

PATIENT/CLIENT DATA - CLINICAL DECISION-MAKING WORKSHEET

Student Name: Gladys Miraku Week: 2 Dates of Care: 7/10/2020

Patient Initials	Sex	Age	Room	Admitting Date	Admitting Chief Complaint: What symptoms cause the patient to come to the hospital?
TN	M	66	4112	7/8/2021	Fall and difficulty Breathing

Attending physician/Treatment team: Dr. Cisneros Jr. Consults:

Present Diagnosis: (Why patient is currently in the hospital) Respiratory and a fall ER Management: (if applicable) Chest X-ray.

Allergies: Peniciline Code Status: Full code Isolation: (type and reason) NO

Admission Height: 190.5cm 6'3 Admission Weight: 117.5kg / 259lbs Arm Band Location (colors & reasons) Right arm

Communication needs: (verbal, nonverbal, barriers, languages) English

Past Medical History: (pertinent & how managed) Brain aneurysm, Bladder cancer cell

Significant Events during this hospitalization but not during this clinical time: (include date, event and outcome)

Bilateral redness on both legs cellularhites.
 Difficulty in Breathing (Pneumonia)

Tests/Treatments/Interventions impacting clinical day's care (include current orders)

Chest x ray
 OI and PT

Assessments and interventions: (Include all pertinent data)

Vital signs: (2 sets per day)

Time	8:00 am	
T	97.9	
P	81	
R	18	
B/P	176/81	

Time	12:30	
T	97.8	
P	76	
R	18	
B/P	175/80	

GI:

Diet: *General*
 Swallow precautions: *N/A*
 Tube feedings: *N/A*
 NG / G tube: *N/A*
 Blood Glucose: (time & date) *N/A*
 Last bowel movement: (time & date) *in the morning*
 Pertinent Labs/Test:
 Assessments/Interventions: (stool, bowel sounds, tenderness, distention, appetite, nausea, vomiting)

<p><u>Respiratory:</u></p> <p>02 modalities: Nasal cannula 29%</p> <p>02 Saturation: 97</p> <p>Suction:</p> <p>Resp Rx's:</p> <p>Trach:</p> <p>Chest Tubes:</p> <p>Pertinent Labs/Test:</p> <p>Assessments/Interventions: (Lung sounds, cough, sputum, SOB) Regular coughs</p>	<p><u>Neurosensory:</u></p> <p>Neuro checks:</p> <p>Alert & Orientated: x4</p> <p>Follows commands: yes</p> <p>Speech Comprehensible: yes</p> <p>Pertinent Labs/Test:</p> <p>Assessments/Interventions: lift head of bed. (LOC, pupils, Glasgow Coma scale, dizziness, headaches, tremors, tingling, weakness, paralysis, numbness)</p>
<p><u>Cardiovascular:</u></p> <p>Telemetry: 76</p> <p>Pacemaker/IAD:</p> <p>DVT Prevention:</p> <p>Daily Weights:</p> <p>Pertinent Labs/Test:</p> <p>Assessments/Interventions: (peripheral pulses, heart sounds, murmurs, bruits, edema, chest pain, discomfort, palpitations)</p>	<p><u>Musculoskeletal:</u></p> <p>Activity: walks with assist/walk can</p> <p>Traction:</p> <p>Casts/Slings:</p> <p>Pertinent Labs/Test:</p> <p>Assessments/Interventions: (strength, ROM, pain, weakness, fractures, amputation, gait, transfers, CMS or 5 Ps)</p>
<p><u>Renal:</u></p> <p>Catheter (indwelling/external): None</p> <p>CBI:</p> <p>Dialysis:</p> <p>A/V access:</p> <p>Pertinent Labs/Test:</p> <p>Assessments/Interventions: (location, bruit, thrill)(urine-quality, burning with urination, hematuria, incontinent, continent, I & O)</p>	<p><u>Skin:</u></p> <p>Braden Score: None</p> <p>Pertinent Labs/Test: None</p> <p>Assessments/Interventions: (bruising, characteristics, turgor, surgical incision, finger & toe nails, wounds, drains, bed type)</p> <p>Turgor 2+ No surgical wounds</p>

