Running head: NURSING PROCESS

Nursing Process

FirstName LastName

Kent State University

Client Profile

Elderly, 87 year-old female. Admitted on 11/1/2009 due to rectal bleeding, vomiting and diarrhea. Patient states that she had the urge to eliminate following a family dinner. She had diarrhea and vomiting continuously for approximately 90 minutes, when she started to bleed rectally. It was then she decided that she needed medical attention. She was transported to Mercy Medical Hospital by her daughter, where she was admitted.

Medical history of acute renal failure. Signs and symptoms include hypertention, anemia, weight gain, and edema. The treatment patient received was not in chart, but may have consisted of rehydration by administration of saline IV fluids. (Black and Hawkes 2005)

Surgical history of cholelithiasis in December 2005. Treatment consisted of endoscopic retrograde cholangio-pancreatography (ERCP) followed by extraction of stones.

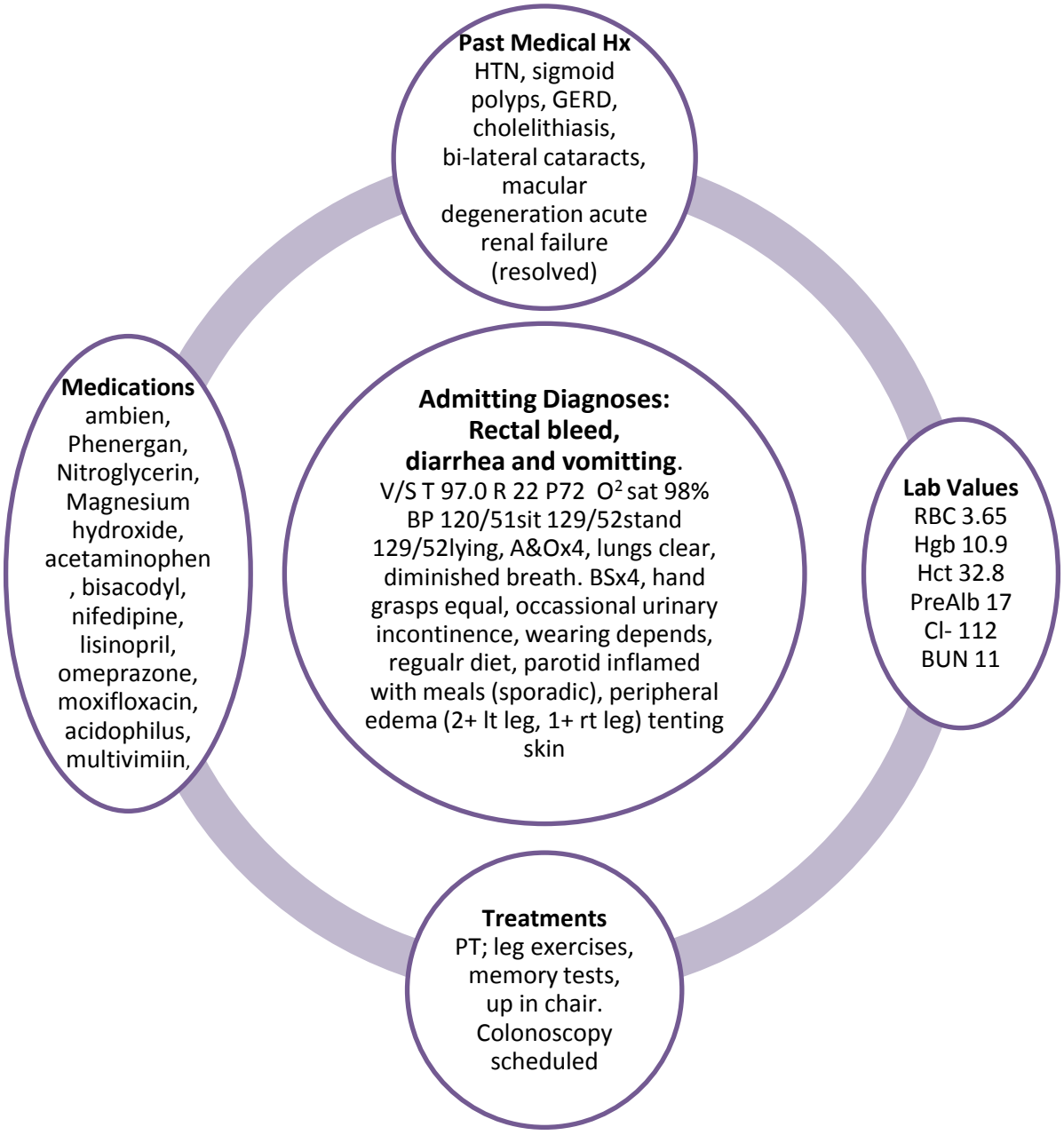
Client has made continuous improvement since admission. She was transferred to the rehab floor on 11/7/2009. She is on a regular diet, and is independently eating as of today (11/10/2009). Her activity includes physical therapy, up slowly, ambulate with walker, contact guard assist.

