N431 Care Plan #3

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
10/15/2020	SW	80 y/o	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Divorced	No known allergies
Code Status	**Height**	**Weight**	
Full	154.9 cm	56.7 kg	

Medical History (5 Points)

Past Medical History: Dementia, allergic rhinitis, Alzheimer's disease, anxiety, dehydration, failure to thrive, functional dyspepsia, gastroesophageal reflux disease, hyponatremia, hypernatremia, hypocalcemia, mood disorder, muscle weakness, and vitamin deficiency.

Past Surgical History: tubal ligation

Family History: Patient is a poor historian due to Alzheimer's disease and patient can't recall history. There is no history present in patient chart.

Social History (tobacco/alcohol/drugs): Patient has no history of tobacco, alcohol, or drug use.

Assistive Devices: No assistive devices needed.

Living Situation: Patient lives at Hawthorne Inn in Danville, IL.

Education Level: Patient earned GED.

Admission Assessment

Chief Complaint (2 points): Altered mental status and lethargy

History of present Illness (10 points): When the patient was asked what brought her to the hospital, she states "I am not sick, I am just here". The following information is from the providers notes. The patient is an 80-year-old Caucasian female who has arrived at the Emergency Department by EMS on 10/15/2020. The patient lives at Hawthorne Inn in Danville, IL. The staff at Hawthorne Inn noticed, on 10/15/2020, that the patient was not "her usual self".

The staff member states that the patient is up independently and has good conversation with other residents and staff but was not responding when being spoken to. The provider noted that the patient appeared to be ill and did not respond to verbal stimuli. The patient opened eyes in response to pain. The patient Glasgow Coma Scale was 8 when arrived in the emergency department. The patient received 200 mL of fluids and there was significant improvement of the patient's mental status. A urinalysis, computed tomography scan (CT scan) of head and brain and abdomen/pelvis, ultrasound of abdomen, x-ray of chest, and electrocardiogram were ordered. The patient was diagnosed with an acute cystitis without hematuria, dehydration, and acute cholecystitis.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute cystitis without hematuria

Secondary Diagnosis (if applicable): Acute cholecystitis

Pathophysiology of the Disease, APA format (20 points): Cystitis, also known as urinary tract infection, is an infection in the bladder (WebMD, 2019). Urinary tract infections occur when a foreign microorganism is introduced the urinary tract and causes inflammation and an infection. The type of urinary tract infections depends on what part of the urinary system is infected, and these types of infection include urethritis, pyelonephritis, and cystitis (WebMD, 2019). The urethritis is an infection in the urethra and common signs and symptoms include discharge and a burning sensation when urinating" (WebMD, 2019). Pyelonephritis is an infection in the kidneys (WebMD, 2019). A few signs and symptoms for pyelonephritis can include "fever, chills, nausea, vomiting, and pain in your upper back or side" (WebMD, 2019). Cystitis is an infection in the bladder (WebMD, 2019). Signs and symptoms of cystitis include frequent urination, pain

while urinating, lower belly pain, and cloudy or bloody urine" (WebMD, 2019). Signs and symptoms of a urinary tract infection may present differently in elderly patients. For an "older adult, especially those with dementia, may experience behavior symptoms such as confusion" (McDermott, 2020), a change in mental status, and "decreased mobility" (McDermott, 2020). S.W is an 80-year-old female who has a history of dementia had an acute change in mental status and mobility. The cause of urinary tract infection includes bacteria and anatomy of urinary system. Women chances for urinary tract infection are higher than a male because their urethra is shorter and "close to the anus" (WebMD, 2019). Women, also, can introduce bacteria to the urethra by wiping back to front. The most common type of bacteria to cause and infection is Escherichia coli (Mayo Clinic, 2020). If a provider is suspecting a urinary tract infection, the test that would be order would include urinalysis, urine culture, cystoscopy, x-ray, and/or ultrasound. The patient's provider ordered a urinalysis, urine culture, x-ray, and ultrasound. The provider also ordered a computer tomography (CT) scan due to the patient's acute mental status change. The patient's urinalysis was abnormal and the findings were yellow, cloud urine, white blood cells present in urine (21-50), red blood cells present in urine (6-10), 2+ leukoesterase, trace of blood in urine, multiple bacteria present, and small amount of epithelial cells. These findings are consistent with a urinary tract infection. The urine culture was positive with more than 100,000 CFU/mL of Escherichia coli, the common type of bacteria to cause a urinary tract infection. This finding supports that the urinary tract infection is caused by Escherichia coli. The CT scan and chest x-ray did not have abnormal findings. The CT scan of abdomen pelvis with contrast and ultrasound of abdomen abnormal findings included gallstones, thickening of stomach wall, and multiple sub-centimeter cystic areas in kidneys bilaterally. Treatment for urinary tract infection include antibiotics and increase in fluids (WebMD, 2019). The patient received Rocephin and