<p><u>Pain:</u></p> <p>Pain score: 7</p> <p>Assessments/Interventions: <i>tyloral</i> (scale used, location, duration, intensity, character, exacerbation, relief, interventions)</p> <p><i>General body pain</i></p>	<p><u>Vascular Access: (IV site)</u></p> <p>Assessments/Interventions: (include type of fluid & access, location, dressing, date inserted, tubing change, Site Appearance)</p> <p><i>0.9 Dextrose & 1000 ml Right arm 7/10/2021 tube was new site was clean.</i></p>
<p><u>Gyn:</u></p> <p>Gravida/Para: LMP: Last Pap: Breast exam: Pertinent Labs/Test Assessment/Interventions: (bleeding, discharge)</p>	<p><u>Post-operative /procedural:</u></p> <p>Assessments/Interventions: (immediate post procedure care)</p>
<p><u>Safety:</u></p> <p>Call light: ✓ Bed Rails: ✓ Bed alarms: Fall risk: Assistive Devices: <i>walker</i> Sitter use: Restraints (type, duration & reason): Assessment/Interventions (modifications to room, environment, Patient)</p>	<p><u>Advance Directives/Ethical considerations:</u></p> <p>DPOA: <i>Patient had no</i> Hospice: <i>advance directives.</i></p>

Pertinent Data (Labs, X-rays, Etc.)	Results	Normal Lab Values	Significance to your patient
WBC	26.7		
RBC	4.10		
HGB	10.4		
HCT	33.1		
MCV	80.8		
MCH	25.4		
MCHC	31.4		
Platelets			
RDW	17.7		
MPV	7.7		
PT			
INR			
APTT			
Glucose			
BUN			
Creatinine			
Sodium			
Potassium			
Chloride			
Calcium			
T Protein			
Albumin			
SGOT			
SGPT			
Alk Phos			
Magnesium			
Amylase			
Lipase			
CPK			
LDH			
Cholestrol			
CK			
CK-MB			
Troponin I			
Myoglobin			
LDI			

Psycho/Social: Assessment/Interventions: (mental illness, social history, living arrangements, primary care giver, substance abuse, maternal/infant bonding, family dynamics)

The patient mental status is ok. His alertness was x4. The patient is very sociable. Patient is living alone in an apartment. I suggest he move to an assisted living so he can be well taking care. He has been smoking and we advised him if he can stop smoking since it's harmful to his health. He has a son who I believe he can get in contact with to bond as a family.

Cultural/Spiritual needs: Assessment/Interventions: (religious preference, adaptations & modifications, end of life decisions)

Patient admitted he has no religious preference or adaptation he just believe there is God.

Growth & Development: (physical, psychosocial, cognitive, moral, spiritual using various theorist) What stage of development evident with patient:

patient is alert very social, does not have any cognitive problems

Current overall plan of care: (A short statement that summarizes the anticipated plan of care)

patient was to be discharged in two days to a assisted living facility until he gain his strength. He will go back to his apartment.

Discharge plans and needs:

Discharge in 2 days to assisted living.
Patient will need physical therapy
financial assistance.

Teaching needs: (Disease process, medications, safety, style, barriers)

patient should try and walk more and engage in physical activities as tolerated. Patient should continue with medication to cure the pneumonia. Patient should eat healthy and do breathing exercises to prevent re-occurring of the disease.

The disease is pneumonia.

Pathophysiological Discussion: Discuss the current disease process at the **cellular level** (in your own words). Explain why this patient is encountering this particular health deficit. What is the relationship of this current health alteration to the patient's other medical conditions? Describe the current disease process the patient is encountering **etiology, epidemiology, pathophysical mechanism, manifestations and treatment (medical and surgical)**. Also note the complications that may occur with these treatments and the patient's overall prognosis. Include appropriate references and use APA format.

ADH II: attach a research article pertaining to diagnosis of patient. Write a summary about the article.

List of nursing diagnoses (NANDA format). Place diagnoses in priority order and provide rationale for priority setting. May only list one nursing diagnosis that is a **Risk For** diagnosis.

Priority	Nursing Diagnosis	Related to	As Evidence By	Rationale (reason for priority)
1				
2				
3				
4				
5				

ications	Classification	Dose	Route	Freq	Purpose/Mechanism of Action	Significant Side Effects / Adverse Reactions	Nursing Implications

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Nursing Diagnosis: Identify the top two nursing Diagnoses and expand

<p>Assessment as evident by (AEB) or data collection relative to the nursing diagnosis (Appropriate for chosen diagnosis. Includes objective & Subjective historical data that support actual or risk for nursing diagnosis)</p>	<p>Patient Goal(s) Statement of purpose for the patient to achieve</p>	<p>Patient Outcome (Should be measurable, attainable, realistic and timed, all criteria should be present and specific to the patient Dx.) (Must have at least two short term outcomes and two long term outcomes)</p>	<p>Interventions/Implementations (Must have at least four nursing interventions for each outcome written that directly relate to the patient's goal statement and help to reach the patient outcomes. They should be specific in action, frequency, and contain a rationale.</p>	<p>Evaluation. (Was the outcome met, partially met or not met and why? And is the plan of care revised or continued and new evaluation date/time is set)</p>
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