N441Care Plan

Lakeview College of Nursing

Kaytlynn Roberts

Demographics (3 points)

Date of Admission 8/31/2020	**Patient Initials** RAS	**Age** 68	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Single	**Allergies** Doxycycline – causes N/V Acetaminophen – causes jitter
Code Status Full code	**Height** 157.2 cm	**Weight** 94.5 kg	

Medical History (5 Points)

Past Medical History: Abdominal digital rectal exam, anxiety, depression, elevated PSA, fall risk, hypertension (HTN), increased BMI, overweight, hyperlipidemia, and insomnia.

Past Surgical History: cystoscopy ureteroscopy stone manipulation (8/12/2020)

Family History: Father – emphysema Brother – Non-Hodgkin's lymphoma

Social History (tobacco/alcohol/drugs): Alcohol – current user, liquor, occasional use. Substance abuse – denies use. Tobacco – denies use, no exposure to secondhand smoke.

Assistive Devices: None needed

Living Situation: Lives at home alone but has the support of his sister.

Education Level: The patient has his GED.

Admission Assessment

Chief Complaint (2 points): Shortness of breath (SOB)

History of present Illness (10 points): This is a 68-year-old male who presented to the emergency departments with weakness, dyspnea, dysuria, lower abdominal pain, hematuria, and dizziness. The patient rated his pain an 8/10 on admission with a chief complaint of SOB. The patient's signs and symptoms started to occur a few days ago, around 8/29/2020. The patient

states as of today, 9/1/2020, he is experiencing no pain. The patient denies chest pain, cough, Upper Respiratory Infection (URI) symptoms, or sore throat. The patient tested negative for COVID-19.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute UTI

Secondary Diagnosis (if applicable): Sepsis

Pathophysiology of the Disease, APA format (20 points):

"Urinary tract infections (UTIs) are caused by pathogenic microorganisms in the urinary tract" (Brunner, 2014, pg. 1574). UTIs can be upper or lower, and complicated or uncomplicated. Testing was still being completed to determine which type of UTI my patient is experiencing. "A UTI is the second most common infection in the body" (Brunner, 2014, pg.1575).

An acute UTI's signs and symptoms include “burning on urination, urinary frequency, urgency, nocturia, incontinence, and suprapubic or pelvic pain” (Brunner, 2014, pg.1575). Hematuria and back pain may also be present (Mayo Clinic, 2019). According to the Medical-Surgical textbook, "about half of all patients with bacteriuria have no symptoms" (Brunner, 2014, pg.1576). My patient presented to the ED with dysuria and hematuria, which can be seen in patients with a UTI.

According to Brunner, older patients often lack the typical UTI symptoms. Although older adults may experience some symptoms, "nonspecific symptoms, such as altered sensorium, lethargy/weakness, anorexia, new incontinence, hyperventilation, and low-grade fever, may be the only clues" (Brunner, 2014, pg. 1577). My patient presented to the ED with a chief complaint

of SOB/dyspnea as well as weakness. These symptoms point us towards possible infection, especially in the gerontological population.

Diagnostic studies such as "computed tomography (CT) and ultrasonography are useful diagnostic tools" (Brunner, 2014, pg. 1578). My patient received a CT scan to rule out pyelonephritis or any abscesses.

Many different tests can effectivley diagnose a patient with a UTI such as "bacterial colony counts, cellular studies, and urine cultures" (Brunner, 2014, pg. 1577). My patient received a urine culture to confirm his diagnosis. The results showed positive for an infection.

"The ideal medication for the treatment of UTI is an antibacterial agent that eradicates bacteria from the urinary tract" (Brunner, 2014, pg. 1578). According to Brunner, cephalosporins are very effective in treating this type of infection (Brunner, 2014). My patient is being treated with NaCl 0.9% cefepime 1000mg, which is a cephalosporin.

Pathophysiology References (2) (APA):

Brunner, S., Hinkle, L., Cheever, H., & Suddarth, S. (2014). *Brunner & Suddarth's textbook of medical-surgical nursing*. Lippincott Williams & Wilkins.

