Rivier College  
Division of Nursing  
Associate of Science Degree Program in Nursing  
NSG 203 - Care of the Adult II  

Patient Data Base

Student Name__________________________  Clinical Date(s):  1/25/07 – 1/26/07

DEMOGRAPHICS DATA/ MEDICATION HISTORY
Gender  M   Age  89yo   Admission Date  1/24/07 @ 7:50
Primary Language  English   Other Language  No   Name Band  On

Advanced Directives:  YES  x  NO  If no, information provided?  YES  NO  If no, explain:
DNR  &  DNI

Admitting Diagnoses:  
Anemia

Explanation of Pathophysiology of Medical Diagnoses (list source):
Anemia is a condition in which the RBC count and the hemoglobin (Hgb) levels are lower than normal. Because of this, there is a less amount of O₂ being transported to the body’s tissues. RBCs contain hemoglobin, which carries O₂ from the lungs to all of the body’s muscles and organs. Oxygen is necessary for energy which is needed for the cells of the body to function efficiently. There are many forms of anemia. It can be caused by blood loss, diseases, medication effects, poor diet, and vitamin or Fe deficiencies. This particular patient condition and lab results were being researched. It was believed the patient was experiencing a blood loss related to internal bleeding.
(http://www.mayoclinic.com/health/DiseasesIndex/) and
(www.anemia.com)

Name of Surgical Procedure (if applicable)  
N/A
Date of Surgery:  N/A  This patient’s ________ (#) postoperative day.

Past Health History (Include all previous and existing diagnoses with explanation, surgeries, accidents, fractures, hospitalizations and their dates.)
Non-Q wave MI  1/8/07: when myocardial tissue becomes necrotic because of absent or diminished blood supply. Pain develops form irritation of nerve endings in the ischemic and injured areas. Partial thickness (of the ventricular wall) also called non-Q waves, are characterized by ST-T wave changes but no abnormal Q waves.

Glaucoma: An acute or chronic condition in which there is an of intraocular pressure (IOP) which leads to (tissue damage) damage from compromised blood flow of retina and optic nerve = visual field loss.
CHF: Inadequacy of the heart so that as a pump it fails to maintain the circulation of blood, with the result that congestion and edema develop in the tissues. ↓ cardiac output r/t impaired cardiac function. Excess fluid volume r/t impaired excretion of Na and H₂O. Workload of heart with HTN.

Atelectasis: collapse of lung tissue r/t airway obstruction, an abnormal breathing pattern, or compression of the lung tissue s/a: from a tumor, pleural effusion or pneumothorax. Other causes are mucous plugs in pts. who smoke heavily and inflammation from inflammatory lung disease. Cigarette smoking causes arterial vasoconstriction and plaque formation. Also cholesterol atherosclerosis.

CVHD: cardiovascular Heart disease r/t heart and blood vessels. pulmonary embolism: r/t detached fragments of thrombus from a leg

HTN: Persistent or intermittent elevation of systolic arterial blood pressure > 140mm HG or diastolic pressure > 90 (3 readings > 140/90) cause unknown but r/t risk factors s/a: genetics, stress, obesity, Na diet & vascular disorders. Workload of heart with HTN.

Hyperlipidemia: an elevated level of lipids (fats) in the blood

left side pleural effusion: amounts of fluid with in the pleural cavity, usually r/t inflammation.

TURP: tumors on bladder (transurethral resection of the prostate): inserting a resectoscope through the urethra. Hypertropic tissue is cut away, ∴ relieving pressure on the urethra. Enlarged prostate: related tumors on bladder.

Alcohol Use, on-going smoker: 1 pack/day for 65 years. Alcohol is a primary and continuous depressant of the CNS. Depresses leukocytes movement to inflamed areas. ↓ platelet functions and leads to fibrinogen and clotting factor deficiency.

