Nursing Process Data form and Case Study

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Nursing Care of Adults/Aging UNRS 212

Professor Lumawod and Professor Boyd

11/24/13

Student: Amanda Bessler Date of Care: November 7, 2011

**A. Identifying Data**

**Patient** **Initials**: MM **Age**: 56 **Gender**: Female **Allergies**: no allergies

**Primary** **Language**: English **Ethnicity**: Caucasian **Religion**: Christian

**Marital Status**: Widowed **Occupation**: Not Currently Working

**Insurance**: Blue Cross Prudent Buyer

**Family Composition:** Patient has one son and a deceased husband. Some extended family lives around Southern California.

**Home/Living Situation:** Patient states she lives at home with her son.

**Date/s of Care:** 11/7 **Date of Admission**: 11/5 **Date/s of Surgery**: 11/5

**Physician(s)/Specialty:** Todd Dietrick: Surgeon, Christopher Tirce: Anesthesiologist, John K de Beix: Primary Care

**Admitting Diagnosis/es:** Patient admitted for degenerative arthritis of the left knee.

**Surgical Procedure(s) this hospitalization:**

* Abdominal Surgery by Dr. George Williams
* Cholecystectomy in 2002
* Right Knee Replacement by Dr. Richard Diehl

(11 points total)

**B. Biological**

1. **Past Medical/Surgical History/Chronic Conditions:** (2)

*(Provide date of onset and/or diagnosis for each condition)*

**Past Medical:**

Morbid Obesity-Diagnoses at age 50

Obstructive Sleep Apnea- Diagnoses at age 44

**Surgical History**

Abdominal Surgery by Dr. George Williams

Cholecystectomy in 2002

Right Knee Replacement by Dr. Richard Diehl in 2012

**Chronic Conditions**

Morbid Obesity- Diagnoses at age 50

Obstructive Sleep Apnea- Diagnoses at age 44

**2. Recent Medical History/Reason for Admission/Course of Hospitalization:** (2)

*(Discuss all related details that led to the pts. admission to the hospital up until*

*the moment you assumed pt. care on your shift. This tells the story of current stay)*

Patient MM arrived at Huntington Hospital on 11/5 for a Left Knee Replacement because of complaints of worsening left knee pain. Patient states that she has had pain for years now, but the pain suddenly became worse. With the new onset of pain she is having difficulty completing activities of daily living, these including walking, cleaning and cooking. The patient has tried more conservative approaches to relinquish the knee pain, including activity modification, oral pain medicine and injection and therapy. However, after the pain continued to worsen and there was no sign of release from other approaches, she was given the option of Left Total Knee surgery. The patient readily agreed to go through with the procedure.

On 11/5, after clearance from her primary care physician, MM was admitted to the hospital to undergo Total left knee arthroplasty because of failure of conservative methods. She was taken into surgery at 1300 and the surgical/medical team was finished at 1500. She arrived on 6E in late afternoon on 11/5. She has been given antibiotic treatment to prevent infection, sequential compression devices, a nerve block and is closely monitored for pain levels. The first day the patient needed complete help toileting and moving around, while the nurse managed her pain. The following day on 11/6 the patient’s pain was maintained in the latter half of the day at level of 3 and small improvements in pain and body movement were noticed. On 11/7, the patient was able to ambulate to the restroom with help and was able to take a shower with help from PCA and nurse. Patient continues to make strides in her recovery while nurses continue to keep pain level around 2-3.

**3. Home Medications: Provide name, dose, frequency and WHY the pt. needs the**

**medication based on their medical history & chronic conditions:** (2)

|  |  |  |  |
| --- | --- | --- | --- |
| **Generic/Trade Name** | **Dose** | **Frequency** | **Purpose** |
| **Celecoxib/Celebrex** | **200 mg Tablet** | **Daily** | **This is used as an anti-inflammatory for arthritis pain. Patient has degenerative arthritis of the left knee.** |
| **Cholecalciferol/Vitamin D** | **1000 Units** | **Daily** | **This is taken daily as a supplement to help with calcium and phosphorous absorption and overall body health.** |
| **Ibuprofen/Advil** | **200 mg Tablet** | **Every six hours as needed** | **This is used as a pain medication to help alleviate severe pain patient is experiencing in Left knee from degenerative arthritis.** |

Add to table as needed. All home meds must be included.

**4. Definition of Medical Diagnosis with patient’s signs & symptoms at time of admission:** (2)

According to Uptodate.com, degenerative arthritis, closely associated with osteoarthritis, is one of the most common of knee arthritis. This disease is a slow and gradual process that develops overtime, mainly affecting the middle-aged to the older adults. The disease affects the joint cartilage and causes the underlying bones to wear and tear, causing inflammation. The breakdown of bone and cartilage causes mild to severe pain and stiffness in the area(s) affected. These symptoms are clearly seen in patient MM. She has had degenerative arthritis for years now, wrestling with the mild pain each day. Because of the continued breakdown of her knee joints, she is now experiencing increased levels of pain in her knee. She reported to the hospital with worsening pain radiating in her left knee that increased with movement. The pain and stiffness occurring in her left knee has limited her daily routine and function

Patient was also admitted to the hospital with obstructive sleep apnea and morbid obesity. Uptodate.com states that sleep apnea is a chronic disorder that often stems from obesity. Patients with obstructive sleep apnea reportedly wake up at night and experience disturbed sleep and restlessness due to hypoxia. Patient MM is using a CPAP machine to help keep her airways open to prevent hypoxia and sleep disturbances at night. In addition, patient MM is reported to have morbid obesity. Potter and Perry (2013) state that morbid obesity is a growing problem among middle aged adults and affects the quality of life and risk for chronic diseases. Potter and Perry (2013) also mention that Osteoarthritis is said to be a health consequence of morbid obesity and this finding is supported in patient MM’s diagnoses.

**5. Physical Assessment:** (3 points total)

**Ht** : 163.83 cm **Wt**: 145.6 kg **BSA**: 2.41 m2 **BMI**: 54.2 kg/m2

### VITAL SIGNS/HEMODYNAMICS:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Time | Temp F/C | Pulse (apical/radial)  BPM | Resp/min | BP in mmHg  R or L | Pulse Ox % |
| 5:44 AM | 36.4 C | 90 | 18 | 120/62 | 96 |
| 8:00 AM | 36.4 C | 91 | 18 | 110/60 | 98 |
| 12:00 PM | 36.8 C | 89 | 18 | 112/68 | 98 |
| 5:00 PM | 36.4 C | 92 | 20 | 110/62 | 98 |

**PAIN ASSESSMENT**:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Time | Pain Tool Used | Pain Rating | Pain Description (OLDCART) | Functional Pain Goal | Pain Medication (or other care) | Response To Intervention |
| 8 AM | NUMERIC | 3-4 | Patient stated that the pain started early in the morning when she woke up around 7:00 AM. Patient stated that there was a dull pain that resided in her left knee and it was continuous. Patient also reported minor stiffness to the leg and knee. She stated that movement in/out of bed aggravated the knee pain and that rest, ice and medication alleviated the knee pain. Ice and pain medication was administered. | 2-3 | The patient was given an ice pack throughout the morning to help with swelling. In addition, the patient was receiving a nerve block (that got discontinued at 10:00 AM that morning). Patient was receiving oxycontin, ultram, and toradol round the clock. | Patient stated a relief of the pain symptoms. Patient said that after morning pain medications her pain went down to a 2. |
| 11:30 AM | NUMERIC | 5 | Patient stated that the pain started up again in the early afternoon around 10:30AM-11:00 AM after the nerve block was discontinued. Patient stated that there was a more intense pain and tenderness that resided in her left knee and it was continuous. Patient also reported continued stiffness to the leg and knee. She stated that movement in/out of bed aggravated the knee pain and that rest, ice and medication alleviated the knee pain. | 2-3 | The patient was given an ice pack again throughout the mid-morning to help with swelling. Patient was receiving oxycontin, ultram, and toradol round the clock to help with pain. | Patient’s complained of pain increase after the nerve block was discontinued. However, after ice and medication, patient MM stated a relief of the pain symptoms. Patient said that after pain medications her pain went down to a 2-3 again. |
| 6:30 PM | NUMERIC | 4 | Patient stated that the pain started up again in the early evening around 5:00PM after a day of movement from showering and toileting. Patient stated that there was increased soreness, pain and tenderness that resided in her left knee and it was continuous. Patient also reported continued stiffness to the leg and knee. She stated that movement in/out of bed aggravated the knee pain and that rest, ice and medication alleviated the knee pain. | 2-3 | The patient was given an ice pack again throughout the late afternoon and evening to help with swelling. Patient was receiving oxycontin, ultram, and toradol round the clock to help with pain. | Patient’s pain spiked slightly in the later evening. But again, it was maintained with ice and medication. Patient MM stated a relief of the pain symptoms. Patient said that after pain medications her pain went down to a 2-3 again. |

LABORATORY DATA : (2 points)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| TEST | NORMAL  VALUE | RESULTS | RESULTS | **RATIONALE FOR ABNORMALS** |
| CHEMISTRY |  | Date / Time  11/6/13  @ 04:50 AM | Date / Time  11/7/13  @ 05:15 AM | State the reason why **this pts**. lab values are abnormal |
| Na | 135-145 mEq/L | 139 | 140 | Normal upon 11/6 and 11/7. |
| K | 3.5-5.2 mEq/L | 4.6 | 4.4 | Normal upon 11/6 and 11/7. |
| Cl | 96-106 mEq/L | 103 | 101 | Normal upon 11/6 and 11/7. |
| Mg | 1.8-2.6 mg/dL | N/A | N/A | N/A |
| HCO3- | 22-26 mEq/L | 34.6 H | 37.3 Ha | HIGH: Potential elevated levels due to sleep apnea and inability to take in enough oxygen and higher concentrations of CO2. Therefore HCO3- raises to buffer the levels of CO2 in blood. Also, opioid pain medication depresses the respiratory system and could take part in high levels of CO2 in body. |
| Glucose | 70-100 mg/dL | 118 | 102 | Normal upon 11/6and 11/7. |
| BUN | 6-20 mg/dL | 15 | 15 | Normal upon 11/6 and 11/7. |
| Creatinine | 0.6-1.3 mg/dL | 0.66 | 0.68 | Normal upon 11/6 and 11/7. |
| T. Protein |  | N/A | N/A | N/A |
| Albumin | 3.5-5.2 mg/dL | N/A | N/A | N/A |
| Uric Acid | 2.4-7 mg/dL | N/A | N/A | N/A |
| Calcium | 8.5-10.2 mg/dL | 8.5 | 9.3 | Normal upon 11/6 and 11/7. |
| Phosphorus | 2.4-4.1 mg/dL | N/A | N/A | N/A |
| Bilirubin | 0.3-1.0 mg/dL | N/A | N/A | N/A |
| Alk Phos | 25-100 U/L | N/A | N/A | N/A |
| ALT (SGPT) | 7-35 U/L | N/A | N/A | N/A |
| AST (SGOT) | 10-36 U/L | N/A | N/A | N/A |
| LDH | 140-280 U/E | N/A | N/A | N/A |
| Cholesterol | 140-199 mg/dL | N/A | N/A | N/A |
| LDL | <130 mg/dL | N/A | N/A | N/A |
| HDL | 35-80 mg/dL | N/A | N/A | N/A |
| Troponin | <0.35 mg/mL | N/A | N/A | N/A |
| CPK isos  MM, MB, BB | 26-140 U/L | N/A | N/A | N/A |
| CBC | Normal | Date/Time  11/5/13  @ 14:10 PM | Date/Time  11/7/13  @ 05:15 AM | Rational for Abnormals: |
| Hgb | 12-16 g/dL | 15.1 | 12.3 | Normal upon admission and 11/7. |
| Hct | 36%-48% | 47.0 | 38.5 | Normal upon admission and 11/7. |
| WBC | 4.5-10.5 X10^3 cells/mm^3 | 14.9 | 9.3 | WBC level was high after surgery (11/5) because of inflammation, trauma and stress caused by the surgery. However, on 11/7, the level was normal again, showing no infection or problem. |
| RBC | 3.6-5 X10^6/mm^3 | 4.73 | 3.83 L | Red Blood Cell count on 11/7 was low because of minor lose of blood from surgery incision. |
| Diff |  | N/A | N/A | N/A |
| Plates | 140-400 X10^3/mm^3 | 107 L | 92 L | Normal upon admission and 11/7. |
| PT/INR | 11-13 sec | N/A | N/A | N/A |
| PTT | 25-35 seconds | N/A | N/A | N/A |
| Other | Normal | Date/Time | Date/Time | Rational for Abnormals: |
| C & S |  | N/A | N/A | N/A |
| Cultures |  | N/A | N/A | N/A |
|  |  |  |  |  |
|  |  |  |  |  |