Mayo Clinic. (2019). *Urinary tract infection (UTI)*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/urinary-tract-infection/symptoms causes/syc-20353447.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value (08/31)	Most Recent Value (09/01)	Reason for Abnormal Value
RBC	**3.80-5.41 mcl**	4.51 mcl	4.30 mcl	WNL
Hgb	**11.3-15.2 g/dL**	11.1 g/dL	11.3 g/dL	WNL
Hct	**33.2-45.3%**	35.7%	34.2%	WNL
Platelets	**149-393 k/mcl**	258 k/mcl	281 k/mcl	WNL
WBC	**4.0-11.7 k/mcl**	55.7 k/mcl	70.8 k/mcl	Sepsis can cause rebound leukocytosis reflecting rapid production of WBC and immature WBC also known as bands (Doenges, 2010).
Neutrophils	**45.3-79.0%**	NA	NA	NA
Lymphocytes	**11.8-45.9%**	NA	NA	NA
Monocytes	**4.4-12%**	NA	NA	NA
Eosinophils	**0.0-6.3%**	2.0%	2.0%	WNL
Bands	**0.0-5.0%**	4.0%	9.0%	Sepsis can cause rebound leukocytosis reflecting rapid production of WBC and immature WBC also known as bands (Doenges, 2010).

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value (08/31)	Today's Value (09/01)	Reason For Abnormal
Na-	**135-145 mmol/L**	136 mmol/L	136 mmol/L	WNL

K+	**3.5-5.0 mmol/L**	3.8 mmol/L	3.8 mmol/L	WNL
Cl-	**98-106 mmol/L**	106 mmol/L	102 mmol/L	WNL
CO2	**21-31 mmol/L**	17 mmol/L	17 mmol/L	In later stages of sepsis ABGs may be altered because of failure of compensatory mechanisms (Doenges, 2010).
Glucose	**74-109 mg/dL**	92 mg/dL	82 mg/dL	WNL
BUN	**7-25 mg/dL**	97 mg/dL	88 mg/dL	"Increased levels of BUN and Creatinine are associated with dehydration and liver/renal failure" (Doenges, 2010, pg. 689).
Creatinine	**0.50-0.90 mg/dL**	3.72 mg/dL	3.06 mg/dL	"Increased levels of BUN and Creatinine are associated with dehydration and liver/renal failure" (Doenges, 2010, pg. 689).
Albumin	**3.5-5 g/dL**	NA	NA	NA
Calcium	**9.0-10.5 mEq/dL**	6.7 mEq/dL	5.9 mEq/dL	When a patient is septic, "various electrolyte imbalances may occur R/T altered renal function" (Doenges, 2010, pg. 689).
Mag	**1.3-2.1 mEq/dL**	NA	2.2 mEq/dL	WNL
Phosphate	**2.5-4.5 mg/dL**	NA	NA	NA
Bilirubin	**0.3-1 mg/dL**	2.0 mg/dL	NA	"Commonly during sepsis, increased bilirubin levels are a late event in the course of multiorgan dysfunction" (Nesseler, 2012, para. 8).
Alk Phos	**35-105 units/L**	161 units/L	NA	Sepsis can cause elevated liver enzymes (American Thoracic Society, 2020).
AST	**0.0-32 units/L**	16 units/L	NA	WNL
ALT	**4-33 units/L**	33 units/L	NA	WNL
Amylase	**30-220 units/L**	NA	NA	NA

Lipase	**0.0-160 units/L**	6 units/L	NA	WNL
Lactic Acid	**0.5-1 mmol/L**	2.8 mmol/L	2.2 mmol/L	"Increased blood lactate concentration and lactic acidosis are common in patients with severe sepsis or septic shock" (Lee, 2016, para. 1).
Troponin	**0-0.4 ng/mL**	0.017 ng/mL	0.035 ng/mL	WNL
CK-MB	**3-5%**	NA	NA	NA
Total CK	**22-198 u/L**	25 u/L	NA	WNL

