**Patient’s profile**

* Patient’s Name
* Age: 68 years
* Gender: Male

**Medical history**

* The patient is a 68-year-old man with a history of diabetes mellitus and hypertension (HTN).
* He presented to the hospital with vomiting, which he had been experiencing along with nausea two days prior to admission.
* However, the patients denied the presence of any other symptoms. He was afebrile and had stable signs during the admission.

**Presenting Complaint**

* The chief symptom that the patient presented with was vomiting. The patient had been vomiting for two days

**Admission details**

* The patient was admitted in the observation room for 48 hours for monitoring.
* He was kept on NPO for several hours and the gradually reintroduced clear liquids. As a result, his vomiting subsided and was able to tolerate his diet.
* A CT scan conducted to rule out Transient Ischemic Attack was conducted as well as an MRI.
* The CT scan and MRI tests were negative for abnormalities and all the other laboratory tests were within normal range. After 48 hours, he was discharged in a stable condition.
* The discharge instructions included a follow-up appointment with his primary care physician, maintenance of healthy diets and taking the usual medications.
* He was also advised to return to the hospital if his symptoms returned.

**Physiological data**

* **Vital signs:** Temperature was at 98.6 °F, heart rate 72 beats per minute, blood pressure 130/80 mmHg, respiratory rate 16 breaths per minute
* Height: 5’10”
* Weight: 180lbs
* BMI: 27.3
* HEENT: normocephalic, extraocular movements intact, atraumatic, conjunctivae pink, sclerae white, pupils equal and reactive to light, mucosa pink and moist, no oral lesions, teeth in good repair, nares patent
* Neck: supple, trachea, no lymphadenopathy
* Cardiovascular: heart regular rate and rhythm, no murmurs
* Respiratory: lungs clear to auscultation
* Neurological: alert and oriented x4, cranial nerves intact, motor and sensory function intact
* Skin: dry, intact, no rashes or lesions

**Psychological data**

* Affect: appropriate, mood euthymic
* Speech: clear and coherent
* Thought process: logical and goal-directed
* Insight: intact
* Judgement: intact

**Socioeconomic data**

* Occupation: retired
* Education: high school diploma
* Marital status; married
* Living situation: lives with wife at home
* Social support: has strong network of family and friends

**Cultural data**

* Ethnicity: Caucasian
* Religion: Christian
* Language: English
* Cultural belief: values hard work and family

**Physical Assessment**

* The patient was alert and oriented times 4 (to person, place, time and situation) with a friendly demeanor. He also showed no apparent signs of physical distress.
* The possible intervention to reverse the conditions of the patient include monitoring the intake and output of fluids, administration of antiemetics.
* There was also obtainment of CT and MRI to rule out TIA and ordering ofc laboratory tests to evaluate underlying cause of vomiting.

**Outcomes**

* The patient was adequately hydrated. In addition, the underlying cases of vomiting were identified and treated.
* The patient was able to prevent and control future episodes of vomiting.

**Care plan**

* The primary goal of this care plan includes preventing dehydration. The interventions include administering fluids as needed and monitoring fluid and output.
* Secondly, the underlying cause of vomiting has to be identified and treated. This includes obtaining CT scan and MRI to rule out TIA, ordering laboratory tests to evaluate underlying causes of vomiting, testing for viral infections and, identifying and treating underlying causing of vomiting
* Thirdly, the patent has to be educated on how to prevent future occurrences of vomiting. This encompasses advising the patient to avoid foods that are likely to trigger vomiting, avoiding alcoholic rinks and educating him on how to prevent vomiting
* The patient was also encouraged to drink more water frequently in order to compensate for the body fluids that were lost during the vomiting episodes
* The urine output rate and amount by the patient were measured and monitored to gain insights into the fluctuations

**Assessment**

* Continue monitoring the important signs regularly especially blood pressure, blood glucose levels and the health of the condition of the neurological functions.
* Review and record any new symptoms or any significant changes in the condition of the patient
* Carry out an in-depth review of the medical history of the patient and medications.
* Identify any previous medications that may induce vomiting in the patient