200 mL of fluids. The patient's mental status improved significantly. The patient was then diagnosed with acute cystitis.

Two complications of cystitis include pyelonephritis and urosepsis. Pyelonephritis is when the kidneys become infected and inflamed from the bacteria causing the infection. Signs and symptoms include "fever, chills, back/side/groin pain, abdominal pain, frequent urination, burning sensation or pain when urinating, pus or blood in urine, and urine with a smell" (Mayo Clinic, 2020). If a urinary tract infection goes without treatment, the infection can be septic and enter the blood stream affecting all organ systems. "Older adults are at risk for sepsis" (Mayo Clinic, 2018). Signs and symptoms of sepsis includes a "change in mental status, a systolic pressure reading less than or equal to 100 mm Hg, and respiratory rate high or equal to 22 breaths/minute" (Mayo Clinic, 2018).

Pathophysiology References (2) (APA):

Mayo Clinic. *Cystitis.* (2020).

https://www.mayoclinic.org/diseases-conditions/cystitis/symptoms-causes/syc-20371306

Mayo Clinic. (2020). *Kidney infection*.

https://www.mayoclinic.org/diseases-conditions/kidney-infection/symptoms-causes/syc-20353387

Mayo Clinic. (2018). *Sepsis.*

https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214

McDermott, A. (2020). ***Urinary tract infections (UTIs) in older adults.***

https://www.healthline.com/health/uti-in-elderly

WebMD. ***Urinary Tract Infection (UTI): Symptoms, Causes, Treatment.*** **(2019).**

https://www.webmd.com/women/guide/your-guide-urinary-tract-infections#1

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	Today's Value	Reason for Abnormal Value
RBC	3.5-5.20	4.95	3.86	
Hgb	Female: 12-16 Male: 14-18	14.5	11.5	Pagana (2019) states that Hgb decreases due to "nutritional deficiency" (p.489)
Hct	Female: 37%-47% Male: 42%-52%	42.3	32.6	Pagana (2019) states that Hct decreases due to "nutritional deficiency" (p.489)
Platelets	140-400	230	2196	
WBC	4-11	6.0	6.2	
Neutrophils	55%-70%	54.4%	59.0%	Pagana (2019) states that neutrophils can increase due to "inflammatory disorder" (p.977)
Lymphocytes	20%-40%	32.8%	26.8%	
Monocytes	2%-8%	9.4%	10.2%	Pagana (2019) states that monocytes can increase due to "fighting bacteria" (p.975)
Eosinophils	1%-4%	2.7%	3.2%	
Bands				

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145	141	144	
K+	3.5-5.0	4.0	3.9	
Cl-	98-106	106	114	Pagana (2019) states that chloride can be increased due to "excessive infusion of normal saline" (p.234)
CO2	23-30	27	24	
Glucose	74-106	107	89	Pagana (2019) states that glucose can be increased due to "acute stress response" (p.464) Pagana (2019) states that glucose levels for elderly adults can range from "82-115" (p.462).
BUN	10-20	23	14	Pagana (2019) states that BUN can be increased due to "dehydration" (p.156).
Creatinine	0.6-1.2	1.0	0.80	
Albumin	3.5-5.5	3.6		
Calcium	9-10.5	9.1	8.0	Pagana (2019) states that calcium can be decreased due to a "vitamin D deficiency" (p.191).
Mag	1.3-2.1	2.0	1.7	
Phosphate				
Bilirubin	0.3-1.0	0.3		
Alk Phos	30-120	77		

