Nursing Process Paper-Nursing 30030

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Client Profile:

F.W. a 90 year old male was admitted September 15th, 2012 for rectal bleeding and Syncope followed by an admitting diagnosis of Gastrointestinal bleed. His history includes hypertension, pacemaker, Cerebrovascular Accident (stroke), prostate cancer, and heart failure.

Black and Hawk (2009) outlines Cerebrovascular Accident (Stroke) as:

Neurologic changes caused by an interruption in the blood supply to a part of the brain. The two major types of stroke are ischemic and hemorrhagic. Ischemic stroke is caused by a thrombotic or embolic blockage of blood flow to the brain. Bleeding into the brain tissue or the subarachnoid space causes a hemorrhagic stroke. Ischemic strokes account for about 83% of all strokes; the remaining 17% of strokes are hemorrhagic. CVA are the third leading cause of death in the U.S. Disorders after strokes can manifest as hemiparesis, aphasia, dysarthria, visual changes, apraxia, dysphagia, homonymous hemianopia, Horner syndrome, Agnosia, unilateral neglect, sensory deficits, behavioral changes, and incontinence. (p. 1843-1870). The patient dementia limited me to notice any behavior changes, but as for my assessment there were no abnormalities (i.e. cranial nerves, physical equal strength, and commands).

Black and Hawk (2009) described Heart failure as:

Is a physiologic state in which the heart cannot pump enough blood to meet the metabolic needs of the body. Heart failure results from changes in systolic or diastolic function of the left ventricle. The heart fails when, because of intrinsic disease or structural defects, it cannot handle a normal blood volume or, in the absence of disease, cannot tolerate a sudden expansion in blood volume. Heart failure is not a disease itself; instead the term refers to a clinical syndrome characterized by manifestations of volume overload, inadequate tissue perfusion, and poor exercise tolerance. Whatever causes the pump failure results in hypoperfusion of tissue, followed by pulmonary and systemic venous congestion, and it's often called congestive heart failure.

Risk factors include intrinsic and extrinsic factors (p. 1430-1448). Without the patients history I would have never known he was a heart failure patient. His medications flagged my attention that clearly there was something going on with his heart, but during his assessment I didn't hear anything that suggested his situation wasn't being handled with the upper most care.

Black and Hawk (2009) defined Hypertension:

As a persistent elevation of systolic and diastolic blood pressure (DBP) at a level of 90mm Hg or higher. Hypertension is characterized by type, cause, and severity. Most clients with a combination of systolic and diastolic blood pressure elevation are diagnosed with primary hypertension, also known as essential or idiopathic hypertension. Blood pressure remains elevated and continues to rise over time because of a persistent, progressive increase in peripheral arterial resistance. The persistent raise in arterial resistance is due to inappropriate renal retention of salt and water or abnormalities of or within the vessel wall. Clients who develop hyperse3ion from an identifiable cause- a specific disease state or problem – are diagnosed with secondary hypertension, and in many cases the underlying cause is correctable. Risk factors for hypertension include family history, age, gender, ethnicity, diabetes, stress, obesity, nutrients, and substance abuse. Ways in which to reduce hypertension include normalizing arterial pressure, lifestyle modifications, weight reduction, Na restriction, dietary fat modification, exercise, alcohol restriction, caffeine restriction, relaxation techniques, smoking cessation, K supplementation, and pharmacologic interventions and provider interventions. As a major risk for other cardiovascular conditions, although it does not usually produce symptoms of its own (p. 1290-1306). This patient had many markers that I gathered to outline a clear path to him having a history of hypertension. My concept map really was able focus on his hypertension with so many signs and symptoms and the physiologically.

Black and Hawk (2009) described prostate cancer as:

Is the second most commonly diagnosed cancer in men and has recently emerged as the leading cause of cancer-related deaths in American men. The cause of prostate cancer is unknown, but it is known that two types of tumors are diagnosed in the clincial setting. Men with a family history of prostate cancer are at high risk for developing adenocarcinomas and 10% are believed to be inherited90% are classified as sporadic and that these non-inherited prostate cancers has led to hypotheses that these tumors may arise from damage or loss of genes that control essential cellular processes such as replication or apoptosis. (p. 886-896). I did not conduct a prostate exam on this patient, so I have nothing to report on this matter.

Alert and Oriented Only to Person; Responds when spoken to; Awakens when shaken drowsiness present; speech garbled; skin warm dry with minimum scars present; +1 skin turgor; capillary refill <3 seconds; no clubbing present. Intact basic cerebellar functioning; skull normocephalic, smooth with even hair distribution. Ears symmetrical without drainage. Patient does not wear glasses, PERRLA 3mm; Sinus' without edema or tenderness, nares without deviation, mucosa pink and moist. Oral mucosa pink and moist; tongue center, artificial dentation present. Facial expression moderate/symmetrical; Trachea midline; thyroid and lymph nodes non-palpable; No JVDF or Bruits present; +ROM to neck, arms, legs, moves upper extremities without difficulty, limited mobility in lower extremities; able to sense most light and sharp touch all over; S1S2 heart sounds with regular apical of 76; Lungs are clear bilaterally with equal expansion; Respirations increased with easy and even; abdomen soft, tender with hypoactive bowel sounds; no sputum present; bilateral, temporal, carotid, radial, brachial, femoral pulse equal and regular (+2), Popliteal, pedal pulses shallow and regular (equal) (+1). Bilateral Patellar reflexes +1; +2 edema present in Left lower leg; Left internal jugular, triple lumen catheter, do not use distal port on IV access (9/18/12). Stage 1 ulcer on coccyx (wound stage consult); large bloody bowel movement on admission. September 18th 2012 mahogany

blood tinged stool, Foley present; amber in color/no abnormalities; I & O 720/325; consumed 100% breakfast; bed rest, No SOB/DOE; Pt. complains of no pain 0/10, but physical appearance suggests otherwise; 2x bed rails, bed alarm in place (risk for falls); Pt. is restraint 2x for physical violence attempts & for trying to remove his Foley; SCDs/TED hose; daughter making decisions on his behalf, being located to nursing home on discharge.

F.W. may never have received medical attention if he had not been found by a neighbor with syncope. Black and Hawk (2009) defined Syncope (fainting):

> Which is defined as generalized muscle weakness and an inability to stand erect accompanied by loss of consciousness. It is a good measure of cardiovascular status because it may indicate decreased cardiac output, fluid volume deficits, or defects in cerebral tissue perfusion. (p. 1305). Although I didn't witness his syncope, I would agree with the numerous issues he has going on that it's only likely.

This patient was admitted to Mercy hospital with a gastrointestinal bleed which "results from local trauma or irritation that causes erosion or ulceration of the GI tract mucosa. The disorders involved include stomach neoplasms, gastric ulcer, gastritis, anastomotic ulcers, and duodenal ulcers" (Black and Hawk, 2009, p. 623). Lower gastrointestinal (LGI) bleeding is a common medical problem associated with significant morbidity and mortality. Most patients stop bleeding spontaneously and most do not re-bleed (Ciccociopppo, Walker, Taylor, Padbury, Wattchow, 2010, p. 451). During my observation of this patient, I provided comfort care measures by changing his clothes, linen, and depends in which I was able to assess his bottom and indicate blood tinged on his depend.

This patient is still at risk for syncope because it's a common concern in patients would are bedridden as this patient is currently on bed rest and is restrained to the bed. Syncope involves the patient trying to changes positions from sitting to standing to quickly and with the

sudden “detection in the fall of cardiac output that occurs with the lack of venous return and the increase sympathetic tone to compress arterioles to improve venous return” (Black and Hawk, 2009, p. 1305). Medications for blood pressure can cause orthostatic hypotension or postural hypotension and other drugs used for preventing fluid volume overload and heart medications. It’s important to teach the client in these situations to adjusting from each position slowly, breathe deeply and keep both eyes open to prevent them from becoming dizzy. An important tool to evaluate syncope is the medical history, which usually uncovers the likely, because risk factors leading to falls in older people may be broadly classified into those that are extrinsic or intrinsic (Whitaker, 2011, p. 51).