Family History (Include age and state of health of all members of immediate family - mother, father, siblings. If deceased, age, year of death and cause of death)

mother       deceased       age: 68yo       year of death: 1948       cause of death: does not know
father       deceased       age: 75yo       year of death: 1954       cause of death: pneumonia
sister       deceased       age: 94yo       year of death: 1994       cause of death: does not know

Also Taken @ home: Aspirin 325mg 1 tab daily AM
Warfarin 4mg 1 tab daily PM

Medications (attach an additional sheet if necessary)

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>OTC or Taken @ Home</th>
<th>Ordered in Hospital</th>
<th>Reason Taken Patient Need</th>
<th>Patient’s explanation for Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambien</td>
<td>10mg PRN PO HS</td>
<td>Induction of sleep</td>
<td>Pt. did not know what</td>
<td></td>
</tr>
<tr>
<td>Tylenol</td>
<td>650mg q 4° PRN PO</td>
<td>h/a and pain</td>
<td>his medications are</td>
<td></td>
</tr>
<tr>
<td>Zofran</td>
<td>0.4mg q 6° PRN IV</td>
<td>nausea</td>
<td>for. However, pt.</td>
<td></td>
</tr>
<tr>
<td>Vit K</td>
<td>10mg SQ x1</td>
<td>Aid in blood clotting</td>
<td>states that he thinks</td>
<td></td>
</tr>
<tr>
<td>Indur</td>
<td>Taken @ Home but 80mg/qd</td>
<td>60mg q day PO</td>
<td>antianginal</td>
<td>they are mostly for</td>
</tr>
<tr>
<td>Lisinopril</td>
<td>Taken @ Home</td>
<td>20mg q day PO</td>
<td>Anti hypertensive</td>
<td>high blood pressure.</td>
</tr>
<tr>
<td>Lipitor</td>
<td>Taken @ Home</td>
<td>80mg q day PO</td>
<td>To lower cholesterol</td>
<td></td>
</tr>
<tr>
<td>Bisoprolol</td>
<td>Taken @ Home</td>
<td>10mg q day PO</td>
<td>Anti hypertensive</td>
<td></td>
</tr>
<tr>
<td>Clonidine</td>
<td>Taken @ Home</td>
<td>0.1mg 2x/day PO</td>
<td>Anti hypertensive</td>
<td></td>
</tr>
<tr>
<td>Furosemide (lasix)</td>
<td>Taken @ Home</td>
<td>40mg q AM PO</td>
<td>Edema</td>
<td></td>
</tr>
<tr>
<td>Nitroglycerin</td>
<td>Taken @ Home</td>
<td>4mg S/L q 5min PRN</td>
<td>For chest pain</td>
<td></td>
</tr>
</tbody>
</table>

HEALTH PERCEPTION/HEALTH MANAGEMENT

Patient’s perception of general health: “I feel good on 6 hours of sleep since I was in the service. I get up every morning.”
around 5 am, take a shower, and get dressed every day. I feel pretty good every day. At 86 years old, everything went to hell, right after my first heart attack.”

Health practices and effects: (list frequency, amount, type, duration, and length of time since quitting.)

- **Physical Exercise:** walks daily about 2 miles, and it takes about an hour or two.

- **Smoking:** smoked for 65 years. Just quit two weeks ago, after a heart attack. He smoked 1 pack/day.

- **Caffeine:** Dependent on coffee. About 6-8 cups/day with cream or milk and no sugar.

- **Alcohol:** socially. “I have an occasional drink.”

- **Recreational Drugs:** no

- **Frequency of health checkups:** “only when I feel like it and I have to.”

- **Breast/Testicular Self exam:** no

- **Seat Belts:** Yes. He no longer drives.

- **Dental Care:** Patient has dentures. When he was in the service he had his teeth pulled. Only goes when there is a problem.

Ability to follow care plan, knowledge of health practices: Yes, patient is aware and is knowledgeable of health practices.

Allergies: Prednisone Symptoms/treatment: pruritis & rash. He is not sure of the treatment. It happened many, many years ago when he was in the service.

Health Insurance: Yes x No

Tricare: for being in the service for more than 20 years. Whatever they don’t pay, Medicare will pay the rest. (100% covered)

Do you feel safe? Yes

Potential Nursing Diagnoses: Knowledge Deficient r/t patients lack of knowledge of his own health issues aeb not knowing what medications he is taking and what they treat, smoking for 65 years but recently stopped after a MI, intake of a substantial amount of caffeine daily, no consistent and frequent and preventative health checkups, visits the doctor “when I feel like it and I have to”, he does not perform testicular self exams, he does not know the treatment he was given to an allergic reaction to Prednisone and insufficient knowledge regarding care of his diseases (HTN=↓ Na intake)
### Laboratory Test (attach an additional sheet if necessary)