AST	**0-35**	**16**		
ALT	**4-36**	**13**		
Amylase				
Lipase	**0-160**	**55.4**		
Lactic Acid	**0.6-2.2**	**1.3**		
Troponin	**<0.03**	**0.03**		
CK-MB				
Total CK		**24**		

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	Today's Value	Reason for Abnormal
INR				
PT				
PTT				
D-Dimer				
BNP				
HDL				
LDL				
Cholesterol				
Triglycerides				
Hgb A1c				
TSH				

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	Today's Value	Reason for Abnormal
Color & Clarity	Clear, yellow	Cloudy, yellow		
pH	4.6-8	6.0		
Specific Gravity	1.005-1.030	1.025		
Glucose	Negative	Negative		
Protein	Negative	Negative		
Ketones	Negative	Negative		
WBC	0-4	21-50		Pagana (2019) states that WBC can be increased due to "bacterial infection in urinary tract" (p.944)
RBC	<2	6-0		Pagana (2019) states that AST can be increased due to "cystitis" (p.944)
Leukoesterase	Negative	2+		Pagana (2019) states that a "possible urinary tract infection" can leukoesterase to be present in urine (p.942).

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	Today's Value	Explanation of Findings
pH				
PaO2				
PaCO2				
HCO3				
SaO2				

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	Today's Value	Explanation of Findings
Urine Culture	**No growth**	**Greater than 100,00 CFU/mL Escherichia coli**		**Pagana (2019) states that "bacteria growth greater than 100,00 CFU/mL indicates a urinary tract infection" (p.948).**
Blood Culture				
Sputum Culture				
Stool Culture				

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 (5 points):

Computed tomography (CT) scan of head and brain without contrast: Performed on 10/15/2020. The findings include marked cerebral and cerebellar atrophy and white matter ischemic changes. There is no acute ischemic infarction or intracranial hemorrhage.

X-ray of chest single view: Performed on 10/15/2020. The findings include calcified granuloma in left base and left hilum of lungs. No acute disease noted.

Computed tomography (CT) scan of pelvis with contrast: Performed on 10/15/2020. The findings include multiple gallstones and thickening of the stomach wall. Thickening of stomach wall may be related to gastritis. Multiple sub centimeter cystitis in kidney's bilaterally. Endometrial fluid collection in uterus. There is no free air or small bowel obstruction noted.

Ultrasound of abdomen: Performed on 10/15/2020. The findings include that the gallbladder contained multiple gall stones with shadowing. WES sign. There was mild thickening to the gallbladder wall without pericholecystic fluid collection.

Electrocardiogram: Performed on 10/15/2020. The findings include sinus bradycardia with sinus arrhythmias.

Diagnostic Test Correlation (5 points):

Ultrasound of abdomen: An ultrasound of the abdomen gives a good visual of kidneys, ureters, and bladder (Pagana et al, 2019). This procedure is to identify if there is any underlying condition that is causing the patient to have altered mental status. This procedure did find multiple gallstones with in the gallbladder and that there was thickening of the gallbladder without pericholecystic fluid collection.

Xray chest: A chest x-ray is a "complete evaluation of the pulmonary and cardiac systems" (Pagana et al., 2019, p.227). This allow the provider to assess the function to find any underlying causes that could be potentially causes altered mental status.

CT scan abdomen and pelvis: A CT scan of the abdomen is a noninvasive procedure that provides a good visual of "tumors, cysts, abscesses, inflammation, perforation, bleeding, obstructions" (Pagana et al., 2019, p.272) and to support urinary tract infection diagnosis or supporting a different condition. This procedure found multiple cystic areas in both kidney's and found that there were multiple gallstones present in gallbladder.