F.W. is on many different medications to control his heart condition and his health care team taught him that syncope was a side effect of a combination therapy of ACE inhibitors and ARB which are known to reduce cardiovascular events (Berra & Miller, 2009, p.72). Grief can also be a contributing factor to an episode of syncope in situations of sudden death (Pattison, 2007, p.50). Syncope is also linked to Parkinson disease and cardiac problems (Amella, 2004, p. 44, & Smith & Buckwalter, 2005, p. 43). Many episodes are a warning of manifestations such as rapid heart action, vision changes, weakness, dizziness, nausea, and diaphoresis. Medications and volume depletion (from diuretics, nausea, vomiting, diarrhea, and severe anemia) can cause syncope. Seizures often have a prodromal aura preceding the seizure as well as urinary incontinence and a postictal state of confusion (Black and Hawk, 2009, p. 1362).

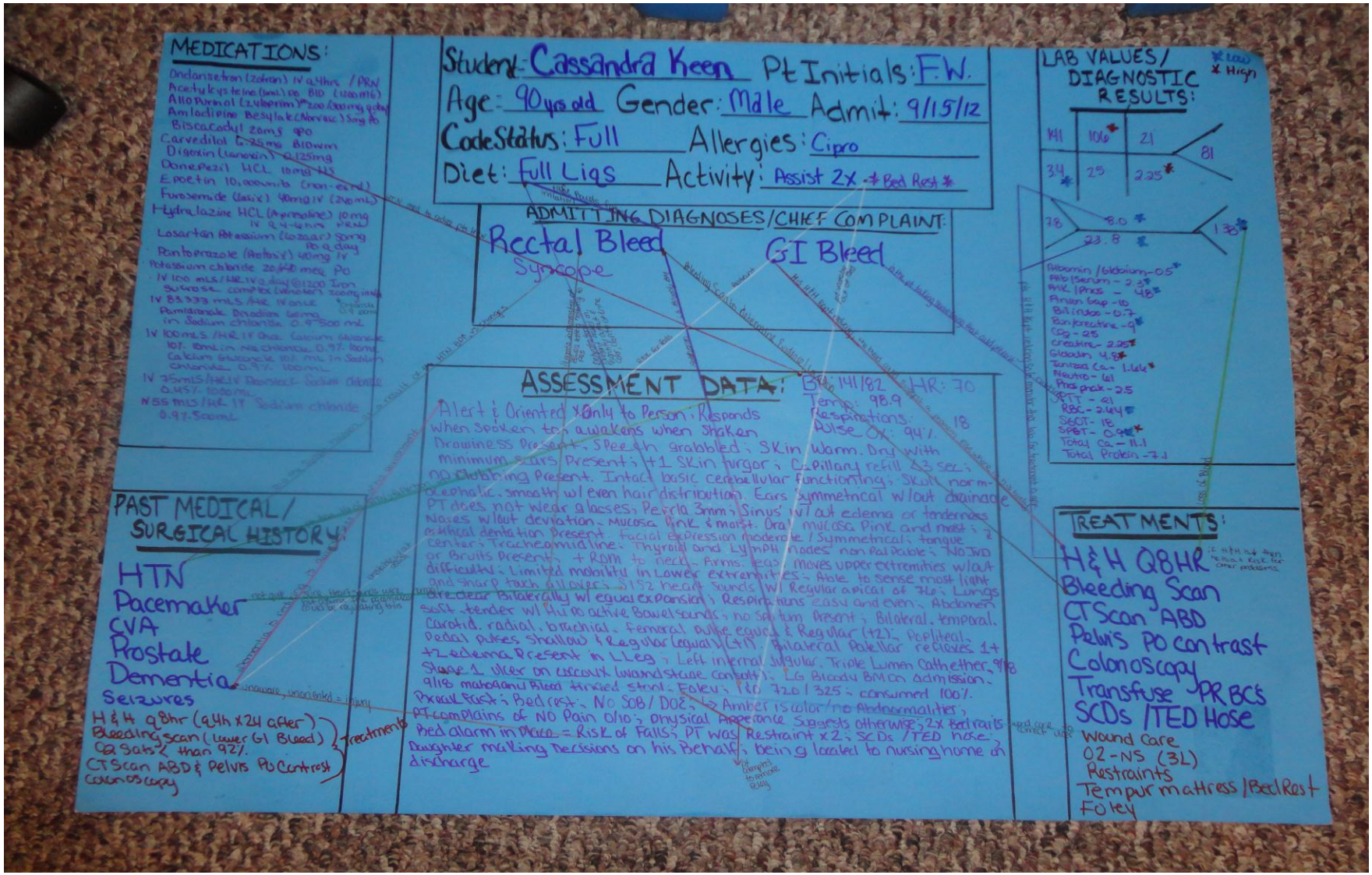
Tabloski (2010) outlined the following:

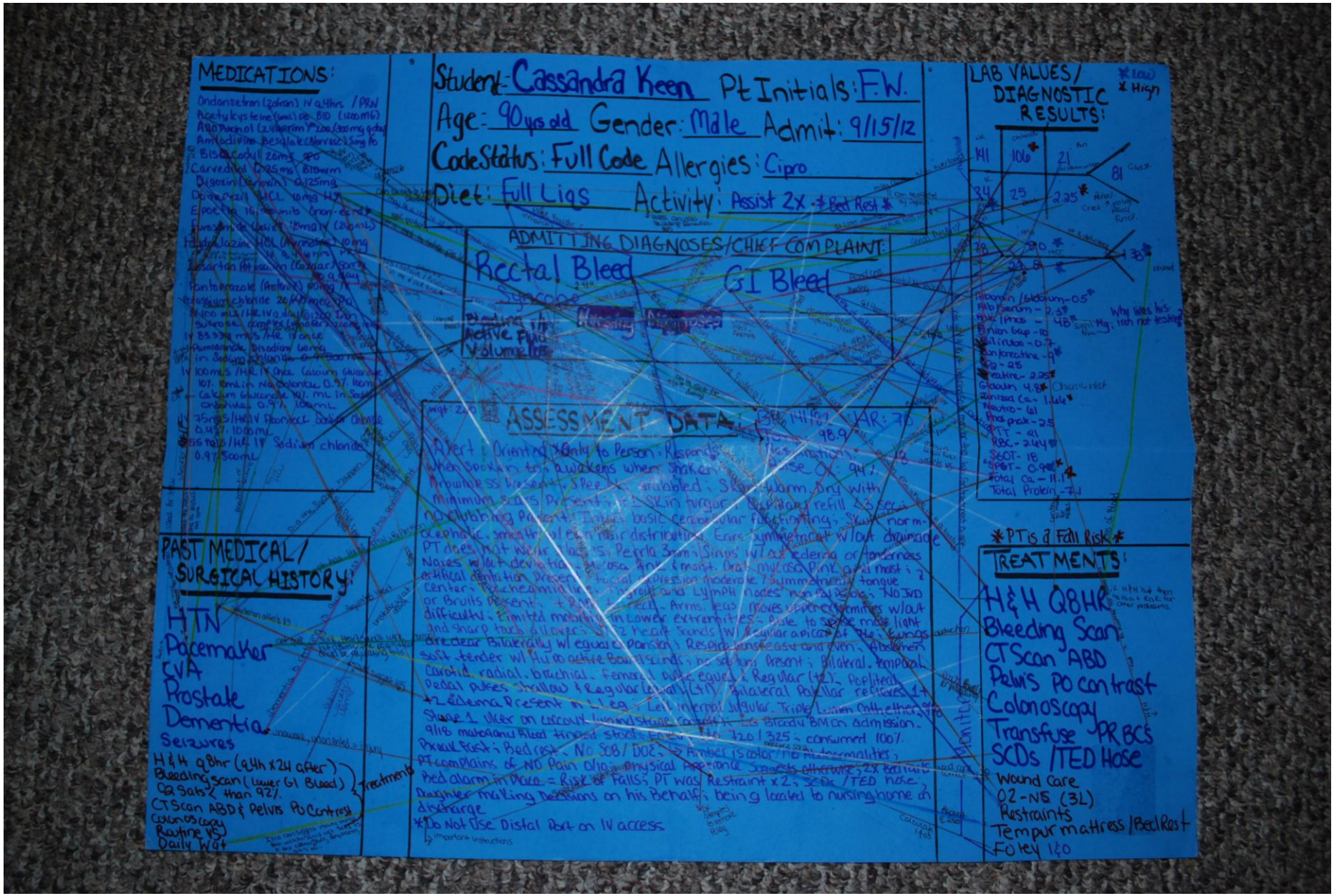
> Drugs used to for syncope or falls used to treat are short- to intermediate-acting benzodiazepine and tricyclic antidepressants (imipramine hydrochloride, doxepin hydrochloride, and amitriptyline hydrochloride). The concerns with these are that