(Holloway 2004)

ARTERIAL BLOOD GASES:

|  |  |  |
| --- | --- | --- |
| ABGs | RESULTS  Date / Time: | RESULTS  Date / Time: |
| pH | N/A | N/A |
| pO2­ | N/A | N/A |
| O2 Saturation | 11/5 @8:00 AM  98 | 11/7 @ 8:00  98 |
| pCO2 | N/A | N/A |
| HCO3 | N/A | N/A |
| Overall Interpretación: | N/A | N/A |

(Holloway 2004)

**DIAGNOSTIC TEST & PROCEDURES:** (2 points)

**(Include 12 Lead EKG, CXR, Cardiac Cath, CT, MRI, Ultrasound, Endoscopy, Echocardiogram, etc)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Test: | Pt. Results:  (Date/Time) | Normals:  (referenced) | Rationale For Test Being Performed On This Patient: | Rationale for Abnormal Test Results: |
| EKG: Electrocardiogram | 10/24  @ 11:19 AM  Patient was shown with sinus rhythm with PAC(s). | Normal Sinus Rhythm has regularity of the R-R intervals, rhythm is regular, heart rate is between 60-100, the P waves are uniform, the PR interval measure between 0.12-0.20 and the QRS complex measures less than 0.12s.  (Lewis 2011) | This test is required preoperatively to test the cardiac function and confirm that the patient’s heart is healthy enough to undergo a surgery. | The test results showed normal sinus rhythm with PACS. PACs are benign cardiac dysrhythmias originating from the atrium. According to Lewis, (2011 )the PACs can be brought on by caffeine, physical fatigue and or stress, these of which patient MM experienced before surgery. But these are totally normal findings in healthy young and elderly people. |
| Knee AP and Lateral Lt | 11/05/13  No Time Stated  Patient showed expected postoperative changes, this including skin staples and joint effusion. Dr. Wang reported of “good anatomic alignment of the left total knee prosthesis.” There were no acute fracutres identified. | Normals for an X-Ray postoperatively of the knee will show no fractures or displacement and correct placement of surgery equipment, this including staples and other materials. | This test is performed to confirm the accuracy of the surgery and procedures and to make sure the joint alignment is correct. | There are no abnormal test results for this patient. |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

### INTAKE AND OUTPUT Past 24º Balance \_\_\_+/-\_\_\_+400mL\_\_\_\_\_\_\_\_\_

Does the patient have a positive or negative fluid balance as of this date? How much?\_\_

positive approximately 400\_\_\_\_ML

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Intake | 1º | 12º | Output | 1º | 12º |
| PO / Enteral | Breakfast PO: 300 mL  Snack PO: 100 mL | Lunch PO: 350 mL  Snack PO: 75 mL  Dinner PO: 500 mL | Source: |  |  |
| IV  IV Tylenol | 200 mL | 200 mL | urine | The patient’s urine output was not being strictly measured. The patient had bathroom privilege with help of nurse/PCA. | The patient’s urine output was not being strictly measured. The patient had bathroom privilege with help of nurse/PCA. |
| Blood Products | No Blood Products | No Blood Products |  |  |  |

### Medications

**IV Solutions/Parenteral Nutrition/Blood Products**: (0.5)

|  |  |  |
| --- | --- | --- |
| Name of Infusant: | Rate: | Site:  (describe the appearance) |
| IV Solution:  Lactated Ringer’s | 1000 mL/HR  (d/c AM of 11/7) | The IV site is clean and clear and flushes easily to saline solution. There is not redness, tenderness or swelling to the area of insertion. Patient MM does not complain of any pain on IV site. |
| Lipids/TPN: | Patient was not receiving lipids. | N/A |
| Blood Products: | Patient was not receiving blood products. | N/A |

### Routine/PRN Medications ( 1.5 points)

**List all the patient’s medications ordered**. Why would THIS patient have this medication specifically? Consider diagnosis, medical history, lab values, procedures when discussing the rational for each medication.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication:**  **Celebrex-Celecoxib** | **Dose:**  **200 mg capsule** | | **Route:**  **PO** | **Frequency:**  **Daily** |
| Classification: | | NSAID | | |
| Action: | | Inhibits prostaglandin synthesis by selectively inhibiting cyclooxygenase-2 an enzyme needed for biosynthesis | | |
| Safe dose range for age/wt: | | 200mg/day as a single dose or 100 mg bid for adult with osteoarthritis | | |
| Rational for use in THIS patient: | | Patient experiencing pain and inflammation from osteoarthritis | | |
| Desired Effect: | | This medication helps to relieve pain, swelling and inflammation that results from osteoarthritis. | | |
| Side Effects: | | Fatigue, Stroke, MI, tachycardia, tinnitus, nausea, anorexia, vomiting, nephrotoxicity, oliguria | | |
| Toxic Efect: | | Stevens Johnson syndrome, toxic epidermal necrolysis | | |
| Nursing Implications: | | Assess for pain of osteoarthritis, check for ROM, inflammation of joints and characteristics of pain.  Check the CBC during therapy, watch for decreasing platelets. Also check Creatinine/BUN, stool guaiac.  Also check for bruising, fatigue and bleeding.  Look for skin disorders including Stevens-Johnson syndrome. | | |
| Pt/Fam teaching needs: | | Teach family/patient about dosing instructions, of change in GI symptoms including black, tarry stools, cramping or rash, edema of extremities, weight gain. Also to report any bleeding, bruising, fatigue to physician. | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication:**  **Chromagen-FE**  **Fumarate/VIT C/B12/STOMC** | **Dose:**  **1 capsule** | | **Route:**  **PO** | **Frequency:**  **Daily** |
| Classification: | | multivitamin | | |
| Action: | | Combination of vitamins and minerals that increases the amount of iron and B12 in the body. | | |
| Safe dose range for age/wt: | | One tablet orally once a day for adult | | |
| Rational for use in THIS patient: | | Patient will have blood loss due to surgery and iron levels may drop. Patient has degenerative arthritis which breaks down health of nerves and RBC. | | |
| Desired Effect: | | Treat and prevent low blood levels of iron and vitamin B12. Osteoarthritis breaks down ligaments and bones, the B12 will help strengthen nerve and blood cells. Increase in iron intake because of loss of blood and iron from surgery. | | |
| Side Effects: | | Constipation, diarrhea, nausea, stomach pain, black stools or urine, headache, unpleasant taste in mouth | | |
| Toxic Effect: | | Serious allergic reaction | | |
| Nursing Implications: | | Check with patient for constipation or black stools. Ask about headache, nausea or dizziness before moving patient. | | |
| Pt/Fam teaching needs: | | Teach about dosing instructions for patient/family.  Teach about side effects and when to call physician. | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication:**  **Aspirin-Ecotrin** | **Dose:**  **325 mg Tablet** | | **Route:**  **PO** | **Frequency:**  **BID** |
| Classification: | | Nonopiod analgesic, NSAID, salicylate | | |
| Action: | | Blocks pain impulse in CNS, reduces inflammation by inhibition of prostaglandin syntheses, antipyretic action from vasodilation, decrease platelet aggregation | | |
| Safe dose range for age/wt: | | 50-325 mg/day for Adult | | |
| Rational for use in THIS patient: | | Patient has disposition for DVT being bedridden, so aspirin helps to reduce risk of DVT. | | |
| Desired Effect: | | To prevent thrombosis | | |
| Side Effects: | | Drowsiness, rapid pulse, tinnitus, hypoglycemia, nausea, vomiting, rash, wheezing | | |
| Toxic Effect: | | Seizures, coma, GI bleeding, hepatitis, Reye’s Syndrome, anaphylaxis, laryngeal edema | | |
| Nursing Implications: | | Assess pain OLDCART. Assess temperature 1 hour before and after administration. Hepatic Studies: AST, ALT, creatinine, BUN.  Check for allergic reaction to medication. Check for signs of ototoxicity. And evaluate therapeutic response in patient. | | |
| Pt/Fam teaching needs: | | Teach patient to report any symptoms of hepatotoxicity, renal toxicity , visual changes, ototoxicity, allergic reactions ,bleeding. | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication:**  **Pepcid-Famotidine** | **Dose:**  **20mg tablet** | | **Route:**  **PO** | **Frequency:**  **Daily** |
| Classification: | | H2 histamine receptor antagonist | | |
| Action: | | Competitively inhibits histamine at histamine H2-receptor site thus decreasing gastric secretion while pepisn remains at a stable level | | |
| Safe dose range for age/wt: | | 20 mg Q6h, may give 160 mg q6hr if needed | | |
| Rational for use in THIS patient: | | Patient is taking NSAID, which can have a negative effect on the stomach. Famotidine is used to treat and prevent ulcers in the stomach and intestines. | | |
| Desired Effect: | | Prevent GI disorders in patient taking NSAID, prevent stress ulcers | | |
| Side Effects: | | Headache, dizziness, taste change, rash, diarrhea, nausea, vomiting, constipation | | |
| Toxic Efect: | | Seizures, dysrhythmias, QT prolongation, thrombocytopenia, aplastic anemia, toxic epidermal necrolysis, Stevens- Johnson Syndrome | | |
| Nursing Implications: | | Assess for epigastric pain, abdominal pain, blood in stool, pH, and creatinine for ulcer check up.  Ask patient about bowel movements to ensure there is no constipation. Increase fluids and bulk for patient. | | |
| Pt/Fam teaching needs: | | Teach patient and family about dosing information. Teach patient and family about harmful side-effects, those including bleeding, bruising. Teach patient to Avoid irritating foods and avoid smoking. Teach patient about potential for drowsiness and dizziness when on medication. | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication:**  **Cholecalciferol-VitD Supplemement** | **Dose:**  **1000 Unit Tablet** | | **Route:**  **PO** | **Frequency:**  **Daily** |
| Classification: | | Fat-Soluble vitamin | | |
| Action: | | Supplies body with vitamin D3 to strengthen bone. | | |
| Safe dose range for age/wt: | | Adult Dose: 1000 international units orally once a day | | |
| Rational for use in THIS patient: | | Patient has weak bones from osteoporosis and Vitamin D helps to strengthen them. | | |
| Desired Effect: | | Vitamin D is given to treat weak bones from osteoporosis. | | |
| Side Effects: | | Weakness, fatigue, sleepiness, headache, loss of appetite, dry mouth, metallic taste, nausea, vomiting | | |
| Toxic Effect: | | Cause excessively high levels of calcium in the blood. | | |
| Nursing Implications: | | Check patient for any signs of weakness, nausea or fatigue. | | |
| Pt/Fam teaching needs: | | Inform patient of dosing information for medication. Inform patient of potential side effects for the medication and what to look out for. | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication:**  **Toradol-Ketorlac** | **Dose:**  **30 mg/mL SVR** | | **Route:**  **IV** | **Frequency:**  **Q6** |
| Classification: | | NSAID | | |
| Action: | | Inhibits prostaglandin synthesis by decreasing an enzyme needed for biosynthesis; analgesic, anti-inflammatory, antipyretic effects | | |
| Safe dose range for age/wt: | | 20mg then 10 mg q4-q6 hr, max 40 mg/day | | |
| Rational for use in THIS patient: | | Patient has pain from left total knee surgery, patient has pain and stiffness from osteoarthritis | | |
| Desired Effect: | | Reduce mild to moderate pain | | |
| Side Effects: | | Dizziness, drowsiness, hypertension, nausea, tinnitus | | |
| Toxic Efect: | | Seizers, MI, stroke, GI bleeding, hepatitis, hepatic failure, nephrotoxicity, dysuria, angioedema, | | |
| Nursing Implications: | | Assess for aspirin sensitivity. Assess for pain, OLDCART. Watch for renal failure and bleeding times in patient. Evaluate therapeutic response for pain throughout the day. | | |
| Pt/Fam teaching needs: | | Teach patient and family about correct dosing requirements for medications. Tell the patient/family to report if they experience any blurred vision. Teach them to avoid driving. Instruct patient and family to call if there is change in urine pattern, weight increase, edema. | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication:**  **Oxycontin-Oxycodone** | **Dose:**  **20mg Tablet** | | **Route:**  **PO** | **Frequency:**  **Q12h** |
| Classification: | | Opiate analgesic | | |
| Action: | | Inhibits ascending pain pathways in CNS, increases pain threshold, alters pain perception | | |
| Safe dose range for age/wt: | | 10-30 mg/day q4hr Adult dosing | | |
| Rational for use in THIS patient: | | Patient is experiencing pain from post-operative surgery on left knee. | | |
| Desired Effect: | | Help to reduce moderate to severe pain. | | |
| Side Effects: | | Drowsiness, dizziness, confusion, headache, sedation, palpitations, tinnitus, nausea, vomiting | | |
| Toxic Efect: | | Respiratory Depression | | |
| Nursing Implications: | | Assess intermittently for pain and OLDCART. Check I/O ratio to check for decreasing urine output. Observe for CNS changes and allergic reactions. Keep an eye on breathing function. | | |
| Pt/Fam teaching needs: | | Teach patient about proper dosing procedure. Teach patient about standing and moving slowly so to avoid dizziness. Teach patient trouble about overdosing. | | |

