NURSING CARE PLAN #1

Date: 3/31/21
Patient Initial: RB
Patient Need:
Nursing Diagnosis: Craniotomy

P: Risk for bleeding in the brain
E: related to surgical procedure
S: Risk to have infection in the incision site, pain, fall, and seizure disorder.

Expected Outcome	Nursing Intervention	Rationale	Evaluation
Short Term Goal: 1. The nurse will discuss precaution to prevent bleeding complications at the end of the shift.	1) Perform risk assessment for fall and for signs of bleeding. 2) The patient will monitor closely for hemorrhage. 3) The nurse will reassess the patient's vital signs at frequent intervals to assess for physiological evidence for bleeding. 4) Monitor all medication for the potential to increase bleeding including aspirin. 5) Instruct the patient and family on signs of bleeding and appropriate actions should bleeding occur. 6) The patient will eat 75% of each meal tray at the end of the shift. .	1. The nurses should assess for fall risk factors that could increase the risk of bleeding. 2. Safety precautions should be implemented. 3. Assess for changes associated with bleeding including increased heart rate and respiratory rate. 4. Antiplatelet medications can increase the risk of bleeding in high-risk clients. 5. The patient and family need to be aware what to do in case the	The goal met by evidence the patient was free from bleeding at the end of the shift.

		patient is bleeding. 6. Showing the patient different variety of foods available. [edited by] Betty J. Ackley, Gail B. Ladwig. Nursing Diagnosis Handbook : an Evidence-Based Guide to Planning Care. St. Louis, Mo. :Mosby Elsevier, 2008.	
Long Term Goal: 1. Patient will remain free from symptoms of infection for seven days.	1. The nurse will perform hand hygiene before and after each client care activity. 2. The nurse will assess the IV line for sign of infection and ensure aseptic handling. 3. Ensure appropriate wound care technique. 4. Note and report labs values. 5. Teach client and family members how to avoid infections. 6. Assess skin for color, moisture, texture and turgor.	1. Hand washing is currently recommended to reduce infection. 2. There are some factors associated with risk of surgical wound infection. 3. Daily showers or baths can help to reduce the number bacteria on the client's skin. 4. Educate the patient about the infections. 5. Monitor patient vital signs. 6. Encourage fluids intake. [edited by] Betty J. Ackley, Gail B. Ladwig.	The goal met by evidence the patient was free from infection.

		Nursing Diagnosis Handbook : an Evidence-Based Guide to Planning Care. St. Louis, Mo. :Mosby Elsevier, 2008	

A75 year old patient was diagnosed with Subdural Hematoma. He has a past medical history of Hypertension, HLD, DM and a permanent pacemaker. He has a stage 2 pressure ulcer on his buttock, and a post-operative wound on his right cranial. His vital signs were stable expect his glucose. BP was 147/83, HR 98, RR 15, Oxygen 98%. He has indwelling catheter. seizure and fall precautions protocol. He also was in one-to-one observation.
Amlodipine 10 mg PO daily, Aspirin 81 mg, PO daily, Insulin determir 12 units SC Q12h SCH, Heparin injection 5000 units, SC Q8H SCH, Atorvastatin 40 mg , PO nightly.