

Crisy Smith  
Concept map 2

### **Nursing assessment, vital signs, medical diagnosis/surgical procedure, lab values, Test, medication**

Pt is a 73 year old male. He was presented to the ER with a hip and head injury. No allergies, patient is alert and oriented x3 (Name, Date, Location). Pt is laying in the bed with no signs of distress or discomfort. History of hypertension and diabetes. He is a fall risk.

Temp: 98.5F Pulse:81 RR:19 BP:121/69

Diagnosis: Seizure

Medication: enoxaparin 40mg, memantine 5 mg, Tamsulosin 0.4 mg, aspirin 81 mg

**1. Nursing Diagnosis:** risked for ineffective airway clearance related to accumulated secretions during seizure

#### **Nursing Interventions**

- Place patient in supine position with head turned to the side during seizure activity
- Loosen clothing around neck and chest
- Have suction availability at Patients bedside, supplemental oxygen if needed
- Encourage the client to cough and deep breathe.

**Evaluation:** Family will properly demonstrate airway clearance interventions within 3 days

#### **Expected Outcome:**

- The patient will maintain clear, open airways as evidenced by normal breath sounds, normal rate and depth of respirations, and the ability to effectively cough up secretions after treatments and deep breaths.
- The patient will demonstrate increased air exchange.
- The patient will classify methods to enhance secretion removal.
- The patient will recognize the significance of changes in sputum to include color, character, amount, and odor.

**2. Nursing Diagnosis:** Impaired Skin Integrity related to pressure over bony prominence as evidenced by pain, bleeding, redness, wound drainage.

#### **Nursing Interventions**

- Assess the overall condition of the skin.
- Evaluate the patient's awareness of the sensation of pressure.
- Assess the skin for signs of Long-term steroid use.
- Reassess the skin regularly and whenever the patient's condition or treatment plan results in an increased number of risk factors.

**Evaluation:** The patient will maintain an intact tissue integrity within 6 months.

**Expected Outcome:**

- The patient will verbalize a plan of care to maintain uncompromised tissue integrity
- The patient will be free of pain
- The patient will experience an improved wound healing process
- The patient will verbalize and demonstrate wound care correctly

**3. Nursing Diagnosis:** Risk for Trauma related to Weakness, balancing difficulties; reduced muscle, hand or eye coordination

**Nursing Intervention**

- Evaluate the need for or provide protective headgear.
- Carry out medications as indicated
- Reorient the patient following seizure activity.
- Use and pad side rails with the bed in the lowest position, or place the bed up against the wall and pad floor if rails are not available or appropriate.

**Evaluation**

The patient will verbalize understanding of factors that contribute to the possibility of trauma and or suffocation and take steps to correct the situation within 6 months

**Expected Outcome**

- The patient will identify and correct potential risk factors in the environment.
- The patient will demonstrate behaviors, and lifestyle changes to reduce risk factors and protect self from injury.
- The patient will modify the environment as indicated to enhance safety.
- The patient will maintain a treatment regimen to control or eliminate seizure activity.

**4. Nursing Diagnoses:** Risk for Situational Low Self-Esteem related to inconsistent behavior

**Nursing Interventions**

- Discuss with the patient current and past successes and strengths.
- Refrain from overprotecting the patient; encourage activities, providing supervision and monitoring when indicated
- Help the individual realize that his or her feelings are normal; however, guilt and blame are not helpful.
- Refer a patient to a support group

**Evaluation:**

The patient will express positive self-appraisal within a month

**Expected Outcome**

- The patient will demonstrate behaviors to restore positive self-esteem.
- The patient will participate in the treatment regimen or activities to correct factors that precipitated a crisis.
- The patient will identify feelings and methods for coping with the negative perception of self.
- The patient will verbalize an increased sense of self-esteem in relation to the diagnosis.