All Medications Above:

(Skidmore-Roth, Linda. *Mosby's 2013 Nursing Drug Reference*. St. Louis, MO: Mosby,

2013. Print.)

\*\*Continue to copy the above chart as often as needed to include ALL Routine & PRN meds\*\*

### (Included in part 5 above and worth 3 points total)

Head-to-Toe Assessment

### INTEGUMENTARY:

Skin: Color \_\_\_pink\_\_\_ Turgor \_no tenting\_\_ Temp \_warm\_\_\_\_\_ Moisture appropriately moist\_

Lesions \_No lesions present. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Incisions\_incision left knee for surgery.\_ Dressings \_gauze dressing dry and intact

Varicose Veins \_not present\_\_ Scars no scarring observed\_ Nails \_smooth, pink nail bed; no clubbing\_

Pressure Ulcer: Location \_no pressure ulcer\_ Stage \_N/A\_\_\_\_\_\_\_\_\_ Characteristics \_N/A\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unusual Pigmentations/Tattoos/Piercings\_no unusual pigmentations/ tattoos/ piercings present.\_\_

Drainage/ Suction \_no drainage or suction

Dressings (describe each by site, size, appearance, characteristics, drainage, etc.) \_Gauze covering all of left knee; dry and intact; no drains but small serosanguinous blood on bandage

Note: **\*Labs & Medications for the integumentary system must be address here**

### MUSCULOSKELETAL:

Activity Level \_independent ADLs\_ROM \_full\_\_\_\_\_Gait/Mobility appropriate\_ Posture \_erect\_\_

Muscle Tone/Strength \_Pt able to push hands and feet against applied force.\_\_\_\_\_\_\_\_\_\_\_

Any Contractures\_no contractures present. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LUE\_\_none\_\_\_\_ RUE\_\_\_\_\_none\_\_\_\_\_\_ LLE\_\_none\_\_\_\_\_ RLE\_\_\_none\_\_\_\_

Assistive Devices \_none\_\_\_\_\_\_\_\_\_\_\_\_\_\_Prosthesis/es\_\_none\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Devices\_\_none\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent position of pt. on your shift\_Pt moved independently.\_Needed some help however with movement because of her weight. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: **\*Labs & Medications for the musculoskeletal system must be address**

### NEUROLOGICAL:

Level of consciousness, alertness, orientation, cognition memory (short/long term) \_LOC awake and cooperative; A&O x4; short and long term memory intact.

Sleep/rest patterns \_6-8 restless hours a night because of sleep apnea\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speech \_clearly understood with no trouble forming thoughts and sentences.\_\_\_\_\_\_\_\_\_

Sensory (taste, smell, touch)\_smell and touch intact via pts ability to smell food (CN I) and distinguish between sharp and dull sensation (CN V). Taste in tact, tested with applesauce.

Motor (fine/gross) \_Fine and gross motor skills intact per pts ability to walk and use her cellular device to text

Vision \_intact via pts ability to read RNs name on white board in pts room (CN II).\_\_\_\_

Hearing \_intact via pts ability to answer questions in dialogue and hold a conversation (CN VIII).\_\_\_

Reflexes \_intact via testing of deep tendon reflexes.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cranial Nerves (All must be included, how tested & results) :\_CN I tested and intact via pts ability to smell. CN II tested and intact via pts ability to read white board in room. CN III, IV, and VI tested and intact via extra ocular movements. CN V tested and intact via pts ability to distinguish between sharp and dull sensations. CN VII tested and intact via pts ability to change facial expressions. CN VIII tested and intact via pts ability to answer questions. CN IX and X tested and intact via pts ability to swallow. CN XI tested and intact via pts ability to turn head against resistance. CN XII tested and intact via pts ability to stick out tongue.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARDIOVASCULAR:**

Heart Sounds present\_ Rate \_92 bpm\_\_\_\_\_ Rhythm \_regular\_\_\_\_ Apical MCL 5 ICS\_

Pulses: R/L Radial \_+2\_\_\_\_\_\_\_ Brachial \_+1\_\_\_\_\_Femoral \_+1\_\_\_DP\_+1\_\_ PT \_+1

Capillary Refill \_<3 sec\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Skin color/temp \_pink/warm\_\_\_\_\_\_\_\_\_\_\_ Edema/Location\_no edema\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shunts/Location (bruit, thrill)\_no shunts or bruits heard.\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: **\*Labs, Vitals & Medications for the cardiovascular system must be address**

**PULMONARY:**

Rate/Min \_\_18\_\_ Rhythm\_regular\_ Depth:\_no use of accessory muscles.\_ Effort/Ease\_ease\_\_ Pulse Ox \_\_\_98%\_\_\_\_

Breath Sounds (all lobes & bilateral comparison) R/L – Crackles (fine, coarse) Wheezes (inspiration, expiration), Diminished, Absent \_lung sounds clear to auscultation, no adventitious sounds heard.\_\_\_\_\_\_

Sputum/Secretions\_no sputum or secretions noted.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oxygen Therapy/Rate:\_2.0 Liters\_\_\_\_\_\_\_\_\_\_\_\_ Via\_\_\_nasal cannula (NC)\_\_\_\_\_\_\_\_\_\_

RT Treatments (type, frequency)\_NC on 2.0 L\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest Tubes \_none\_\_\_\_\_\_\_\_\_\_\_\_ Suction \_none\_\_\_\_\_\_\_ Drainage \_none\_\_\_\_

Note : **\*Labs, Vitals & Medications for the pulmonary system must be address**

### GASTROINTESTINAL:

Diet\_regular house diet\_\_\_\_\_\_\_\_\_\_\_\_ Appetite \_increased\_\_\_\_\_\_ Intake% \_100%\_\_\_\_\_N/V yes\_

Kcal per day needed \_2,400 Kcal/day\_\_\_\_\_ receiving \_ 1500-2000 Kcal/day

Enteral nutrition: NG Tube \_none\_\_\_\_\_\_\_\_\_ G Tube \_none\_\_\_\_\_\_\_\_\_\_ J Tube \_none\_\_\_\_\_\_

Mouth /oral mucosa\_pink and intact.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teeth/Dentures\_Teeth clean with a few crooked teeth on bottom

Abdomen: (soft, distended, ascites, stomas): \_soft and tender. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bowel sounds: Location\_abdomen\_\_\_\_\_\_ Activity: normo active \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bowel Patterns \_no existent in hospital Last BM \_11/4/13\_\_ Stool Characteristics \_brown and soft.\_

Note: **\*Labs & Medications for the gastrointestinal system must be address**

### GENITOURINARY:

Urine: Output \_1°: approx. 100 mL; 12°: apporx 500 mL \_\_\_\_\_\_ Characteristics \_yellow, clear\_\_\_\_\_\_\_

Patterns of voiding \_3-4 times a day regularly.\_\_\_\_\_\_\_\_\_\_\_\_\_ Catheter (type) \_none\_\_\_

Genitalia: Female\_no urethral swelling, lesions, or discharge.\_\_\_\_\_\_\_\_\_\_\_ Male\_N/A\_

Sexual History (if applicable) \_not currently sexually active

Childbearing History (if applicable):\_pt has been pregnant ocne, in 1988.\_\_\_\_