<table>
<thead>
<tr>
<th>Test/Procedure</th>
<th>Client Results</th>
<th>Nsg. Safety Measures Taken</th>
<th>How does this relate to Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemetry: (5 leads)</td>
<td>No: to detect/Id abnormal</td>
<td></td>
<td>Anemia can cause the heart to</td>
</tr>
</tbody>
</table>

#### WBC

<table>
<thead>
<tr>
<th>WBC</th>
<th>Date 1/25/07 6am</th>
<th>Pt. Value 9.9</th>
<th>Normal Range 5-10 x10⁹</th>
<th>What do you do because of this result?</th>
<th>What diagnosis does this value relate to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC</td>
<td></td>
<td>2.96 (L)</td>
<td>4.7-6.1 x 10³ units of RBC</td>
<td></td>
<td>Anemia: internal bleed</td>
</tr>
<tr>
<td>Hgb</td>
<td></td>
<td>8.7 (L)</td>
<td>14-18g/dL RBC units &amp; O₂</td>
<td></td>
<td>anemia</td>
</tr>
<tr>
<td>Hct</td>
<td></td>
<td>23.8 (L)</td>
<td>42-52% units of plasma</td>
<td></td>
<td>Blood loss anemia</td>
</tr>
<tr>
<td>Pt</td>
<td></td>
<td>120 (H)</td>
<td>10.5 - 13.1 Vitamin K</td>
<td></td>
<td>Anemia:internal bleed</td>
</tr>
<tr>
<td>PTT/INR</td>
<td></td>
<td>12.9 (C&amp;)</td>
<td>0.9-1.1 Vitamin K</td>
<td></td>
<td>Anemia:internal bleed</td>
</tr>
</tbody>
</table>

#### Electrolytes

<table>
<thead>
<tr>
<th>Electrolytes</th>
<th>Date</th>
<th>Pt. Value</th>
<th>Normal Range</th>
<th>What do you do because of this result?</th>
<th>What diagnosis does this value relate to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Na</td>
<td>1/25/07 6am</td>
<td>137</td>
<td>135-145</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K</td>
<td></td>
<td>4.1</td>
<td>3.5-5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cl</td>
<td></td>
<td>105</td>
<td>98-106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bl. Glucose</td>
<td></td>
<td>106</td>
<td>80-120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BUN</td>
<td>1/25/07 6am</td>
<td>44 (H)</td>
<td>10-20</td>
<td></td>
<td>Renal Failure</td>
</tr>
<tr>
<td>CREATINE</td>
<td>1/25/07 6am</td>
<td>1.4 (H)</td>
<td>0.6-1.2</td>
<td></td>
<td>Renal Failure</td>
</tr>
<tr>
<td>D-dimer test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SGPT</td>
<td></td>
<td>22</td>
<td>4-36 u</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SGOT</td>
<td></td>
<td>22</td>
<td>0-35 u</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Platelets

<table>
<thead>
<tr>
<th>Platelets</th>
<th>Date 1/25/07 6am</th>
<th>Pt. Value 330</th>
<th>Normal Range 150-400 x 10⁹/L</th>
<th>What do you do because of this result?</th>
<th>What diagnosis does this value relate to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>lymphocytes</td>
<td></td>
<td>16.6 (L)</td>
<td>5-10 x10⁹/L</td>
<td>Vitamin K / Blood</td>
<td>Anemic-internal bleed</td>
</tr>
<tr>
<td>albumin</td>
<td></td>
<td>2.1 (L)</td>
<td>3.5-5.0</td>
<td>protein intake PO</td>
<td>Alcohol use/ Diet: nutritional deficiency</td>
</tr>
<tr>
<td>Ca</td>
<td></td>
<td>7.8 (L)</td>
<td>9-10.5</td>
<td>Ca/vit D intake</td>
<td>Alcohol use/ Diet: nutritional deficiency</td>
</tr>
<tr>
<td>Triponin-1</td>
<td></td>
<td>0.4 (H)</td>
<td>&lt; 0.03 ng/ml</td>
<td>Stop plasma, telemetry</td>
<td>MI, rxt. to plasma ?</td>
</tr>
<tr>
<td>protein</td>
<td></td>
<td>4.6 (L)</td>
<td>6.4-8.3</td>
<td>protein intake PO</td>
<td>Alcohol use/ Diet: nutritional deficiency</td>
</tr>
<tr>
<td>neutrophils</td>
<td></td>
<td>73.2 (H)</td>
<td>55-70</td>
<td>Blood, monitor: good nutrition, fluids, rest</td>
<td>Anemic</td>
</tr>
<tr>
<td>monocytes</td>
<td></td>
<td>10 (H)</td>
<td>2-8</td>
<td>Monitor: good nutrition, rest fluids.</td>
<td>Anemic::mono?Second-ary to dehydration.</td>
</tr>
<tr>
<td>UA/Urine RBC</td>
<td></td>
<td>1/24/07 7.7 (H) small bleeding in urine</td>
<td>Up to 2</td>
<td>Monitor urine, address Pt &amp;PTINR</td>
<td>Anemic-internal bleed. Alcohol use</td>
</tr>
<tr>
<td>C&amp;S</td>
<td>1/24/07 + guaiac</td>
<td></td>
<td>(-) No occult blood within stool</td>
<td>Monitor urine, address Pt &amp;PTINR</td>
<td>Anemic- internal bleed</td>
</tr>
<tr>
<td></td>
<td>1/25/07 + guaiac</td>
<td></td>
<td></td>
<td>Monitor urine, address Pt &amp;PTINR</td>
<td></td>
</tr>
</tbody>
</table>