> it may produce ataxia, impaired psychomotor function, syncope and additional falls. (p. 760)

Primary nursing diagnosis is bleeding related to gastrointestinal bleeding supported by admitting diagnosis, decreased hemoglobin and hematocrit lab levels, increased BUN and Creatine lab levels, dehydration, and diarrhea. Short term goal includes reducing blood in stools; Long term goal includes increasing H&H lab levels, and decreasing BUN and Creatine lab levels. Interventions with rationale as follows 1) monitor vital signs by comparing previous readings, reflects changes in patients vitals 2) monitor intake and output and correlate with weight changes, measuring blood and fluid losses from emesis, gastric suction or lavage, and stools providing guidance with fluid replacement 3) assess clients individual physiological response to bleeding such as changes in mental status, weakness, restlessness, anxiety, pallor, diaphoresis, tachypnea, and temperature elevation to indicate severity and length of bleeding episode, with worsening of symptoms which may reflect continued bleeding, inadequate fluid replacement, and shock 4) maintain bed rest: prevents vomiting and straining at stool, by scheduling activities for undisturbed rest periods because activity and vomiting increases intra-abdominal pressure and can predispose to further bleeding 5) fresh whole blood or packed RBCs, for acute bleeding with severe volume and RBC depletion because stored blood may be deficient in clotting factors.

Concept Care Map:




MEDICATIONS:
Student: Cassandra Keen Pt Initials: F.W.
Age: 90yrs old Gender: Male Admit: 9/15/12
Code Status: Full Code Allergies: Cipro
Diet: Full Liqs Activity: Assist 2x *Bed Rest*
ADMITTING DIAGNOSES/CHIEF COMPLAINT:
Rectal Bleed
GI Bleed
LAB VALUES/ DIAGNOSTIC RESULTS:
ASSESSMENT DATA:
PAST MEDICAL/ SURGICAL HISTORY:
HTN
Pacemaker
CVA
Prostate
Dementia
Seizures
H&H q8hr (q4h x24 after)
Bleeding scan (Lower GI Bleed)
O2 Sats < than 92%
CT Scan ABD & Pelvis PO Contrast
Colonoscopy
Routine VS
Daily Wgt
Treatments
PT is a Fall Risk
TREATMENTS:
H&H Q8HR
Bleeding Scan
CT Scan ABD
Pelvis PO contrast
Colonoscopy
Transfuse PRBCS
SCDs /TED Hose
Wound Care
O2-NS (3L)
Restraints
Tempur mattress/BedRest
Foley I&O

Assessment Data

Functional Health Patterns

AREA OF HEALTH	SUBJECTIVE DATA	OBJECTIVE DATA	INDIRECT DATA *Identify source of indirect data	INTERPRETATION (effective patterns or barriers/potential barriers)
HEALTH / PERCEPTION **HEALTH MANAGEMENT** General Survey, perceived health& well-being, self-management strategies, utilization of preventative health behaviors and/or services.	The patient was not able to discuss with me his well-being, self-management strategies, prevention of health behaviors or services because when I asked him such questions he didn't seem to understand what I was asking.	PT admitted 9/15/12, and his records didn't include much to suggest he maintained a healthy management.	I was only able to view a small portion of his medical history, in which include a few times he was admitted.	Patient is unaware of his situation. During the assessment I tried to ask the patient basic information about himself and he seemed unaware of where he was, where he lived, what state we were located in, what the date was, or his family.
NUTRITIONAL/ METABOLIC Patterns of food and fluid consumption, Weight, skin turgor. (Skin, Hair, Nails; Head & Neck; Mouth, Nose, Sinus; swallowing, Ht. Wt.)	The patients has stated before was no help for providing me his information. He only seemed to answer a question I was already suggesting an answer for: Would you like to eat this, can I give you a bath)	Pt. was currently on a full liquid diet, in which he had eaten all of his breakfast. The patient arrived at the hospital weighing 220, and left weighing 221. A height assessment hadn't been done, but I could easy say he was 6'3, and that was because he practically touched both ends of the bed.	From his condition, I could tell that he hadn't had good care, with any of his personal behavior, and during my assessment I had received a call from a woman stating that he was living alone, and was found unconscious.	This patient has many limitations that are causing him from being successful in his life. Whether this is HTN, Stroke, or Heart failure related, it's best for him to be in a situation that someone can monitor him and ensure that his safety is being put at the highest priority.

ELIMINATION Patterns of excretory function & Elimination of waste; relevant labs, Medications, impacting, etc. (Abdominal - bowel and bladder)	The only subjective data I was able to gather from this man that during his bed bath, he found the cleaning of his genitalia to be very ticklish	I was able to indicate that this client needed someone to help him in all aspects related. He was wearing a depend and had a Foley in which the patient didn't really seem to even notice.	This patient was unaware of his situation and what was happening to him and what the necessary steps were for him to recover. It was very clear that he was going to need to be placed in a facility so someone could care for him.	I think a huge barrier to his recovery may be that no one will be there to care for him because he won't either have the proper support channel from loved ones or that he doesn't have / the proper insurance that will cover the care he will require.
ACTIVITY/EXERCISE Patterns of exercise & daily living, self-care activities include major Body systems involved. (Thoracic & Lung; Cardiac; Peripheral vascular; Musculoskeletal,vital signs)	The client was unable to express any interest in ADLs, IADLs, things he enjoyed to do. He couldn't even discuss to me how he felt about being restraint to the bed	This patient requires someone to assist him in all his needs. I had to help him as well during breakfast, he would follow through if you had started the act or he could mimic it. He was completely unaware when his tray was sat down in front of him that it meant to eat.	The only other resources I had were his charts that didn't provide much other than a Braden score that was under 12, in which I knew I needed to be there for him and provide him full care.	F.W. is unable to understand that he is hungry and this is a huge limitation. He is restraint to the bed and that limits his mobility completely.
SEXUALITY/ REPRODUCTION Satisfaction with present level of Interaction with sexual partners (Breast; Testes; Abdominal-Genitourinary-reproductive)	The conversation of his personal sexual life was never a discussion, The priority was to ensure he was fed, changed, and that he wasn't in any pain. I was never able to assess this aspect	The only level of stimulation may have been during his bed bath, in which this was really only reaction observed. He needed to be cleaned because clearly this area had been overlooked.	The patient didn't seem to be shy about being cleaned and this outlined to me he was really unaware of what was going on.	If the patient is not alert and orientated at all, it reflects that his body could probably suffer physical damage and his mind really wouldn't register the action.