Note: **\*Labs & Medications for the genitourinary system must be address**

**6. Clinical Manifestation of Current Condition(s):**  (2 points)

|  |  |
| --- | --- |
| Expected Manifestations. According to Literature for ***Each Medical Diagnosis and Surgical Procedure.*** Must be referenced and cited per APA | Assessment findings on Day of Care r/t each diagnosis. Include vitals, labs and physical assessment data  (Date)\_\_\_\_\_11/7/13\_\_\_\_\_\_ |
| Dx #1: Sleep Apnea  According to Potter and Perry (2013), Obstructive Sleep Apnea is characterized by a lack of airflow through the body during sleep, usually lasting more than ten seconds. Potter and Perry (2013) suggest that when nasal airflow decreases or stops, the patient tries to breath but experiences “loud snoring and snorting.” In addition, the patient may experience difficulty staying asleep, morning headaches, and or awakening with a dry mouth or sore throat (p. 943).  Dx #2: Morbid Obesity  Morbid Obesity is a condition that increases risk for serious disease and death. Obesity is usually seen within comorbidities of a patient. Potter and Perry (2013) state that obesity can lead to “high blood cholesterol, type 2 diabetes, coronary heart disease osteoarthritis and sleep apnea” (p. 166).  Dx #3: Left Total Knee  Left Total Knee was performed on the patient because of an increased amount of pain in the knee and leg with no relief from moderate treatments. As authors from Medscape (2013) address, that drains are removed from the patient within twenty four hours. In addition, the hospital staff is responsible for encouraging the patients to walk on the second day postoperatively. Great attention is paid to physical therapy and the patient is improvement in their flexibility and basic movement. In addition, according to Lewis (2011), “a compression device may be used to immobilize the knee in extension immediately after the operation” (p. 1616).  Dx #4: Osteoarthritis  Osteoarthritis is a severe form of joint disease that, as authors of uptodate.com addresses (2013), affects the “joint cartilage and causes underlying bone to wear.” This breakdown of the knee and related bone and cartilage causes severe inflammation, which can lead to “pain and stiffness,” as reported by authors at uptodate.com. | Upon the morning introduction and assessment, the patient expressed feelings of tiredness and exhaustion after waking up. When I met the patient around 7:30, she had already been up for an hour and still felt out of it. In addition to her feelings of tiredness, she stated she had a slight scratchy, dry throat. The patient expressed how she has felt like many times before.  In addition to observing physical assessment, it is key to look at the patients oxygen saturation. In the morning around 05:44 AM, the patient was reading a 96%, and following at 8:00 during morning vitals the patient read at a 95%. It is key to notice that sleep apnea is not disrupting the patient’s overall oxygen intake.  Dx #2:  When looking at physical attributes you can see the obesity of patient MM. Exhibited by larger neck, arms, abdomen and legs. In addition, I observed there was very little skin breakdown on patient MM. Overall, the physical assessment and observation are key to recognizing the obesity.  Patient’s BMI is 54.2 kg/m2. Potter and Perry (2013) state that a BMI greater than 30 is considered obese and places patients at a “higher risk” for comorbidities (p. 1009). It is evident that the patient is overweight and it is causes many of her other health disparities.  Patient MM under her current weight does not have high blood pressure. The Blood pressure is maintained at 110/62, which is considered a normal BP.  Another key vital to look at is the patient’s oxygen saturation. Throughout the morning the levels were marinated at 96% at 05:44 AM, 98% at 08:00 AM and throughout the rest of the day.  Dx #3:  The physical assessment of the patient was spot on with the projected healthy development. Patient MM’s drain was taken out within twenty-four hours of surgery. There was no excessive draining or inflammation of the knee during this time. The dressing was tightly applied and showed no signs of distress.  In addition, the patient had a physical therapist visit her twice in one day. Both times, the Physical Therapist aided in getting the patient up and moving, helping to increase blood circulation and body strengthening.  Patient MM’s vitals were consistent with normal values. Blood pressure throughout the day was kept around 110/62. Oxygen saturation as maintained between 96 and 98.  Patient MM lab values supported healthy healing of her incision point. Her white blood cell count was 14.9 on the day of surgery, this value being high showing the body’s action of keeping down infection of the incision site. After a day of rest, the WBC was back down to 9.3, within a normal range of 5-10 (citation of lab book). The normal WBC value shows the healthy healing of the surgery and normal recovery process. In addition, a key lab value to observe is the Red blood cell count. On the day of surgery, patient MM’s value read 4.73 and the day after surgery her values had dropped to 3.83 L. This is expected and normal based on natural drainage from the incision sight.  Dx #4:  The patient reported with pain the level of 3-4 upon arousal in the early morning. The pain was described as tender, sore and stiff at the sight of surgery. Much of the surgery should relieve the signs of osteoarthritis in the left knee.  The patient’s vital sign values were all normal throughout the day and there were no presenting abnormalities to be of concern.  Patient’s lab values showed no sign of infection or electrolyte abnormality. |

7. Patient Care Needs on your shift: *(Discus your focus/concerns /care for the day)* (2)

|  |
| --- |
| * One major concern and focus of the day was getting the patient to have a bowel movement. The last recorded date of a bowel movement was on November 4th. On the day of care, we administered stool softeners and medications to help increase the process of excrement. In addition, I brought the patient cranberry juice to sip on throughout the day to help to getting the intestines moving again. On top of medication, the physical therapist and nursing staff all encouraged movement and mobility to help with digestion. * Another focus of the day was pain management. The patient’s nerve block was discontinued in the morning of 11/7, so it was key that the nursing staff began a medication routine that would decrease the pain levels in the patient. The functional goal for patient MM was a pain level of 2-3. Directly after the discontinuation of the nerve block, medication was given to patient MM. Many of these including pain and inflammation reducing medications including but not limited to Celebrex, toradol-ketorlac, and oxycontin. In addition, the nursing team and myself used various therapeutic methods of touch, ice pack and tv distraction throughout the day to help defer attention from pain to other thoughts. After mid-afternoon, the body became accustomed to the pain medications and pain remained at level of 2-4 for the remainder of the shift. * Another focus of the day was to help the patient with feelings of anxiety. During discussion with the patient, she expressed feelings of sadness and anxiousness as she awaited treatment in the hospital. To combat this feelings, the medical team and myself worked with therapeutic touch and words. I took time to listen to what she had to say and offered words of hope and encouragement to her. Also touch on the shoulders helped with easing tension. During conversation, I made a point to pick out encouraging things in the patient’s situation and bring light into her positive recovery in the hospital. * During the day, I helped a lot with ambulation of the patient. The movements throughout the day varied between small walks to and from the bathroom, to larger walks around the pod with the walker. The movement throughout the day helped to increase energy levels and build moral and hope in the patient. * Another aspect of the day revolved around the cleaning side of patient care. I was able to give my patient a bath, change the sheets and do basic bedside care to my patient. This care helped again to make the patient more comfortable and at ease. * Preventative skin care was another focus throughout my shift. Aside from ambulating the patient every two to three hours, I would make sure the patient was shifting her body weight whenever she was lying in bed. This included shaping pillows, bed height and sheets to fit her comfort and fit a certain movement and position. The simple actions help to prevent skin breakdown in pressure point areas. * Another aspect of care maintained throughout the day was the collection of vital signs for this patient. Beginning upon initial assessment in the morning vitals were taken periodically throughout the day. By taking vitals, I was able to keep track of my patients overall health. Taking the vitals gave me a baseline of what I should expect in the patient and helped me to measure their health throughout the day. * Another care implemented throughout the day was prevention of DVT and clots. During my shift, I applied sequential compression devices (SCD) to my patient and explained the purpose of them to her. In addition, I administered aspirin alongside my nurse to help prevent any blood clots in the body. In addition, movement alongside of SCD and medication helped to decrease the risk of deep vein thrombosis. * Another aspect of the physical assessment of the patient focused on care of the surgical incision site. I monitored the incision site and measured the amount of drainage during the day. I also promoted protective measures during movement or bed positioning in which the site of incision would not be injured. * During the day I also encouraged the use of the incentive spirometer the patient had at the bedside. In the morning, I performed a small demonstration and reminded the patient of the vitality of using the incentive spirometer. Because of the patient’s decreased mobility we were worried about build up of fluid in the lungs, leading to pneumonia. Therefore, we heavily encouraged the use of incentive spirometer throughout the day. * Throughout the day, myself along with the nursing team addressed various issues of nutrition with the patient. She is morbidly obese and is a heavy set individual. We were able to discuss with the patient about her eating and exercise habits. In addition, we were able to help coach her in what foods she should be ordering and eating during her stay at the hospital. * Another part of the day included preventing my patient from falling. In the morning, I addressed the vitality of my patient MM to call the nurse or me whenever she needed to get up and ambulate. In addition, I supplied the walker during the patient’s movement out of bed to ensure stability. I would also make sure the patient’s room was orderly and there wasn’t clutter or items littering the floor that would inhibit the patient’s ability to walk. These small actions helped to prevent fall and further injury of patient MM. |

8. Pathophysiology (Discuss pathophysiology of patient’s current and relevant past medical/surgical problems. Integrate with clinical data such as vital signs, labs, diagnostic test, procedures, medication use, and family history) Most patients have multiple diagnosis, ALL must be discussed:

Integrate textbook details with specifics of your patient. Make this very specific to the patient you have cared for. Cite references per APA

*(This generally requires 2-3 pages MINIMUM)*  (2)

Osteoarthritis as defined by Lewis (2011), is a degenerative joint disease, usually occurring to those individuals between the ages of 50-60 and above. It is labeled as a “slowly progressive non-inflammatory disorder” of the joints around the body. In regards to osteoarthritis, there are several factors that all take part in the slow degeneration of the joints, muscle and bone in the affected area. A key factor that is the root of many other ailments is that of older age. According to Lewis (2011), the ages of 50-60 and above are the age in which osteoarthritis starts to take place in individuals’ lives. However, alongside old age, Authors from uptodate.com state that factors like “joint integrity, genetics, local inflammation, mechanical forces, cellular and biochemical process” aid in joint degeneration. The beginning of degeneration begins when cartilage damage occurs from physical forces and stress. Lewis (2011) states that the early stages involve destruction of articular cartilage and “narrowing of the joint spaces” (p. 1643). The physical stress and force placed on the joints activates a metabolic response incorporating chondrocytes and proteases (p. 1643). The chondrocyte is a cartilage fixer and helps to build up the cartilage, where as the proteases, when activated break down the cartilage. According to the research team from Uptodate.com (2013), chondrocytes, the cartilage enhancers, decrease greatly the more an individual ages. In addition, the metalloproteases, which inhibit the destruction of the cartilage, again decrease with age. With a decrease in cartilage enhancer, chondrocytes, and a decrease in enzymes that inhibit cartilage breakdown, metallopreoteases, there only leaves room for continued breakdown of cartilage (Uptodate.com 2013). Mentioned by Lewis (2011), as the cartilage continues to be broken down and changed, “fissuring and erosion” occur in the cartilage (p. 1642). As excessive amounts of cartilage break down, subarticular bone starts to rub against each other and cause friction. This rubbing of the bones induces the growth of osteophytes (bony growth) on the joint margins. This results in early pain and stiffness of the joint. As summed up by Lewis (2011), the “uneven distribution of stress across the joint” contributes to a reduction in motion” and onset of pain (p. 1642).

Lewis’ (2011) text continues to explain of the variations of the color of the cartilage before and during current stressors. Usually, the cartilage presents as smooth, white and translucent. However, with osteoarthritis the cartilage becomes dull, yellow and granular; becoming soft, elastic and resistant abilities. The bodies attempt to support the cartilage is nothing against the bodies rate of cartilage destruction. Lewis (2011) states that the changes in inflammation and cartilage result with “early pain and stiffness” in the affected joint (p. 1642). Overtime, the increased amount of pain and stiffness in an individual’s joint tends to inhibit them from performing daily activities with ease and without pain. Much of the time, individuals with osteoarthritis are taken out of activities because of pain until surgery or adequate rest reduces the pain.

The pathophysiology of sleep apnea primarily involves inadequate airflow during rest.