Concept Map

Date: 11/10/2009 Admit Date: 11/1/2009

Client Initials: GW Age: 87 Gender: F

Code Status: Full Allergies: None Diet: Soft Activity: walker, contact guard assist Braden Score: 17



Functional Health Patterns

Health Perception and Management

Subjective Data. Patient states that she has been in good health all of her life. She has no chronic illness, and has only been hospitalized two times before this. For the birth of her second child (first one born at home), and for gall stone removal three years ago. She is proud that she is 87 years old and has no sign of arthritis, which she attributes to a home remedy of honey, vinegar, and water that she drinks a gulp of twice daily. Patient further states that she is a non-smoker, and a social drinker. Prior to admission she walked daily with her 5-year-old great-granddaughter.

Objective Data. PERRLA, sclera clear, mucous membranes moist without lesions, teeth in poor repair. Uses walker to steady gait and lean on during episodes of orthostatic hypotension. Gait belt used for regular walks. She was able to rise from sitting position in bed to standing position without my assistance, used walker for support. I walked beside her to restroom without having to give assistance. Appears to be in good spirits, smiling face with bright eyes. Seemed happy to have my company. Braden score 17. Fall risk.

Indirect Data. Cataract surgery 2002. Flu vaccine 9/24/2009. Pneumonia vaccine 12/2006. (hospital chart)

Interpretation. Strength showing signs of improvement. I was pleased to see she made it to bath room and back independently with aid of walker. She misses her granddaughter, and looks forward to going home.

Risk for injury r/t medications: phenergan, ambien, meclizine, and poor eyesight.

Nutritional/ Metabolic

Subjective data. Patient states she eats two main meals a day. She does not like pepper. She further states that often times, the sides of her neck become swollen when she eats. Possible causes include parotiditis or food allergy.

Objective data. Independent with meals, ate 100% of dinner. No dentures, has most of her own teeth. IVs discontinued this morning. Ruddy complexion, skin dry and intact. 1+ non-pitting edema bilateral, lower extremities. Medications: multivitamin, acidophilis, prilosec. Labs: Cl^- 112 elevated.

Indirect data. Inferior parotid gland becomes inflamed with meals, sporadic, right more than left. Hx of GERD. Supposed to be wearing TEDs. (hospital chart)

Interpretation. Hospital worklist states that "pt cannot participate" with meals, however, she is independent. Patient is improving. Imbalanced nutrition: less than body requirements, r/t diarrhea, secondary to infection.

Elimination

Subjective data. Patient states that she wears a pad because she leaks. Patient further states that she is having two formed bowel movements a day. Before hospital admission, she had one soft, formed bowel movement per day with Metamucil.

Objective data. Normal bowel sounds, all four quadrants. Abdomen soft and round. Unable to collect stool specimens, so not sure if she is actually having two BMs per day or not. Told her that the next time she has a BM that staff needed to get a sample. Put heme-occult card, spatula, and specimen container in bathroom. Medications: bisacodyl, magnesium salts. Labs: GFR 51 (wnl for elderly), BUN 11 low.

Indirect data. Need stool sample to test for c-diff and occult. Colonoscopy ordered. Hx of sigmoid polyps. (hospital chart)

Interpretation. Bowel habits returning to normal. Occasionally incontinent of bladder. Regaining B & B independence. Dysfunctional gastrointestinal motility.

Overflow urinary incontinence.