SLEEP/REST Patterns of sleep, rest, relaxation, tfatigue, (Appearance, behavior)	The patient didn't appear to have any sleep disturbances	During my assessment with this patient, he dozed off several times. I assumed that with all the different medications he was taking, that probably caused much drowsiness.	His records provided me with his medication list, but I didn't have any home meds, family members to give me the information I was missing.	The patient clearly doesn't have a sleep and rest barrier. I would imagine in any environment this client is provided he will still be able to sleep.
COGNITIVE/ PERCEPTUAL Patterns of thinking & ways of Perceiving environment, orientation Mentation, neuron status, glasses, Hearing aids, etc.	I would have enjoyed having the opportunity for this client to speak to me, to give me the missing information in his assessment, to understand his life and how he came to this day. I didn't even know if he actually wore glasses or an aid because he couldn't tell me that.	As I stated his file didn't provide me much to work with but I did the best I could to create and complete my project. At one point the patient laughed like I was joking when I told him we were at Mercy medical center.	without proper medical paper work, help from the client on his health, lack of family members, I had to fill in the blanks as much as I could in order to provide this client with the best possible care.	If this client is unable to think, perceive, and have some sort of thought process, he is unable to care for himself. This is a huge limitation because the client doesn't even realize he has a problem
ROLE / RELATIONSHIP Patterns of engagement with others, Ability to form & maintain meaningful Relationships, assumed roles; Family communication, response, Visitation, occupation, community involvement	His chart reflected that this daughter was his benefice, but there was no indication of instruction or that she had visited her father. I had no understanding his relationships.	As stated his file indicated a daughter, but no wife, didn't state whether he lived with family, friends, or alone. I had no method to assess this subject either.	The patient didn't speak of his family, and I didn't know if that meant he didn't want to discuss it or that if he honestly didn't know what to say because he couldn't think of anything with his limiting memory or cognitive impairment.	If this patient doesn't have the proper support channel, or the necessary care to help him recover, how can he be supported so he doesn't cause severe harm to himself.

SELF-PERCEPTION/ SELF-CONCEPT Patterns of viewing & valuing Self; body image & psychological state	Could not assess this area of the client from his perspective	The patient didn't provide me with any guidance that I could use to fill this area out.	I am sure the client probably has many nursing diagnoses in this topic but without nay support from the client to fill in his history, I am unable to provide an accurate assessment.	The client is unable to discuss such topics and therefore leading to a pattern of incomplete data assessment
COPING/STRESS TOLERANCE Stress tolerance, behaviors, patterns of coping with stressful events & level of effectiveness, depression, anxiety.	At one point the client was anxious, and there was a moment with a little fuss with his restraints but his behavior was moderate the whole morning. He just seemed relaxed and calm for the time I was his student nurse.	The only information I could gather is that the patient didn't appear to be in discuss. I didn't visualize any stress, his behavior didn't change, he wasn't alert, or appeared depressed	At least if the patient is going through this, doesn't appear to be upset or frustrated about that. Which is a huge factoring that providing care to a client who doesn't object to anything.	This can be an issue if the client is actually in pain or uncomfortable because he isn't stressing any fears, issues, concerns, anxiety, or behavior changes. This is very difficult for a nurse that is unable to read her patients behavior
VALUE/BELIEF Patterns of belief, values, Perception of meaning of life that guide choices or decision; includes but is not limited to religious beliefs	As I have stated over and over, the client was unable to provide me with this information and his records didn't provide them either.	The clients records didn't suggest any religious behavior, nor did the patient provide any indication of a religious or personal beliefs or values	If a family member or his records had listed this, he may feel comfortable knowing that during his last opportunity he could have that comfort.	If the client wanted a religious or a specific individual there to listen to his last thoughts, to ask for forgiveness, or even express his last wishes, he was unable to express any guidance do to his deteriorating mental status.

Lab Information & Diagnostic test results:

Lab Test	Result 1 9/14/2012	Result 2 9/18/2012	Result 3 9/21/2012	Normal Range	Interpretation
Albumin/ Globulin		**0.5 L**		0.8-2.0	Low total protein levels can suggest a liver disorder, a kidney disorder, or a disorder in which protein is not digested or absorbed properly. Low levels may be seen in severe **malnutrition** and with conditions that cause **malabsorption**, such as Celiac disease or **inflammatory bowel disease (IBD).**
Albumin Serum		**2.3 L**		3.5-5	Low levels of Albumin/Serum may be a sign of kidney disease, liver disease, weight loss after surgery, or **low protein diets** and can also be seen in **inflammation**, **shock, and malnutrition.**
Alkaline Phosphatase		**48 L**		51-153	Low levels are sometimes found in hypoadrenia, protein deficiency, **malnutrition** and a number of **vitamin deficiencies (pernicious)**
Anion Gap	10	10	10	4-14	An increased measurement is associated with metabolic acidosis due to the overproduction of acids (a state of alkalinity is in effect). Decreased levels may indicate metabolic alkalosis due to the overproduction of alkaloids (a state of acidosis is in effect).
Bilirubin		0.7		0.1-1.2	Bilirubin is a breakdown product of heme and heme is a part of hemoglobin in red blood cells. The liver is responsible for clearing the blood of bilirubin. Bilirubin is taken up into hepatocytes, conjugated (modified to make it water-soluble), and secreted into the bile, which is then excreted into the intestine.
Blood Urea Nitrogen	**22 H**	**21 H**	**22 H**	5-20	Increases can be caused by excessive protein intake, kidney damage, certain drugs, **low fluid intake suggesting dehydration**, **intestinal bleeding**, exercise, or prerenal failure or heart failure.
Carbon Dioxide	**27 H**	25	24	19-25	The CO2 level is related to the respiratory exchange of carbon dioxide in the lungs and is part of the bodies buffering system. Generally when used with the other electrolytes, it is a good indicator of **acidosis and alkalinity**.

Chloride	**106 H**	**106 H**	103	95-105	Elevated levels are related to acidosis as well as **too much water crossing the cell membrane**. Decreased levels with **decreased serum albumin may indicate water deficiency crossing the cell membrane (edema)**.
Creatine	**2.65 H**	**2.25 H**	**2.3 H**	0.5-1.4	Elevated levels are sometimes seen in kidney disease due to the kidneys job of excreting creatinine, muscle degeneration, and some drugs involved in impairment of kidney function. Also in patients with **shock**, leukemia, SLE, acute MI, CHF, diabetic neuropathy.
Globulin		**4.8 H**		2.2-4.2	Globulins have many diverse functions such as, the carrier of some hormones, lipids, metals, and antibodies(IgA, IgG, IgM, and IgE). Elevated levels are seen with **chronic infections**, liver disease, rheumatoid arthritis, myelomas, and lupus are present.
Glucose	**105 H**	81	93	70-110	Patient doesn't have a history of diabetes. Possibly acute stress or trauma, **renal failure**, potentially hyperglycemia or **hypertension.**
Hemacrait	**26 L**	**23.8 L**	**24.9 L**	40-54%	The patient is **dehydrated** related to **diarrhea** (anemia), and already experiencing a decrease in Hemoglobin due to blood loss. Which this tends to mirror RBC results.
Hemoglobin	**8.2 L**	**8.0 L**	**8.2 L**	13.5-18	Blood levels are low due to loss of blood. Can also be related to **HTN, Dementia**, and seizures which are all chronic medical conditions. Also mirrors RBC results.
Ionized Calcium		**1.66 H**		2.24-2.46	Hypercalcemia, **Decreased levels of calcium in the urine** from an unknown cause- Hyperparathyroidism, **Lack of mobility**, Milk-alkali syndrome, multiple myeloma, Paget's disease, Sarcoidosis, **Thiazide diuretics**, Tumors, Vitamin D excess.
INR		1.1		0.76-1.27	The PT may be ordered when a person **who is not taking anticoagulant drugs has signs or symptoms of a bleeding disorder,** which can range from nosebleeds, bleeding gums, bruising, heavy menstrual periods, blood in the stool and/or urine to arthritic-type symptoms (damage from bleeding into joints), loss of vision, and chronic anemia.