As addressed by researches from UpToDate.com, sleep apnea is the “recurrent collapse of the pharyngeal airway” during a time of sleep and rest (2013). Basically, tissues in the upper throat relax and come together and this leads to the blocking of the airway. The moment of airway blockage, the patient stops breathing, and slowly the amount of the oxygen in the blood decreases. UpToDate.com addresses that this closing of the airway leads to “intermittent disturbances in gas exchange” (2013). The inability to exchange gases in the lungs can lead to potential hypercapnia and hypoxia, increased levels of carbon dioxide and decreased levels of oxygen in the body (uptodate.com 2013). According to Harvey Simon (2013), this sudden lack of oxygen in the blood triggers “the lungs to suck in air” and the patient will make “gasping or snorting sounds” but does not usually wake up. In addition, the closing of the airways can lead to disjointed sleep. This closing of the airway manifests itself in loud snoring from the affected patient and can result in daytime sleepiness. This not only affects the patient themselves, but individuals around them as well. Patient MM complained of tiredness upon waking up and complained of disjointed sleep throughout the entire night. When checking the patients oxygen saturation, the levels ranged between 96% and 99% so there was no need to worry about adequate profusion and oxygen concentration.

The patient uses the CPAP machine during the night and this helps to improve the patient’s quality of sleep, but Ms. MM states that some mornings she still wakes up feeling exhausted and annoyed form the machine’s affect on her nose. In a research article headed by Maria William and associates titled *Experiences with CPAP treatment in patients with obstructive sleep apnea syndrome and obesity,* the authors addressed various ways in which the CPAP intervention was beneficial but also caused irritations to its users. One thing the article addressed was that of the shortcomings of the use of CPAP machines as addressed by patients who used them. The article stated that “there were smaller disturbances with comfort” these including “dry nose, sore membranes of the nose and bleeding” (2012). These findings rang true with patient MM, for she complained of slight nostril irritation and dry nose from the CPAP machine. These results are a common finding in CPAP users however it does help to fight off bouts of apnea. Overall, sleep apnea affects patient’s MM sleep during the night and can take a toll on her well-being.

Obesity results from many different factors, these including environmental, genetic and biological basis. In lay mans terms, obesity results because energy intake exceeds the energy output. According to a uptodate.com authors when there are periods of prolonged abundance of food, the body becomes very efficient and stores excessive fat in the body, this eventually leading to obesity. According to Osama Hamdy (2013), there are two main types of obesity that both involve the fat cell, adipocyte. In persons with increased energy intake and low energy output, the fat in the body accumulates and is stored in two different ways. One way being hypertrophic obesity, being that the fat cells enlarge and take in a greater amount of fat. The other being hypercellular obesity, this resulting from an increased amount in the number of fat cells in the body. Individuals who experience an excessive intake of food begin to gain weight because the fat increased the amount of fat being stored in the body.

This is quite evident in my patient when observing her physical characteristics. She has an excessive amount of body fat around the abdomen, legs, neck and arms. A key piece of data to identify in this patient would also be to look at her BMI. Potter and Perry (2013) state that a BMI greater than 30 is considered obese. When looking at Patient MM, one can see that her BMI is 54.2 kf/m2, which is leagues above the normal value. This data supports the findings that patient MM is morbidly obese. In addition, patient MM is consistently sluggish and tired throughout the day caused by her obesity. On top of all of this, the obesity is a key factor in the cause of her sleep apnea and her osteoarthritis. Patient MM also stated that her mother was heavier set and much of the obesity could result from genetics.

Two other important vitals to observe are blood pressure and oxygen saturation. Patient MM under her current weight does not have high blood pressure. The Blood pressure is maintained at 110/62, which is considered a normal BP. Another key vital to look at is the patient’s oxygen saturation. Throughout the morning the levels were marinated at 96% at 05:44 AM, 98% at 08:00 AM and throughout the rest of the day.

**9. Potential Complications (based on pathophysiology & referenced):** (2)

|  |  |
| --- | --- |
| Medical Diagnosis: | Potential Complication: |
| Dx #1: Osteoarthritis | A main complication that revolves around osteoarthritis revolves around pain. Like mentioned above in the pathophysiology, after the degradation of cartilage in a specific joint, extreme pain, tenderness and inflammation occur. According to authors from mayoclinic.com (2013), they state that pain reaches the point in which it makes it difficult for the patient to perform activities of daily living by themselves. It states that some people are taken out of work and other highly exhausting activities until they can get surgery or rest. Aside from pain that comes along with osteoarthritis, there are some very serious complications that can arise from this. According to authors from WebMD (2013), “bone death, stress fractures, bleeding inside joint and infection” are also potential complications of that result from osteoarthritis. |
| Dx #2: Sleep Apnea | A major complication of sleep apnea revolves around interrupted and incomplete sleep. According to Harvey Simon (2013), sleep apnea interferes with “mental alertness and quality of life.” In addition, because of disrupted sleep, Harvey Simon points out that sleep apnea can also lead to an increased for risk of accident-related-injury. Alongside sleep quality complications, Simon (2013) points out that “ heart problems such as high blood pressure, heart failure, stroke, heart attack, and atrial fibrillation” are common complications of sleep apnea.  Sleep apnea can also induce psychological complications between sleep partners. The individual with sleep apnea snores loudly at night and much of the time causes a bed partner with disrupted sleep as well (Simon 2013). |
| Dx #3: Morbid Obesity | In a larger scheme, morbid obesity affects the overall quality of life. In MayoClinics Research Team (2013), they address that many people with weight-related issues develop forms of “depression, disability, physical discomfort, sexual problems, shame and social isolation.” In addition to social problems, serious physical health problems can also occur because of obesity. As addressed by the research team of MayoClinic (2013), many serious health problems include high cholesterol, type 2 diabetes, high blood pressure, metabolic syndrome, heart disease, stroke, cancer, sleep apnea. Overall, morbid obesity causes both serious psychological and physical complications. |

**10. Nursing / Medical Therapies and Treatments:** (2)

(Utilize Potter and Perry& Lewis textbooks. Cite all rational & nursing implications)

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment | Rationale for Treatment / Patient Application | Nursing Implications | Frequency |
| Vital Signs | Vitals are used to provide basic health information about a patient and their current status. They can be used to track health throughout the day and can be assessed in case of sudden change in patient’s well being. (Potter and Perry, 2013) | The nurse must know how to accurately obtain the vital signs from a patient and must know how to accurately record them. The patient must also be aware of the abnormal values of each vital sign and know what treatments and medications alike can affect them. (Potter and Perry, 2013). | Vital signs are taken every four hours, or in adherence to a specific hospital’s protocol. |
| Ambulation | The act of ambulation helps to increase adequate blood flow throughout the body, reaching to the lower extremities. Ambulation also helps to relive pressure that could be placed in specific areas from laying/sitting for an extended period of time. In addition, it helps to prevent any form of blood clot or thrombi from forming in the lower extremities. (Potter and Perry, 2013). | When ambulating a patient, the nurse must adhere to proper technique, reposting and movement techniques regarding each individual patient. In addition, the nurse must watch for signs of nausea, dizziness, or orthostatic hypotension in the patient. Patient must confirm that the patient is stable enough to perform the exercise or movement. (Potter and Perry, 2013). | Ambulation must happen at least two times a day. However, most of the time it is as needed determined by the patients requests and needs of movement. |
| Documentation | Proper documentation of interventions and observations of a patient helps to give all members of the care team the necessary information for proper care of the patient. It helps to written communication between members and helps to decrease error in patient care. (Potter and Perry, 2013). | The nurse must know what exacts to document in the chart regarding observations, test and information gathered during interventions. In addition, the nurse must know how to properly and accurately input the information into the computer charting system. | The nurse will document at the time of care. |

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment | Rationale for Treatment / Patient Application | Nursing Implications | Frequency |
| Medication Administration | Medication administration is used to combat side effects of a patient’s underlying disease and diagnose. (Potter and Perry 2013). | It is the nurses responsibility to know the rights of administration, this including the right patient, time, dose, reason, route, documentation, medication, right to refuse, and right education. This way the nurse knows what they are giving the patient and the ways to combat any adverse effects that may come about. (Potter and Perry, 2013). | The frequency depends on the order of the medication by the doctor. |
| Physical Therapy | Physical therapy is used to help patients increase their strength and independence by working on gait training, education, endurance and transfer training.  (Lewis 2011) | It is key for the nurse to observe and interact with the physical therapist regarding the patient’s performance during PT. The nurse can obtain a baseline and expected performance of the patient and thus help ensure proper strengthening training during the day. (Lewis, 2011). | Physical Therapy usually happens one to two times a day. |
| Application of Sequential Compression Devices | The patient is prone to deep vein thrombosis and blood clot when they are sedentary. By applying the SCDs, the blood will be forced up from the lower extremities so it does not pool and cause complications. (Lewis 2011) | During assessment, the nurse can look for edema on the lower extremities and ask the patient about pain and tenderness in the lower extremities. The nurse must also confirm that the SCDs are placed correctly on the patient and that they are continuously pumping.  (Lewis, 2011) | The sequential compression devices are kept on throughout the day. |
| Occupational Therapy | The occupational therapist is ordered to work with patients to improve the fine motor movements, assist with activities of daily living, and sensory and perceptual skills as well as teaching about assistive devices.  (Lewis, 2011) | It is the nurses responsibility to understand the discussion and work between the patient and the occupation therapist. This way, the nurse can encourage the patient throughout the day to adhere to the OT’s instructions and help them accomplish goals for the day. (Lewis, 2011). | The occupational therapist comes one time a day or as needed. |
| Reposition and Turning | The patient is older and has weaker skin integrity. By turning the patient every two hours, this will help prevent potential abrasion, lesions and pressure ulcers. (Potter and Perry, 2013) | When turning, assess the patient for any skin integrity issues, look for redness, bleeding, or edema. Ask the patient if they are experiencing any tenderness on specific bony prominences. (Potter 2013) | Reposition the patient every 2 hours. |

This should be a comprehensive list of **all** the care provided to your patient during your shift. It may be care offered by other disciplines or by nursing. Examples include: ADL’s, ambulation, ROM, feeding, I&O, Vitals, Med pass, documentation. PT, ST, RT, OT, MD visit, repositioning, dressing changes, pt/family education, emotional or spiritual care, visit from chaplain, etc. etc. **ALL care provided** to a patient requires some level of nursing assessment and monitoring and has a nursing implication. This chart is designed for you to explain how busy you were providing **outstanding care** to your patient!! ☺

(2)

1. Individual/Family Developmental Stage and Family Dynamics:

**C. Psychosocial Subsystem**

(Discuss stages per Ericson and Maslow with rational based on your assessment of pt)

Both Erikson and Maslow generated theories that outlined the various stages of development throughout an individual’s life. Erikson’s theory touches upon specific age groups of people from birth to death to analyze their mental and cognitive functions. Where as Maslow took to looking at how an individual needs to reach certain levels of adequacy in physiological needs, feelings of safety, sense of belonging and self confidence to reach self-actualization. Both of these theories allow one to analyze a patient and help to prioritize a patients care plan.

