N321 Care Plan #1

Lakeview College of Nursing

Joey Runde

Demographics (3 points)

Date of Admission 02/23/2020	Patient Initials R.A.B	Age 53 Years	Gender Female
Race/Ethnicity Caucasian	Occupation Cleans Houses	Marital Status Single	Allergies Ceclor, Erythromycin, Sulfa Drugs
Code Status Full Code	Height 5 Feet 3 Inches	Weight 68.5 kg	

Medical History (5 Points)

Past Medical History: Chronic Back Pain, Lumbar Radiculopathy, Spinal Stenosis, Anxiety, Depression, Constipation, Risk for Infection, Increase in Liver Enzymes, Fibromyalgia, Hyperlipidemia, Hypertension, Impaired Gas Exchange, Insomnia, Kidney Stones, Migraines, Myofascial Pain, Psoriasis, Trochanteric Bursitis, Urinary Tract Infection

Past Surgical History: Hysterectomy, Cholecystectomy, Lumbar Laminectomy

Family History: Mother- Aortic Valve Disorder, Hypertension, Hyperlipidemia. Father- Patient did not know her father.

Social History (tobacco/alcohol/drugs): Patient states she does drink alcohol occasionally and was a past user of marijuana. She states she has never used any tobacco products.

Assistive Devices: She states she has been using a walker to get around in the hospital. At home she says she does not use any assistive devices.

Living Situation: Patient lives at home by herself. She says she feels safe at home.

Education Level: She states that she spent a year and a half at a junior college.

Admission Assessment

Chief Complaint (2 points): Low Back Pain

History of present Illness (10 points): The patient was admitted to the hospital for lower back pain that started about a year. She said her pain is constant and has worsened in the past two weeks. She states that sharp pains will shoot down her right leg randomly. She stated that the only thing that relieved her pain was coughing and that every time she moved, she could feel her pain. She rated her pain at a 7 due to the Dilaudid she just received in her IV.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Low Back Pain

Secondary Diagnosis (if applicable): N/A

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

The patient is at the hospital for chronic back pain. Chronic pain is pain that has a duration longer than six months (Capriotti & Frizzell, 2016). Chronic pain can arise from reoccurring inflammation and noxious stimuli (Capriotti & Frizzell, 2016). It usually will occur because of a pathological condition in the body that doesn't seem to disappear (Capriotti & Frizzell, 2016). Chronic pain will start as acute pain, and after the acute pathology goes away, the pain will stay. The pain will continue due to the neural network becoming imprinted in the brain (Capriotti & Frizzell, 2016).

The type of chronic pain that my patient had was back pain. Back pain is one of the leading reasons why people go to the doctor and surgery is often rarely needed or used as a treatment for the pain ("Back Pain," 2016). It is often unknown to what causes back pain ("Back Pain," 2016). Certain types of strains in the patients back muscles and spinal ligaments can cause him or her to have lower back pain ("Back Pain," 2016). Also, if the

patient has poor posture or putting constant strain on his or her muscles can cause the pain to increase (“Back Pain,” 2016). Bulging or ruptured disks could be another cause of chronic back pain because the soft material inside the patient’s disc can bulge or rupture. That will then put pressure on the nerves in the back (“Back Pain,” 2016). Arthritis is another reason that can cause chronic back pain (“Back Pain,” 2016). Arthritis in the lower spine will narrow space around the spinal cord, which leads to the pain (“Back Pain,” 2016). Along with that, skeletal disorders or the curvature of the spine can also lead to the chronic pain (“Back Pain,” 2016). All of this pain could lead to a loss of functional ability, depression, and changes in the structure of the patient’s brain (Capriotti & Frizzell, 2016).

Some of the signs and symptoms that come with back pain are muscle aches, pain that worsen with specific movements, shooting pain down the patient’s leg, and pain that improves with reclining (“Back Pain,” 2016). The patient that I cared for expressed all of those symptoms. She specifically told me that she had pains that would shoot down her right leg. The patient with chronic back pain is likely to have an elevated white blood cell count due to the inflammation in her back (“High White,” n.d.). She did have elevated white blood cells due to her inflammation in her back. For diagnostic tests, the doctor will most likely order an x-ray with a patient that has chronic back pain to diagnose the inflammation (“Back Pain,” 2016). The doctor could also get a CBC to find out if there is inflammation in the back (Capriotti & Frizzell, 2016).

