, 2020, from https://vascular.org/patient-resources/vascular-conditions/aortoiliac-occlusive-disease

Atherosclerosis. (n.d.). Retrieved January 24, 2020, from https://www.nhlbi.nih.gov/health-topics/atherosclerosis

Aortoiliac Occlusive Disease Symptoms & Treatment: UPMC. (n.d.). Retrieved January 24, 2020, from https://www.upmc.com/services/heart-vascular/conditions-treatments/aortoiliac-occlusive-disease#overview

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC .	3.8-5.41	4.28	3.48	RBC levels can be low after surgery due to the blood loss amount (Whitlock, 2019)
Hgb .	11.3-15.2	14.0	11.5	
Hct	33.2-45.3	41.8	34.1	
Platelets	149-393	271	238	
WBC	4-11.7	14.9	12.5	Surgery is a stressor that can

				cause WBC's and neutrophils to increase a few hours after (Riley and Rupert, 2015).
Neutrophils	**45.3-79**	**93.0**	**80.5**	**Surgery is a stressor that can cause WBC's and neutrophils to increase a few hours after (Riley and Rupert, 2015).**
Lymphocytes	**11.8-45.8**	**4.6**	**7.8**	**Surgery is a stressor for lymphocytes as well, but causes them to decrease (Sampson, 2018).**
Monocytes	**4.4-12.0**	**11.6**	**11.4**	
Eosinophils	**0-6.3**	**0.4**	**0.1**	
Bands	**.0-1**	**0.4**	**0.2**	

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**	**137**	**137**	
K+	**3.5-5.1**	**3.9**	**3.9**	
Cl-	**98-107**	**106**	**106**	
CO2	**21-31**	**26**	**24**	
Glucose	**74-109**	**133**	**122**	**Surgery and anesthesia can be a stresser and cause**

				hormones to make the body be less sensitive to insulin making glucose run high (Diabetes and Surgery).
BUN	**7-25**	**13**	**14**	
Creatinine	**0.5-0.9**	**0.68**	**0.75**	
Albumin	**3.5-5.2**	**N/A**	**N/A**	
Calcium	**8.6-10.3**	**9.1**	**8.8**	
Mag	**1.5-2.5**	**18**	**N/A**	
Phosphate	**2.5-4.5**	**N/A**	**N/A**	
Bilirubin	**0.3-1**	**N/A**	**N/A**	
Alk Phos	**35-105**	**N/A**	**N/A**	
AST	**0-32**	**N/A**	**N/A**	
ALT	**0-33**	**N/A**	**N/A**	
Amylase	**23-85**	**N/A**	**N/A**	
Lipase	**0-160**	**N/A**	**N/A**	

Lactic Acid	**0.5-1**	**N/A**	**N/A**	
Troponin	**0-30**	**N/A**	**N/A**	
CK-MB	**0-4.3**	**N/A**	**N/A**	
Total CK	**20-180**	**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	**2-3**	**N/A**	**N/A**	
PT	**11-13.5**	**N/A**	**N/A**	
PTT	**60-70**	**N/A**	**N/A**	
D-Dimer	**<.5**	**N/A**	**N/A**	
BNP	**<450**	**N/A**	**N/A**	
HDL	**40-59**	**N/A**	**N/A**	
LDL	**<100**	**N/A**	**N/A**	

Cholesterol	**<200**	**N/A**	**N/A**	
Triglycerides	**<150**	**N/A**	**N/A**	
Hgb A1c	**4-5.6**	**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	**Yellow/clear**	**yellow/clear**	**N/A**	
pH	**5-8**	**7**	**N/A**	
Specific Gravity	**1.005-1.034**	**1.006**	**N/A**	
Glucose	**Normal**	**normal**	**N/A**	
Protein	**Negative**	**Negative**	**N/A**	
Ketones	**Negative**	**negative**	**N/A**	
WBC	**<5**	**<1**	**N/A**	

RBC	**0-3**	**<1**	**N/A**	
Leukoesterase	**Negative**	**Negative**	**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**	**N/A**	**N/A**	
PaO2	**75-100**	**N/A**	**N/A**	
PaCO2	**35-45**	**N/A**	**N/A**	
HCO3	**22-28**	**N/A**	**N/A**	
SaO2	**93-97**	**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	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):

Whitlock, J., & Msn. (2019, November 19). Are You at Risk for Anemia After Surgery? Retrieved January 24, 2020, from https://www.verywellhealth.com/anemia-after-surgery-3156852

Riley, L. K., & Rupert, J. (2015, December 1). Evaluation of Patients with Leukocytosis. Retrieved January 24, 2020, from https://www.aafp.org/afp/2015/1201/p1004.html

Sampson, S. (2018, February 14). What Is Lymphocytopenia? Retrieved January 24, 2020, from https://www.healthline.com/health/lymphocytopenia

Diabetes and Surgery. (n.d.). Retrieved January 24, 2020, from https://www.hamiltonhealth.com/services/diabetes-metabolic-center/diabetes-and-surgery/

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The patient received an ankle-brachial index.