#### Diagnostic Tests: Include Radiograph, EKG, EEG, Biopsy, Etc....
CXR: BNP (lab for measure % of CHF)
Venous duplex
EKG: A graphic representation of the electrical impulses that the heart generates during the cardiac cycle.
EKG STAT

Stopped plasma IV: STAT
Telemetry, V/S

Activity

<table>
<thead>
<tr>
<th>Exercise Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>Level 1:</td>
</tr>
<tr>
<td>Level 2:</td>
</tr>
<tr>
<td>Level 3:</td>
</tr>
<tr>
<td>Level 4:</td>
</tr>
</tbody>
</table>

Subjective: Prior to Admissions (Patient Reports)
(Patient Exhibits)

Functional Level
- Eating 0: breakfast, lunch and drinks
- Hygiene 0: pt. shaves, washes dentures, cleans self
- Dressing 0: pt. dressed into own clothes
- Toileting 0: pt. urinates in urinal, BM in toilet
- Ambulation 0: pt. walks to BR and around room
- Home Maintenance 0: pt. charges electric shaver,

Subjective: (Patient Reports)

Objective: (Patient Exhibits)

Gait normal

Falls in Hospital no

Joint Appearance ankles, edema +1

<table>
<thead>
<tr>
<th>ROM</th>
<th>full</th>
<th>limited</th>
<th>absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LL</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

History of Falls no

Symptoms related to Activity (chest pain, difficulty

SAFETY NEEDS no
breathing, leg or arm pain, joint or muscle pain, fatigue, palpitations)

No. He does not know what caused his chest pain. He was not doing any activities that linked to his chest pain. He does not push himself.

Physical Exercise habits: He walks daily, about 2 miles/day

<table>
<thead>
<tr>
<th>Location</th>
<th>Rate</th>
<th>Rhythm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apical</td>
<td>63</td>
<td>normal</td>
</tr>
<tr>
<td>Carotid</td>
<td>60</td>
<td>Present x Absent</td>
</tr>
<tr>
<td>Radial</td>
<td>64</td>
<td>normal</td>
</tr>
<tr>
<td>Pedal</td>
<td></td>
<td>Present x Absent</td>
</tr>
</tbody>
</table>

Temperature: 35.6°C  Route: oral

Quality of Pulses: strong and defined.

CRT  
R Hand: 3 sec L Hand: 3 sec
R Foot: 3 sec L Foot: 3 sec
SUBJECTIVE (PATIENT REPORTS)

Dizziness  yes  no  x

Shortness of breath  yes  no  x

When?  N/A

Cough  sometimes first in the morning

Sputum Production  spits a little into a tissue

Color change with O2  yes  no  x

OBJECTIVE (PATIENT EXHIBITS)

BR:  R  L

ORTHO STATIC BP

SIT  ____________

STAND  ____________

LAY DOWN  ____________

RESP:  Rate  normal +  Depth  normal +

symmetrical

Rhythm  normal

Symmetry  normal

Cough  no

Lung Sounds  (describe)  both days

lungs sounds are clear.

