Christianah Omodewu
Professor Hwang

Comprehensive Nursing Assessment

Refer to Chapter 2. Recording Your Findings: The case of Mrs. N Case Study Document

Patient Information: G. C. **DOB**: 4/10/1967 **Gender:** M

Source of History: Patient who is a reliable historian and medical record

Reason for seeking care (Chief Complaints): "I'm having stomach pain."

History of Present Illness (HPI):

A 55 year old adult pmh DM, HTN,HLD,CHF, ESRD on TTS HD, liver cirrhosis with ascites. Patient went 4 days with left eye vision loss and 1 month inc abd distension and pain. According to the patient, vision loss was gradual , painless and he sees like red blood in left eye , but cannot see fingers and can only see some light. At baseline he wears glasses for reading. Patient also stated that he has inc abd distension, pain around the umbilicus over his hernia, denies nausea, vomiting, fevers and chills. He states that he used to get taps every 3 months, but it has been a long time. Patient denies pain associated with exertion , change in exertional status , chest pain, dyspnea, fever, chills, nausea/vomiting, diarrhea/constipation

Past History:

Past Medical History: Diabetes mellitus (HCC), dialysis patient (HCC), ESRD (end stage renal disease (HCC), heart failure (HCC), hypertension.

Past Surgical History: back surgery , leg surgery (left), PR sigmoidoscopy FLX w/ biopsy

Immunizations: influenza IIV4 (12/14/2016), H1N1 Inj Preservative free (01/29/2010)

Allergy: Fish - Rash

Medications: apixaban (ELIQUIS) 5 MG 1 tablet every 12 hours
Atorvastatin (LIPITOR) 20 MG Tablet daily
(Blood Glucose monitor system) w/device kit
Carvedilol (COREG) 3.125 MG tablet two times with meals
Insulin detemir (LEVEMIR FLEXTOUCH) 100 unit injection
Lancets Misc
sitaGLIPtin (JANUVIA) 25MG

Social and Personal History

Social: N/A
ETOH: N/A
Illicit drug use: none
Smoking: none

Family History: N/A

Health Patterns (Chapter 4. Table 4-3) Health Patterns

Self-concept:N/A
Value-belief:N/A
Exercise and diet: renal diet
Sleep-rest:N/A
Relationship: N/A
Coping-stress-response:

Review of Systems

- General: Patient reports feeling fatigued, weak, and short of breath.
- Head, Eyes, Ears, Throat (HEENT): Patient reports no headaches, vision changes, hearing changes, or sore throat.
- Neck: Patient reports no neck pain or stiffness.
- Breasts: Patient reports no breast lumps or pain.
- Respiratory: Patient reports shortness of breath and a productive cough.
- Cardiovascular: Patient reports no palpitations, chest pain, or swelling in the extremities.
- Gastrointestinal: Patient reports anorexia, nausea, and abdominal pain.
- Urinary: Patient reports no dysuria, hematuria, or frequency.
- Genital: Patient reports no genital pain or discharge.
- Peripheral Vascular: Patient reports no swelling in the extremities.
- Musculoskeletal: Patient reports no joint pain or stiffness.
- Psychiatric: Patient denies any depressive symptoms or anxiety.
- Neurologic: Patient reports no dizziness, weakness, or numbness.
- Hematologic: Patient reports no easy bruising or bleeding.
- Endocrine: Patient reports no heat or cold intolerance.

Physical Exam

Height: 5’3 Weight: 149 BMI: 26.56 kg/ml
Vital Signs BP: 115/63 Heart rate: 69 Respiration rate: 17 Temperature: 99.1 degrees F

General Survey: G.C is 55 y/o man who admitted for abdominal distension. He is alert and oriented x2-3 (unable to recall year , month, or seasons at this time). I reoriented the patient. Patient is Spanish speaking. No shortness of breath noted. Abdomen distended, umbilical hernia noted (soft to touch). Patient has no complaints at this time, no signs and symptoms of acute distress noted at this time, safety precautions in place.

Head, Eyes, Ears, Throat (HEENT): Head is normocephalic and atraumatic. Pupils are equal, round, and reactive to light Ears are clear bilaterally with normal hearing. Throat is clear without erythema or exudates.
Neck and lymph nodes: Neck supple without palpable masses or adenopathy.

Thorax and Lungs: Lungs are clear to auscultation bilaterally with no wheezes, rhonchi, or rales. No chest wall deformities or tenderness noted.

Cardiovascular: Regular rhythm, normal S1 and S2, with no murmurs,s3,S4. Peripheral pulses are 2+ and equal bilaterally. No peripheral edema.

Breasts: No masses or discharge.
Abdomen: distended, no pain upon palpation
Genitalia: Normal male genitalia with no erythema, discharge, or lesions.
Extremities: No cyanosis, clubbing, or edema. Full range of motion with no joint deformities.
Peripheral Vascular: No palpable pulses, bruits, or edema noted.
Musculoskeletal: No muscle atrophy or weakness noted. No joint deformities or crepitus.
.

Laboratory Data:

TEST		***PATIENT RESULTS***	
CBC	***HGB***	***7.8***	
	HCT	***24.0***	
	WBC	***4.42***	
	RBC	***2.73***	
CHEMISTRIES	***NA***	***133***	
	K	***5.4***	
	CL	***98***	
	CA	***8.3***	
	MG	***2.10***	
	BUN	***70.0***	
	CREATININE	***7.3***	
	GLUCOSE	***197***	
URINALYSIS	***COLOR***		
	CLARITY		

	PH		
	PROTEIN		
	KETONES		
	SG		
	WBC		

Nursing Assessment/Plan

1.
Problem: pain

Interventions: assess and monitor patients' pain using appropriate pain scale. Collaborate with an interdisciplinary team and initiate plans and interventions as ordered. Reassess patient pain level 30-60 minutes after pain management intervention

Evaluation: patient pain/discomfort is manageable

2.
Problem: safety

Interventions: assess and monitor vital signs , neurological status including level of consciousness and orientation. Assess patients risks for falls and implement fall prevention plans of care and interventions per hospital policy.
Ensure armband on, uncluttered walking paths in room lighting, call light and overbed table within reach, bed in lower position, wheels locked, side rails up per policy and non-skid footwear provided.

Evaluation: patient will be injury free during hospitalization

3.
Problem : psychosocial needs

Interventions: monitor patients ability to cope with his/her illness.

Evaluation: demonstrates ability to cope with hospitalization/illness

4.
Problem: knowledge deficit

evaluation : patient will verbalize understanding of fall precautions