**Interventions**

* Identify and treat underlying causes of vomiting: the underlying cause of vomiting will be determined and treated. The most common probable cause of vomiting in a man aged 68 years with a history of diabetes and hypertension could be TIA, side effects of certain medications or a viral infection. Th patients will undergo CT scan and MRI to rule out a TIA. He will also be assessed for medications side effects and will be teste for viral infections
* Monitor fluid intake and output: the patient will be further monitored for any signs of dehydration such as decreased amounts of urine production, dry skin and sunken eyes. Fluids will be administered as needed to prevent dehydration.
* Educate patient on how to prevent future occurrences of vomiting: the patient will be educated on ways of preventing future episodes of vomiting. He will be advised on the foods to avoid, especially foods that are highly likely to induce vomiting such as spicy, greasy and acidic foods. He will also be advised to avoid alcohol, caffeine and alcoholic beverages.
* Continue to administer antiemetics as needed: the patient will begiven antiemetic medication to control vomiting. The medication will be administered as needed and the dosage will be adjusted as needed.

**Diabetes management**

* The management of diabetes involves ensuring that the patient strictly follows the diabetic management plan including insulin and oral hypoglycemic medications
* The next step to educate the patient on the significance of keen monitoring of blood glucose levels and regular maintenance of a healthy diet

**Hypertension control**

* Monitoring blood pressure regularly was significant in the management of hypertension as well as adjusting to antihypertensive medications as required to maintain the blood sugar levels within the targeted ranges.
* In addition, the patient should be encouraged to adopt lifestyle modifications such as reducing the intake of sodium intake and regular exercise.
* He should also be encouraged to adopt to stress management techniques.

**Vomiting evaluation**

* The assessment of vomiting involves investigating the cause of vomiting, dietary habits and possible gastrointestinal issues.
* Moreover, potential triggers associated with medications should also be considered. Additionally, dietary modifications should be considered as well as antiemetic medications as appropriate.
* The patient was also advised to eat small and frequent meals
* Relaxation and stress management strategies such as exercise and yoga were also advised

**Neurological assessment**

* This approach includes monitoring for potential signs of neurological deficiencies or any changes in the patient’s wellbeing.
* Another approach to neurological assessment is educating both the patient and his family members on how to identify symptoms related to stroke or TIA for prompt medical assistance if required.

**Medication management**

* The medical management requires review of a medications to ensure the correct dosage, adherence and potential interactions.
* It also involves the provision of detailed instructions on the medications schedules and the possible side effects of the patient as well as the caregivers.

**Patient education**

* The patient needs to be educated on the importance of adopting lifestyle changes such as changing their diet, techniques for reducing stress and exercise plans.
* It is also significant to provide the patient with information on the significance of returning for regular medical check-ups and adhering to the prescribed treatments.
* The patient will have a follow-up appointment with his primary care physician to monitor his condition and discuss any further concerns that may arise.

**Discharge plan**

* This includes ensuring that the patient understands the instructions for discharge which include strict follow-up of appointments and change of necessary lifestyles.
* It also entails coordinating with the primary care provider for a smooth transition and continuation of care.

**Support system**

* The necessary support systems for the patient at home should be assessed and consideration of availability of family members or care givers to assist the patient with medication management and monitoring should be done.

**Follow-up care**

* The patient will have a follow-up appointment with his primary care physician to monitor his condition and discuss any further concerns.
* Scheduling of the follow-up appointments requires the access to the relevant specialists such as neurologist and endocrinologist according to the recommendations as per the evaluation ad tests conducted during the period of hospitalization.

**Documentation:** the interventions and outcomes will be recorded in the medical record book for the patient for future treatments

* The diabetic and hypertensive conditions of the patient should be recorded to assess future conditions and determine if he is getting better or worse

**Conclusion**

* The patient care plan underscores a profound approach toward addressing the acute concerns of the patient which include vomiting while managing his chronic conditions including diabetes and hypertension.
* The plan covers all the key areas of concern such as continued monitoring, education and coordination of the care to ensure optimal health outcomes while preventing any future complications.
* Furthermore, the patient is discharged upon meeting vital signs of stability, attaining normal laboratory results and having no issues pertaining acute neurological problems.
* To promote the overall wellbeing of the patient and prevent future hospital readmissions, it is vital to emphasize further support. education and follow-up care.