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission (08/31)	Most Recent Value (09/01)	Reason for Abnormal
INR	**2 – 3**	1.79	NA	WNL
PT	**11-12.5 seconds**	21.3 seconds	NA	PT may be prolonged in sepsis, indicating coagulopathy in response to a shock state (Doenges, 2010).
PTT	**30 – 40 seconds**	32.3 seconds	NA	WNL
D-Dimer	**<0.4 mcg/mL**	NA	NA	NA
BNP	**0.5-30 pg/mL**	NA	NA	NA
HDL	**>55 mg/dL**	NA	NA	NA
LDL	**<130 mg/dL**	NA	NA	NA
Cholesterol	**50-60 mg/dL**	NA	NA	NA
Triglycerides	**35-135 mg/dL**	NA	NA	NA
Hgb A1C	**4-5.9%**	NA	NA	NA
TSH	**0.4-4.2 mU/L**	NA	NA	NA

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission (08/31)	Today's Value (09/01)	Reason for Abnormal
Color & Clarity	**Yellow/clear**	Amber/cloudy	NA	The patient's primary diagnosis is an acute UTI. A UTI can cause excess protein in the urine, causing it to appear cloudy (Doenges, 2010).
pH	**5.0-8.0**	5.0	NA	WNL
Specific Gravity	**1.005-1.035**	1.013	NA	WNL
Glucose	**Normal**	Normal	NA	WNL
Protein	**Negative**	1+ (A)	NA	WNL
Ketones	**Negative**	Negative	NA	WNL
WBC	**>5**	>100	NA	The patient's primary diagnosis is an acute UTI. A urinary tract infection is a common cause of leukocytes in the urine (Doenges, 2010).
RBC	**0-3**	>100	NA	RBC are present because of the inflammation and irritation that the UTI has caused in the lining of the urinary tract (Doenges, 2010).
Leukoesterase	**Negative**	2+ (A)	NA	WNL

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission (08/31)	Most Recent Value (09/01)	Explanation of Findings
pH	7.35-7.45	7.30	NA	NA
PaO2	80-100 mmHg	40.7 mmHg	NA	In later stages of sepsis, ABGs may be altered because of the failure of compensatory mechanisms (Doenges, 2010).

PaCO2	35-45 mmHg	36.4 mmHg	NA	NA
HCO3	21-28 mEq/L	17.6 mEq/L	NA	In later stages of sepsis, ABGs may be altered because of the failure of compensatory mechanisms (Doenges, 2010).
SaO2	95-100%	66.3%	NA	In later stages of sepsis, ABGs may be altered because of the failure of compensatory mechanisms (Doenges, 2010).

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission 08/31	Today's Value 09/01	Explanation of Findings
Urine Culture	Negative	Positive	NA	The patient's primary diagnosis is an acute UTI. A positive culture confirms that there are bacteria in the urine (Doenges, 2010).
Blood Culture	Negative	Negative	NA	WNL
Sputum Culture	Negative	NA	NA	WNL
Stool Culture	Negative	NA	Negative	WNL
Wound Culture	Negative	NA	NA	WNL

Lab Correlations Reference (APA):

American Thoracic Society. (2020). General Information About Sepsis. https://www.thoracic.org/patients/lung-disease-week/2011/sepsis-week/general-information-about-sepsis.php.

Doenges, M. E., Geissler-Murr, A., Moorhouse, M. F. (2010). *Nursing care plans: guidelines for individualizing client care across the life span* (Eight). F.A. Davis Co.

Lee, S. M. (2016). *New clinical criteria for septic shock: serum lactate level as new emerging vital sign*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4958885/.

Nesseler, N., Launey, Y., Aninat, C., Morel, F., Mallédant, Y., & Seguin, P. (2012). *Clinical review: The liver in sepsis*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3682239/.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Echocardiogram (Echo), XR Chest, CT abdomen w/o contrast, CT pelvis w/o contrast, CT chest without contrast.

Diagnostic Test Correlation (5 points): The patient underwent an Echocardiogram to ensure efficient perfusion. The results for the Echo were still pending at the end of my shift. The patient underwent a chest x-ray d/t, the chief complaint of SOB. Chest x-ray's rule out "fluid in or around your lungs, enlarged heart, blood vessel problems, congenital heart disease, and calcium build-up in the heart or blood vessels" (Beckerman, 2018, para. 2). The results include normal heart size, a low lung volume, and no visualized pneumothorax or pleural effusion. The patient underwent a CT of his abdomen and pelvis d/t his reported abdominal pain and dysuria. The results include a pancreatic mass, hepatic metastasis, left ureteral stone, a stent in the left kidney, and ascites. The patient also underwent a CT chest d/t his hypotension. The results show hepatic metastasis, right middle lobe, and right lower lobe partial atelectasis and small right pleural effusion.