Neutrophils	61			48-73%	If this lab was abnormal then labs could be linked to infection, inflammation, autoimmune disorders, tissue death, trauma, heart attack, burns, chemo, stress, exercise, leukemias, or bone marrow damage.
Phosphate		2.5		2.5-4.5	Lower than normal levels (hypophosphatemia) may be due to: Alcoholism, **Hypercalcemia, hypokalcemia**, hyperparathyroidism, **Very poor nutrition, Too little dietary intake of phosphate,** Vitamin D, resulting in rickets (childhood) or osteomalacia (adult)
Platelets	217	**138 L**	166	150-450	A low platelet count, also called thrombocytopenia, may be caused by a number of conditions and factors. The causes typically fall into one of two general categories: Disorders in which the bone marrow cannot produce enough platelets and Conditions in which platelets are used up (consumed) or **destroyed faster than normal, or Long-term bleeding problems, Massive blood transfusion, prosthetic heart valve, Thrombotic thrombocytopenic purpura (TTP),** Celiac disease, **Vitamin K deficiency.**
Potassium	3.8	**3.4 L**	3.9	3.5-5.0	Potassium is the major intracellular cation. Very low value: Cardiac arrhythmia. Decrease in K is seen usually in states characterized by excess K^+ loss, such as in **vomiting**, **diarrhea**, villous adenoma of the **colorectum**, certain renal tubular defects, hypercorticoidism, etc. Redistribution hypokalemia is seen in **glucose/insulin therapy**, alkalosis (where serum K^+ is lost into cells and into urine), and familial periodic paralysis. Drugs causing hypokalemia include amphotericin, carbenicillin, carbenoxolone, corticosteroids, diuretics, licorice, salicylates, and ticarcillin. F.W. was experiencing Glucose/insulin therapy and was having diarrhea and that would be my reason for the decrease K.
PTT		21		35-45 seconds	The activated partial thromboplastin time is equivalent to the Kaolin cephalin clotting time, and is a measure of the activity of the intrinsic pathway of coagulation (VIII, IX, XI, XII). The normal range is 30-45 seconds.

RBC	**2.69 L**	**2.64 L**	**2.77 L**	4.6-6.2	The patient is **malnutritioned, inflammation of the intestines, deficient in nutrients, acute/chronic bleeding, edema**, which can be cause of a number of factors.
SGOT		18		7-21	I am happy to learn that this patient is not also suffering renal inflammation or sensitive indicators of liver damage.
Sodium	143	141	137	135-145	A high blood sodium level is almost always due to **inadequate water intake and dehydration**. Symptoms include **dry mucous membranes, thirst, agitation, restlessness, acting irrationally**, and coma or convulsions if the sodium level rises to extremely high concentrations. In rare cases, hypernatremia may be due to Cushing syndrome or a condition caused by too little ADH called diabetes insipidus.
SPGT		**0.9L**		8-32	I expect this lab to be outside of its normal range since it measures how the renal system are functioning and if medications are affecting the liver
Total Calcium	**13.3 H**	**11.1 H**	9.6	8.8-10.3	Suggests **cancer** (which he has recovered from): that can cause hypercalcemia when it spreads to the bones and causes the release of Calcium from the bone into the blood or when cancer increases calcium levels. It could also suggest **prolonged immobilization** when I find possible because of his mental status (Dementia was clear during my assessment of his alert and orientation).
Total Protein		7.1		6.0-8.5	This lab value monitors for malnutrition, low-protein diet, severe liver disease, chronic renal failure, **dehydration, vomiting**, multiple myeloma.
WBC	8.3	7.8	7.4	5-10,000	This lab value was a little high suggesting a possible outcome of infection, **inflammation**, allergies, asthma, tissue death, **stress**, or exercise.

Reference:

(Deglin & Vallerand, 2007)

(Edwards, N., Baird, 2005)

(Kaslow, 2012)

Medication Information:

Drug Name (Generic / Trade name)	**Drug Action / Purpose**	**Normal Dose Range**	**Major Side Effects**	**Nursing Considerations**	**Interpretation Why taking MED**
Acetylcysteine / (Mucomyst) (6ml) PO BID (1200 MG)	Decreases viscosity of respiratory tract secretions and promote their removal by breaking disulfide bonds. In acetaminophen overdose, it protects the liver from injury by restoring glutathione levels or by acting as alternate substrate for acetaminophen metabolism.	200 mg + 50cc Water	**CNS:** mild fever, hypotension **GI:** N&V **RESP:** dyspnea, wheezing **SKIN:** generalized urticaria, stomatitis	Assess patient's respiration and pulmonary secretions, exercise caution on patients with respiratory insufficiency and history of bronchospasm. Assess patient's history of underlying condition, cough: type, frequency, character.	I am not quite sure why this patient is taking this drug: I have read its used for overdoses of acetaminophen (Tylenol), stomach ulcers or it can help improve breathing in patients with COPD or other lung diseases. Which I have no concern that my patient is in need of this drug.

Allopurinol (Zyloprim) PO 200/300 mg qday	Inhibits the enzyme responsible for the conversion of purines to uric acid, thus reducing the production of uric acid with a decrease in serum and sometimes in urinary uric acid levels, relieving the signs and symptoms of gout	Tablets—100, 300 mg	**CNS:** Headache, drowsiness, peripheral neuropathy, neuritis, paresthesias. **Derm:** Rashes **GI:** N/V/D, ab pain, gastritis, hepatomegaly, hyperbilirubinemia, cholestatic jaundice **GU:** Exacerbation of gout and renal calculi, renal failure. **Hemat:** Anemia, leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia, bone marrow depression	• History: Allergy to allopurinol, blood dyscrasias, liver disease, renal failure, lactation • Physical: Skin lesions, color; orientation, reflexes; liver evaluation, normal urinary output; normal output; CBC, renal and liver function tests, urinalysis	Allopurinol is also sometimes used to treat seizures (pt. has a HX of), and certain infections.

Amlodipine Besylate (Norvasc) 5 mg PO	Inhibits influx of calcium ion across cell membranes to produce relaxation of coronary vascular smooth muscle (dilation of coronary arteries), decrease peripheral vascular resistance of smooth muscle (decrease blood pressure) and increases myocardial oxygen delivery in patients with vasospastic angina.	PO (Adults): 5-10mg once daily. Antianginal – initiate therapy at 5mg/day, increase as required/tolerated (up to 10mg/day).	CNS: headache, dizziness, fatigue CV: peripheral edema, angina, bradycardia, hypotension, palpitations GI: gingival hyperplasia, nausea DERM: flushing	**Monitor** -BP and pulse before therapy, during dose titration, and periodically during therapy. - ECG during prolonged therapy. -I & O ratios and daily wgt. Assess for signs of CHF (peripheral edema, rales/crackles, dyspnea, weight gain and jugular venous distention) -Lab test considerations: Total serum calcium are not affected by calcium channel blockers.	Patient has a history of Hypertension, Pacemaker, CVA. Which can also result in some sort of Heart distress such as a Heart attack, or MI. This patient's lab values also put him at risk (i.e. potassium). Most likely taking this to treat the high blood pressure.
Bisacodyl / Dulcolax 20 mg PO	alters fluid and electrolyte transport, producing fluid accumulation in the colon. Stimulates peristalsis. Alters fluid and electrolyte transport, producing fluid accumulation in the color.	Dose 10 mg Route rectal	Abdominal cramps, nausea, diarrhea, rectal burning, hypokalemia, muscle weakness	- Assess patient for abdominal distension, presence of bowel sounds, and usual pattern of bowel function. - Assess color, consistency and amount of stool produced.	Bisacodyl is used on a short-term basis to treat constipation. It also is used to empty the bowels before surgery and certain medical procedures. It works by increasing activity of the intestines to cause a bowel movement.