Treatment that is used for chronic back pain is to supply and to inform the patient to use pain a medicine when needed (Capriotti & Frizzell, 2016). Also, the nurse can educate the client to try using coping strategies instead of taking pain medication all the time. My

patient was receiving Dilaudid to treat her pain. She was also encouraged to ambulate some to keep the muscles from stiffening up in her back.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives. Philadelphia*: F.A. Davis Company.

Back pain. (2018, August 4). Retrieved from https://www.mayoclinic.org/diseases-conditions/back-pain/symptoms-causes/syc-20369906

High White Blood Cell Count Results and Follow-Up. (n.d.). Retrieved from https://my.clevelandclinic.org/health/diagnostics/17704-high-white-blood-cell-count/results-and-follow-up

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	4.0-4.9 mcL	4.44	4.60	N/A
Hgb	12-15 g/dL	13.9	14.5	N/A
Hct	36-47 %	41.5	43.2	N/A
Platelets	150-400	295	275	N/A
WBC	4-10	10.7	10.2	The patient has an increased in her white blood cell count due to the inflammation she has in her back ("High White," n.d.)
Neutrophils	2-8	9.2	6.3	The patient has increase in neutrophils due to the inflammation in her back (Mortaz et al., 2018). Neutrophils are first to arrive to the inflammation region (Mortaz et al., 2018).

Lymphocytes	**1-4**	**1.3**	**3.0**	**N/A**
Monocytes	**0.2-0.8**	**.15**	**.66**	**N/A**
Eosinophils	**<0.5**	**0.7**	**0.6**	**The patient has increased Eosinophils due to the inflammation in her lower back ("Eosinophilia," 2019).**
Bands	**<1.0**	**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-	**135-145 mmol/L**	**135**	**137**	**N/A**
K+	**3.5-5 mmol/L**	**4.1**	**3.6**	**N/A**
Cl-	**95-105 mmol/L**	**97**	**97**	**N/A**
CO2	**23-29 mEq/L**	**29**	**31**	**The patient has an increase of CO2 levels due to being on an opioid (Emery et al., 2016). Opioids can cause respiratory distress. (Emery et al., 2016).**
Glucose	**70-110 mg/dL**	**107**	**113**	**The patient could have an increase in blood glucose due to eating to many carbohydrates (Capriotti & Frizzell, 2016).**
BUN	**8-21 mg/dL**	**23**	**18**	**My patient that I did care on has an elevated BUN due to possible dehydration ("Blood Urea,"2019).**
Creatinine	**0.8-1.3 mg/dL**	**0.94**	**0.99**	**N/A**
Albumin	**3.4-5.4 g/dL**	**4.8**	**N/A**	**N/A**
Calcium	**8.5-10.2 mg/dL**	**9.7**	**9.5**	**N/A**
Mag	**1.5-2 mEq/L**	**N/A**	**N/A**	**N/A**

Phosphate	**0.8-1.5 mmol/L**	**N/A**	**N/A**	**N/A**
Bilirubin	**0.1 – 1.2 mg/dl**	**0.3**	**N/A**	**N/A**
Alk Phos	**50-100 U/L**	**74**	**N/A**	**N/A**
AST	**10-40 U/L**	**24**	**N/A**	**N/A**
ALT	**7-56 U/L**	**33**	**N/A**	**N/A**
Amylase	**30-125 U/L**	**N/A**	**N/A**	**N/A**
Lipase	**10-150 U/L**	**N/A**	**N/A**	**N/A**
Lactic Acid	**0.7 – 2.1 (meq/L)**	**N/A**	**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	**<1.2 seconds**	**N/A**	**N/A**	**N/A**
PT	**11-15 seconds**	**N/A**	**N/A**	**N/A**
PTT	**25-40 seconds**	**N/A**	**N/A**	**N/A**
D-Dimer	**<500 ng/mL**	**N/A**	**N/A**	**N/A**
BNP	**<125 pg/mL**	**N/A**	**N/A**	**N/A**
HDL	**40-80 mg/dL**	**N/A**	**N/A**	**N/A**
LDL	**85-125 mg/dL**	**N/A**	**N/A**	**N/A**
Cholesterol	**3-5.5 mmol/ L**	**N/A**	**N/A**	**N/A**