Diagnostic Test Reference (APA):

Beckerman, J. (2018, August 1). Chest X-Ray for Diagnosing Heart Disease, Lung Cancer, and

More. Retrieved from https://www.webmd.com/heart-disease/guide/diagnosing-chest-x-ray

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Hospital Medications

Brand/ Generic	**NaCl 0.9% Maxipime 1000mg/ NaCl 0.9% cefepime 1000mg**	**Levophed IV additive 4 mg+premix NaCl 0.9% 250 mL/ Norepinephrine IV additive 4 mg+premix NaCl 0.9% 250 mL**	**0.9% NaCl 1000mL**	**heparin**	**Protonix/ pantoprazole**
Dose	200 mL/hr	15 mL/hr	100 mL/hr	1 mL	40 mg
Frequency	Daily	Daily	Daily	Every 12 hrs.	Daily
Route	IV Piggyback	IV Drip	IV Drip	Subcutaneous Injectable	PO Tablet
Classification	Cephalosporins	Alpha/Beta Adrenergic Agents	Crystalloid Fluid	Anticoagulants	Proton Pump Inhibitor
Mechanism of Action	Has gram-negative and gram-positive coverage; rapidly penetrates the gram-negative cells.	Uses strong beta1- and alpha-adrenergic to increases cardiac output and heart rate, decreases renal perfusion.	The administered fluid remains in the extracellular compartment, where it helps restore blood volume and supports peripheral perfusion.	A low dose inactivates factor Xa and inhibits the conversion of prothrombin to thrombin.	Binds to H+/K+, resulting in blockage of acid secretion.
Reason Client Taking	This medication can be used for patients who have a UTI. My patient's primary diagnosis is an acute UTI.	This medication can be used when a patient is septic. My patient has been diagnosed with acute UTI and sepsis.	This medication can be used when a patient is dehydrated, hypertensive, in shock, and many other instances. My patient has a PMH of HTN and	This medication can be used for DVT & PE prophylaxis. My patient's age puts him at high risk for a DVT or PE.	This medication can help to prevent over secretion of acid and stomach ulcers.

			is currently diagnosed with sepsis.		
Contraindications (2)	Hypersensitivity is a contraindication. These contraindications do not pertain to my patient.	Hypersensitivity and hypotension from blood volume deficits are contraindications. These contraindications do not pertain to my patient.	Congestive heart failure and renal failure are contraindications. These contraindications do not pertain to my patient.	Hypersensitivity and uncontrolled, active bleeding are contraindication. These contraindications do not pertain to my patient.	Hypersensitivity and concomitant administration with rilpivirine containing products are contraindications. This contraindication does not pertain to my patient.
Side Effects/ Adverse Reactions (2)	Rash and diarrhea may occur.	Bradycardia and hypertension may occur.	Redness, pain, or swelling at the injection site may occur.	Mild pain and hemorrhage may occur.	Headache and abdominal pain may occur.
Nursing Considerations (2)	Prolonged use may cause superinfection.	Monitor blood pressure every two minutes from the time of administration until the desired BP is reached. The infusions site should be checked frequently for free flow.	Assess fluid balance throughout therapy. Assess for signs and symptoms of hyponatremia.	Monitor patient closely for signs and symptoms of hemorrhage. Lower doses: patients over 60 may have enhanced serum levels.	Can cause severe hepatic impairment. Therapy increases the risk of infections.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	INR – may increase INR	Monitor blood pressure before administration.	Monitor serum sodium, bicarbonate, and potassium.	Monitor therapy with PTT, platelet count, and hematocrit.	Monitor for signs and symptoms of hypomagnesemia.
Client Teaching needs (2)	Explain to the patient the purpose of the infusion. Educate the client on S/S of infiltration.	Explain to the patient the purpose of the infusion. Educate the client on S/S of infiltration.	Explain to the patient the purpose of the infusion. Educate the patient on S/S of hyponatremia. (N/V/headache, cramps, ect.)	Inform patient about increased risk of bleeding. Urge patient to report any abnormal signs or symptoms.	Tablets must be taken whole. May result in false positive urine screening.