According to Erickson, at the age of 56, patient MM is deep into the stage of Middle Adulthood. Erickson’s developmental theory focuses upon the life challenges and circumstances that individuals will experience, depending on their age group. Potter and Perry (2013) address that at her current age, Ms. M. would fall under the category of “generativity versus self-absorption and stagnation,” typically labeled for the middle-aged individuals (p. 132). During this stage in life, individuals are wrestling the waters of being invested in work, family and making a change in the community. Potter and Perry (2013) simply state that this stage is one where the individual looks outside of oneself and cares and nurtures for the world around them. Many times this is expressed through parenting and community involvement. When looking at patient MM is is evident to see that she is living out the nurturing aspect of this stage. She is currently nurturing and caring for her twenty four year old son who continues to live at home. She is currently “contributing to future generations” (Potter and Perry 2013, p. 132) by investing time and energy into him. The patient also states that she is intermittently involved in her community. The patient says that she would like to be more involved but finds it difficult to commit and participate in the events. Judging by MM’s involvement in the upbringing of her children and occasional involvement in the larger community, she would be deemed suitable for the title of generativity. Patient MM is residing in her stage of generativity as she continues to look outside herself and care for those around her. However, in order for her to truly blossom in this stage and thrive patient MM should look into becoming more involved in community programs through schools, libraries, work or churches.

Maslow pioneered the idea of a tier of needs that need to be met in an individual’s life in order to reach self-actualization. Potter and Perry (2013 pg 43) address that there are five levels in this stage that patients can be placed into, this including the base of physiological needs, followed by safety, love/belonging, esteem and self actualization. The first of the five levels, physiological needs, is met by having access to fundamental human needs, including food, air water and fundamental needs. When looking at patient MM, it is obvious to see that her needs nutritionally are being met because she has access to food, water and air. The second level of the pyramid is safety, having a security in resources, morality, family, health and property (Potter and Perry 2013). When looking at patient MM, it is clear to see that she meets the levels of this stage. She has monetary resources, a source of income through her accounting job, and a plethora of resources around her for outreach. By talking with her throughout the day, it is also obvious to see that patient MM has high morals and values that she holds true to herself. The family aspect of patient MM is one area is which she lacks. She is currently living with her twenty-four year old son. However she is widowed and most of her family lives far away from her. But in all, she does have he son to provide therapy and support for the family. Patient MM also has property in her possession which supplies shelter and protection to her. By looking at patient MM’s safety, it is clear to she has met most areas of safety including family, money and property. The next level in Maslow’s pyramid according to Potter and Perry (2013) are needs revolving around the sense of belonging. The sense of love, affection and being part of a larger group are key characteristics in this level. When looking at patient MM, it is obvious to see that her love and belonging needs are not being met. Although she has love coming from her son, her husband passed away and a huge source of affection and encouragement from him passed away with him. In addition, the love and affection supplied by her husband and the greater family is not always present in her life, which definitely takes a toll on Patient MM’s spirits and morale. The last aspect of this stage is that of being part of a larger group. Patient MM states that she has a small group of friends at her workplace, where she works as an accountant. However, she said she lacks any support group outside of her son and work friends. She said since her husband has died there has been a huge void and sense of loneliness. It is evident to see that patient MM, has not met the requirements of the belonging stage. For she states that she “does not feel connected” to larger groups and family and husband support are not prevalent in her life. Potter and Perry (2013) state that “sexual love” and “social relationships” are key to conquering the stage of belonging, but these two aspects are missing in MM’s life (pg. 43). It is evident to see that Patient MM is stuck in the stage of belonging. Ways in which MM can meet the sense of belonging is to get involved in outreach programs and social groups in her community. Whether it be volunteering or getting involved in a church group, MM can fill the void of loneliness through social interaction.

**2. Cultural Influences/Health Beliefs and Values:**

**(Provide general information regarding pts identified culture first)**

Ms. MM states that her culture has not necessarily impacted her view on health and medicine. She was born to a couple that was also born in the United States so she doesn’t have much connection to her cultural heritage. However, she states that she believes in western medicine and will see specialty physicians when her health requires it. The patient supports the work that hospitals do worldwide and appreciates their help. Overall, the patient does not hold any specific cultural and heritage beliefs but does support the western belief in medicine.

Health care is a facet of life that Ms. MM does value however. She explained a bit of her medical history and the ways in which the medical system has aided her in recovery and the advancing of her health. Overall, Patient MM believes in western medicine and values the work of hospitals and medical professionals worldwide.

**3. Individual/Family Challenges VS. Individual/ Family Strengths (minimum of 3)**

|  |  |
| --- | --- |
| Individual/Family Challenges | Individual/Family Strengths |
| 1. Not a lot of communication with extended family | 1. Good communication among mother and son |
| 2. No father figure/husband in the family | 2.Humor and laughing together |
| 3. Not asking each other what the other person needs | 3. Getting Along with each other |

**4. Individual/Family Coping with the Current Stressors:**

Patient states that she watches TV or sits and thinks to help with coping and stress. She states that she should probably incorporate walking or construction crafts into her stress regime to get her active and doing something creative. Patient verbalized that her son does not deal well with stress, and he has sometimes has bouts of anger toward her. She said they are working on his actions and how they can combat the stress and arguments.

**D. Spiritual Subsystem**

(2)

**1. Spiritual Assessment:** (Ref. Taylor (2002), Potter & Perry, Articles for a variety of spiritual assessment tools that can be used. Student must identify the specific model/tool/assessment used, the questions asked and the patient’s response including patient’s own words in quotations)

The tool used during the spiritual assessment was the Stoll (Taylor, 114, 2002). The client was asked various questions from Taylor’s book of spirituality regarding, do you consider yourself a spiritual individual, how do you practice your spirituality and what is your source of hope? (Taylor 2002) In response to these questions, Patient MM stated that she does consider herself a spiritual individual. She says she affiliates herself with the Presbyterian Church. She stated that she only participates in prayer occasionally, and will attend a local church for large holiday celebrations. In addition, she states that she owns a Bible and will occasionally pick it up read through various chapters; she says this helps her to “refresh my spirituality.” Patient MM states that her sense of hope stems form seeing her son succeed and enjoy life.

|  |  |  |
| --- | --- | --- |
| **Spiritual Strengths** | **Spiritual Resources** | **Spiritual Needs** |
| 1.  Occasional Biblical Study | 1. Bible | 1. Patient MM needs to religiously attend a church |
| 2.  Occasional Prayer | 2. Church | 2. Patient MM needs to involve herself in a church small group |
| 3. Statement and willingness to learn | 3. Praying | 3.Patient MM needs to rediscover a passion and curiosity for her faith |

**5. Link between spiritual assessment findings and overall health of patient:**

Note: This is a great place to integrate the required research article, then link to

specific patient issues

From the interview about spirituality, it was easy to see the ways in which Patient MM’s spiritual slum affected her current state of health. Patient MM didn’t have much to say aside from generic answers and commonalities during the spiritual assessment. Patient MM is definitely lacking in her spirituality and this is most evidenced by her current health. In addition, Patient MM stated, “I want to learn more and know more.” One key issue to address with the patient is her morbid obesity. Although the patient regarded herself as having an affiliation with the Presbyterian church, she is not consistently living her faith out in her life. One spiritual shortcoming that I saw in the patient was that she didn’t find her source of hope in the Lord. It’s as if Patient MM is living for worldly things and not living in hopes of a better future with the Lord. In many cases, the patient never stated that she cared about her physical health enough to the point where she would strive to change it. In a peer review journal by Chris Barber discussing health and spirituality, it indicated that much of their research shows that the “expression of spirituality can have significant benefits in terms of improved physical and mental health” (2013 p. 68). It is clearly stated here that patient MM could have improved health if she related more with her spirituality. Her outlook and physical health could drastically improve with a better outlook and sense of Hope in God. Patient MM could gain a more positive outlook and she may even have more encouragement to work on reducing her weight.

(http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=89b0eb64-d175-45de-bf21-0eab68ccc529%40sessionmgr14&vid=4&hid=25)

**E. Nursing Diagnoses/ Collaborative Problems**

**Provide 5 prioritized Nursing Diagnosis (per NANDA format) with “related to” and” manifested by”. Two must be physiological, 1 psychosocial, 1 spiritual and 1 other……. (1)**

1. Acute pain related to total knee arthroplasty discomfort as manifested by patient stating “I have pain at level of 5,” patient seen wincing when moving, and patient moaning and groaning during ambulation.
2. Impaired physical mobility related to total knee arthroplasty as manifested by patient stating it is painful to move and walk, patient getting tired easily when walking from obesity, discomfort during movement.
3. Risk for constipation related to opioid medication, immobility, and 0 bowel movements since the fourth 11/4.
4. Spiritual distress related to loneliness and social isolation as manifested by patient living at home without a significant other and partner, patient states that she “feels lonely at home sometimes,” patient does not have a current home/church or community group to attend.
5. Impaired social interaction related to patients inability to receive a satisfying sense of social engagement and belonging as manifested by patient stating “I want to be more involved in social groups,” patient is not currently involved in a support group, patient showing feelings of sadness when discussing her feelings of not belonging.

**Provide your rational on why you prioritized your nursing diagnosis the way you did related to patient condition: (1)**

I prioritized my nursing diagnoses the way above based upon the most pressing issues my patient was facing and the ones that directly had to do with her admitting diagnoses. The first diagnoses that I chose to deal with was my patient’s acute pain related to her surgery. On the morning I worked with her, the Dr. had just ended her nerve block and she was taking a while to adjust to the regular medicine. In addition, a large part of post-operative care is treating a patient’s pain. Therefore, because of osteoarthritis being her admitting diagnoses and increased pain from surgery, I decided to prioritize controlling the pain.

The second prioritized nursing diagnoses was related to impaired physical mobility related to total knee arthroplasty. Another key aspect of patient recovery on a postoperative floor is getting patients to be independently mobile again. Directly related to osteoarthritis and the surgery, this prioritized nursing goal aims to bring quick recovering and focus to mobility. Especially with middle age adults, mobility and freedom is a key factor to their lives. By focusing on ways to strengthen overall muscle and build stability in movement in the patient, the process of discharge can be expedited.

The third prioritized nursing diagnoses was risk for constipation related to medication, immobility, and 0 bowel movements since the fourth 11/4. This was placed in position three because mobility and pain are a major focus of the floor and getting patient released from the hospital. However, next in line is the treatment of constipation, resulting from analgesic from surgery and opioid medications administered daily.

The fourth prioritized nursing diagnoses deals with spiritual distress related to loneliness and social isolation. This diagnoses was placed fourth because the physical and biological problems must be addressed primarily, but then the spiritual side of health care comes in. Spiritual health care is a huge aspect of healing, in which it can give the patient a hope and trust in a greater power to help them along during the healing.

The fifth prioritized nursing diagnoses deals with impaired social interaction related to patient’s inability to receive a satisfying sense of social engagement and belonging. This one was placed fifth because a sense of belonging and engagement with individuals around oneself is a key part in self-actualization and feelings of contentment. If we want the healing process to continue past the stages of physical healing with the surgery and osteoarthritis, which is the hospital’s to priority, then we must look after the patients’ involvement outside the hospital. By incorporating care of the psychosocial aspect, the nurse can better care for the whole patient. The nurse will be able to incorporate discussion and instruction to help the patient reach out and find a community group.

**Provide key assessment findings (defining characteristics) for the nursing diagnosis above: (2)**

The key assessment findings for the first diagnoses include patient stating their pain levels, notice of wincing and protective movements of the patient’s hurting knee, patients slow and painful ambulation. The key assessment findings for the second diagnoses include the patient’s slow movement, use of walker to move, patients need of assistance to move and ambulate, patient’s tiredness and weakness upon moderate activity. The key assessment findings for the third diagnoses are patient stating they have not had a bowel movement since 11/4, patient complaining of moderate pressure in abdomen, addressing that patient is on opioid medication that causes constipation. The key assessment findings for the fourth diagnoses are observation of loneliness in patient, patient expresses lack of love, patient expresses lack of hope in a greater power. The key assessment findings for the fifth diagnoses are limited physical mobility, absence of significant others, changes in family interaction, inability to feel belonging in social engagements.

