N311 Care Plan #1

Lakeview College of Nursing

Anita Wilson

Demographics

Date of Admission	**Patient Initials**	**Age**	**Gender**
9/19/2020	F.R.	8/31/1935 (85 years old)	Widowed
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White or Caucasian	Worked at Arthur Cheese Company for 16 years, but is now retired	Widowed (Married two times; 1953 & 1956)	No Known Allergies
Code Status	**Height**	**Weight**	**Assistive Device**
Full code per daughter request (daughter available bedside and indicated she is the power of attorney)	5’3”	383 pounds (164.7 kg)	Walker, glasses, dentures
Primary Language	**Religion**		
English	Utilized chapel in the hospital; a member of the Southern Baptist Church		

Medical History

Past Medical History:
anemia, arthritis, cervicalgia, congestive heart failure (CHF), chronic kidney disease (CKD), stage III (moderate), diabetic neuropathy (HCC), hypercholesterolemia, hyperkalemia, hypertensive, kidney disease with chronic kidney disease, hypertensive nephrosclerosis, lumbago, poor vision, rectocele, diabetes

Patient denies any childhood illness or infection. Patient was hospitalized prior due to surgery. Patient denies any past screenings or examinations with the exception of her mammogram which was last completed in 2019.

Past Surgical History:
1. Capsulotomy (bilaterally; 3/1/18)
2. Rotator cuff repair (left shoulder; 2005)

Patient denies any other past surgeries (besides the one listed above) or upcoming surgeries. Patient denies any c-section. Patient has had surgery to remove all her teeth in 2012 and now has full dentures.

Family History:
Mom (decreased)- history of diabetes and hypertension

Dad (deceased)- history of hypertension

Social History (tobacco/alcohol/drugs):
Patient states she never smoked or used smokeless tobacco. Patient stated she tried it once when she was younger, but "it didn't do anything for [her]" so she never did it again. Patient denies any use of recreational or illicit drug and alcohol use. For living arrangements, patient lives alone.

Admission Assessment

Chief Complaint:
Intermittent hallucination and paranoid for a few weeks

History of present Illness:

Onset:
On September 19th, 2020 an 85 year old, widowed female presented to the emergency department at OSF Urbana with his daughter for intermittent visual, auditory and tactile hallucinations and paranoia that has persisted for the last few weeks and is getting worse. Patient's family noticed that patient gets paranoid that people will hurt her. Patient's family found she is carrying a knife and her purse to protect herself.

Location:
Patient was at her home, when her daughter stayed with her over the course of a month and noticed her increase confusion and the difference in her mental status.

Duration:
This behavior persisted for the last few weeks. On September 19th, 2020, the patient came into the emergency department due to delirium.

Characteristics:
According to the patient's daughter, she described the patient's condition as being "distorted in her perception of reality", frightening. Patient states she does not recall the events that occur during those few weeks nor does she recall the day of admission. Patient stated her daughter expressed to her that she was having an "outer body experience".

Aggrieving/ Alleviating factors:
Patient stated she is unsure was to what caused the hallucination, but stated she recalls prior that she was heavily fixated on the passing of her son and late husband who passed in 2008. Patient stated she was overwhelmed with the loss of her loved ones and "really started missing them". Patient stated that is the last thought she can recall thinking about prior to being hospitalized.

Treatment:

Patient is currently working with the health care team to continue to figure out the cause of the hallucinations and continuing to restore her normal level of function in hopes that she will return back home and living alone with the assistance of her daughter and son.