Fluid volume deficit r/t vomiting and diarrhea

Ineffective tissue perfusion r/t decreased circulating volume, secondary to dehydration

Activity-Exercise

Subjective data. Patient states that before hospital admission, she walked 15-20 minutes every day with her great-granddaughter. She assisted her granddaughter with housework, including dishes, sweeping and washing the floor. She goes to church on Sundays, and keeps busy with family. She misses quilting, since her eyesight is so bad she can no longer do it.

Objective data. BP 120/51, HR 81, P 72, R 22, O_2Sat 98%. Slight muscular atrophy from extended hospital stay, this is her 10^{th} day. Walker used for transferring and ambulating, gait steady. Dependent use of stairs. Posture normal, no deformities noted. Brisk capillary refill, popliteal and pedal pulses present and regular. Foot pushes strong and equal. Medications: nifedipine, lisinopril, nitroglycerin. Labs: RBC 3.65, 10.9, 32.8, Prealbumin 17 (all low).

Katz Index of Independence in Activities of Daily Living assessment: 2/6. Independent for toileting and feeding. Dependent for bathing, dressing, transferring, and continence.

Indirect data. Up with contact guard assist (hospital chart).

Interpretation. Showing marked improvement with activity too. After using restroom, patient wanted to sit up in chair, and preferred to stay there for my entire shift. I asked several times, if she needed to lay back down in bed, but she preferred to sit up, alternating leg elevation and dangle.

Risk for disuse syndrome r/t extended hospital stay

Impaired walking r/t immobility AEB use of walker

Ineffective tissue perfusion r/t immobility AEB pulse deficit

Self care deficit, bathing d/t immobility

Self care deficit, dressing d/t immobility

Self care deficit, toileting d/t immobility

Sleep-Rest

Subjective data. Patient states she normally sleep 8-10 hours each night, and that she gets up 2-3 times to urinate. Denies taking naps or using medications to promote sleep.

Objective data. Patient is alert and orientated during the late afternoon/evening shift. Does not appear to be in need of rest. Patient refused several offers to assist her into bed, preferring to stay seated in chair. Medications: phenergan (dc today), ambien.

Indirect data. None available regarding sleep habits.

Interpretation. Patient is getting enough rest at night.

Cognitive-Perceptual

Subjective data. She enjoys talking about her great-granddaughter. She misses babysitting her. She had me get her purse out of closet so that she could retrieve a stack of photos she keeps in her wallet and show me her great-granddaughter, along with several other grandchildren, including a grandson in Florida who married two years ago and has a one-year-old baby.

Objective data. Alert and orientated x4. Pleasant and happy. Wears glasses, blind in right eye. Geriatric Depression Rating Scale score: 5/15, mild depression.

Indirect data. Macular degeneration, bi-lateral cataracts. (hospital chart)

Interpretation. Failing eye sight. Recent and long-term memories sharp.

Risk for falls r/t failing eye sight.

Self Perception – Self Concept

Subjective data. Patient is proud that she is in good health for 87 years old. No chronic diseases. One thing she would improve would be her eyesight. Due to the lack of it she can no longer quilt. She knows she fills an important role at home by watching her great-granddaughter and helping with housework as she is able.

Objective data. Calm, open body language with hands resting in lap. Appropriate dress in street clothes, despite hospital setting. Makes eye contact with clear bright eyes and interest. Answers questions accurately, and is eager to have the chance to talk about her life.

Indirect data. Widowed. (hospital chart)

Interpretation. Patient has a positive view of herself.

Ineffective role performance d/t change in physical capacity to resume role.

Role-Relationship

Subjective data. Patient states that she lives in her grand-daughters home and helps care for her great-granddaughter. She has two daughters who she sees frequently. The extended family gets together regularly, usually on Sundays for dinner. The patient is concerned that her extended hospital stay is hard on her grand and great-granddaughter.

Objective data. Retired.

Indirect data. Widowed, two daughters. Father, mother, and sister all deceased with history of cancer. (hospital chart)

Interpretation. Interrupted family process.

Sexuality-Reproduction

Subjective data. Was happily married for fourty-four years, until her husband died. Patient states that they got along most of the time. Patient states that she still misses him. She does not feel the need to have an intimate relationship.