Home Medications

Brand/ Generic	**Vantin/ cefpodoxime**	**Questran/ cholestyramine**	**Celexa/ citalopram**	**cyproheptadine**	**Lortel/ amlodipine**
Dose	200 mg	4 – 5 g	10 mg	4 mg	5 – 10 mg
Frequency	Twice daily, BID	Daily	Daily	Four times daily, QID	Daily
Route	PO Tablet	Oral powder	PO Tablet	PO Tablet	PO Capsule
Classification	Cephalosporins, 3rd Generation	Bile Acid Sequestrants	Antidepressant, SSRIs	Antihistamines, 1st Generation	Antihypertensive Combos, Calcium Channel Blockers
Mechanism of Action	Bactericidal against gram-positive and gram-negative bacteria; inhibits bacterial cell-wall synthesis by binding to 1 or more of penicillin-binding proteins.	Forms complex with bile acids that is not absorbed through intestine; inhibits enterohepatic reuptake of intestinal bile salts, which reduces serum cholesterol.	Inhibits the reuptake of serotonin in presynaptic neurons.	Serotonin and histamine antagonist; prevents histamine release in blood vessels and is more effective in preventing a histamine response.	Inhibits influx of extracellular Ca ions across the membrane acting on the smooth muscles without changing serum calcium concentrations.
Reason Client is Taking	Can be used to treat urinary tract infections (UTIs). My patient's primary diagnosis is an acute UTI.	Can be used to treat hyperlipidemia. My patient has a PMH of hyperlipidemia.	This medication can be used to manage depression. My patient has a past medical history of depression.	This medication can be used to a help a decreased appetite. My patient has a decreased appetite.	This medication is used to treat hypertension (HTN). My patient has a PMH of HTN.
Contraindications (2)	Hypersensitivity is a contraindication. This contraindication does not pertain to my patient.	Hypersensitivity and complete biliary obstruction are contraindications. These contraindications do not pertain to my patient.	Hypersensitivity and coadministration with pimozide are contraindications. These contraindications do not pertain to my patient.	Hypersensitivity and narrow-angle glaucoma are contraindications. These contraindications do not pertain to my patient.	Hypersensitivity and idiopathic angioedema are contraindications. These contraindications do not pertain to my patient.
Side Effects/	Diarrhea and	Constipation and	Dry mouth and	Muscular	Abdominal pain

Adverse Reactions	nausea may occur.	heartburn may occur.	nausea may occur.	weakness and urinary retention may occur.	and fatigue may occur.
Nursing Considerations (2)	Obtain culture and sensitivity test results before administering. Assess bowel pattern daily.	Give other drugs at least 1 hour before or 4-6 hours after cholestyramine to minimize interference with absorption. Always mix with water or fluids	Monitor for increased suicidal behavior. Monitor for signs and symptoms of hyponatremia.	Avoid use in elderly patients because of high incidence of anticholinergic effects. Administer at low end of dosage range.	Monitor for hypotension during therapy. Be educated on how to aid a patient in relieving symptoms of possible angioedema.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Monitor serum digoxin before administering the loading dose.	Monitor fat-soluble vitamins (A, D, E, K) because it can interfere/decrease absorption.	Monitor electrolytes, especially magnesium and potassium.	Assess lung sounds and respiratory function prior to administration.	Monitor serum potassium levels for possible hyperkalemia.
Client Teaching Needs (2)	Tell patient to report watery, bloody stools immediately. Be aware that an allergic reaction can	Always mix with fluids or food. Take before or with meals.	Explain that full effects may take up to four weeks. May cause an increase in suicidal thoughts.	Avoid alcohol during therapy. Educate patient to report skin rashes, GI problems, or problems with urination.	Tell patient to take missed dose as soon as remembered and next dose 24 hrs. after. Teach patient to report dizziness, arm or leg swelling, difficulty breathing, or rash.