Primary Diagnosis

Primary Diagnosis on Admission: delirium due to multiple etiologies
Secondary Diagnosis: hallucination and paranoia

Pathophysiology of the Disease, APA format: (Delirium)

Delirium is defined as being, " a transient, usually reversible, state of cerebral dysfunction; manifested by a wide range of neuropsychiatric abnormalities and can be exhibited as a hyperactive or a hypoactive state" (Capriotti, 2020). The onset is typically sudden that days for days and impairs one's level of consciousness, attention and psychomotor abilities (Capriotti, 2020). It forces on the effects of the neurotransmitters acetylcholine, dopamine, and serotonin. Acetylcholine is decreased with delirium. With treatment, the delirium will be fully resolved. There are many causes of delirium, one of which is drug toxicity. Other causes can be related to liver failure, renal failure, hypoxia, dehydration, infections such as pneumonia, sepsis, urinary tract infections (Huang, 2019). It is not usual for hospitalized patients to experience delirium due to withdrawal of a drug that has been taken for so long. A few risk factors of developing delirium is alcohol or sedative withdrawal, metabolic causes like kidney issues, cardiovascular issues like heart failure and shock, infectious diseases like HIV and the use of illicit drugs (Capriotti, 2020). Statistically, "20% of 12.5 million patients over 65 years age hospitalized each year in the US experience delirium" (Fong, Tulebaev & Inouye, 2011). Treatment used in cases of delirium include non-pharmacological supportive therapy like fluid and nutrition since these individuals often times forget to eat; and pharmacological management like antipsychotic drugs like haloperidol and benzodiazepines such as lorazepam (Capriotti, 2020). Although, it has not been

clearly stated as to why my patient developed delirium, it is a possibility she got it because of malnutrition. Her being elderly and living alone, she could have easily forgotten to eat. Another possibility could be sleep deprivation, urinary tract infections, sensory deprivation and hypoxia.

Pathophysiology References (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives 2nd Edition* (2nd ed., p. 562). Philadelphia: F A Davis.

Fong, T. G., Tulebaev, S. R., & Inouye, S. K. (2009). Delirium in elderly adults: diagnosis, prevention and treatment. *Nature Reviews Neurology*, *5*(4), 210–220. https://doi.org/10.1038/nrneurol.2009.24

Huang.Juebien. (2019, December). Overview of Delirium and Dementia. Retrieved October 16, 2020, from MSD Manual Professional Edition website: https://www.msdmanuals.com/professional/neurologic-disorders/delirium-and-dementia/overview-of-delirium-and-dementia

Laboratory Data

COMPLETE BLOOD COUNT

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RED BLOOD CELLS (carry oxygen)	F: 4.2-5.5	**3.95**	**3.36**	This patient has a medical history of rheumatoid arthritis. With an RA flare up, the immune response causes inflammation in the joints and other tissues. Chronic inflammation can lower the production of RBCs in the bone marrow over time.
HEMOGLOBIN (oxygen-carrying protein in RBCs)	F: 12-16	12.2	**10.4**	This patient has chronic kidney failure. When the kidneys are damaged, the bone marrow makes fewer RBC causing anemia. With lower RBCs, it makes it difficult for the body to get the adequate oxygen it needs.
HEMATOCRIT (the proportion of RBCs to the fluid component, plasma in your blood)	F: 36-46	36.1	36.8	
PLATELETS (help with blood clotting)	150,000-400,000	228,000	280,000	
WHITE BLOOD CELLS (fight infection)	4,000-10,000	9	7.40	
NEUTROPHILS (type of WBC that the bone marrow creates; travel into blood stream and move to areas of infection and neutralize that area)	40-60	**71.6**	56.3	On admission, the reasoning for elevated neutrophils levels with this patient is because bacteria is present. In the patient's urine culture results showed a "mixed growth of one or more distal urethral" on the date of admission. Bacteria causes an increase in neutrophils because they are the first responder to the site of an infection in an admit to fight off infection.
LYMPHOCYTES (B cells: produce antibodies to attack bacteria T-cells: kill infected cells	20-40	21.6	31.7	

MONOCYTES (fight infection; help remove dead tissues; destroy cancer cells)	2-8	5.7	6.2	
EOSINOPHILS (participating in immediate allergic reactions)	1-4	1.0	**5.1**	This patient's eosinophils levels are elevated due to infection within the urine.
BANDS (immature form of neutrophils; produced in excess during infection to help fight disease)	3-7	5	5	