CT scan of head/brain: A CT scan of head/brain gives an analysis of brain tissue. This was performed to find any underlying cause for altered mental status.

Electrocardiogram: The electrocardiogram is a “graphic representation of the electrical impulses that the heart generation during the cardiac cycle” (Pagana et al., 2019, p.342). This is used to identify any abnormalities (Pagana et al., 2019, p.344).

Diagnostic Test Reference (APA):

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

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

Home Medications (5 required)

Brand/Generic	Aleve Naproxen Sodium	Aricept Donepezil hydrochloride	Zyprexa Olanzapine	Imodium Loperamide	Ativan Lorazepam
Dose	440 mg	5 mg	2.5 mg	2 mg	0.25 mg
Frequency	BID, PRN	Nightly	Daily	QID, PRN	Nightly
Route	PO	PO	PO	PO	PO
Classification	Naproxen Sodium is an “analgesic, anti-inflammatory, antipyretic” (Jones & Bartlett Learning, 2019, p.842).	Donepezil hydrochloride is an “antidementia” (Jones & Bartlett Learning, 2019, p.363).	Olanzapine is an “antipsychotic” (Jones & Bartlett Learning, 2019, p.886) medication.	Loperamide is an “antidiarrheal” medication (Drugs.com, 2020)	Lorazepam is an “amnestic, antianxiety, anticonvulsant, sedative” (Jones & Bartlett Learning, 2019, p.720) medication
Mechanism of Action	Naproxen Sodium “relives pain” (Jones & Bartlett Learning, 2019, p.842).	Donepezil hydrochloride “raises acetylcholine level in the cerebral cortex may improve	Olanzapine "antagonizing dopamine and serotonin receptors” (Jones & Bartlett	Loperamide “slows the rhythm of digestion so that the small intestines have more	Lorazepam “inhibits excitatory stimulation which helps control emotional behavior”

		cognition" (Jones & Bartlett Learning, 2019, p.364).	Learning, 2019, p.886).	time to absorb fluid and nutrients from the foods you eat" (Drug.com, 2020)	(Jones & Bartlett, 2019, p.721).
Reason Client Taking	Pain	Dementia	Mood disorder	Diarrhea	Anxiety
Contraindications (2)	Two contraindications of Naproxen Sodium are "asthma and rhinitis" (Jones & Bartlett Learning, 2019, p. 842).	Two contraindication of Donepezil hydrochloride are "hypersensitivity to donepezil and hypersensitivity to piperidine derivatives" (Jones & Bartlett Learning, 2019, p.364)	Two contraindications of Olanzapine are "hypersensitivity to olanzapine and hypotension" (Jones & Bartlett Learning, 2019, p.886).	Two contraindications of Loperamide are "ulcerative colitis" (Drug.com, 2020) and a hypersensitivity to loperamide	Two contraindications of Lorazepam include "hypersensitivity to lorazepam and psychosis" (Jones & Bartlett Learning, 2019, p.721).
Side Effects/Adverse Reactions (2)	Side effects of Naproxen sodium "ecchymosis and thrombocytopenia" (Jones & Bartlett Learning, 2019, p.843).	Side effects of Donepezil include "bradycardia and hypotension" (Jones & Bartlett Learning, 2019, p.364)	Side effects of Olanzapine include "bradycardia and urinary tract infection" (Jones & Bartlett Learning, 2019, p.887).	Side effects of Loperamide include "stomach pain and watery or bloody diarrhea" (Drugs.com, 2020).	Side effects of Lorazepam include "constipation and abdominal pain" (Jones & Bartlett Learning, 2019, p.721).
Nursing Considerations (2)	To prevent further dehydration "Rehydrate	When taking this medication, the nurse	When this medication is being administered	When this medication is being administered	When giving this medication, the nurse