Triglycerides	**50-150 mg/dL**	**N/A**	**N/A**	**N/A**
Hgb A1c	**<6%**	**N/A**	**N/A**	**N/A**
TSH	**0.5-5 mIU/L**	**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**	**N/A**	**N/A**	**N/A**
pH	**4.5-8.0**	**N/A**	**N/A**	**N/A**
Specific Gravity	**1.005-1.025**	**N/A**	**N/A**	**N/A**
Glucose	**Negative**	**N/A**	**N/A**	**N/A**
Protein	**Negative**	**N/A**	**N/A**	**N/A**
Ketones	**Negative**	**N/A**	**N/A**	**N/A**
WBC	**Negative**	**N/A**	**N/A**	**N/A**
RBC	**Negative**	**N/A**	**N/A**	**N/A**
Leukoesterase	**Negative**	**N/A**	**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**	**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):

Laboratory Values. (n.d.). Retrieved from https://globalrph.com/laboratory-values/

Lab Values, Normal Adult: Laboratory Reference Ranges in Healthy Adults. (2019, May 29). Retrieved from https://emedicine.medscape.com/article/2172316-overview

Urinalysis: Reference Range, Interpretation, Collection and Panels. (2019, July 3). Retrieved from https://emedicine.medscape.com/article/2074001-overview

Prothrombin time test. (2018, November 6). Retrieved from https://www.mayoclinic.org/tests-procedures/prothrombin-time/about/pac-20384661

NT-proB-type Natriuretic Peptide (BNP). (n.d.). Retrieved from https://my.clevelandclinic.org/health/diagnostics/16814-nt-prob-type-natriuretic-peptide-bnp

Mortaz, Esmaeil, D., S., Adcock, M., I., Mumby, … Leo. (2018, September 3). Update on Neutrophil Function in Severe Inflammation. Retrieved from https://www.frontiersin.org/articles/10.3389/fimmu.2018.02171/full

High White Blood Cell Count Results and Follow-Up. (n.d.). Retrieved from https://my.clevelandclinic.org/health/diagnostics/17704-high-white-blood-cell-count/results-and-follow-up

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives. Philadelphia*: F.A. Davis Company.

Emery, M. J., Groves, C. C., Kruse, T. N., Shi, C., & Terman, G. W. (2016, April 1). Ventilation and the Response to Hypercapnia after Morphine in Opioid-naive and

Opioid-tolerant Rats. Retrieved from https://anesthesiology.pubs.asahq.org/article.aspx?articleid=2481093

Eosinophilia. (2019, October 8). Retrieved from https://www.mayoclinic.org/symptoms/eosinophilia/basics/definition/sym-20050752

Blood urea nitrogen (BUN) test. (2019, July 2). Retrieved from https://www.mayoclinic.org/tests-procedures/blood-urea-nitrogen/about/pac-20384821

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

My Patient received a CT scan on her abdomen when she was admitted. She received the CT scan due to not having a bowel movement for two days.

Diagnostic Test Correlation (5 points):

My patient that I took care of had not had a bowel movement for a couple days so they took a CT scan to make sure there was no bowel obstruction. A CT scan is a really good tool to see if there is something going on in the GI tract like a bowel obstruction, diverticulitis, ulcerative colitis, and appendicitis (Hinkle, J.L. & Cheever, K.H., 2018). The results ended up showing stool retention but not any bowel obstruction. To help relieve the stool retention the doctor ordered her MiraLAX.

Diagnostic Test Reference (APA):

Hinkle, J.L. & Cheever, K.H.(2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, PA: Wolters Kluwer Health Lippincott Williams & Wilkins

Current Medications (10 points, 1 point per completed med)

10 <u>different</u> medications must be completed

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Home Medications (5 required)