Chemistry

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
NA- (Control BP and blood volume; needed for muscle and nerves to work)	135-145	137	140	
K+ (helps your nerves to function and muscles to contract; heartbeat stay regular; move nutrients into cell and waste products out of cell)	3.5-5.0	3.9	4.0	
Cl- (helps keep the amount of fluid inside and outside of your cells in balance; maintain blood volume, BP and pH)	95-105	103	104	
CO2 (regulates the pH of blood, stimulates breathing, and influences	23-30	24	28	

the affinity hemoglobin has for oxygen)				
Glucose (for energy)	70-110	**157**	**227**	It is not abnormal for hospitalized patients to experience high levels of glucose due to stress. Stress blocks your body from releasing insulin which causes your glucose to build up. In addition, with this patient she is morbidly obese and eats poorly at home. With this increase weight, the less sensitive her body is to insulin which can cause the blood sugar levels to rise.
BUN (measures the amount of nitrogen in your blood that comes from the waste product urea; indicates how well your kidney are working)	10-20	**29**	**33**	An increase in both BUN and creatinine levels are a good indicator of poor kidney function. This patient has chronic kidney disease so that is most likely the reason. The kidney is not filtering as it should. This patient also experienced delirium for three weeks so it will very common that she was malnourished during that time and forgetting to eat and drink and dehydration is another cause of the decreased levels.
CREATININE (to be filtered and eliminated in urine)	0.6-1.5	**1.67**	1.03	^
ALBUMIN (helps keep fluid in your bloodstream so it doesn't leak into other tissues)	3.5-5.0	3.8	4.0	
CALCIUM (stored in bones and teeth; supports structure; carries massages between the brain and body parts)	8.5-10.0	8.8	9.1	
MAGNESIUM (required for energy production)	1.5-2.5	1.7	1.8	
PHOSPHATE (build and repair bones and teeth, help nerves function, and make muscles contract)	2.8-4.5	3.5	3.8	
BILIRUBIN (orange-yellow pigment	0-0.3	negative	negative	

that occurs normally when part of your red blood cells break down)				
ALK PHOS (mostly found in the liver, bones, kidneys, and digestive system. When the liver is damaged, ALP may leak into the bloodstream)	20-90	64	58	

Urinalysis

Lab Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Reason for Abnormal**
COLOR & CLARITY	Colorless-Yellow, Clear	Yellow, clear	Yellow, clear	
pH	6-8.0	8.0	6.0	
SPECIFIC GRAVITY (test compares the density of urine to the density of water; help determine how well your kidneys are diluting your urine)	1.005-1.030	1.017	1.014	
GLUCOSE	Negative	Negative	Negative	
PROTEIN	0-8	Negative	Negative	
KETONES (fuels for the body that are made when glucose is in short supply)	Negative	Negative	Negative	
WBC	0-4	1	2	
RBC	0-3	0	0	
LEUKOESTERASE	Negative	Many	Few	Leukoesterase are present in the urine with this patient due to a possible diagnosis of a

				urinary tract infection.

Cultures

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
URINE CULTURE	Negative	Mixed growth of 1 or more distal urethral	"Results to follow"	This indicates contamination with vaginal, skin or bowel organisms. A repeated sample is needed.
BLOOD CULTURE	Negative	None ordered		
SPUTUM CULTURE	Negative	None ordered		
STOOL CULTURE	Negative	None ordered		

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference. St. Louis, MO: Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests:

XR Chest Single View Portable (9/26/2019) @ 1845

Heart size normal. Mediastinum is not widened. No infiltrate or effusion. Mild degenerative change bony structures. No acute cardiopulmonary process.

XR Lumbar Spine 2 or 3 Views (9/22/2019) @ 1228

Anterior spondylosis at upper middle lower lumbar levels as well as lower thoracic levels can be seen. A calcification is seen on lateral view in the upper abdomen possible reflecting a gallstone for example.