	the patient prior to giving this medication" (Jones & Bartlett Learning, 2019, p.844) In elderly adults, encourage short term use of this medication. "Long term use can lead to serious GI reactions" (Jones & Bartlett Learning, 2019, p.844)	should "monitor heart rate and rhythm for bradycardia" (Jones & Bartlett, 2019, p.364) When this medication is being administered, "take safety precautions if patient is dizzy" (Jones & Bartlett Learning, 2019, p.364).	, the nurse should "monitor blood pressure routinely" (Jones & Bartlett Learning, 2019, p.888) because it can cause orthostatic hypotension. The nurse should "monitor for tardive dyskinesia" (Jones & Bartlett, 2019, p.888).	, the nurse should encourage "plenty of fluids" (Drugs.com, 2020) to prevent dehydration. If a chewable tablet is chewed, "the tablet should be taken on an empty stomach 2 hour or 2 hours before a meal" (Drugs.com, 2020).	should make sure a patient with depression should "already take an antidepressant, because of the increase of suicide in patient with untreated depression" (Jones & Bartlett Learning, 2019, p.721) A nurse should "use extreme caution when giving lorazepam to elderly patients" (Jones & Bartlett, 2019, p.721). This medication can cause unsteadiness.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	In elderly adults, "monitor BUN and serum creatinine" (Jones & Bartlett Learning, 2019, p.844)	Assess "heart rate and rhythm" (Jones & Bartlett Learning, 2019, p.364) when giving this medication	The nurse may monitor "glucose levels, CBC, and lipids" (Jones & Bartlett, 2019, p.888).	The nurse should assess the last time the patient had a bowel movement before administer medication.	A nurse should assess respiratory rate prior to administration of medication to prevent "respiratory

					depression" (Jones & Bartlett Learning, 2019, p.722)
Client Teaching needs (2)	It is important to educate the patient to take this medication "with food to reduce GI distress" (Jones & Bartlett Learning, 2019, p.844) It is important to educate this patient to drink "a full glass of water and to remain upright for 15 to 30 minutes to prevent dislodging in esophagus" (Jones & Bartlett Learning, 2019, p.844).	Instruct the patient "to take donepezil just before going to bed" (Jones & Bartlett, 2019, p.364) Instruct the patient this medication can be taken "with or without food" (Jones & Bartlett, 2019, p.364)	The nurse should "instruct the patient to change positions slowly" (Jones & Bartlett, 2019, p.889). Instruct the family and patient to "report persistent, severe, or worsening adverse reactions, including fever, rash, or swollen glands or changes in body function" (Jones & Bartlett, 2019, p. 889)	Educate the patient to "avoid drinking tonic water" (Drugs.com, 2020). Educate the patient that loperamide is ordered as needed/	Instruct the patient to "not stop without consulting prescriber because of the risk of withdrawal" (Jones & Bartlett Learning, 2019, p.722). Instruct the patient to "report excessive drowsiness and nausea" (Jones & Bartlett Learning, 2019, p.722).

Hospital Medications (5 required)

Brand/Generic	Tylenol Acetaminophen	Lovenox Enoxaparin sodium	Rocephin Ceftriaxone sodium	Zofran Ondansetron hydrochloride	Seroquel Quetiapine fumarate
Dose	650 mg	40 mg	1 mg	4 mg	25 mg
Frequency	Q4 hours, PRN	Q24 hours	Q24 hours	Q12 hours, PRN	Nightly
Route	PO	SUBQ	IV	IV	PO
Classification	Acetaminophen is an "antipyretic, nonopioid analgesic" (Jones & Bartlett Learning, 2019, p.12).	Antithrombotic	Ceftriaxone sodium is an "antibiotic" (Jones & Bartlett Learning, 2019, p.216)	Ondansetron hydrochloride is an "antiemetic" (Jones & Bartlett Learning, 2019, p.900)	Quetiapine fumarate is an "antipsychotic" (Jones & Bartlett Learning, 2019, p.1042)
Mechanism of Action	Acetaminophen "interferes with pain impulse generation in the peripheral nervous system and acts directly on temperature-regulating center in the hypothalamus" (Jones & Bartlett Learning, 2019, p.13)	Prevents blood clotting by binding to the clotting factor to prevent activation. fibrinogen cannot convert to fibrin	Ceftriaxone sodium "interferes with bacterial cell wall synthesis by inhibiting cross-linking of peptidoglycan strands" (Jones & Barlett Learning, 2019, p.216) which results in cellular death.	Ondansetron "reduces nausea and vomiting by preventing serotonin release in the small intestine" (Jones & Bartlett Learning, 2019, p.901).	Quetiapine "produce antipsychotic effects by interfering with dopamine binding to dopamine type 2 receptor sites in the brain" (Jones & Bartlett Learning, 2019, p.1043)
Reason Client Taking	Pain	To prevent blood clotting	To treat UTI	Nausea and vomiting	Mood disorder
Contraindications (2)	Two contraindications for	Hypersensitivity to enoxaparin	Two contraindications for	Two contraindications for	Two contraindications for