**E. Nursing Diagnoses / Collaborative Problems / Plan of Care** (15 points total)

(Prioritize 3 problems from your list of five above. Include related to and manifested by. Process 2 physiological and 1 psychosocial or spiritual problem. Use SMART (specific, measurable, appropriate, realistic, time focused) goals with realistic iInterventions). Every intervention must be referenced. Cite your references per APA.

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| **NANDA-I Nursing Diagnosis #1**  **Bio/Physiological** | **Patient Goals / Outcomes**  **(short and long term )** | **Nursing/Health Care Interventions**  **(Min. of 4/goal)** | **Rationale for Each Interventions** | **Evaluation of each Goal/Intervention** | **Modifications to the Plan of Care.**  **(Potential or Actual)** |
| Acute pain related to total knee arthroplasty as manifested by patient stating “I have pain at level of 5,” patient seen wincing when moving, and patient moaning and groaning during ambulation. | **Short term goal <24 H:**  **Patient’s pain will be kept at a tolerable level of 2-3 throughout the day until the end of the shift.**  **Long term goal > 24H:**  **The patient’s pain will be controlled and under a level of three before the patient is discharged home with her son.** | **Interventions for short term goal:**  **1. Provide routine therapeutic medication to patient throughout the day. (**Ackley and Ladwig, 2011, p. 603)  **2. Provide medication to patient before activity. (**Ackley and Ladwig, 2011, p.600 )  **3. Put TV on to distract patient of pain in knee. (**Ackley and Ladwig, 2011, p. 605 )  **4. Place pillows and reposition for comfort. (**Ackley and Ladwig, 2011, p. 605)  **5. Encourage relaxation by putting the lights off. (**Ackley and Ladwig, 2011, p.604 )  1. RN will routinely check pain levels throughout the day. (Ackley and Ladwig, 2011, p.602 )  **2. RN will administer routine pain medication to patient. (**Ackley and Ladwig, 2011, p. 604)  **3. RN will discuss therapeutic methods of pain alleviation with the patient to try in the hospital. (**Ackley and Ladwig, 2011, p. 603 )  **4. RN will continuously supply patient with ice packs (**Ackley and Ladwig, 2011, p.604 )  **5. Assess patient’s knowledge on their pain medication routine and ways to reduce pain. (**Ackley and Ladwig, 2011, p. ) | **1.** Pain medication will help to reduce the pain the patient is experiencing and provide more comfort during the recovery process. Routine medication administration will keep the patient at a constant pain level without having any escalating pain levels. (Ackley and Ladwig, 2011, p. 603)  **2**. Administering pain medication before activity will help reduce major pain and stiffness of site of surgery after exercise. This will also help the patient to participate more freely and actively in movement. (Ackley and Ladwig, 2011, p. 600)  **3**. These actions help to supplement pharmacological treatments of pain and help to distract patient from their pain. (Ackley and Ladwig, 2011, p. 605)  **4**. Making the patient feel comfortable and relaxed will help keep their mind off of pain and act as another form of therapy for their pain. (Ackley and Ladwig, 2011, p. 605 )  **5**.Patient will be able to gain more rest when relaxation encouraged and lights are off. Patient can learn to control pain with no pharmacological interventions.(Ackley & Ladwig, 2011, 604)  1. Allows nurse to obtain a baseline of patient’s pain and can see what adjustments need to be made if pain is not subsiding. **(**Ackley and Ladwig, 2011, p.602 )  2.Providing routine medication administration helps to keep patients pain level at a consistently controlled level so there are no up/downs. **(**Ackley and Ladwig, 2011, p.604 )  3. This will allow pt to better understand method to personally relieve pain. **(**Ackley and Ladwig, 2011, p.603)  4. This helps to reduce swelling and inflammation that causes pain. **(**Ackley and Ladwig, 2011, p.604)  5. See what RN needs to teach PT. **(**Ackley & Ladwig, 2011, p.602 ) | **1. Goal was unmet. Patient MM’s pain was kept between a four and a five throughout the whole day and never stayed at a functional level of 2-3.**  **Goal was unmet due to inability to be at the hospital on the day of discharge.**  **However, if all of the interventions were carried through, the goal would have been met and the patient would verbally state their pain was a two and they would be discharged home by the RN.** | **1. RN will provide additional resources to patient about therapeutic ways to relieve pain without medication. In addition, the RN can further look into PRN medications that could be administered to the patient to help relieve pain.**  **Potential modifications for the plan would be to provide the patient with flyers and handouts that addressed various nonpharmocological methods in which to alleviate pain. This would help the patient to remember and get ideas for home healing and pain reduction.** |

**Care Plan – Continued**

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| --- | --- | --- | --- | --- | --- |
| **NANDA-I Nursing Diagnosis #2**  **Bio/Physiological** | **Patient Goals / Outcomes**  **(short and long term )** | **Nursing/Health Care Interventions**  **(Min. of 4/goal)** | **Rationale for Each Interventions** | **Evaluation of each Goal/Intervention** | **Modifications to the Plan of Care.**  **(Potential or Actual)** |
| Impaired physical mobility related to total knee arthroplasty discomfort as manifested by stating “it is painful to move,” patient getting tired easily when walking from obesity, discomfort during movement. | **Short term goal < 24H:**  **Short term goal < 24H:**  **Patient will verbalize feeling of increase strength and ability to move by the end of the shift.**  **Long term goal > 24H:**  The patient shall report increased muscle and movement abilities to nursing staff because of performing muscle strengthening activities that involve all major muscle groups by the time of discharge. | 1. Student nurse will assess the patient’s mobility upon arrival to hospital. **(**Ackley & Ladwig, 2011, p. 551)  2. Student nurse will massage back to alleviate muscle stress. **(**Ackley & Ladwig, 2011, p. 550)  3. Nurse will discuss exercises with PT. **(**Ackley & Ladwig, 2011, p. 550)  4. Student nurse will obtain assistive devices and teach proper use to patient. **(**Ackley & Ladwig, 2011, p. 551)    **Interventions for long term goal:**  Long Term:  1.Nurse will lead patients in simple ROM exercises (Ackley & Ladwig, 2011, p. 550 )  2. Nurse will speak with PT and OT about excerises to teach and encourage with the pt. (Ackley & Ladwig, 2011, p. 550)  3. Nurse will ambulate patient two times a day. (Ackley & Ladwig, 2011, p. 551 )  4. Nurse will provide pharmological therapy to patient before movement and ambulation to reduce pain during exercise. (Ackley & Ladwig, 2011, p. 552 ) | 1. This gives the SN a baseline to of pt and to see if pt improving throughout the day. (Ackley & Ladwig, 2011, p. 551)  2. Therapeutic massage alleviates tension in other aspects of body, making patient more willing to cooperate and move. **(**Ackley & Ladwig, 2011, p.550 )  3. Student nurse will learn about exercises done with PT and implement them into daily regime for pt. **(**Ackley & Ladwig, 2011, p. 550)  4. The assistive walker will help the patient to move freely and with support. Gives them a means to move. **(**Ackley & Ladwig, 2011, p. 551)  1. This allows patients to improve overall muscle strength and promote circulation while still being in bed. **(**Ackley & Ladwig, 2011, p. 550)  2. Creating a regimen of regular physical activity for aerobics and exercise strengthens muscles and creates repetition that the pt can take home. **(**Ackley & Ladwig, 2011, p. 550 )  3. Ambulation helps to increase coordination and increase muscle mass in the areas affected by surgery. **(**Ackley & Ladwig, 2011, p.551 )  4. By providing medication to reduce pain before exercise, the patient will more easily perform the needed muscle building exercises and will tolerate the work easier. **(**Ackley & Ladwig, 2011, p. 552 ) | Goal was met. By the end of the day, although there were still considerable amounts of pain, patient MM was able to ambulate to use the restroom or walk down a length of the hall.  **Goal was unmet because I was not able to be at the hospital on the day of discharge. However, if I was the goal would have been met. The patient would be able to freely move with a walker around the hall and would express a feeling of strengthened muscles throughout her body.** | **Potential modifications would be to try and incorporate the patient’s son with the teaching. This would allow for another set of eyes and ears at the home environment to help patient MM with recovery.**  **Potential modifications could be to inform the CNA with ROM exercises so they can instill them and have the patient repeat the necessary steps of the muscle strengthing routine and perform them themselves, so the nurse knows the patient knows them.** |

**Care Plan – Continued**

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| **NANDA-I Nursing Diagnosis #3**  **P/S or Spiritual** | **Patient Goals / Outcomes**  **(short and long term )** | **Nursing/Health Care Interventions**  **(Min of 4/goal)** | **Rationale for Each Interventions** | **Evaluation of each Goal/Intervention** | **Modifications to the Plan of Care.**  **(Potential or Actual)** |
| Spiritual distress related to loneliness and social isolation as manifested by patient living at home without a significant other and partner, patient states that she “feels lonely at home sometimes,” patient does not have a current home/church or community group to attend. | **Short term goal< 24H:**  By the end of the shift, the patient will express an increased sense of hope for the future and her current health status.  **Long term goal> 24 H:**  By the end of the patients tenure at the hospital, the patient will express a sense of connectedness with self, others, and a power greater than herself. | Interventions for short term goal:  1. Student nurse will assess pt degree of sorrow and sadness. (Ackley & Ladwig, 2011, p.793 )  2. Student nurse will get in touch with Patient’s son and try to incorporate him in recovery process. (Ackley & Ladwig, 2011, p. 794 )  3. SN will discuss personal definition of wellness with the client.  4. Nurse will provide empathetic therapeutic communication techniques to pt. (Ackley & Ladwig, 2011, p. 793)  Interventions for long term goal:  1. Nurse will ask and see if they can contact extended family to see if they can help in the recovery process. (Ackley & Ladwig, 2011, p.794 )  2. Nurse will encourage patient to seek mental health services outside of hospital. (Ackley & Ladwig, 2011, p. 795)  3. Student nurse will ask patient if they would like to speak to a chaplain during the day. (Ackley & Ladwig, 2011, p. 794 )  4. SN will encourage the patient to use positive coping techniques including talking and journaling. (Ackley & Ladwig, 2011, p. 794) | 1. This will give the SN a baseline as to the pt’s spiritual status and allows one to see change through the day. (Ackley & Ladwig, 2011, p.793 )  2. Student nurse will incorporate son into care plan and will strengthen connection in the family. (Ackley & Ladwig, 2011, p. 794)  3. This gives nurse a better idea of struggles of patient and where SN can better support and help. (Ackley & Ladwig, 2011, p. 794)  4. An empathetic person helps the pt to open up more and can better offer support to the pt. (Ackley & Ladwig, 2011, p. 793)  1. Patient discussed feelings of isolation from extended family, being in contact with them could alleviate tension and increase amount of support. (Ackley & Ladwig, 2011, p. 794)  2. This gives the patient an opportunity to get involved in support group outside of hospital. (Ackley & Ladwig, 2011, p. 795)  4. Speaking to a chaplain can give patient encouragement and support and spiritual rejuvenation. (Ackley & Ladwig, 2011, p. 794)  4. This allows patient to express feelings and figure out the root of their emotions. (Ackley & Ladwig, 2011, p. 794 ) | **Goal was met. By the end of the day the patient called me in and thanked me for being a light in her day. The patient said she felt filled and loved during the day.**  Goal was unable to be met because I was not there on the day of discharge. However, if the interventions were followed through, the goal would be met. Upon discharge, the patient would report of a better sense of being connected to her family, having a positive outlook on her health stressors and realize potential for connections in her community. | **Potential modifications would be to ask the patient if they want to see and or speak with a chaplain and gain a better idea of their health progression and their faith.**  Potential modifications could be to provide the patient with contact information of local social groups and church outreach programs. |