EKGM on admission (9/16/2020)

Atrial rate- 258
QRS duration- 122
QTC duration- 436
QT duration- 416
R axis- 107
T axis- 53
Ventricular rate- 66

Ultrasound (9/16/2020) @ 1855

The vessels are easily compressed. There is a good augmentation of flow. No intraluminal echo's to suggest thrombus are identified. No sonographic evidence of deep venous thrombus of the bilateral lower extremities deep venous system.

Current Medications

Medications

Brand/Generic	**Duloxetine (Cymbalta)**	**Glimepiride (Amaryl)**	**Levothyroxine (Synthroid)**	**Linagliptin (Tradjenta)**	**Magnesium Oxide (mag-ox)**
Dose	60 mg capsule (do not crush)	1 mg (1 tablet)	50 mg (1 tablet)	5 mg (tablet)	400mg (1 tablet)
Frequency	Daily (once a day at 9a)	Daily (with lunch)	Once a day (every morning before breakfast)	Daily (with lunch)	Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Serotonin-norepinephrine reuptake inhibitors	Sulfonylureas	Thyroid Hormones	Dipeptidyl peptidase- 4 (DPP-4) inhibitors	Mineral
Mechanism of Action	Inhibits the reuptake of serotonin and norepinephrine in the central nervous system. It increases dopamine specifically in the prefrontal cortex	It lowers blood sugar by stimulating the release of insulin by inducing increased activity of intracellular insulin receptors.	Thyroid hormone exert their physiologic action through control of DNA transcription and protein synthesis. T3 and T4 diffuse into the cell nucleus and bind to thyroid receptor.	An enzyme that degrades the incretin hormones glucagon-like petide-1 and glucose-dependent insulinotropic polypeptide	A cofactor in many enzymatic reactions in the body involving protein synthesis and carbohydrate metabolism
Reason Client Taking	Depression and nerve pain	Control high blood sugar	Hypothyroidism	Diabetes	Constipation
Contraindications (2)	low amount of sodium in the blood and an increased risk of bleeding	Low blood sugar, Addison's disease, blood disorder like anemia, pituitary hormone deficiency	Diabetes, overactive thyroid glands, osteoporosis, weak bones, pituitary hormone deficiency	Hypersensitivity to linagliptin, anaphylaxis, urticaria, angioedema, exfoliative dermatitis, bronchial hypersensitivity	Renal impairment, myasthenia gravis, neuromuscular disease
Side Effects/Adverse Reactions (2)	Insomnia, dry mouth, constipation,	Weakness, tiredness, dizziness,	Weight loss, sweating, headache,	Stuffy or runny nose, sore throat, diarrhea,	Hives, peeling skin, severe diarrhea,

	nausea	headache	hyperactivity, nervousness, anxiety	decreased appetite, vomiting	trouble breathing

Medications Reference (APA):

Institute for Safe Medication Practices: ISMP Medication Safety Alert

http://www.ismp.org/. Jones & Bartlett Learning. (2019). 2019 Nurse's Drug

Handbook. Burlington, MA

Assessment: *Physical Exam*

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is an elderly Caucasian female. She is alert and orientated to situation and person, but disorientation to time and place. Patient wears glasses and is hear of hearing (wearing aides are at home). Patient appears to be well groomed and in no acute distress. **Patient denies fatigue, weight changes, fevers, chills, night sweats.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient's skin is warm, pink and dry. No rashes or lesions present. Patient has a bruise on lower left abdomen quadrant. When asked, patient stated it was from her insulin shot. This information was confirmed with the nurse who also stated it was from her insulin. Patient's nails are without clubbing and cyanosis. Skin turgor normal mobility, quick to return to original state. Patient had no wounds or drains at the time of this assessment. Patient had an IV in her left hand. When asked patient stated her peripheral IV site does not feel painful or tender. Patient's Braden score is an 18 (sensory perception 3 (slight limited), moisture 3 (occasional moist), activity 3 (walks occasional), mobility 3 (slightly limited), nutrition 3 (adequate), friction shear 3 (no apparent problem)). **Patient denies dryness, rashes, lesions, non-healing sores, hair changes, purities.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head and neck are symmetrical. Trachea is midline without deviations, thyroid is not palpable, no nodules noted at the time of assessment. Bilateral carotid pulses are palpable and strong. No swollen lymph nodes in the head or neck region. Bilateral sclera white, bilateral cornea clear. Bilateral conjunctiva pink, slight visible discharge in left eye. Bilateral lids are pink and dry without lesion. PERRLA bilaterally, red light reflux present bilaterally. EOMs intact bilaterally. Septum is midline. Bilateral frontal sinuses are nontender and to palpation. Bilateral auricles moist and pink without lesions noted. Dentition is good with dentures, oral mucous overall is moist and pink without lesions noted. Dental appliance present. Patient's hair is normal quality, distribution and texture. **Patient denies experiencing headaches, head injury, blurry vision, double vision, earache, drainage, change in hearing, nasal congestion, nose bleeds, nasal drainage, dry mouth, sore throat, swallowing**