Objective data. No record of a mammogram. Currently post-menopause. Has two daughters who are very attentive to her needs.

Indirect data. Widowed, two daughters. (chart)

Interpretation. She states that an intimate relationship is not a priority for her. She states that she is content with her children, grand-children, and great-grand children for love and affection.

Coping-Stress Tolerance

Subjective data. Patient states that she copes with stress by reading the Bible. She is not worried about her health outcome in regards to the hospital stay. She was very concerned upon admission, however, feels she has made great strides in her return to health. She has lost a couple of close friends in the past year, but states at her age that is to be expected.

Objective data. Patient is not displaying any outward signs of distress. Medication: acetaminophen.

Indirect data. None available regarding coping-stress tolerance.

Interpretation. Patient seems to handle life stresses with a positive attitude. Her strong family and faith keep her strong.

Value-Belief

Subjective data. Patient states that she enjoys going to church and reading her Bible. She attends the First Christian Church on a regular basis.

Objective data. Patients states faith keeps her at peace with life's challenges.

Indirect data. Full code status. (hospital chart)

Interpretation. Patient participates in church, but does not seem too upset at having missed services the past two Sundays.

Care Plan

Primary Nursing Diagnosis: Fluid Volume Deficit r/t vomiting and diarrhea

Supporting data (AEB). Decreased values; RBC 3.19, Hgb 9.6, Hct 28.4, PreAlbumin 17. Constipation, decreased urinary output, and tenting skin turgor.

Goals. Improve deficient lab values to reflect rehydration by 1400 11/10/2009.

Interventions with Rationale. Keep water pitched filled and encourage consumption of at least 2L per day, increased water consumption will rehydrate. Diligent monitoring of 0.45NaCl IV, replace bag before it is empty to maintain replenishment of lost fluid and electrolytes, preventing an interruption in IV fluids will promote rehydration. Weigh daily, accurate daily weights will reflect fluid gain or loss.

EBP Citation. Bekheirnia and Schrier (2006), Bennett (2000), Debnam (2005)

Evaluation. Lab results showing improvement over last 24 hours. IV disconnected per orders.

Ineffective Tissue Perfusion r/t decreased circulating volume, secondary to dehydration

Supporting data (AEB). Pulse deficit -9. Bi-lateral peripheral edema, 2+ left leg, 1+ right leg.

Goals. Prevent increase in pulse deficit by 1400 11/10/2009. Prevent increase in peripheral edema by 1400 11/10/2009.

Interventions with Rationale. Monitor BP q4h to know base line. Daily I & O and weight to closely monitor edema, accurate I & O and weight will reflect a change in edematous state. Restrict sodium in diet to reduce water retention. Rest with legs elevated following physical therapy, to prevent further accumulation of lower extremity edema.

EBP Citation: Schrier, R. (2006).

Evaluation. No increase in edema or pulse deficit by end of shift 11/10/2009.

Imbalanced Nutrition: less than body requirements, r/t diarrhea, secondary to infection

Supporting data (AEB). Vitamin deficiency, anorexia, edema (↓ protein).

Goals. Identify dietary deficiencies. Increase oral intake of vitamin and protein rich foods by 1400 11/10/2009.

Interventions with Rationale. Order high calorie, high protein foods served when patient feels most like eating to increase the likelihood of consumption. Administration of multivitamin and acidophilus as ordered.

EBP Citation: Stephens, B. R. & Braun (2008).

Evaluation. Appetite continues to show improvement. Patient consumed 100% of dinner on 11/10/2009.

Lab Interpretation

Lab test	Client result 11/8	Client result 11/9	Normal Range	Interpretation
WBC	6.5	9.4	4.5-11.0	wnl
RBC	3.19	3.65	3.9-5.3	dehydration
HGB	9.6	10.9	11.5-15.5	dehydration
HCT	28.4	32.8	35.0-47.0	blood loss, anemia
PLT	171	252	150-450	wnl
Na^+	143		136-148	wnl
K^+	3.7		3.5-5.2	wnl
Cl^-	112		96-108	diarrhea
CO2	28		24-32	wnl
Glu	99		85-125	wnl
Creat	1.02		0.44-1.03	wnl
GFR	51		90-120	moderately reduced wnl for 87yo
BUN/Creat	11		15-24	malnutrition
Ca^{2+}	8.6		8.5-10.5	wnl
PreAlbumin	17		18-45	dehydration

Source: Black and Hawks (2005).