(2 points)

**F. Discharge Needs**

(2 points)

Community Referral, Follow-up Appointments, Medications, Treatments, Equipment, Support Groups, Home Health Needs and Long Term Care Concerns.

|  |  |  |  |
| --- | --- | --- | --- |
| **Educational Needs** | **Evaluation of Teaching** | **Medications/Treatments/Equipment** | **Referrals / Follow-up / Disposition** |
| How to manage pain at home.  Incentive Spirometer  Implementation of an efficient and conservative Exercise routine  Teach patient importance of a well balanced diet and information about eating and energy output  Teaching patient about relaxation techniques.  Teach patient about risk factors for falls in household setting.  Patient will need to be scheduled with follow up Physical therapy.  Patient told to involve herself in support groups. | Successful, pt able to repeat proper care back to nurse.  Successful, pt able to repeat proper care back to nurse.  Successful, patient able to verbalize understanding of slow and steady exercise and path of slowly building up strength  Successful, patient was able to repeat back instruction and various ways to incorporate foods into her diet.  Successful. Pt both demonstrated and explained various relaxation techniques to perform in the home setting when pain has increased in the knee.  Successul. Patient reiterated potential complications that could arise from a fall. In addition, patient stated changes that need to be made to her house to ensure easy ability to move around.  Patient agreed and was successful in stating the physical therapist she will be seeing after discharge.  Patient agreed and reported she would look into different programs after discharge. | Pain medication, written treatment plan with medications. Numbers to call if medication side effects.  Patient will need an incentive spirometer and a hand out explaining the purpose and use of the IS.  Patient will need handout of exercise routine and ROM activities. Patient will need walker to move around with for exercise and any movement.  Patient will need a handout describing steps to healthy eating. Patient will also need a journal to keep track of her eating habits. Patient will also need to increase household supply of vitamins, minerals, and other nutrient dense foods.  Patient will need a hand out of the information to use as a guide.  Patient will need handouts to help remind patient of tasks when they get in the home setting. This will guide her transformation.  Patient will need walker for PT and the contact information for the PT to get the appointments.  Patient will need contact information about group to join for social interaction and support. | Follow-up with the primary care physician.  Patient will need no referral or follow up. Just continue to watch for signs and symptoms of pneumonia.  Follow-up with the primary care physician to see improvement and healing of the surgical incision.  Referral to a dietician to help with daily requirements and follow up care with physician to evaluate changes and progress.    Patient does not need follow up care for this. Just the ability to track her relaxation progress.  Patient will not need a referral for this but can talk with main physician about this upon next visit.  Referrals will be given to the assigned PT for the patient. Patient excited for PT.  Patient was excited for these interventions and referrals could be given to the specific groups pt is looking in to. |

Provide a list of names and contact information in the patient’s neighborhood, for necessary support groups

or other types of resources that might be required by patient upon discharge:

Hunington Hospital

100 W California Blvd, Pasadena, CA 91105

(626) 397-5000

Presbyterian Chruch of Pasedena

Email - [general.mailbox@ppc.net](mailto:general.mailbox@ppc.net)

Phone - (626) 793-2191   ---

Fax: (626) 584-6544 Mail –

585 E. Colorado Blvd., Pasadena CA  91101

(2 points)

**G. References and Reference list per APA guidelines**

1. At least one general clinical or specialty article

a) Use articles from peer reviewed professional journals.

b) Must include copy of the article.

Link for Peer Review Journal

<http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=89b0eb64-d175-45de-bf21-0eab68ccc529%40sessionmgr14&vid=4&hid=25>

2. At least one Evidenced Based Research Article (minus 5 points if omitted)

Article Title: Experiences with CPAP treatment in patients with obstructive sleep apnea syndrome and obesity

Link: <http://ejournals.ebsco.com/Direct.asp?AccessToken=6LLXCL289J3NOIXJOFVF92K3X3HI8F9FH&Show=Object>

**My Review**

This research article helped me to gain a better understanding of the CPAP machine and the uses of it in patients with sleep apnea. It addressed the main successes of the machines but also the shortcomings and difficulties with the product. By reading this, I was able to offer suggestions to my patient about different ways to use and methods to prevent side of effects of the CPAP machine. I was also able to further explain the use of the CPAP machine to my curious patient.

a) One research article required for full credit.

b) Include a copy of all the articles **used** to obtain credit.

c) Write a brief statement on how a research article was applied to nursing care for this specific patient.

**3. Formatting & Appearance of completed work** (1 point)

a. APA format

b. Pagination

c. Title & Running header

d. Margins

e. Quotations

f. References

g. Spelling

h. Grammar

**Reference Page**

Ackley, B., & Ladwig, G. (2011). *Nursing diagnosis handbook (*9th ed). St. Louis, MO: Mosby-Elsevier

Barber, Chris. BritishJournalof Healthcare AssistantsFebruary. 2013.

Emedicine.com "Total Knee Arthroplasty ." *Total Knee Arthroplasty*. N.p., n.d. Web. 25 Nov. 2013.

Holloway, B (2004). *Nurses Fast Facts; your quick source for core clinical content* (3rd ed). Philadelphia, PA: Davis Company

Lewis, S.T., Dirksen, S.R., Heitkemper, M.M., Bucher, L. & Camera, I.M. (2011). Medical

surgical nursing: Assessment and management of clinical problems (8th ed.). St Louis,

MO: Mosby – Elsevier.

Lauralee Sherwood. *Fundamentals of Human Physiology.* Yolanda Cossio, 2012. Print

William, maria, Igelström, Helena, Martin, Cathrin & åsenlöf Pernilla .Experiences with CPAP treatment in patients with obstructive sleep apnea syndrome and obesity. 2012

Mayoclinic.com Staff, Mayo Clinic. "Definition." *Mayo Clinic*. Mayo Foundation for Medical Education and Research, 09 Apr. 2013. Web. 25 Nov. 2013.

"Obstructive Sleep Apnea." *University of Maryland Medical Center*. N.p., n.d. Web. 24 Nov. 2013.

Potter, Patricia Ann., and Anne Griffin. Perry. *Fundamentals of Nursing*. St. Louis, MO:

Mosby Elsevier, 2009. Print.

Skidmore-Roth, Linda. *Mosby's 2013 Nursing Drug Reference*. St. Louis, MO: Mosby,

2013. Print.

Taylor, Elizabeth Johnston. Spiritual Care: Nursing Theory, Research, and Practice.

Upper Saddle River, NJ: Prentice-Hall, 2002. Print.

Uptodate.com "Clinical Manifestations of Osteoarthritis." *Clinical Manifestations of Osteoarthritis*. N.p., n.d. Web. 25 Nov. 2013.

Uptodate.com "Overview of Obstructive Sleep Apnea in Adults." *Overview of Obstructive Sleep Apnea in Adults*. N.p., n.d. Web. 25 Nov. 2013.

Uptodate.com "Patient Information: Total Knee Replacement (arthroplasty) (Beyond the Basics)." *Total Knee Replacement (arthroplasty)*. N.p., n.d. Web. 25 Nov. 2013.

**Total Available Points for Nursing Process Data Form 55**

**Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\*MUST include with completed, submitted Data Form \*\*Acknowledgement of MedSurg Grading Rubric: \_\_\_\_\_\_\_\_\_\_ (initials)**

**Geriatric Nursing Process Data Form: One-page Summative Grading Sheet**

A. Identifying Data Possible Pts. / Points Rec’d

B. Biological System (11 points total)

1. Past Medical / Surgical / Anesthesia History Chronic Condition 2 \_\_\_\_\_\_\_

2. Recent Medical History/Course of Hospitalization 2 \_\_\_\_\_\_\_

3. Home Medications 2 \_\_\_\_\_\_\_

4. Medical Diagnosis w/ signs & symptoms 2 \_\_\_\_\_\_\_

5. Complete Head-to-Toe Physical Assessment 3 \_\_\_\_\_\_\_

Laboratory Data & ABG’s 2 \_\_\_\_\_\_\_

Diagnostic Test & Procedures 2 \_\_\_\_\_\_\_

IV Therapy/ Medication Admin, including all PRN’s, completed 2 \_\_\_\_\_\_\_

6. Clinical Manifestations, Signs/Symptoms of Current Condition 2 \_\_\_\_\_\_\_

7. Patient Care Needs on Your Shift 2 \_\_\_\_\_\_\_

8. Physiology/Pathophysiology 2 \_\_\_\_\_\_\_

9. Potential Complications based on Patho & Pt S/Sx 2 \_\_\_\_\_\_\_

10. Nursing/Medical Treatments/Therapies 2 \_\_\_\_\_\_\_

C. Psychosocial Subsystem 2 \_\_\_\_\_\_\_

D. Spiritual Subsystem 2 \_\_\_\_\_\_\_

E. Nursing Diagnosis Collaborative Problem/Care Plan/Eval

1. Prioritized Nursing diagnoses/Collaborative Problem 1 \_\_\_\_\_\_\_

Minimum 2 Physio, 1 P/S, 1 Spiritual, 1 Other,

2. Correct Prioritization & complete rational 1 \_\_\_\_\_\_\_

3. Key Assessment Facts for Prioritization 2 \_\_\_\_\_\_\_

4. Three Care Plans 2 Bio/ Physio, 1 P/S or spititual

a. Three NANDA, 3 part complete Nsg Dx,/ Collab. Prob. (only RN Dx) 1 \_\_\_\_\_\_\_

b. Goals (SMART) (1 ST and 1 LTper goal) – total 2 per dx 2 \_\_\_\_\_\_\_

c. Nsg Interventions (min. 4 interventions for each ST & LT goal) 4 \_\_\_\_\_\_\_

d. Scientific Rationale for each Nsg Intervention 4 \_\_\_\_\_\_\_

e. Evaluation of each goal/interventions 2 \_\_\_\_\_\_\_

f. Modifications (for each unmet goal/interventions) 2 \_\_\_\_\_\_\_

F. Discharge Needs (include Support Group information) 2 \_\_\_\_\_\_\_

G. Complete References List per APA guidelines, including: (2 points total)

1. Specialty and General Clinical (not just texts) 1 \_\_\_\_\_\_\_

2. Evidence Based Research article w/ incorporating statements/paragraph 1 \_\_\_\_\_\_\_

H. Format/Appearance (1 point total)

1. APA Format (-0.25 per each issue) 0.25 \_\_\_\_\_\_\_

a. Pagination, running header, margins, title, etc

b. Quotations 0.25 \_\_\_\_\_\_\_

c. References

d. Spelling 0.25 \_\_\_\_\_\_\_

e. Grammar 0.25 \_\_\_\_\_\_\_

**TOTAL (55) \_\_\_\_\_\_\_\_**

**Instructor Comments:**