	difficulty.
CARDIOVASCULAR: **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:**	Clear S1 and S2 sounds heard without the presence of murmurs, gallops or rubs. PMI at 5th intercostal space at MCL. All extremities warm, pink and dry. Peripheral pulses are 2+ throughout bilaterally with the exception of left dorsal pedis pulse being +1. +1 trace edema noted in patient's left and right ankle. No other edema inspected or palpated in all other extremities. Homan's sign is negative bilaterally. Capillary refill less than 3 seconds in fingers and toes bilaterally throughout. No neck vein distention noted in this patient. **Patient denies chest pain, palpitations, diaphoresis, dyspnea, PND, Orthopnea, claudication.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular, even and symmetrical and nonlabored bilaterally. I did observe the patient display signs of nonlabored breathing when ambulating to the bathroom and the chair. Nonlabored breathing decreased once patient was seating and resting for 5 minutes. Lung sounds are clear throughout bilaterally. No wheezes, crackles or rhonchi noted. **Patient denies wheezing, cough, increase in sputum production. Patient did state she does have difficulty breathing with increase activity especially when ambulating to the bathroom, that's occurred for the past year. Patient stated resting makes her breathing better. Anterior, lateral, clear and equal bilaterally.**
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒**	.Patient's describes diet at home as being "eating whatever [I] wanted, fruits, green beans, hamburger, biscuits and sausage for breakfast". Patient states she had a good appetite and no trouble eating. Patient is on a cardiac diet. Patient eats well and shows no signs of difficulty eating. Patient uses no assistive devices to aide in eating. Patient does require set up help with each meal. Patient stated she was constipated yesterday evening, and was given something to aid in her stool production and was able to have a productive and successful bowel movement. Patient is 5'3". Patient weights 363 pounds. Patient's abdomen is soft, nontender, no masses noted upon palpation or all four quadrants. Bowel sounds are normoactive in all four quadrants. No CVA tenderness noted bilaterally. Patient's abdomen is obese. No signs of distention, incision, scars, drains or wounds, ostomy or nasogastric feeding nudes/ PEG tubes.