Diagnostic Test Correlation (5 points): An ABI is a test that can tell the doctor how the patient's blood is flowing (Ankle-Brachial Index Test). This test was indicated for the patient because of worsening symptoms of a blockage from being a long time smoker and a decrease in the patient's pedal pulse. The test results came back as a mildly decreased right ABI with severely decreased left ABI suggesting occlusion of the left iliac artery.

Diagnostic Test Reference (APA):

Ankle-Brachial Index (ABI) Test: Procedure, Risk Factors, and Results. (2019, October 21). Retrieved January 23, 2020, from https://www.webmd.com/heart-disease/ankle-brachial-test#1

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

Home Medications (5 required)

Brand/Generic	**Famotidine (Pepcid)**	**Losartan (Cozaar)**	**Clopidogrel (Plavix)**	**Aspirin**	**Amitriptyline (Elavil)**
Dose	**20mg**	**50mg**	**75mg**	**25mg**	**25mg**
Frequency	**Daily**	**Daily**	**Daily**	**Daily**	**Daily at night**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Histamine H2 antagonist**	**Angiotensin II receptor antagonists**	**Platelet aggregation inhibitors**	**Antipyretics, nonopioid analgesics, salicylates**	**Tricyclic antidepressant**

Mechanism of Action	**Inhibits the action of histamine at the H2-receptor site located primarily in gastric parietal cells, resulting in inhibition of gastric acid secretion**	**Blocks the vasoconstrictor and aldosterone-secreting effects of angiotensin II**	**Inhibits platelet aggregation by irreversibly inhibiting the binding of ATP to platelet receptors**	**Produce analgesia and reduce inflammation and fever by inhibiting the production of prostaglandins. Decreases platelet aggregation**	**Potentiates the effect of serotonin and norepinephrine in the CNS**
Reason Client Taking	**The client is taking this for her history of GERD**	**The client has a history of HTN**	**The patient was put on medication after previous angiogram**	**The patient has chronic back pain**	**The patient has a history of depression**
Contraindications (2)	**Renal impairment** **Hypersensitivity**	**Hepatic impairment** **Impaired renal function**	**Patients at risk for bleeding** **Hypersensitivity**	**Cross-sensitivity with other NSAIDs** **Severe hepatic or renal disease**	**Recent MI** **Heart failure**
Side Effects/Adverse Reactions (2)	**Anaphylaxis** **Dizziness**	**Fatigue** **Nasal congestion**	**Depression** **Chest pain**	**Tinnitus** **GI bleeding**	**Suicidal thoughts** **Sedation**

Nursing Considerations (2)	**Assess elderly patients for confusion** **May cause an increase in serum transaminases and serum creatinine**	**Assess the patient's BP when lying down, sitting, and standing** **Assess for signs of angioedema**	**Assess for signs of stroke** **Monitor bleeding time during therapy**	**Assess pain: type, location, and intensity before and after medication is given** **Assess fever**	**Obtain weight and BMI before and during treatment** **Monitor BP and pulse**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assess for epigastric or abdominal pain**	**Monitor renal function. Can cause an increase in BUN and creatinine**	**Monitor CBC with differential and platelet count throughout therapy**	**Monitor and assess bleeding times**	**Assess the patient's mental status and for suicidal tendencies**
Client Teaching needs (2)	**May cause drowsiness or dizziness** **Inform patient that smoking interferes with the action of histamine antagonists**	**Take missed doses as soon as remembered but do not double doses** **The patient should notify the health care provider if**	**Notify the provider if patient experiences fever, chills, sore throat, rash, or unusual bleeding and bruising** **Notify the provider**	**Take with a full glass of water** **Report unusual bleeding, bruising, or black tarry stools**	**Advise patients family and caregivers to watch for suicidal tendencies** **Instruct patient to notify health care professional if urinary retention,**

		swelling of the face, eyes, lips, or tongue occur	about medication before surgery		dry mouth, or constipation persists

Hospital Medications (5 required)