(1/25/07: Pt is on 2L O2 Nasal cannula.)

Oxygen/Oximetry 0; Rate 2L  Delivery System  NC___

0; Sat 99%

Potential Nursing Diagnoses: At risk for falls r/t physiological presence of an illness, anemia, that can potentially cause weakness, fatigue, confusion, tiredness, impaired balance, orthostatic Bp aeb patient on presently 2L of oxygen and may experience signs/symptoms of anemia when taken off oxygen, also blood lab results indicate low RBC, Hgb and Hct also physical equipment s/a: extra long oxygen tubing, IV(for blood).

Nutrition/Metabolic

SUBJECTIVE: (PATIENT REPORTS)  OBJECTIVE: (PATIENT EXHIBITS)

Diet in Hospital (Include Supplements)  cardiac diet

Typical food intake at home

Height  5’7”

Weight  58.70 kg or 129.14 lbs.

Ideal Weight  148

Food

% over or underweight  underweight= 13%

Fluid

Rationale for diet order  r/t CHF, hyperlipidema, edema, CVHDI

Morning

cereal.
toast  coffee (3 cups)  OJ 1 cup
Noon  sandwich, any type  Mostly cold cuts  Coffee
Evening  Big dinners, mostly  Meat and potatoes  Coffee
Snacks  very seldom  Coffee-7 cups/day

Problems with eating, drinking, digesting
Usually no problems at all. But since heart attack two weeks ago, he has not had much of an appetite.

Food preferences not picky at all. Like all types of foods.

Prescribed diet  eats anything.
Problems with healing  no

SUBJECTIVE: (PATIENT REPORTS)

Nutritional status  fine, I usually eat well except for the last couple of weeks, since my MI

Recent weight gain/loss?  Yes, I used to weigh 185lbs. I have not been eating a lot since my heart attack. Lost weight in the last two months, especially the last two weeks.

Changes in appetite?  Yes, does not feel like eating a lot of times. No desire.

ENTRAL feedings (type, amount, strength, intermittent, continuous)

NG tube:  yes   no   x  residual

Desire to suction  yes   no  N/A

Describe drainage  N/A

OBJECTIVE: (PATIENT EXHIBITS)

Description of teeth and oral cavity:  The pt has dentures.  Oral cavity pink, intact and moist. Lips very dry.
Condition of nails:  very dry. Clean and groomed
Skin condition:  very dry. Especially the legs, hands and top of head.
Skin color  WNL  Temperature  warm

Moisture  dry  Turgor  poor

WOUNDS:

Color  Temperature

Edges

Drainage

Sutures/Staples

Edema  yes   no

DSG Type

Frequency

FLUID/ELECTROLYTE THERAPY

Venous access:  yes  Saline lock  yes (at times)
Site: L forearm/peripheral  Date inserted  1/25/07(from R arm)
Inspection of site:  dry  Intact  yes
Red  no  Swelling  no  Pain  no
Ecchymosis  yes on both  Temp  warm

Arms and ears

IV Solution:  0.9% NaCl 20g/L for arm (1/24/07)

Rationale for use  KVO
Potential Nursing Diagnosis: Imbalanced nutrition: less than body requirements r/t eating habits aeb underweight 13%, blood work electrolytes, labs indicate low calcium, albumin, and protein, eats a big meal at night, eats any types of foods, not a well balanced diet, sometimes lack of interest in food and has hyperlipidemia.

**Elimination**

**SUBJECTIVE:** (PATIENT REPORTS)

**BOWEL:**
- Frequency (usual) 1 q AM
- Character normal
- Control yes
- Use of laxatives, enemas, stool softener, fiber in diet very seldom. Will use prune juice if no BM in 2-3 days.
- Change in bowel pattern? Just since in the hospital. Has not been able to have a BM since 2 days ago.