Type:	**Patient denies nausea, vomiting, diarrhea, abdominal pain, heartburn, jaundice, hematochezia, melena. Last episode of nausea and/or vomiting was "a while ago" according to patient. Patient is passing gas. Patient's last bowel movement was 10/14/2020. Patient's bowel movement was described as being hard, small and brown. _____**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient's urine appears to be yellow, clear and absent of foul odor. Patient has a normal stream of urine and consent flow. Patient's genitals appear to be intact, no abnormalities noted. Patient does not have a catheter at the time of this assessment. Patient voids spontaneous without difficulty. Patient voided 450 ml in total during my shift. **Patient denies burning or pain, hematuria, incontinence, flank pain while urinating. Patient is not on dialysis.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	Patient appeared to be alert LOC. Patient arousal level was she opened her eyes spontaneously. Patient is a one assist with a walker. Patient demonstrated active range of motion bilaterally throughout. Patient fall risk score is a 12 (2 mobility deficit/ weakness, 2 age greater than 65, 8 unsteady gait and or weakness). The safety promotion/ prevention plan for this patient is bed alarm, chair alarm, light adjusted for task/ safety, non-skid socks or slippers when out of bed. I was able to observe patient while physical therapy was ambulating with her. Patient maintains good balance with the assistance of a walker. Patient did seem to be short of breath with physical therapy. When ambulating the patient to and from the bathroom she also appeared to be short of breath. Patient is a one assistance with a walker. Patient needs cueing, encouragement and prompting. Patient was encouraged to engage in as much a she can independently; all personal objects within reach. Patient's general motor response was normal.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☒ Both ☐** **Orientation:** **Mental Status:** **Speech:**	Patients speech was logical, well-paced, spontaneous and clear. Patient's mood and behavior was cooperative, calm and talkative. Patient's memory happened to be forgetful at times. PERRLA bilaterally. Patient's hand grip and ankle strength were moderate. Patient's right side was stronger than her left side. Patient's left and right dorsiflexion and planar flexion was also moderate bilaterally. Patient is alert and orientated to situation and person, but disorientation to time and place. Patient is full

Sensory: **LOC:**	concisions and alert at times but on other times appeared confused.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient states she copes with different stressor in her life by spending quality time her with son and daughter. Patient stated she really enjoying also spending time with her grandchildren because they bring her so much joy and happiness. Patient's developmental level is appropriate for her age. Patient stated she is a member of the southern Baptist church. Patient stated she enjoys have the chapel at the hospital visit her. Patient states her support team consist of her daughter, who is her POA, and her son who is a retired veteran who lives in Indiana but visits her often. Patient lives alone, but in close proximity to her daughter who visits and checks on her frequently. Patient has 6 children in total, 4 of which are still living. Patient stated her other two children lives further away but she still keeps in contact with them from to time when according to the patient they aren't so busy and the holidays.

Vital Signs

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0805	74	133/65	16	97.8 F	94%

	(right radial)	(right arm)	(unlabored)	(oral)	(room air)

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
1006	8 out of 10	Left lower back radiating to her hip	Moderate pain	Sharp, stabbing especially in the morning when she's ambulating	Patient has PRN Tylenol. Patient uses "aspercreme lidocaine" and icy hot which patient states helps relieve her pain for a short amount of time

Intake and Output

Intake (in mL)	Output (in mL)
480 mL (coffee) 200 mL (orange juice)	450 mL (yellow, clear urine, free of foul odor)

For breakfast patient ate sausage, egg, muffin with a cookie and orange juice and coffee with 2 sugar.

Nursing Diagnosis

Nursing Diagnosis	Rational	Intervention	Evaluation
1. Risk for falls **related to** diminished mental status,	Patient was hospitalized with delirium due to	1. With each encounter with the patient, explain	1. Patient was free from injuries and falls during shift on