Brand/Generic	**Wellbutrin/ bupropion**	**Microzide/ hydrochlorothiazide**	**Antivert/ meclizine**	**Imitrex/ sumatriptan**	**Pepcid/ famotidine**
Dose	**75 Mg**	**25Mg**	**25 Mg**	**100 Mg**	**20 Mg**
Frequency	**1 Tablet Daily**	**1 Tablet Daily**	**1 Tablet Daily PRN**	**2 Tablets BID PRN**	**1 Tablet BID**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Antidepressants**	**Thiazide Diuretics**	**Antihistamine**	**Triptans**	**Histamine 2 Receptor Antagonists**
Mechanism of Action	**Inhibits the reuptake of dopamine, norepinephrine, and serotonin.**	**Inhibits the reabsorption of Na and Cl in the distal renal tubule, which will increase excretion of Na and water.**	**Release nausea and vomiting by blocking the action of acetylcholine in the brain**	**Binds to the serotonin receptors, producing vascular constriction of the cranial blood vessels.**	**Inhibits the action of histamine at the H2 receptors of the stomach, decreasing the acidity.**
Reason Client Taking	**To reduce depression**	**To lower blood pressure**	**To treat vertigo**	**To treat headaches**	**Acid-reflux**
Contraindications (2)	**1.Abrupt discontinuation of alcohol. 2. Abrupt discontinuation of benzodiazepines.**	**1.Anuria 2. Renal Failure**	**1. Caution with HTN 2. Caution with use of depression meds**	**1.Uncontrolled HTN 2.Basilar Migraine**	**1.Hypersensitivity to the drug 2. Renal Impairment**
Side Effects/Adverse Reactions (2)	**1.Insomnia 2.Seizures**	**1.Hypotension 2. Hyperglycemia**	**1.Dizziness 2.Dry mouth**	**1. Alterations in blood pressure 2. Shock**	**1. Confusion 2. Dizziness**
Nursing Considerations (2)	**1.Assess patients' blood pressure before Bupropion therapy. 2. Monitor for increased depression or**	**1.Give early in the morning and early evening to avoid nocturia. 2. Assess for evidence of hypokalemia.**	**1.This drug may mask signs of brain tumor 2.Instruct the patient to report blurry**	**1. Assess patient for chest pain 2. Monitor patient's blood pressure**	**1. Caution patient to avoid alcohol 2. Advise patient to notify provider if he or she has vomit or black stools**

	suicide risk.		**vision**		

Hospital Medications (5 required)

Brand/Generic	**Ativan/ Lorazepam**	**Dilaudid/ hydromorphone**	**Zofran/ ondansetron**	**Phenergan/ promethazine**	**Miralax/ polyethylene glycol 3350**
Dose	**500 Mg**	**0.5 Mg=0.5 mL**	**4 Mg= 2 mL**	**12.5 Mg=0.5 mL**	**17 Grams**
Frequency	**1 tablet every 6 hours PRN**	**Every 2 hours PRN**	**Every 6 hours PRN**	**Every 4 Hours PRN**	**Daily PRN**
Route	**Oral**	**IV push injectable**	**IV Push Injectable**	**Injectable in Intramuscular**	**Oral**
Classification	**Benzodiazepine**	**Opioid Agonists**	**5-Hydroxytryptamine Receptor antagonist**	**Phenothiazines**	**Cathartics**
Mechanism of Action	**May potentiate the effects of GABA to relieve anxiety, tension, and promote sleep.**	**Binds to receptors in the brain, spinal cord, and peripheral tissues. That will then decrease pain impulses.**	**Antagonize Serotonin receptors and preventing their activation.**	**Block Dopamine from receptor sites in the brain and CTZ.**	**Irritates the GI mucosa by pulling water into the bowel lumen.**
Reason Client Taking	**To reduce anxiety**	**For back pain**	**Nausea**	**Nausea/ Vomiting**	**Constipation**
Contraindications (2)	**1.Psychosis 2. History of alcohol or drug abuse**	**1. Increased intracranial pressure 2. Respiratory Depression**	**1. Electrolyte imbalances 2. Caution if bradycardia**	**1. Stenosing Peptic Ulcer 2. Use of depressant medicines**	**1.Fecal Impaction 2. Abdominal Pain**
Side Effects/Adverse Reactions (2)	**1.Chest Pain 2. Apnea**	**1.Respiratory Depression 2. Constipation**	**1. Headache 2. Constipation**	**1. Hypertension 2.Hyperglycemia**	**1. Cramping 2. Diarrhea**
Nursing Considerations (2)	**1.Monitor the patient's respiratory status 2. Do not stop the**	**1. Tell client to drink fluids and eat fiber foods. 2. Use**	**1. If hypokalemia or hypomagnesemia is present, correct them first before**	**1. Monitor the patient's hematologic status.**	**1.Should not be taken within an hour after**

	drug abruptly due to withdrawal	**cautiously in patients that cannot maintain a normal blood pressure**	**administering 2. Advise patient to report any signs of a rash.**	**2.Monitor respiratory function**	**ingesting milk 2.Monitor for bowel elimination patterns.**

Medications Reference (APA):

Jones & Bartlett Learning. (2019). 2019 Nurses drug handbook. Burlington, MA.

