

Comprehensive Nursing Assessment

Patient Information: F. A. **DOB:** 1970 **Gender:** M

Source of History: Documents from the patient and from document of when he was in the hospital from the past

Reason for seeking care (Chief Complaints): “my hernia is swollen and hurts”

History of Present Illness (HPI):

A 55 year old man has been admitted to the hospital on April 15, 2023 for an umbilical hernia that is draining ascites fluid. He had this umbilical hernia for a year and a half, prior to admitting to the emergency room he was in pain for two days. There was an open wound in the hernia and the patient was scratching it due to the irritation. Patient has a history of hyperkalemia, Acute kidney injury, thrombocytopenia, and warts (possibly due to Human papillomavirus infection) bilaterally on the lower extremities. He is non-amublatory, incontinent, and his scrotum was enlarged. He is currently on CIWA protocol (The Clinical Institute Withdrawal Assessment Alcohol Scale Revised) and had taken his morning medications. The patient was alert and oriented x 2 , was not in any distress or reported any pain. A surgeon had gone to his room and closed up his opened wound. Patient is on a high protein diet and ate his food. He is a full code. The surgeon had drained the fluid, used lidocaine to numb the hernia, covered it in iodine, stitched it 3 times, and applied dressing to cover the hernia. He also had his blood withdrawn for a culture to see if he has an infection, in this test it had included the anaerobic and aerobic culture.

Past History:

Past Medical History: Acute kidney injury, hyperkalemia, thrombocytopenia

Past Surgical History: No past history of surgery

Immunizations: No Covid vaccine or any known other vaccinations

Allergy: No known allergies

Medications: Ammonium lactate 12% - 2x lotion for warts

Enoxaparin injection 40 mg - Daily

Folic Acid tablet 1 mg - Daily

Lorazepam injection 2 mg- every 4 hours

Lorazepam injection 4 mg - every 2 hours

Thiamine injection 200 mg- 3x

Social and Personal History

Social: worker

ETOH: misuse of Alcohol

Illicit drug use: none available

Smoking: Not a smoker

Family History: None available

Activities of Daily Living (ADL): Needs assistance with bathing from the nurse and/or PCA and dressing, uses the urinal, needs assistance when ambulating, Incontinent, and can feed himself with no problem.

Instrumental Activities of Daily Living (IADL): Can use his cell phone. But shopping, preparing food, housekeeping, doing laundry, transportation, taking medicine, managing money are not available for record.

Review of Systems (Subjective - you should not document from your physical exam findings):

General: Not available

Head, Eyes, Ears, Throat (HEENT)

Neck

Breasts: no swelling and discoloration in both breast

Respiratory: patient does not look like he is in respiratory distress and is not on oxygen

Cardiovascular: there is no ekg or any swelling from the extremities due to cardiac problems

Gastrointestinal: Hernia in the umbilical area, aside from that I did not see any distention or swelling

Urinary: incontinent but did not have a catheter on

Genital: scrotum was enlarged

Peripheral Vascular: had warts on the lower extremities

Musculoskeletal: no noticeable atrophy or fractures and or broken bones

Psychiatric: patient appears in calm, undistressed state, does not look anxious, scared, and cooperated with us.

Neurologic: Alert and oriented x2, only communicated back when spoken in spanish

Hematologic: Had to get blood drawn

Endocrine: None available

Physical Exam (objective: you should not document from your review of systems findings)

Height: 5'6 Weight: 142 BMI: 22.9

Vital Signs BP: 102/64 Heart rate: 79 Respiration rate: 19 Temperature: 98.2

General Survey: F.A is a 55 year old man who appears to be calm and relaxed. He appears to be within the healthy range for his age, he was watching television and had no complaints. He is at the moment bed bound.

Head, Eyes, Ears, Throat (HEENT):

Neck and lymph nodes:

Thorax and Lungs: lung sound clear bilaterally

Cardiovascular: S1 and S2 sounds, loud, clear, and normal rhythm

Breasts: no tenderness and lumps in both breast

Abdomen: tympanic sound when percussed

Genitalia: There were swelling in the scrotum and incontinence

Extremities: no bruising or swelling aside from the warts

Peripheral Vascular: No cyanosis or redness. Did not see any pvd, dvt, etc.

Musculoskeletal: can move in the bed and turn around with no problem

Neurologic: Alert and oriented x 2 and was awake

Mental Status.

Cranial Nerves: None available

*Cerebellar:*None available

*Sensory:*None available

Reflexes: None available

Laboratory Data:

None available at this time

Nursing Assessment/Plan

Problem: Risk for dysfunctional gastrointestinal motility, risk for infection, and risk for metabolic imbalance syndrome.

Interventions: Check for bowel sounds and do the IAPP to see if his continence has improve., Check if there is any drainage or leakage and for redness or tenderness. Check for fluids and electrolytes routinely.

Evaluation: In progress