**ABDOMINAL ASSESSMENT**
- Appearance: soft
- Distended
- Bowel sounds yes, Active bowel sounds x 4
- Tenderness no

**URINE:**
- Frequency 4-5x/day
- Clarity clear
- Control yes
- Change in urinary pattern? no

**OBJECTIVE:** (PATIENT EXHIBITS)

**BOWEL:**
- Frequency 0 Last BM 1/26/07 Pt. has BM After OJ, coffee, and prune juice.
- Character hard, odor
- Incontinence yes
- Diarrhea/Constipation no, however hard
- Discomfort no
- Bowel regimen ordered no
- Bowel diversion (colostomy, ileostomy, etc.) no

**ABDOMINAL ASSESSMENT**
- Distended
- Bowel sounds yes, Active bowel sounds x 4
- Tenderness no

**URINE:**
- Frequency 1x by 8:00am
- Clarity clear
- Control yes
- Urinary diversions: no
- Foley no Date inserted N/A
- Type N/A

Medication added to IV zofran for nausea q 6° PRN
Gravity drip no Pump yes Dial-a-flow no
Gtt/min Hourly rate
<table>
<thead>
<tr>
<th>Intake</th>
<th>7 hr shift</th>
<th>Past 24 hr</th>
<th>Output</th>
<th>7 hr shift</th>
<th>Past 24 hr</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO</td>
<td>920ml + 360ml</td>
<td>2560ml</td>
<td>Urine</td>
<td>200 ml + 4 indep.</td>
<td>1440 + indep.</td>
</tr>
<tr>
<td>IV</td>
<td>Liquid Stool</td>
<td>no</td>
<td>Nasogastric Tube</td>
<td>no</td>
<td>Drainage no</td>
</tr>
<tr>
<td>Other</td>
<td>Blood</td>
<td>no</td>
<td>Other</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Totals</td>
<td>1280 ml</td>
<td>2560 ml</td>
<td>Totals</td>
<td>200ml + 4 indep.</td>
<td>1440+ indep.</td>
</tr>
</tbody>
</table>

Potential Nursing Diagnosis: Effective bowel and urinary pattern r/t usual and controlled urine/bowel routine aeb urinary frequency, clear clarity, yellow color, continence, no discomfort, having a BM, no distended abdomen, active bowel sounds in all four quadrants, no diarrhea, and no constipation.

Sleep Rest Patterns

SUBJECTIVE (PATIENT REPORTS)

Usual sleep pattern: 1100 pm – 5:00 am
Number of hours of sleep/24: 6/24
Problems with sleep: no
C/O of drowsiness /fatigue: no
Difficulty falling asleep: no
Difficulty remaining asleep: no
Sleep aids: no
Means of relaxation: listens to the radio

OBJECTIVE (PATIENT EXHIBITS)

Sleep pattern in hospital: 1000pm – 5 am
Number of hours of sleep/24: 7/24 with interruptions
Changes in behavior: was having vivid nightmares
Irritability: no
Lethargy: no
Listless: no
Restless: yes. Ambien may have caused nightmares
He thought he was in many different wars. Yelling to get his gun and walking down the hall.
Difficulty falling/staying asleep: difficulty staying asleep
Napping during the day: yes. One (10min)
Physical changes: no
Dark circles under eyes: no
Yawning: no
Expressionless face: no

Potential Nursing Diagnosis: Effective sleeping pattern r/t usual sleep routine aeb 6-7 hours/night, waking rested, up and active early morning, no dark circles under eyes, no yawning, or behaviors related to a poor nights sleep.
Cognitive/Perceptual

SUBJECTIVE (PATIENT REPORTS)

Ability to speak/comprehend _______ yes
Glasses _________________ yes
Hearing aid ____________ no
Other _________________
Dentures ______________
Dizziness/vertigo _______ no
Sensory smell __________ yes
Taste _________________ yes
Tingling, numbness __________ no
Alteration in feeling ______________ no
Pain: no
Site N/A
Radiation N/A
Duration: N/A
What increases pain __ I do not know
What measures decrease pain ___ nitroglycerin X3
Intensity (0-5 or 0-10) ________ Yesterday, pain was a 1 after 3 nitroglycerin pills. I have no pain now. I do not know why I had chest pain. I was not doing anything that would cause it.

OBJECTIVE (PATIENT EXHIBITS)

LOC (alert, lethargic, comatose) Alert
Orientation ____________ X3
Speech pattern: __ normal pattern, structure, and volume ______________
Clarity ____________ clear
Logical flow ___________ yes
Dysphasia __________ no
Eyes open, clear, no external physical obstruction
PERRLA ___________ present, normal
Ears normal
Sensory smell: glaucoma, legally blind
Parethesia/paralysis __ no
Observed compliance with health care regimen.
Yes. sits in chair, baths, performs hygiene, uses urinal, uses hat in toilet for BM, takes prune juice to promote BM

Self Perception/Self Concept Pattern

SUBJECTIVE (PATIENT REPORTS)

Occupation (if retired, former job)
Self description _______ He was in the US military, Army branch.