Brand/Generic	Enoxaparin (Lovenox)	Fentanyl (Duragesic)	Ondansetron (Zofran)	Atorvastatin (Lipitor)	Metoprolol (Lopressor)
Dose	40mg	25mcg	4mg	40mg	100mg
Frequency	Q24hr	PRN Q5min	PRN once	Daily	Daily
Route	Sub Q	IV push	IV push	PO	PO
Classification	Antithrombotics, anticoagulants	Opioid analgesics	antiemetic	Lipid lowering agent, HMG-CoA reductase inhibitors	Beta blocker
Mechanism of Action	Prevention of thrombus formation.	Binds to opiate receptors in the CNS, altering the	Decreased incidence and severity of nausea and vomiting	Inhibits HMG-CoA reductase, an enzyme which is responsible for	Blocks stimulation of beta 1-adrenergic receptors

		response to and perception of pain	following chemotherapy or surgery	catalyzing an early step in the synthesis of cholesterol	
Reason Client Taking	Prevents blood clots while the patient is in the hospital	Patient is receiving pain meds after her surgery	Client took for nausea after surgery	Patient has a history of hypercholesterolemia	Patient has a history of HTN
Contraindications (2)	Uncontrolled HTN Active, major bleeding	Undiagnosed abdominal pain hypothyroidism	Hepatic impairment Congenital long QT syndrome	History of liver disease hypersensitivity	Pulmonary edema Renal impairment
Side Effects/Adverse Reactions (2)	Insomnia bleeding	Confusion Blurred vision	Headache constipation	Diarrhea rashes	Weakness bradycardia
Nursing Considerations (2)	Assess for signs of bleeding and hemorrhage Monitor patients for hypersensitivity reactions	Assess type, location, and intensity of pain before and 30 min after Double check orders to	Assess for extrapyramidal effects Administer over 30 seconds	Can be given without food Obtain a diet history	Monitor intake and output Monitor daily weights

		prevent overdose			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assess CBC, platelet count, or stools for occult blood periodically**	**Assess respiratory rate and BP throughout therapy to watch for overdose**	**Assess for nausea, vomiting, abdominal distention, and bowel sounds before administering**	**Evaluate serum cholesterol and triglyceride levels before and after therapy**	**Assess BP, ECG, and pulse before and during therapy**
Client Teaching needs (2)	**Report symptoms of unusual bleeding or bruising** **Do not take aspirin, naproxen, or ibuprofen without talking to provider**	**Explain pain assessment scale** **Avoid alcohol or other CNS depressants**	**Take as directed** **Tell provider if they experience irregular heart beat**	**Use in conjunction with diet** **Explain importance of follow up exams**	**Do not stop medication abruptly** **Teach how to check pulse and BP**

Medications Reference (APA):

Up-to-Date Drug Information. (n.d.). Retrieved January 24, 2020, from

https://www.drugguide.com/ddo/

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:awake un sitting up in bed** **Orientation: x4** **Distress: no acute distress** **Overall appearance: calm, cooperative, appropriate**	**Patient was awake sitting up in bed. She is A&O x4. Patient was well nourished and in no acute distress.**
INTEGUMENTARY (2 points): **Skin color: caucasian** **Character: pink, pale, dry** **Temperature: warm** **Turgor: good** **Rashes: N/A** **Bruises: N/A** **Wounds: surgical incisions on upper thigh bilateral** **Braden Score: 18** **Drains present: Y☐ N ■** **Type:**	**Patient is Caucasian. Patient's skin was dry, pink, and warm to the touch. There were no rashes or bruises. There were surgical incisions bilaterally on her upper thighs. No drains were present**
HEENT (1 point): **Head/Neck: N/A** **Ears: N/A** **Eyes: N/A** **Nose: N/A** **Teeth: N/A**	**Head is normocephalic and midline. Ears have no drainage and have a pearly grey tympanic membrane. Noted PERRLA. No presence of deviated septum with bilateral equal turbinate. There is no sinus tenderness. Oral mucosa is moist and pink. Patient does**