Carvedilol / Coreg 6.25mg BIDWM	Beta Blocker, Antihypertensive	6.25 mg twice daily, may be increased q 7-14 days up to 25 mg twice daily	**CNS:** Dizziness, vertigo, tinnitus, fatigue, sleep disturbances, emotional depression, paresthesias, **CV:** Bradycardia, orthostatic hypertension, CHF, cardiac arrhythmias, pulmonary edema, hypotension **GI**: Gastric pain, flatulence, constipation, diarrhea, hepatic failure **Resp**: Rhinitis, pharyngitis, dyspnea **Other**: fatigue, back pain, infections	Pulmonary edema, cardiogenic shock, bradycardia, heart block or sick sinus syndrome (unless a pacemaker is in place), Uncompensated CHF. Use caution in: Diabetes mellitus (may mask signs of hypoglycemia), history of severe allergic reactions (intensity of reactions may be increased).	Decreased heart rate and blood pressure, improved cardiac output. Hypertension- my patient is taking this to reduce HTN.
Digoxin / Lanoxin 0.125mg qday	increases the contractility of the heart muscle (positive inotropic effect).	PO/IV – (0.05, 0.1, 0.2) mg capsules, (0.125, 0.25, 0.5) mg tablets, 0.05 mg/ml elixir, (0.25, 0.1) mg/ml injection	nausea, fatigue, muscle weakness, headache, facial neuralgia, mental depression, hallucinations, confusion, drowsiness, agitation, arrhythmias, hypotension	Allergy, Heart Block, Bradycardia, right/left bundle block	Used for maintenance therapy in CHF

Donepezil HCL / Aricept 10mg HS	Inhibits acetylcholinesterase thus improving cholinergic function by making more acetylcholine available. May temporarily lessen some dementia associated with Alzheimer's disease. Enhances cognition.	Initial: 5 mg at bedtime. After 4 to 6 wk., dosage increased to 10 mg at bedtime, as indicated. Maximum: 10 mg daily.	**CNS:** H/A, abnormal dreams, depression, dizziness, drowsiness, sedation (unusual). **CV**: AFib, hypertension, hypotension, vasodilation. **GI:** diarrhea, N/V, anorexia **GU:** frequent urination. **Derm:** ecchymoses **Metab**: hot flashes, wt. loss.**MS:** arthritis, muscle cramps	Use cautiously in: pts. w/ : -bladder obstruct because drug's weak peripheral cholinergic effect could obstruct outflow. -asthma, COPD, or other pulmonary disorders bc this drug has a weak affinity for peripheral cholinesterase, may increase bronchoconstriction & bronchial secretions. -pt. has cardiac disease, monitor HR and rhythm for bradycardia, may result from increased vagal tone caused by drug's inhibition of peripheral cholinesterase. Reduced HR may be esp. significant if pt. has sick sinus syndrome, bradycardia, or other . upraventricular arrhythmia. -safety precautions if pt. is dizzy or has other adverse CNS rxns.	Well during my assessment I could tell there was definitely some dementia but he has no history of Alzheimer's disease. But assuming maybe they are in the process of diagnosing Alzheimer's disease or they feel this would help in his current situation.

Epoetin / Procrit 10,000units (non-esrd)	A natural glycoprotein produced in the kidneys, which stimulates red blood cell production in the bone marrow.	Anemia of chronic renal failure: Starting dose: 50–100 units /kg three times weekly, Reduce dose if Hct increases > 4 points in any 2-wk period. Increase dose if Hct doesn't increase by 5–6 points after 8 wk. of therapy. Maint. dose, individualize based on Hct, generally 25 units/kg three times weekly. Target Hct range 30%–36%.	• CNS: Headache, arthralgias, fatigue, asthenia, dizziness, seizure, CVA, TIA • CV: Hypertension, edema, chest pain • GI: Nausea, vomiting, diarrhea • Other: Clotting of access line	• History: Uncontrolled hypertension, hypersensitivity to mammalian cell-derived products or to albumin human, lactation • Physical: Reflexes, affect; BP, P; urinary output, renal function; renal function tests; CBC, Hct, iron levels, electrolytes	It works by causing the bone marrow (soft tissue inside the bones where blood is made) to make more red blood cells.

Furosemide (Lasix) 40mg IV (240ml)	Rapid-acting potent sulfonamide "loop" diuretic and antihypertensive with pharmacologic effects and uses almost identical to those of ethacrynic acid. Exact mode of action not clearly defined; decreases renal vascular resistance and may increase renal blood flow	In adults, treatment is usually begun with ½ - 1-2 tablets daily; the maintenance dose is ½-1 tablet daily. PO 20-80 mg/day in am may give another dose in 6 hr., up to 600 mg/day IM/IV 20-40 mg, increased by 20 mg q2h until desired response	**CNS:** vertigo, headache, dizziness, paresthesia, weakness, restlessness, fever. **CV:** orthostatic, hypotension; thrombophlebitis with I.V administration. **EENT:** transient deafness, blurred or yellowed vision **GI:** abdominal discomfort and pain, diarrhea, anorexia, N/V constipation. **Hepatic:** Hepatic Dysfunction Metabolic: volume depletion and dehydration, asymptomatic hyperuricemia, impaired glucose intolerance, hypokalemia, hypochloremic alkalosis, fluids and electrolyte imbalance **MS**: muscle spasm **Skin**: dermatitis, purpura,	• Monitor weight, BP, and pulse rate routinely with long term use and during rapid dieresis. Furosemide can lead to profound and electrolyte depletion. • Monitor fluid I&O and electrolyte, BUN, and CO2 level freq. • Watch for signs of hypokalemia such as muscle weakness and cramps • Advise patient to immediately report ringing ears, severe abdominal pain, or soar throat and fever which may indicate furosemide toxicity.	Fluid volume overload for the edema forming in his leg. Used to reduce the swelling and fluid retention caused by various medical problems, including heart or liver disease. It is also used to treat high blood pressure. It causes the kidneys to get rid of unneeded water and salt from the body into the urine.

			photosensitivity, transient pain at I.V injection site.		

Hydralazine HCL (Apresoline) 10mg IV q 4-6 hrs. PRN	Acts directly on vascular smooth muscle to cause vasodilation, primarily arteriolar, decreasing peripheral resistance; maintains or increases renal and cerebral flow.	Oral Intramuscular Intravenous - Tablets- 10, 25, 50, 100 mg - Injection- 20 mg/mL	**CNS**: Headache, peripheral neuritis, dizziness, tremors, psychotic reactions, charact by depression, anxiety, disorient. **CV**: Palpitations, tachycardia, angina pectoris, hypotension, paradoxical pressor response, orthostatic hypotension. **GI:** Anorexia, N/V/D, constipation, paralytic ileus. **GU:** Difficult micturition, impotence. **Hemat:** Blood dyscrasias **Hypersensitive:** Rash, urticaria, pruritus, fever, chills, arthralgia, eosinophilia; rarely, hepatitis, obstruct jaundice. **Other:** Nasal congestion, flushing, edema, muscle cramps, dyspnea, lupus-like syndrome, lymphadenopathy, splenomegaly, poss. carcinogenesis, lacrimation, conjunctivitis.	**Before** - Check BP. - Arrange for CBC, LE cell preparations, and ANA titers before therapy. - Assess for contraindicated conditions, voiding pattern, bowel sounds. **During** - Give oral drug with food. - Use parenteral drug immed after opening ampule. - Discard discolored solutions. - Arrange for CBC, LE cell preparations, and ANA titers during prolonged therapy. - Instruct take drug exactly as prescrib. **After**- Withdraw drug gradually. - Discontinue if blood dyscrasias occur. - Arrange for pyridoxine therapy if patient develops symptoms of peripheral neuritis. - Monitor for orthostatic hypotension. - Report persistent or severe constipation, unexplained fever or malaise, muscle or joint aching, chest pain, rash, numbness, tingling. - Do proper doc.	This drug will help with the CVA, HTN, and the Renal issuing occurring