OBJECTIVE (PATIENT EXHIBITS)

Posture __________ sitting, straight and comfortably in chair
Also was a selectman, budget committee chairman, policeman

Effect of illness/surgery on self concept

I wish I wasn’t in here. I wish they knew what was wrong with me.

Frequency of anger, fear, anxiety

Specify ______ concerned throughout the day about his unknown illness

What helps with these feelings? ______ I realize it is the way it has to be.

Interests/hobbies/activities ______ walking, listening to the radio (news and sports)

Facial expression ______ smiles when talking of past. Concerned face when talking of illness.

Eye contact ______ looks into eyes when speaking.

Patient expresses feeling by: ______ when he felt pain in his thumb, showed grimace in facial expression. Spoke up of his pain to nurse.

Talking: expresses concern by shaking head and sounds concerned in voice.

Not talking: sits quietly and listens to his radio and looks into hall occasionally.

Behavior (be specific) ______ He mainly is waiting patiently for results of his last tests. He is waiting to hear from his doctor. He passes the time by focusing on the news on the radio and how cold it is outside for distractions.

Role/Relationship Patterns

SUBJECTIVE (PATIENT REPORTS)

Marital Status married, lives with wife
Household members ______ Two, the misses and me

Family reaction to illness ______ daughter visits, son visits. Don’t understand why it can’t be figured out what is wrong with father medically.
Roles in family ______ grandfather

OBJECTIVE (PATIENT EXHIBITS)

Facial expression/body language when talking about roles and relationships.

______ Happy while he is waiting for his wife to come around 10:30 to visit. He smiles and gets excited when he speaks of his grandson. He seems secure and glad that his family lives nearby and he sees them everyday.

Describe interaction of patient and family/significant others/staff, etc. He is willing to do all that he is asked to do by the nurses. He talks for a while to his daughter. He moves to the bed to sit while his visitor can sit in the chair.

Facial expression/body language when talking of illness.

______ smiles when talking of illness.

Eye contact ______ looks into eyes when speaking.

Patient expresses feeling by: ______ when he felt pain in his thumb, showed grimace in facial expression. Spoke up of his pain to nurse.

Talking: expresses concern by shaking head and sounds concerned in voice.

Not talking: sits quietly and listens to his radio and looks into hall occasionally.

Behavior (be specific) ______ He mainly is waiting patiently for results of his last tests. He is waiting to hear from his doctor. He passes the time by focusing on the news on the radio and how cold it is outside for distractions.
Potential Nursing Diagnosis: Effective relationship pattern r/t interactions with significant others (daughter, son). Family is close by, visits often, supportive and the facial expression and body language is positive and happy when speaking of family, especially his grandson.

**Sexuality/Reproductive Pattern**

<table>
<thead>
<tr>
<th>SUBJECTIVE (PATIENT REPORTS)</th>
<th>OBJECTIVE (PATIENT EXHIBITS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any changes or concerns regarding the effects of illness on sexuality.</td>
<td>Vaginal/penile lesions __ No lesions. Pt. has not been circumcised.</td>
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<tr>
<td>N/A</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>LMP __ N/A</td>
<td>Drainage __ N/A</td>
</tr>
<tr>
<td>Number of pregnancies __ N/A</td>
<td></td>
</tr>
<tr>
<td>Number of births __ N/A</td>
<td></td>
</tr>
<tr>
<td>STDs</td>
<td></td>
</tr>
<tr>
<td>Currently sexually active yes _____ no _____</td>
<td>x</td>
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</tbody>
</table>

Potential Nursing Diagnosis: Ineffective health wellness behaviors r/t not taking control of own personal health aeb not performing testicular self-exams, non-informative about own health history and family’s health.

**Coping/Stress Tolerance Patterns**
SUBJECTIVE (PATIENT REPORTS)
Recent life stressors/changes? Just recently. My heart attack two weeks ago and now this. I wish the doctors could figure out what is wrong with me.
Support Systems  He has his 63yo wife for support. A son that lives in his town. Also a grandson that he enjoys his company. A daughter that lives a couple towns over from where he lives and visits.