GFR info Retrieved on 11/17/2009 from: http://www.medicine.ox.ac.uk/bandolier/band156/b156-3.html

Medications for Client

Medication	Dose	Route	Frequency
Zolpidem Tartrate	5mg	PO	PRN
Promethazine HCL	6.25mg	IV	q4h, PRN
Nitroglycerin	0.4mg	SL	as dire
Meclizine HCL	25 mg	PO	q6h, PRN
Mg^{+} Hydroxide	30ml	PO	q day, PRN
Acetaminophen	650mg	PO	q4h, PRN
Bisacodyl	10mg	RS	q day, PRN
Acidophilus	1 pkt	PO	tid
Multivitamins	1 tab	PO	q day
Nifedipine	30mg	PO	q day
Lisinopril	5mg	PO	q day
Omeprazole	40mg	PO	q day
Moxifloxacin HCL	400mg	PO	q day

Name brand (generic)	Purpose	Dose range	Major side effects	Nursing
Avelox (moxifloxacin HCL)	antibacterial	400 mg	fatal hypersensitivity cardiovascular, CNS stimulation hepatic failure, peri-neuropathy	emergency equipment available monitor IV site, and bag levels , assess allergy. Risk for infection
Phenergan (Promethazine HCL)	antiemetic sedative-hypnotic	6.25-12.5 mg starting dose	blurred vision, dizzy hyperexcitability, hypersensitivity OD: anaphylaxis, cardiac arrest coma, convulsions Risk for injury	vesicant, determine absolute patency of vein; extravasation cause necrosis, assess allergy Fluid volume deficit
Ambien (zolpidem)	insomnia	10-12.5 mg	amnesia, diarrhea, n/v physical & psychological dependence Risk for injury	Assess alertness at peak, notify physician if sedation does not occur, assess allergy Disturbed sleep pattern
Nitrostat, NitroQuick (nitroglycerin)	antianginal	0.3-0.6 mg	dizziness, headache, hypotension, tachycardia	assess pain, monitor blood pressure, and pulse before assess allergy. Acute pain Ineffective tissue perfusion
Antivert, Bonine (meclizine)	antiemetic antihistamine	20-50mg	drowsiness, blurred vision Risk for injury	assess sedation after & allergy Fluid volume deficit
Phillips Magnesia (magnesium salts)	laxative, mineral replacement	30-60 ml	diarrhea	assess abd distention, allergy bowel sounds, bowel pattern Constipation
Tylenol (acetaminophen)	analgesic antipyretic	325-650 mg q4-6h	hepatic failure, hepatotoxicity renal failure, rash	assess alcohol use, pain, fever, allergy may alter glucose monitoring antidote; acetylcysteine Acute pain

Name brand (generic)	Purpose	Dose range	Major side effects	Nursing
Carter's Little Pills (bisacodyl)	laxative	10 mg	abdominal cramps, nausea	assess abdominal distention, bowel sounds, function, allergy color, consistency, amount Constipation
Acidophilis	lactose enzyme	individualized	lactose tolerance	assure non-dairy sources of riboflavin, vitamin D, calcium, allergy Imbalanced nutrition <required
Multivitamins	replenish	individualized	hypersensitivity	assess for signs of vitamin deficiency, nutritional status assess allergy Imbalanced nutrition <required
Adalat, Procardia (nifedipine)	antianginal antihypertensive	10-30 mg	arrhythmias, chf, peri-edema, ha, flushing, stevens-johnson syn	BP & P a & during, assess allergy ECG with prolonged therapy Geri: assess fall risk Decreased cardiac output
Prinvil, Zestril (lisinopril)	antihypertensive ACE inhibitor	10 mg	agranulocytosis, angioedema, cough, hypotension, proteinuria taste disturbances	monitor BP, WBC,BUN, CBC, urine protein, assess allergy Decreased cardiac output
Prilosec, Zegerid (omeprazole)	antiulcer	20 mg	abdominal pain,	abdominal pain, occult blood, emesis, gastric aspirate, CBC Acute pain

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