Frandsen, Geralyn. (2020). ***Abrams Clinical Drug Therapy: rationales for nursing practice*****.**

S.l.: Wolters Kluwer Medical.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**R.B was alert and orient x 4. She did state she is under stress because of the pain she is in. Her overall appearance looks well kept.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**R.B skin color is normal for her race. Her skin was warm to touch, loose, intact and elastic. Her skin turgor was normal and returned back quickly. She did not have any visible rash or wounds, but she does have a bruise on her left arm. Her braden score was a 20 with no apparent drains.**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**R.B head was normocephalic with no rashes or lesions. Her trachea was not deviated and all the lymph nodes were normal. Her ears were intact with no visible drainage. Her eyes were both equal, round, accommodated each other and reacted to light. Her nose showed no deviated septum and no signs of drainage or redness. Her teeth are well kept but she did**

	report she is having major dry mouth.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**The patient had normal sounds with no murmurs heard. The rhythm of the heart was normal and all peripheral pulses were palpated. Her capillary refill was under 3 seconds and she did not have any signs of neck distention. She also did not have any signs of edema on her body.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**The patient had clear lung sounds heard through all lobes with no accessory muscles used.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**R.B is currently on 1800-2000 calorie heart healthy diet at the hospital and at home. Her height is 5'3 and she weighs 68.5 kg. All of the patient's bowel sounds were active in all 4 quadrants, but she hasn't had a bowel movement since Saturday. She did not have any type distention, incisions, scars, drains, and wounds. The patient also doesn't have a bowel ostomy, NG tube, and a feeding tube.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**R.B urine was a normal yellow color and character. She stated she has been voiding normally with good quantity. She denies any pain with urination and is not on dialysis. She does not use a catheter at this time.**

MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	**The patient has a palpated pulse in all extremities and her ROM was strong in all limbs. She is currently using a walker at the hospital when needed and she doesn't need help with the walker. She is currently on a fall risk and her fall score is a 45. She is a stand assist and needs help to stand up. Other than that, she is quite independent.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**The patient had great movements in all extremities and her Perla was good in both eyes. She had really good strength in all four limbs. She is alert and orient x4 with a normal mental and speech status. The patient had feeling in all extremities and is very responsive.**
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 is under stress due to the pain she is in. She states she copes with her stress by praying. The patient is very well developed and her religion she follows is Christianity. She feels safe at home and her support comes from her sister.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
08:31	**77 BPM**	**121/69 mmHg** **L. Arm**	**20 BPM**	**36℃** **Temporal**	**96%**
11:15	**78 BPM**	**130/70 mmHg** **L. Arm**	**20 BPM**	**36.3℃** **Temporal**	**94%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
07:34	**6 out of 10**	**Lower Back**	**Mild**	**Sharp and Achy**	**Dilaudid**
11:15	**5 out of 10**	**Lower Back**	**Mild**	**Sharp and Achy**	**Dilaudid**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	**22 gauge**
Location of IV:	**Peripheral R. Forearm IV**
Date on IV:	**02/23/2020**
Patency of IV:	**The IV was correctly placed and has well patency**
Signs of erythema, drainage, etc.:	**No signs of erythema, drainage, or any signs of infection**
IV dressing assessment:	**The IV is dry and intact**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
The patient drank a cup of water and a can of soda.	**The patient voided twice during my shift but it was not recorded.**

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was given her morning medicines without any problems. The Dilaudid did seem to help with her back pain but right when the two hours rolled around, she was having severe pain again. Along with that she still has not had a bowel movement since Saturday. We did give her MiraLAX for her constipation. Her vital signs were stable and she was able to void twice during my shift.