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook*. Burlington, MA

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Judgement is intact. AOx4, oriented to person, place, time, and situation. No acute distress noted. Well nourished, cooperative, appropriate mood.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** No noted rashes **Bruises:** No noted bruises **Wounds:** No noted bruises **Braden Score:** 18 **Drains present: Y☐ N ☒** **Type:** None	 Intact; pink Warm and dry Oral: 36.4 C Elastic; <3 No skin breakdown present. Patient is at a mild risk for skin breakdown. No drains or ports were present on this patient.
HEENT (1 point): **Head/Neck:** Non-tender, no JVD, no thyromegaly **Ears:** Ears are appropriate in size **Eyes:** PERRLA **Nose:** No noted deviated septum **Teeth:** White, oral is moist, tongue is midline.	Normocephalic, atraumatic, normal hearing, moist oral mucosa, no sinus tenderness, no nosebleeds, no oral lesion, tonsil grade 1 without erythema or exudate, uvula midline. Patient had normal pink conjunctiva and white sclera. Patient did not have dentures.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:** NA	No chest pain, palpations or syncope Regular rate and rhythm S1&S2 noted No noted murmurs, gallops or rubs Pedal: 3+ bilaterally LE <3 bilaterally UE No noted edema in upper and lower extremities.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, characteristic** **ET Tube:** **Size of Tube:** NA **Placement (cm to lip):** NA	Breathing is regular, chest expansion symmetric, no obvious accessory muscle use. Patient is on 5 L/min of oxygen. Lungs are clear upon auscultation bilaterally and diminished. No crackles, wheezes, SOB, or stridor upon auscultation. No ET Tube present.

Respiration rate: NA **FiO2:** NA **Total volume (TV):** NA **PEEP:** NA **VAP prevention measures:**	VAP prevention measures include, completing oral care every 2 hrs. or PRN, and maintaining good hand hygiene.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** 157.2 cm **Weight:** 94.5 kg: Patient is overweight **Auscultation Bowel sounds:** **Last BM:** NA **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** No tube present **Feeding tubes/PEG tube Y ☐ N ☒** **Type:** No tubes present	No nausea, vomit, or diarrhea Heart-healthy diet Heart-healthy diet Present; normal/active in all four quadrants. Did not have a BM on my shift. Abdomen was soft, non-tender, ascites present Ascites present resulting in abdominal distention. No noted incisions No noted scars No noted drains No noted masses or hernias
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** NA **Size:** NA **CAUTI prevention measures:**	Hematuria present on admission, but no pain or hematuria as of 09/01 upon urination. Amber Cloudy Patient voided 230 mL in 7 hrs. This is within the 30mL/hr. range. No catheter is present. CAUTI prevention measures include, completing perineal care daily and PRN, ensuring that the procedure was sterile, and avoiding prolonged use of a catheter.
MUSCULOSKELETAL (2 points): **Neurovascular status:**	Patient denies numbness or tingling of extremities. Neurovascular status intact

ROM: **Supportive devices:** None needed **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** 35 **Activity/Mobility Status:** **Independent (up ad lib)** ☒ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	UE and LE normal range of motion. Muscle strength is 5/5 in UE and LE Patient is a fall risk. Patient is independent (up and lib); smooth gait, no crepitus. No assistance with equipment needed, patient can walk independently.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** Glasgow Coma Scale – 15: alert, attentive, oriented, and obeys commands.	CN II-XII intact. Sensation is intact to light, and touch. Speech is clear, patient follows commands. AOx4, oriented to person, place, time, and situation. Patients recent and remote memory is intact. Speech is clear, and follows commands Sensation is intact to light, and touch
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Enjoys watching TV and talking with his sister. GED Not religious Patient lives alone at home but has support from his sister.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen*
0900	83 bpm	97/64 mmHg	26 bpm	36.5 C°	97%
1100	79 bpm	98/68 mmHg	19 bpm	37.2°	97%

*Patient is on 2 L/min oxygen via nasal canula.

