

**Nursing Diagnosis:
Risk for Infection**

Expected Outcome:
 Interventions:
 1. Clean and fresh from moisture
 2. Regularly change dressings, there is no change for bacteria to form
 3. Monitor vitals to check for any signs of infection

**Nursing Diagnosis:
Impaired knowledge and proper dressing care**

Expected Outcome:
 Interventions:
 1. Inform patient on importance of keeping wound elevated on pillow to prevent swelling
 2. Assess patient for and of illness of patient with post operative care by end of shift
 3. Inform patient on importance of keeping wound clean and dry to prevent infection.
 4. Have patient state ways to keep wound clean as well as prevent future adverse effects from occurring.
Evaluation:
 Goal was met as evidenced by patient stating the importance of complying with post operative care by the end of shift.

Past Medical History:
 CAD of bypass graft
 Diabetes
 Primary hypertension
 Hyperlipidemia
 PAD
 Systolic CHF
 Tobacco use

Medical Diagnosis:
 Left foot ulcer and wound infection with diabetes mellitus
Diagnostic Tests and results:
 Hemoglobin dropped from 8 to 6.3
 MRI pelvis (11/24) mal compression, ileac artery,
 EKG 12 lead: NSR 73
Assessment:
 Received patient in bed sleeping, responsive to tactile stimuli. Once fully awake patient was AOX4 PERRLA

Medications:
 Hydromorphone 1mg/ml 0.4 mg injection
 Acetaminophen 650 mg oral
 Amlodipine 10 mg oral
 Aspirin chewable tablet 81 mg oral
 Atorvastatin 40 mg oral
 Carvedilol 25 mg oral
 Dextrose 15 g oral
 Furosemide 4 mg oral
 Gabapentin 300 mg oral
 Glucagon 1 mg injection
 Insulin glargine 20 units injection
 Insulin lispro 1-4 units injection
 Insulin lispro 1-6 units injection
 Insulin lispro 10 units injection

**Nursing Diagnosis:
Risk for impaired skin integrity**

Expected Outcome:
 Interventions:
 1. No signs of impaired skin integrity by end of shift.
 2. Use of pillows or wedges to keep bony prominences from too much direct pressure
 3. Encourage adequate hydration and nutrition. About 2000 ml of water a day.

**Nursing Diagnosis:
Risk for skin breakdown**

Expected Outcome:
 Interventions:
 1. Give patient pillows as indicated in chart. reduced pain levels
 2. Patient education on alternative pain relief methods.
 3. Patient education on relaxation techniques.
 4. Continue to check pain levels throughout the day.
Evaluation:
 Goal was met as evidenced by patient described having pain levels lowered by end of shift.

- Medication list continued
 (too many to fit in chart)
- Isosorbide 120 mg oral
 - Lisinopril 40 mg oral
 - Oxycodone 5 mg oral
 - Oxycodone 10 mg oral
 - Pantoprazole 40 mg oral
 - Piperacillin 100 ml IV
 - Polyethylene 17 g oral packet
 - Ranolazine 500 mg oral
 - Sennosides 17.2 mg oral
 - Spironolactone tablet 25 mg oral

Nyack College
School of Nursing
NUR 393 Clinical
Respiratory Assessment

Student's name: Grace Wells

Patient's Initials: VS Date of care: 09/27/21 Age 62 Gender Male
Preferred language english Ethnicity African American Religion Catholic

Chief complaint:

Left foot pain/numb

Allergies:

Medications: No known allergies
Food: No known allergies
Environmental: Cat, Dog, Pollen

Medical history:

CAD (coronary artery disease) CAD of bypass graft, Diabetes mellitus, essential (primary) hypertension, hyperlipidemia, hypertension, PAD (peripheral artery disease) systolic CHF, chronic tobacco abuse

Surgical history (list date and type):

- Amputation Right Big toe - Hx coronary angioplasty
- CABG arterial single - Hx Heart catheterization - clavicle osteotomy
- Spine surgery proceduree unlisted

Psychiatric history:

None

Lactation Status: N/A Pregnancy Status N/A

Immunizations:

Mandatory Childhood vaccinations UTD unable to obtain
Tetanus (date-year) unable to obtain
Pneumococcal (date-year) unable to obtain
Influenza (date-year) unable to obtain
COVID: (dose-year) 1st - March 2021
2nd - April 2021

Medications (patient takes at home) *unable to obtain*

Name	Dose	Route	Frequency	Use

(If more space is required, write on a separate paper)

Health History

Does the patient have:

Dyspnea: YES or **NO**

at rest _____ mild activity _____ moderate activity _____ strenuous activity _____

supine position _____ Orthopnea _____

worsens while walking? _____ O2 therapy at home? _____

If yes, describe _____

Cough: YES or **NO**

In the morning _____ at night _____ supine position _____

audible wheezing _____ hemoptysis (describe) _____

Sputum production: YES or **NO**

productive _____ if yes, COCAF _____

non productive _____

Chest pain or discomfort: YES or **NO**

Location _____ onset (date & time) _____

quantity (pain scale 0-10) _____ quality _____

Contributing factors _____

Aggravating factor(s) _____ Alleviating factor(s) _____

Social Factors *Former smoker (cigarettes) quit 30 yrs ago. 1 pack = 365 * 15 years =*

Smokes: YES or **NO**
 Frequency *1 pack a day* How many years? *15 years* Pack years *5,975*

Alcohol use: YES or **NO**

Frequency _____ How many years? _____

Drug Use: YES or **NO**

Name (s) _____ Frequency _____ How many years? _____

Any difficulty(ies) performing activities of daily living (describe)?

difficulty ambulating
on bedside urinal or commode

Does the patient have any special needs? (hard of hearing, legally blind...)

None

Physical Exam

Describe the patient's general appearance

received in bed, sleeping, responsive to tactile stimuli, once fully
awake patient was AOX4

Vital signs: T 98.4 °F, HR 68 , R 16 , bp $133/59$, O2 sat 98 %
Height 207 Weight $6'1"$

Skin color homogenous cyanosis (central / peripheral) None

Nose No deviation, normal transillumination

Sinuses no pain on palpation

Mouth & Pharynx pink, no lesions/ulcers

Trachea no pain on palpation

Chest no heaves, no abnormal breath sounds

Describe breathing pattern Normal

Breath sounds: clear bilaterally rhonchi _____ rales _____

wheezes _____ stridor _____ friction rub _____

Extremities

Capillary refill less than 3 clubbing No clubbing

O2 therapy (type, L/min, % of O2) 2L Nasal cannula

Dependent/ Independent/ Collaborative Orders:

Activity: difficulty ambulating w/ assist

Diet: No restrictions

Consults: N/A

Therapies/ Treatments: PT

Diagnostic Tests

CBC: abnormal results N/A

BMP/ CMP: abnormal results ~~N/A~~ N/A

PT/PTT/INR: abnormal results N/A

ABG interpretation: N/A

Pulmonary function tests: N/A

Cultures: N/A

Sputum studies: N/A

BNP results: N/A

Other Laboratory Data: Hemoglobin dropped 8 → 6.53 (9/26/21)

CXR results: unable to obtain

CT/ MRI/ V/Q scan: ~~unable to obtain~~ MRI - Pelvis (11/24) mal compression, iliac artery, vascular imaging (pathology debridement)

Biopsy N/A

ECG 12 lead: ~~unable to obtain~~ NSR 73

Other Diagnostic Studies: N/A

Medications (prescribed since admission):

Name	Dose	Route	Frequency	Use
hydromorphone	1 mg/ml	injection	ix	pain
acetaminophen	650 mg	iv oral	PRN every 4 hours	pain
amlodipine	10 mg	iv oral	iv	LOWER BP
aspirin	81 mg	oral	ix	pain
atorvastatin	40 mg	oral	ix	Lower high cholesterol and triglyceride
carvedilol	25 mg	oral	ix	LOWER BP
dextrose	15g	oral gel		raise blood sugar
furosemide	40 mg	oral		lower BP
gabapentin	300 mg	oral		pain
glucagon	1 mg	injection	ix	increase blood sugar

(If more space is required, write on a separate paper)

Patient Education

Patient barriers to learning? unable to obtain

Continued on back →

Topic	Method (verbal, demonstration, video, pamphlet.....)	Evaluation of learning (Did pt verbalize or demonstrate understanding or does pt require reinforcement)

(If more space is required, write on a separate paper)

Additional Comments:

+2 edema right leg
+1 edema left leg

Continued meds:

insulin glargine	100 units/ml (20 units)	injection	1x	lower Blood sugar
insulin lispro	100 units/ml (1-4 units)	injection	1x	lower blood sugar
insulin lispro	100 units/ml (1-6 units)	injection	1x	lower blood sugar
insulin lispro	100 units/ml (10 units)	injection	1x	lower blood sugar
isosorbide mononitrate	120 mg	oral	24 hour tab	heart related chest pain
lisinopril	40 mg	oral		Lower BP
oxycodone	5 mg	oral	every 6hs every 6hs PRN	Pain
pantoprazole	40 mg	oral		GERD
piperacillin tazobactam	4.5 g			
sodium chloride 0.9%	100 ml			infection
Polyethylene glycol	17 g	oral packet		constipation
ranolazine	500 mg	oral		angina
Sennosides	17.2 mg	oral		Constipation
spironolactone	25 mg	oral		Lower BP
tamsulosin	0.4 mg	oral (24 hour capsul)		urinary retention
ticagrelor	90 mg	oral		Blood thinner
tizanidine	2 mg	oral		Muscle Relaxant
vacomyacin	500 mg	oral		infection
chloride 0.9%	300 ml			