	not wear dentures.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): normal sinus** **Peripheral Pulses: strong** **Capillary refill: < 3** **Neck Vein Distention: Y ☐ N ■** **Edema Y ■ N ☐** **Location of Edema: lower extremities, left pedal 1+ and R pedal 2+**	**Patient heart was auscultated with an S1 S2 heart sound at a normal heart rate and rhythm. Patient has edema in the lower extremities more so on the right side. Good capillary refill <3. No neck vein distention noted. Radial and pedal pulses were assessed at a 1+ bilaterally.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ■** **Breath Sounds: Location, character** **ET Tube: N/A** **Size of tube: N/A** **Placement (cm to lip): N/A** **Respiration rate: N/A** **FiO2: N/A** **Total volume (TV): N/A** **PEEP: N/A** **VAP prevention measures: N/A**	**No accessory muscles were used while patient was breathing. Patient's trachea was midline with no deviations. Patient does not have a wheeze or labored breathing. When patient's lungs were auscultated, lung sounds were clear in all lobes.**
GASTROINTESTINAL (2 points): **Diet at home: regular diet** **Current Diet: Soft** **Height: 165.1 cm** **Weight: 95.9 kg** **Auscultation Bowel sounds:active in all 4 quadrants** **Last BM: 1/19** **Palpation: Pain, Mass etc.: N/A** **Inspection:**	**Patient is on a soft diet. Patient's abdomen is soft and nondistended. Patient has active bowel sounds in all 4 quadrants. There were no masses or palpable hernias present. Patient's last BM was 1/19. There was no ostomy, NG tube, or feeding tubes present.**

Distention: N/A **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:**	
GENITOURINARY (2 Points): **Color: yellow** **Character: clear** **Quantity of urine: 650 cc** **Pain with urination: Y ☐ N ■** **Dialysis: Y ☐ N ■** **Inspection of genitals: normal** **Catheter: Y ■ N ☐** **Type: indwelling/ continuous** **Size: 16 fr** **CAUTI prevention measures: pericare, bag was below bladder, catheter was secured to the leg**	**Her urine was yellow and clear. There was no hematuria present. There were no genital abnormalities noted.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM: active ROM** **Supportive devices: N/A** **Strength: equal in all extremities** **ADL Assistance: Y☐ N ■** **Fall Risk: Y ■ N☐** **Fall Score: 55** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	**Fall risk: 55** **Upper and lower extremities show normal ROM. Patient does not use assistive devices to move around. Patient is a fall risk. There is no tenderness or swelling in extremities.**
NEUROLOGICAL (2 points):	**Patient was awake and sitting up in bed.**

MAEW: Y ■ N☐ **PERLA: Y ■ N☐** **Strength Equal: Y ■ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: x4** **Mental Status:no distress** **Speech: clear, appropriate for development** **Sensory: no deficits** **LOC: awake and sitting up in bed**	**Patient was A&O x4. She felt no acute distress and felt sensation with light touch. Patient speaks English with no speech impairment. Patient's strength was equal in his arms and legs.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): patient likes to spend time with her dog** **Developmental level: appropriate for age** **Religion & what it means to pt.: no religious preference** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Patient was cooperative during the physical assessment. Her mood and affect were appropriate. Patient lives at home with her husband and her dog .**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0835	75	131/62	34	36.7	96
1030	72	137/63	37	36.7	95

Vital Sign Trends/Correlation:

Patients vital signs stayed consistent. Her respirations ran high, but she was walking around and talking each time.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0835	numeric	N/A	0/10	N/A	N/A
1030	numeric	N/A	0/10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18g Location of IV: L forearm Date on IV: 1/20 Patency of IV: patent Signs of erythema, drainage, etc.: no complications IV dressing assessment: clean, dry, and intact Size of IV: 18g Location of IV: R forearm Date on IV: 1/20 Patency of IV: patent Signs of erythema, drainage, etc.: no complications IV dressing assessment: clean, dry, and intact	Saline lock Antibiotics Both IVs were discontinued 1/21
Other Lines (PICC, Port, central line, etc.)	N/A

Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	**N/A**

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
476- Normal Saline IV **600-oral intake** **1076- total**	**650-urine output** **650-total**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was well taken care of. She had no concerns.

Procedures/testing done: ABI

Complaints/Issues:N/A

Vital signs (stable/unstable): vitals were stable

Tolerating diet, activity, etc.: patient tolerated all activities

Physician notifications: N/A

Future plans for patient: patient was being discharged home on 1/21

Discharge Planning (2 points)

Discharge location: home with her husband

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: follow up appointments with her provider

Education needs: patient was told there might be discomfort in the areas around the incision and to get plenty of rest.

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. Risk for bleeding related operative procedure as evidenced by loss of 50cc of blood during procedure	With this patient a risk for blood loss can be high since she is on the blood thinner plavix and also takes aspirin regularly.	1. Assess vital signs in frequent intervals to check for signs of bleeding 2. Inspect the surgical dressing to check for blood	The patient showed she understood the risk for bleeding while on the blood thinners by stopping the use a day before surgery. The goal is for the client to experience no extra bleeding. This goal was met because when we assessed her dressing they were dry and intact.