Losartan Potassium (Cozaar) 50mg PO qday	Angiotensin II receptor (type AT1) antagonist acts as a potent vasoconstrictor and primary vasoactive hormone of the renin–angiotensin–aldosterone system.	Adult: PO 25–50 mg in 1–2 divided doses (max: 100 mg/d); start with 25 mg/d if volume depleted (i.e., on diuretics)	CNS: Dizziness, insomnia, headache. GI: Diarrhea, dyspepsia. Musculoskeletal: Muscle cramps, myalgia, back or leg pain. Respiratory: Nasal congestion, cough, upper respiratory infection, sinusitis.	• Monitor BP at drug trough (prior to a scheduled dose). • Monitor drug effectiveness, especially in African-Americans when losartan is used as monotherapy. • Inadequate response may be improved by splitting the daily dose into twice-daily dose. • Lab tests: Monitor CBC, electrolytes, liver & kidney function with long-term therapy.	This is an antiHTN med, so my first thought would assume this is to resolve is HTN.
Ondansetron (Zofran) IV q 4hrs / PRN	Indicated for prevention of nausea. Blocks the effects of serotonin at 5-HT3 receptor sites (selective antagonist) located in bagal nerve terminals and the chemoreceptor trigger zone in the CNS.	For IV meds, compatibility with IV drips and/or solutions (D5W, 0.9% NaCl, D5/0.9% NaCl, D5/0.45% NaCl.) Admin undiluted. RATE: admin over at least 30 sec and preferably over 2-5 min	CNS: headache, dizziness, drowsiness, fatigue, weakness. GI: constipation, diarrhea, abdominal pain, dry mouth, increased liver enzymes. NEURO: extrapyramidal reactions.	assess patient for N/V, abdominal distention and bowel sounds prior to and following admin. Assess patient for extrapyramidal effects (involuntary movements, facial grimacing, rigidity, shuffling walk, trembling of hands) periodically during therapy.	For the treatment of nausea

Pantoprazole (protonix) 40mg IV	Gastric acid-pump inhibitor: Suppresses gastric acid secretion by specific inhibition of the hydrogen-potassium ATPase enzyme system at the secretory surface of the gastric parietal cells; blocks the final step of acid production.	40 mg PO daily to bid for < 8 wk. for erosive esophagitis. 8-wk course may be repeated if healing has not occurred; 40 mg/day IV for 7–10 days. Up to 240 mg/day PO or IV has been used for hypersecretory syndromes.	**CNS**: Headache, dizziness, asthenia, vertigo, insomnia, apathy, anxiety, parenthesis, dream abnormalities **Derm**: Rash, inflam, urticaria, pruritus, alopecia, dry skin **GI**: Diarrhea, abdominal pain, nausea, vomiting, constipation, dry mouth, tongue atrophy. **Resp**: URI symptoms, cough, epistaxis. **Other:** Cancer in preclinical studies, back pain, fever.	**History:** Hypersensitivity to any proton pump inhibitor or any drug components; pregnancy; lactation **Physical**: Skin lesions; T; reflexes, affect; urinary output, abdominal exam; respiratory auscultation	Antisecretory agent Proton pump inhibitor

Potassium Chloride (Kaylixir, Kay Ciel, Klorvess, Klotrix) 20/40 meq PO	• Prevention and correction of potassium deficiency; when associated with alkalosis, use potassium chloride; when associated with acidosis, use potassium acetate, bicarbonate, citrate, or gluconate. • IV: Treatment of cardiac arrhythmias due to cardiac glycosides.	• Warning: Do not administer undiluted. Dilute in dextrose solution to 40-80mEq/L. Max infusion rate 10mEq/hr. for serum K of more than 2.5 mEq/L	**Derm:** Rash. **GI:** Nausea, vomiting, diarrhea, abdominal discomfort, GI obstruct, GI bleeding, GI ulceration or perforation Hematologic: Hyperkalemia – increased serum potassium, ECG changes (peaking of T waves, loss of P waves, depression of ST segment, prolongation of QTc interval) **Local:** Tissue sloughing, local necrosis, local phlebitis, and venospasm with injection	Arrange for serial serum potassium levels before and during therapy. Administer liquid form to any patient with delayed GI emptying. Administer oral drug after meals or with food and a full glass of water to decrease GI upset. Caution patient not to chew or crush tablets; have patient swallow tablet whole. Mix or dissolve oral liquids, soluble powders, and effervescent tablets completely in 3-8oz of cold water, juice, or other suitable beverage, and have patient drink it slowly. Caution patient not to use salt substitutes.	Electrolyte replacement. Preventing potassium deficiency or recovering from it.

IV 100 mls/hr. IV qday @1200 Iron Sucrose complex (venofor) 200mg in NA Chloride 0.9 100ml	IV iron supplement: Hemodialysis w/ EPO, Abnormal absorption, intolerance to oral, oral noncompliance	Adult: IV 1 mL (20 mg) injected in dialysis line at rate of 1 mL/min up to 5 mL (100 mg) or infuse 100 mg in NS over 15 min 1–3 times/wk.	**CNS:** IM, IV- Seizures, dizziness, headache, syncope **CV:** IM, IV- Hypotension, tachycardia **GI:** nausea, PO- constipation, dark stools, diarrhea, epigastric pain, GI bleeding, IM, IV- taste disorder, vomiting. **Derm:** IM, IV flushing urticaria **local:** pain at IM site (iron detran), phlebitis at IV site, skin staining at IM site (iron dextran) **MS:** IM, IV- arthralgia, myalgia. **Misc.:** Po- staining of teeth (liq preps), IM, IV- allergic rxns including anaphylaxis, fever, lymphadenopathy.	Withhold drug and notify physician when serum ferritin level equals or exceeds established guidelines. Stop infusion and notify physician for S&S over dosage or infusing too rapidly: hypotension, edema; headache, dizziness, nausea, vomiting, abdominal pain, joint or muscle pain, and paresthesia. Lab tests: Periodic serum ferritin, transferrin saturation, Hct, and Hgb. Monitor patient carefully during the first 30 min after initiation of IV therapy for signs of hypersensitivity and anaphylactoid reaction	This medicine is used to treat "iron-poor" blood (anemia) in people with long-term kidney disease. The body may also need more iron if you use the drug erythropoietin to help make new red blood cells. So with the blood loss that is why I assume he is taking this drug

IV 83.333 mls/hr. IV once Pamidronate Disodium / Aredia 60mg in NA Chloride 0.9 500ml	moderate to severe hypercalcemia associated with malignancy. Osetolytic bone lesions associated with multiple myeloma or breast cancer. Decrease serum calcium.	moderate Hypercalcemia - 30- 90mg may be repeated after 7 days.	**Cardio**: Atrial fib; atrial flutter; cardiac fail; HTN; syncope; tachycardia. **CNS:** Asthenia; anxiety; fatigue; headache; insomnia; paresthesia; psychosis; somnolence. **Derm:** Sweating. **Endo:** Hypothyroidism **GI**: Ab pain; anorexia; constip; dyspepsia; GI hemorrhage; stomatitis; N/V/D. **Genit:** UTI; uremia; renal toxicity. **Hemat-Lymphatic:** Anemia; granulocytopenia; leukopenia; neutropenia; thrombocytopenia. **Lab Tests:** Hypocalcemia; hypokalemia; hypomagnesaemia; hypophosphatemia. **Local:** Infusion-site reaction. **Musc:** Arthralgia; arthrosis; back / bone / muscu pain; myalgia; osteonecrosis prim of jaws **Respir:** Cough; dyspnea; pleural effusion; rales; rhinitis; sinusitis; upper Resp infect **Misc.:** Edema; fever; metastases; moniliasis; pain; allergic manifestations (eg, hypotension, dyspnea, angioedema, anaphylactic shock)	Assess IV injection site for thrombophlebitis. Lab tests: Monitor serum calcium and phosphate levels, CBC, and kidney function throughout course of therapy. Monitor for S&S of hypocalcemia, hypokalemia, hypomagnesaemia, and hypophosphatemia. Monitor for seizures especially in those with a preexisting seizure disorder. Monitor vital signs. Be aware that drug fever, which may occur with Pamidronate use, is self-limiting, usually subsiding in 48 hours even with continued therapy.	used to treat the high levels of Ca