Financial concerns  no. He had many jobs after he retired from the Army and is doing fine. Plus he has tricare and medicare for insurance that covers 100% medical expenses.

All coping methods (and how often practiced)
Pt. loves to listen to the radio. He listens mostly to news and sports. He spends time with his 8 year old grandson. He feels he really does not have stress in his life.

OBJECTIVE (PATIENT EXHIBITS)
Facial expression/tone of voice when talking about stress
Pt's facial expression only shows concern about his hospital visit. He shakes his head, lowers his head, and cups one hand around the other and taps the closed hand. His eye lids lower and his lips tighten. His voice is in disbelief as voice lowers and pt. states “Geez, I wish they knew what was wrong with me.” The unknown can be stressful.

Any coping skills utilized during hospitalization
The pt. listens to his own portable radio. It stays on in his hospital room all day and stays within reach at all times. He informs me of the weather, how it is 1 and it will be getting colder. He talks to me about the Patriots. He also continues with his usual daily routine. He gets up early, shaves, cleans up and puts on regular clothes instead of PJ's or hospital gown/clothes. It helps for patient to know what he needs to do beforehand and at times he asks to repeat things.

Potential Nursing Diagnosis  Fear r/t unknown diagnosis of cause of anemia aeb patient facial expression shows concern, shakes his head, lowers head and cups one hand around the other and taps closed hand. His eye lids lower and his lips tighten. He comments “Geez, I wish they knew what was wrong with me”. Numerous times throughout the day. Looks out into the hall throughout the day.

Value/Belief Patterns

SUBJECTIVE (PATIENT REPORTS)
Religion  Protestant
Spiritual beliefs  no
How can we support you in your beliefs? nothing
Do your beliefs give you support/comfort?  no
Cultural orientation/practices  no

OBJECTIVE (PATIENT EXHIBITS)
Patients praying, meditating, reading, etc.

Patients affect after prayer/meditation, etc. N/A

None observed
Relationship of beliefs and health care/well being __________

_________ No relationship

Would you like me to pray with you? ______ no ____________

Potential Nursing Diagnosis: ______ Functional individual coping r/t support (not a religious person himself) aeb family visiting and talking and giving emotional support and patient speaking highly of his family.

**Teaching Learning Needs**

<table>
<thead>
<tr>
<th>SUBJECTIVE (PATIENT REPORTS)</th>
<th>OBJECTIVE (PATIENT EXHIBITS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education level high school/military</td>
<td>Patient Reading Material none</td>
</tr>
<tr>
<td>Preferred method of learning read, listening to radio_____</td>
<td></td>
</tr>
<tr>
<td>reading not as much since eyesight is poor</td>
<td></td>
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<tr>
<td>demonstration yes it could help</td>
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<tr>
<td>audio/video tape yes audio.</td>
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</tbody>
</table>

Changes to be made when discharged: to continue to not smoke.

TEACHING NEEDS: There are several teaching needs. Pt. is a verbal (oral) learner, so this was the method of teachings. Due to the visual limitations, any printed should be large print if available. Good to have family members part of the teaching. They are supportive, live nearby, and visit daily. The pt teaching included information about the medications he is taking, their purpose, and specific teachings as indicated on medication worksheets. (s/a the need to avoid alcohol). Patient is advised to go to the doctors for yearly checkups as a preventative. (Especially to prevent an illness from becoming serious) Because of vitamin, electrolyte imbalances and past history of MI, HTN, and CHF, a cardiac diet should be followed, as well as, a well balanced diet to increase protein, Ca, and also vitamin and minerals to keep the immune system working properly. Pt. aware of a need of a diet low Na because of HTN, CHF, and the symptom of edema. Pt. given verbal suggestions of such foods. Pt. should dry skin completely after bathing/showering and cream to moisten and soften. Pt. commended for no longer smoking and advised to continue to stop smoking. Pt. to use call button, that is in his reach at all times, if feels chest pain, faint, dizzy, confused, or does not feel his normal self. Also pt showed to use the toilet hat for a bowel movement and use call button when done.


Complete 3 nursing care plans (1 for each of the 3 highest priority problems)