history of falls, confusion, older than 65, medications use, cognitive impairment, sensory deficits, diminished activities, use of assistive device **as evidenced by** fall risk score of 12, inability to recall or remember place or time wears glasses and hearing aids, uses walker, taking Glimepiride which increases weakness and dizziness, unsteady gait without assistance	multiple etiologies. Patient was previously hospitalized within the past year for a fall at home that resulted in no injuries. Patient is considered a high fall risk. Patient is wearing a yellow "fall risk" band on arm, yellow non slid socks and bed/ chair alarm. Although patient is getting her mobility back, she still is unsteady with gait at times and requires a one assistant with transfers and walker.	the importance of using the call light and remind patient to call and wait on nurse before getting out of bed from 7a-12:45pm on 10/15/20. 2. Guarantee appropriate room lighting, especially during the night and environment is free of cluster from 7a-12:45p on 10/15/20.	10/15/20 from 7am to 12:45pm. With each encounter with the patient, I explained the important of using the call light. I rounded on the patient frequently. When coming in contact with patient, I was sure to ask her if she needed to be toileted or if I could assist her with anything while I was in there to decrease her chances of falling. Patient verbalize that she understood the important or calling for help and demonstrated the use of using her call light if needing help. 2. 2. Patient remained free from falls caused by confusion by the end of the shift on 10/15/20 from 7am to 12:45pm. I was sure to declutter the patient's room and keep patient's phone, tv remote and call light within reach and the windows open to provide adequate lighting.
2. Complicated grief **related to** loss of loved one, change in activity, insomnia, emptiness, loneliness, intense longing, problems accepting death, having troubles carrying out normal activities, extreme sadness **as evidence by** patient felt the loss of her husband and son was what could have been the cause of her delirium episode, patient states this is the last memory she recalls, tearful while talking about this, states she is still in disbelief they are gone, stated she misses them deeply	Patient was tearful when talking to me about the death of her loved ones. Patient verbalized how this has affected her by stating she sometime it shocks her when she thinks about her husband passing from cancer being that his death was so sudden right years ago.	1. Patient will be able to share feelings with health care team about the experience of loss by 12:45pm on 10/15/20. 2. Patient will be able to participate in spiritual practices once a week by discharge.	Goals are ongoing and partially met. Patient was able to verbalize her emotions regarding the loss of her loved ones and the effect it has had on his emotional and mentally on 10/15/20 by 12:45pm. Patient stated she sees the chapel from the hospital once every day and he comes and prays with her and talks to her and that makes it feel good. Patient states through Christ all things are possible and truly believes God will help her through this. Patient was encouraged to continue to see the chapel as it seems to be improving her outlook in life. I was not there to witness the chapel speaking with the patient before 12:45pm

			on 10/15/20. Goal is still being monitored.

Other References (APA):

Ackley, B. J., Ladwig, G. B., & Makic, M. B. (2017). Nursing diagnosis handbook: An evidence-based guide to planning care (11th ed.). St. Louis, MO: Elsevier

Concept Map

SUBJECTIVE DATA

Patient stated the first time she fell at home, she does not recall how she fell. Patient states she does not recall the weeks of delirium. Patient states the last coherent thought she had was regarding the loss of her husband (due to cancer) and her son.

NURSING DIAGNOSIS/OUTCOMES

1. Risk for falls **related to** diminished mental status **as evidenced by** inability to recall or remember place or time wears glasses and hearing aids, uses walker.
- All goals were met. Patient was free from injuries and falls during shift on 10/15/20 from 7am to 12:45pm.
-All goats are met. Patient's room remained free of cluster on 10/15/20 from 7a-12:45p.

2. Complicated grief **related to** loss of loved one, change in activity **as evidence by** tearful while talking about this, states she is still in disbelief they are gone, stated she misses them deeply.
- Goal met. Patient was able to verbalize her emotions regarding the loss of her loved ones and the effect it has had on his emotional and mentally on 10/15/20 by 12:45pm.
- Patient stated she sees the chapel from the hospital once every day and he comes and prays with her and talks to her and that makes it feel good. Goal was seen being met so goal is still on going and partial met.

OBJECTIVE DATA

Patient is highly confused at time. Patient needs redirecting as she can sometimes get off topic when asked a question. Patient is on Glimepiride which increases her risk of falling. Patient's state is unstable at time. Patient is a high fall risk (12). Patient is a limited one assistant. Patient wears/ uses assistive devices like her glasses, hearing aid and front wheel walker.

Patient Information

On September 19th, 2020 an 85 year old, widowed female presented to the emergency department at OSF Urbana with his daughter for intermittent visual, auditory and tactile hallucinations and paranoia that has persisted for the last few weeks and is getting worse. Patient's family noticed that patient gets paranoid that people will hurt her. Patient's family found she is carrying a knife and her purse to protect herself.

NURSING INTERVENTIONS

1. With each encounter with the patient, explain the importance of using the call light and remind patient to call and wait on nurse before getting out of bed.

2. Guarantee appropriate room lighting, especially during the night and environment is free of cluster.

1. Patient will be able to share feelings with health care team about the experience of loss by 12:45pm on 10/15/20.

2. Patient will be able to participate in spiritual practices once a week by discharge