Vital Sign Trends: The vital sign trend shows that at 0900 my patients' respiratory rate was 26 bpm, and at 1100 it was 19 bpm, which are above normal. The patient could have an increased respiratory rate due to his primary diagnosis of an acute UTI and a secondary diagnosis of sepsis. According to an article, "sepsis may be the cause tachypnea if a person also has had a recent illness or infection, such as pneumonia or a urinary tract infection" (Tachypnea: Causes, symptoms, and treatment, 2020). All other vital signs are stable; no interventions needed at this time.

Reference:

Tachypnea: Causes, symptoms, and treatment. (2020).

https://www.medicalnewstoday.com/articles/324548.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	Numeric	No pain	0/10	No pain	No interventions are needed at this time.
1100	Numeric	No pain	0/10	No pain	No interventions are needed at this time.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Left: 18 gauge Right: 18 gauge **Location of IVs:** Left antecubital and right antecubital **Date on IVs:** 08/31/2020 **Patency of IVs:**	Left: 0.9% NaCl 100mL/hr norepinephrine 8 mcg/min. Right: Saline lock Catheters are patent, infuse w/o difficulty,

Signs of erythema, drainage, etc.: **IV dressings assessment:**	flush easily, and both have good blood return. No erythema/phlebitis/infiltration present Transparent, dry and intact
Other Lines (PICC, Port, central line, etc.)	
Type: NA **Size:** NA **Location:** NA **Date of insertion:** NA **Patency:** NA **Signs of erythema, drainage, etc.:** NA **Dressing assessment:** NA **Date on dressing:** NA **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	No PICC, Port or Central line present. CLABSI prevention measures include, using proper hand hygiene, ensuring to maintain a sterile field while completing insertion, and properly cleaning the area before skill is completed.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
IV: 75 mL NaCl 0.9% Norepinephrine 379.31 mL NACl 0.9% intravenous solution 1,000 mL Total: 454.31 mL	Urine: 230 mL Total: 230 mL

Balance: 224.31 mL

Nursing Care

Summary of Care (2 points)

Overview of care: During my shift, I did a head to toe assessment. The assessment was within normal limits. The patient was given medications to reduce his generalized head pain. The prescriber also ordered an echo for my patient but the results are still pending. Vital signs and pain assessments were obtained at 0900 and 1100.

Procedures/testing done: The prescriber ordered an echocardiogram which was performed during my shift, but the results were still pending at the end of my shift.

Complaints/Issues: There were no complaints or issues during my shift on 09/01.

Vital signs (stable/unstable): The vital sign trend shows that at 0900 my patients' respiratory rate was 26 bpm, and at 1100 it was 19 bpm, which are above normal. The patient could have an increased respiratory rate due to his primary diagnosis of an acute UTI and a secondary diagnosis of sepsis. According to an article, "sepsis may be the cause tachypnea if a person also has had a recent illness or infection, such as pneumonia or a urinary tract infection" (Tachypnea: Causes, symptoms, and treatment, 2020). All other vital signs are stable; no interventions needed at this time.

Tolerating diet, activity, etc.: There was no nausea, vomiting, or diarrhea during my shift. My patient did not like the hospital food therefore, he did not eat much other than toast during my shift.

Physician notifications: The Physician ordered to bump the 0.9% NaCl fluids from 100 mL/hr. to 200 mL/hr.

Future plans for patient: The patient will continue a heart healthy diet. The patient is going to discuss new living arrangements with his sister in hopes that he will no longer need to live alone. The patient does not want to be placed in a retirement home and believes that this is the next best option.

Discharge Planning (2 points)

Discharge location: The patient will be discharged to his home.

Home health needs (if applicable): None needed

Equipment needs (if applicable): None needed

Follow up plan: The patient will better manage his diet. The patient will also practice better medication compliance and ensure that he makes it to all follow-up appointments.