2. Risk for pain related to the surgical procedure as evidenced by the patient wincing when she sat down.	**The patient expressed how she was not in any pain during the stay while she was on the pain medication. The only time she complained of discomfort is when she would sit and the incision site would get pinched.**	**1. Plan interventions on the clients reports of pain** **2. Have patient rate pain on a scale of 1-10 frequently**	**The goal for the patient is to continue to not be in pain before discharge. The patient stated she was not in any pain, but was worried she would be once she was home and not on strong pain medication.**
3. Risk for fall related to surgical procedure as evidenced by needing some help getting out of bed.	**The patient is mostly independent, but with being post surgery and on bed rest, it took her a little bit to catch her balance. The patient has a fall risk score of 55.**	**1. Give patient the call light so she can call for help when wanting out of bed** **2. Set a bed alarm incase the patient forgets to press the call light**	**The goal for this patient is to prevent any falls by discharge. The more the patient got out of bed and walked around the more comfortable she felt.**
4. Risk for slow healing related to history of smoking as evidenced by the patient	**The patient has smoke 1-2 packs of cigarettes per day for 50 years. Patients who smoke have a longer healing**	**1. Provide other ways to help the patient heal such as keeping the affected**	**The goal for the client would be for her to continue to stop smoking like she has done in the hospital setting. She states that she has been thinking about stopping**

not wanting to stop.	**time.**	**area clean** **2. Apply the patients prescribed nicotine patches to help with the overall cessation of nicotine use**	**smoking but not wanting to yet.**
5. Risk for deficient knowledge related to undergoing an unfamiliar procedure as evidenced by the patient having a repeat consult with the surgeon	**The patient had another meeting with the surgeon to understand all her options about the upcoming surgery. Since the client had questions about the surgery itself, she may have a deficient knowledge about the post op care.**	**1. The staff should answer any questions the client has with handouts or images to help her understand** **2. The staff can walk her through dressing changes**	**The goal for the patient would be to fully understand how she will care for herself after she is discharged. She will continue to go to follow up appointments as well.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient was complaining of worsening numbness in her legs.

Nursing Diagnosis/Outcomes

Risk for bleeding related operative procedure as evidenced by loss of 50cc of blood during procedure
The patient showed she understood the risk for bleeding while on the blood thinners by stopping the use a day before surgery. The goal is for the client to experience no extra bleeding. This goal was met because when we assessed her dressing they were dry and intact.

Risk for pain related to the surgical procedure as evidenced by the patient wincing when she sat down.
The goal for the patient is to continue to not be in pain before discharge. The patient stated she was not in any pain, but was worried she would be once she was home and not on strong pain medication.

Risk for fall related to surgical procedure as evidenced by needing some help getting out of bed.
The goal for this patient is to prevent any falls by discharge. The more the patient got out of bed and walked around the more comfortable she felt.

Risk for slow healing related to history of smoking as evidenced by the patient not wanting to stop.
The goal for the client would be for her to continue to stop smoking like she has done in the hospital setting. She states that she has been thinking about stopping smoking but not wanting to yet.

Risk for deficient knowledge related to undergoing an unfamiliar procedure as evidenced by the patient having a repeat consult with the surgeon
The goal for the patient would be to fully understand how she will care for herself after she is discharged. She will continue to go to follow up appointments as well.

Objective Data

Patient's ABI and previous angiogram showed a lack of blood flow

Patient Information

71-year-old female patient came in for femoral to femoral artery bypass surgery. After a previous angiogram she was started on Plavix but stopped the medication the day before surgery. The patient stated that the Plavix relieved her pain she was feeling at night. The patient is also taking aspirin for a blood thinner. The patient was complaining of some lower extremity pain and her chronic back pain. She is a former smoker.

Nursing Interventions

Assess vital signs in frequent intervals to check for signs of bleeding
Inspect the surgical dressing to check for blood
Plan interventions on the clients reports of pain
Have patient rate pain on a scale of 1-10 frequently
Give patient the call light so she can call for help when wanting out of bed
Set a bed alarm in case the patient forgets to press the call light
Provide other ways to help the patient heal such as keeping the affected area clean
Apply the patients prescribed nicotine patches to help with the overall cessation of nicotine use
The staff should answer any questions the client has with handouts or images to help her understand
The staff can walk her through dressing changes