Procedures/testing done: No procedures or testing was done on my shift

Complaints/Issues: The patient complained of her back hurting a lot on my shift.

Vital signs (stable/unstable): Her vital signs were pretty stable. Her O2 saturation was a little low at 94% and her blood pressure was a little elevated at 130/70mmhg.

Tolerating diet, activity, etc.: The patient stated to me that she is tolerating her diet well and she had no complaints about it.

Physician notifications: The doctor was notified during my shift that her back pain has been bothering her and is showing no improvement.

Future plans for patient: The plans for the patient are to gradually reduce her pain to a level that she can deal with. Also slowly weaning her to a lower dose of pain medicine. Once those goals are reached, she should be ready to be discharged.

Discharge Planning (2 points)

Discharge location: The patient home

Home health needs (if applicable): The patient might need a physical therapist.

Equipment needs (if applicable): The patient has a walker at her home if needed.

Follow up plan: The patient should see a follow up with her primary care provider and a physical therapist.

Education needs: Teach the patient how to take her pain medicine, how to cope with her pain other than using a pain medicine, and teach the patient how to use her walker the correct way.

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. Potential for falls related to the pain in her back and as evidenced by the client saying that her pain was a 6.	**Due to the patient having a high risk for falls due to her back pain.**	**1.Provide the patient with her Dilaudid when she has pain.** **2.Provide the patient with way to cope with her pain without taking medicine.**	**1.The patient pain was decreased after her Dilaudid was received.** **2.The patient learned new ways to deal with her pain in order to decrease the use of pain medicine.**
2. Decreased mobility due to the musculoskeletal impairment and as evidenced by the patient saying that her back hurts when she moves.	**Due to patient not wanting to move because it increases her pain.**	**1. Motivate the patient to move to prevent her back from being stiff.** **2.Get the patient up slowly to decrease the amount of movements.**	**1.The patient walked to the bathroom and to her chair.** **2.The patient was helped out of bed without any complaints about her pain.**
3. The patient is constipated possibly due to her pain medicines she is taking and as evidenced by the patient saying that she	**This was chosen due to the patient not able to have a bowel movement.**	**1.Motivate the patient to drink a lot of fluids.** **2Administering Miralax to help with digestion.**	**1&2 The patient was able to have a bowel movement due to the laxatives and an increase in fluids.**

has not had a bowel movement since Saturday.			
4. Potential for skin breakdown due to client sitting in her bed a lot and as evidenced by client saying that her back hurts when she gets up.	**Due to the patient not wanting to move out of bed.**	**1.Try to encourage the patient to get up out of bed 2. Reposition the patient every two hours.**	**1.The patient was agreeing and ambulated. 2.We repositioned the client to prevent bed sores.**
5. The patient is need for health teaching due to client being on fall risk and as evidenced by client say that she has chronic back pain.	**Due to the client being a fall risk.**	**1.Teach the client the proper way to use her walker. 2Educate the patient to get help if she needs it to get up and walk.**	**1.The patient was able to use her walker the correct way. 2. The patient agreed that she would get help if she needed it.**

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). ***All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*****. St. Louis, MO: Elsevier.**

Concept Map (20 Points):

Swearingen, P. L., & Wright, J. D. (2019). ***All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*****. St. Louis, MO: Elsevier.**

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Subjective Data

"I have serious pain in my back"
"I haven't had a bowel movement since Saturday"
"The pain medicine is helping my back pain"
"It hurts my back when I move my body"

Nursing Diagnosis/Outcomes

Potential for falls related to chronic back pain.
Decrease the pain in her lower back with the Dilaudid.
Decrease mobility related to the patient not wanting to move due to back pain.
Get the patient up and walking.
Constipation due to not having a bowel movement since Saturday.
Get the patient to have a bowel movement as soon as possible.

Objective Data

The patients blood pressure read 130/70 mmhg.
The patient voided two times on my shift.
Her O2 saturation read 94%
Her BUN was elevated
The patient had active bowels sounds in all 4 quadrants
Her WBC count was elevated

Patient Information

A 53-year-old female is admitted due to an increase in her chronic back pain.

Nursing Interventions

The patients back pain was decreased when the Dilaudid was given
The patient was able to get out of bed and ambulate.
The patient received her Miralax to promote a bowel movement.

N321 Care Plan

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