IV 100 mls/HR IV once Calcium Gluconate / Kalcinate 10% 10ml in Sodium Chloride 0.9% 100ml	Replaces calcium and maintains calcium level. -Hypocal-cemic emergency -Adjunctive treatment of Magnesium intoxication - Hypophos-phatemia - Hyperkalemia with secondary cardiac toxicity	Adults: 2-15 g/ 24 hrs.	**CNS**: tingling sensation, syncope with rapid I.V. injection. **CV:** mild drop in blood pressure, vasodilation, bradycardia, arrhythmias, cardiac arrest with rapid I.V. injection. **GI:** irritation, constipation, nausea, vomiting, thirst, abd. pain. **GU:** polyuria, renal calculi. **Metabolic:** hyper-calcemia. **Skin:** local reactions, including burning, necrosis, tissue sloughing, cellulites, soft tissue calcification with I.M. use, pain.	**Before:** Make sure prescriber specifies form of calcium to be given; crash carts may contain both calcium gluconate and calcium chloride. -Tell pt. to take oral calcium 1 to 1!/2 hours after meals if GI upset occurs. **During:** Give I.M. injection in gluteal region in adults and in lateral thigh in infants. Use I.M. route only in emergencies when no I.V. route is avail bec. of irritation of tissue by calcium salts.-Tell patient to take oral calcium with a full glass of water. **After:** Monitor calcium levels frequently. Hypercalcemia may result after large doses in chronic renal failure. Report abnormalities.	Calcium levels are currently high, he is on this to maintain Ca level but also the Pamidronate disodium used to break down the Ca

Iv 75 mls/HR IV floor stock Sodium Chloride / Slo-Salt 0.45% 1000ml IV 55mls/hr. IV Sodium Chloride / Slo-Salt 0.9% 500ml	Sodium is a major cation in ECF and helps maintain water distribution, fluid and electrolyte balance, acid-base equilibrium and osmotic pressure. Chloride is the major anion in ECF and is involved in maintaining acid-base balance. Solutions of Na Cl resemble ECF.	IV (adults) 0.9% NaCl (isotonic) 1 L (contains 150 mEq sodium / L), rate and amount determined by condition being treated. 0.45% NaCl (hypotonic) 1-2L (contains 75 mEq sodium /L) rate and amount determined by condition being treated.	**CV:** CHF, Pulmonary edema, edema **F & E:** hypernatremia, hypervolemia, hypokalemia. **Local:** IV- extravasation, irritation at IV site.	Assess for S&S of hypernatremia (headache, tachycardia, lassitude, dry mucous membranes, N/V, muscle cramps) or hypernatremia (edema, weight gain, hypertension, tachycardia, fever, flushed skin, mental irritability) throughout therapy. Na is measured in relation to its concentration to fluid in the body and Symptoms may change based on pts. hydration status. Also assess lab test (serum, K, Na, Bicarb, Cl). Monitor serum osmolality in pts. receiving hypertonic saline solutions.	Pt. has some deficiencies with his chloride levels that are currently high. The goal is probably to shift the fluid with the hypotonic solution

Reference: (Deglin & Vallerand, 2007)

Nursing Diagnoses (Analysis, Documentation/Evaluation, Intervention (NIC), Planning-NOC)

Diagnosis	Goal(s)	Nursing Interventions	Rationales With References (EBP citation)
Statement: Actual Problem of Excess fluid Volume (overload)	**STG-** Decrease / Eliminate edema present in lower left leg within 48 hours	-Provide oral care q4hours (**NIC**: Oral Health Maintenance)	- helps stimulate thirst, can alleviate the sensation without increase in fluid intake
	LTG- Have an extended period of time free from edema such as one month or 6 months, which will be reevaluated at his next appointment.	- Administer diuretic therapy as ordered and evaluate effectiveness of therapy and monitor volume in bag (**NIC**: Hypervolemia management)	- diuretics promote the diuresis of accumulated fluid. Should be increase in urine output, improved breathing, and weight loss
RT(Why): decreased cardiac output, and sodium and water retention		- Follow Sodium diet / Fluid restriction (Teaching family about monitoring and follows) (**NIC**: Hypervolemia management)	- Can decrease water retention. Fluid Restriction maybe used to decrease fluid intake, decreasing fluid volume excess
Supporting Data(AEB)	The client will demonstrate adequate fluid balance as evidenced by output equal to or exceeding intake, clearing breath sounds, and decreasing edema	-Assess JVD, Hepatomegaly, Abdominal pain (**NIC:** Fluid monitoring)	- elevated volumes in venal canal occur from inadequate emptying of the Right atrium, the excess fluid is transmitted to the JV, Liver, and abdominal distention
-Edema present in Lower Left extremity		-Monitor I & Os (q 4hours) and weight daily (**NIC**: Fluid monitoring)	- I&O balance reflects fluid volume status
-Color, Clarity, quantity of urine doesn't support fluid leaving his body but rather pooling in other areas	**NOC: Fluid Balance**	- Assess for peripheral edema (**NIC**: Fluid monitoring)	- Heart failure causes venous congestion, resulting in increase capillary pressure, fluids leak out of capillaries (edema -legs) Venous return to the heart
- High Blood Pressure	**Evaluation:** Met On-going Not met	-Auscultate breathe sounds q 2 hours and PRN for crackles and monitor for frothy sputum production (**NIC**: Fluid monitoring)	- increase pulmonary capillary hydrostatic pressure exceeds oncotic pressure, fluid moves within the alveolar septum and supported by crackles and edema.
-Risk for pneumonia or CHF			
-History of heart failure	On-going (Still Currently On Going)		Black & Hawks, 2009, p. 1442

Diagnosis	**Goal(s)**	**Nursing Interventions**	**Rationales With References (EBP citation)**
Statement: Actual problem impaired physical mobility / Risk for falls	**STG-** create a mobility plan, with mobility devices and small mobility distances to the restroom and chair with in 48 hours	-Teach family and client to assist with transfers and ambulation	-Which prevents falls and injury especially with other contributing factors associated with clients health
		-Obtain slip resistance shoes	-Prevents falls and maintains balance
RT(Why): related to decreased strength/Endurance	**LTG-** Encourage patient mobility with assist devices to ambulate down hallway, nurses station, etc.. Within 1 week	-Avoid physical restraints	-Non restraint adults tend to be less likely for falls
Supporting Data(AEB)		-Consult PT and OT Rehab	-To create a plan to decrease BP, obesity, improve bone density, balance, muscle tone, CVS
-Discomfort		-Note emotional and behavioral responses	-To altered ability to over come anxiety, anger, frustration, and depression
-perceptual or cognitive impairment			
-Impaired coordination, decreased muscle mass and strength	**Evaluation:** Met On-going Not met		
-Inability to purposefully move			
	Not Med- Pts. mental stability prevented mobility to occur		
			Doenges, Moorhouse & Murr, 2010, pg. 816

Diagnosis	**Goal(s)**	**Nursing Interventions**	**Rationales With References (EBP citation)**
Statement: Actual problem activity intolerance	**STG-** create an activity plan, sitting up, chair, ROM exercises with in 24 hours	-Check VS, before, during activity (**NIC:** Vital sign monitoring)	-to prevent hypotension can occur with activity because of medications and physical limitations
		-document cardio response to activity (**NIC**: Vital sign monitoring)	-Can cause increase HR and O2 demands, causing weakness and fatigue
RT(Why): related to prolong bed rest and weakness	**LTG-** Encourage patient activity intolerance with ADLs and activities the patient enjoys with in 4 days	-schedule rest periods (**NIC**: energy management)	-rest periods help alleviate fatigue and decrease myocardial workload.
Supporting Data(AEB)	**Outcomes:** the Client will have improved levels of activity without dyspnea	-increase activity as ordered or according to the rehabilitation nurse's directives (**NIC:** Exercise promotion: ambulation)	- gradually and appropriately increasing physical activity may help the client gain cardiac conditioning and improve activity tolerance
-weakness and fatigue	**NOC:** Activity tolerance	-instruct the client to avoid actives that increase cardiac workload. (**NIC**: Vital sign monitoring)	-actives such as stair climbing, working with arms above the had, or sustained arm movement may cause extreme fatigue and demand more cardiac output than the body can supply.
-restraints		-space nursing activities (**NIC**: Counseling)	- clustering activities increase myocardial demand and may cause extreme fatigue
-alterations in vital signs	**Evaluation:** Met On-going Not met		
-pain			
-edema	On going- Pts. mental stability and departure from hospital prevented Long term goal from occurring	Evaluation: the client will perform spaced activities without dyspnea and will gradually increase activity tolerance which is still currently on going	
			Doenges, Moorhouse & Murr, 2010, pg. 56

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