Education needs: The patient will be able to verbalize the understanding of the importance of a healthy diet. The patient completed a medication schedule to be more compliant with his daily medications.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for shock R/T reduction of arterial/venous blood flow.	1. My patient had an increased respiratory rate at 0900 and 1100. 2. My patient is septic, and this can cause a decreased rate of perfusion.	1. Monitor trends in blood pressure. 2. Maintain bedrest and assist with care activities.	1. With the help of a vasopressor, my patient was able to maintain a normal blood pressure throughout my shift on 09/01. 2. The patient did not enjoy maintaining bed rest but understands the benefits.
2. Hyperthermia R/T dehydration AEB increased respiratory rate.	1. My patient had an increased respiratory rate at 0900 and 1100. 2. Patient may become febrile d/t septicemia.	1. Monitor patient's temperature. 2. Monitor patient's room temperature.	1. The patient responded well. Temperature was WNL at 0900 and 1100. 2. The patient maintained a consistent room temperature which aided in maintaining a normal body temperature.
3. Risk for infection (progression of sepsis to septic shock) R/T failure to recognize or treat infection and/or	1. Patient has a secondary diagnosis of sepsis. 2. Patient is part	1. Practice proper handwashing and hygiene to reduce the risk of infection. 2. Encourage or	1. The patient was able to demonstrate proper handwashing technique on 09/01. 2. The patient's plan of

exercise proper preventative measures.	of the gerontological population. Older adults can be asymptomatic when an infection is present.	provide frequent position changes, deep-breathing, and coughing exercises.	care included position changes every hour. Patient was compliant with position changes.
4. Risk for impaired Gas Exchange R/T interference with oxygen delivery and utilization in the tissues.	1.Patient has a secondary diagnosis of sepsis. 2. My patient had an increased respiratory rate at 0900 and 1100.	1.Monitor respiratory rate and depth. 2.Reposition frequently. Encourage coughing and deep-breathing exercise.	1. The patient's respiratory rate at 0900 was 26 bpm and at 1100 it was 19 bpm with no accessory use of muscles. 2. The patient's plan of care included position changes every hour. Patient was compliant with position changes.

Other References (APA):

Doenges, M. E., Geissler-Murr, A., Moorhouse, M. F. (2010). *Nursing care plans: guidelines for individualizing client care across the life span* (Eight). F.A. Davis Co.

Concept Map (20 Points

Subjective Data

Presented to the department with “weakness, dyspnea, dysuria, lower abdominal pain, and dizziness.”

Chief Complaint: “SOB”

1. Risk for shock R/T reduction of arterial/venous blood flow.
2. Hyperthermia R/T dehydration AEB increased respiratory rate.
3. Risk for infection (progression of sepsis to septic shock) R/T failure to recognize or treat infection and/or exercise proper preventative measures.
4. Risk for impaired Gas Exchange R/T interference with oxygen delivery and utilization in the tissues

Objective Data

Vital sings:
0900, BP: 97/64 mmHg, Pulse: 83 bpm, Resp Rate: 26, Temp: 36.5 C, Oxygen: 97%. 1100 BP: 98/68 mmHg, Pulse: 79, Resp Rate: 19, Temp: 37.2 C, Oxygen: 97%

General Assessment:
Ascites present. Amber/cloudy urine.
Height: 157.3 cm
Weight: 94.5 kg

Testing:
Patient tested negative for COVID-19.

Abnormal Labs:
Hgb: 11.1 and 10.3
Hct: 35.7 and 34.2
WBC: 55.7 and 70.8
Cl-: 108
CO2: 17
BUN: 97 and 98
Creatinine: 3.72 and 3.06
Calcium: 6.7

Patient Information

This is a 68-year-old male who presented to the emergency departments with weakness, dyspnea, dysuria, lower abdominal pain, hematuria, and dizziness. Patient rated his pain an 8/10 on admission with a chief complaint of SOB. Patient’s signs and symptoms started to occur a few days ago around 8/29/2020. Patient states as of today, 9/1/2020, he is experiencing no pain. Patient denies chest pain, cough, Upper Respiratory Infection (URI) symptoms, or sore throat. Patient tested negative for COVID-19.

Nursing Interventions

1. Monitor trends in blood pressure.
2. Maintain bedrest and assist with care activities.
3. Monitor patient’s temperature.
4. Practice proper handwashing and hygiene to reduce the risk of infection.
5. Encourage or provide frequent position changes, deep-breathing, and coughing exercises.
6. Monitor respiratory rate and depth.