	acetaminophen include "hypersensitivity to acetaminophen and severe hepatic impairment" (Jones & Bartlett Learning, 2019, p.13).	Hypersensitivity to pork products	ceftriaxone sodium include "hypersensitivity to ceftriaxone sodium and hypersensitivity to penicillin's" (Jones & Bartlett Learning, 2019, p.217)	ondansetron include "hypersensitivity to ondansetron and congenital long QT syndrome" (Jones & Bartlett Learning, 2019, p.901).	quetiapine include "hypersensitivity to quetiapine and taking antibiotics such as gatifloxacin and moxifloxacin" (Jones & Bartlett Learning, 2019, p.1043).
Side Effects/Adverse Reactions (2)	Two side effects of acetaminophen "constipation and hypotension" (Jones & Bartlett Learning, 2019, p.13).	Bloody stools Dyspnea	Two side effects of ceftriaxone sodium includes "abdominal cramps and headaches" (Jones & Bartlett Learning, 2019, p.217)	Two side effects of ondansetron include "abdominal pain and urticaria" (Jones & Bartlett Learning, 2019, p.901).	Two side effects of quetiapine include rhinitis and constipation" (Jones & Bartlett Learning, 2019, p. 1044).
Nursing Considerations (2)	A nurse should monitor for "signs of hepatotoxicity such as bleeding, easy bruising, and malaise" (Jones & Bartlett Learning, 2019, p.14) The nurse should "ensure that	A nurse should monitor for bleeding and implement bleeding precautions The nurse should keep protamine sulfate at bedside	The nurse should "protect powder from the light" (Jones & Bartlett Learning, 2019, p.217) The nurse should mix 10 ml of normal saline to inject into the IV.	The nurse should assess the patient for "serotonin syndrome, which include chills, confusion, diaphoresis, diarrhea, fever" (Jones & Bartlett Learning, 2019, p.901). The nurse	The nurse should monitor patient closely for "suicidal tendencies" (Jones & Bartlett Learning, 2019, p.1044). The nurse should "institute fall precautions because

	the daily dose of acetaminophen from all sources does not exceed maximum daily limits" (Jones & Bartlett Learning, 2019, p.14)			should "monitor for signs and symptoms of hypersensitivity reactions including anaphylaxis and bronchospasm" (Jones & Bartlett Learning, 2019, p.901).	patients receiving quetiapine have a greater risk of falling" (Jones & Bartlett Learning, 2019, p.1044).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	A nurse should "monitor renal function in patients on long-term therapy" (Jones & Bartlett Learning, 2019, p.14).	Monitor platelet level and notify provider if platelet count is below 100,000. Monitor potassium level	The nurse should "assess for superinfection such as diarrhea" (Jones & Bartlett Learning, 2019, p.218). The nurse should "asses the patient's bowel patterns daily" (Jones & Bartlett Learning, 2019, p.218)	The nurse should monitor potassium and magnesium to prevent "increasing risk for QT interval prolongation" (Jones & Bartlett, 2019, p.901).	The nurse should monitor blood pressure
Client Teaching needs (2)	Instruct the patient that "tablets may be crushed or swallowed whole" (Jones & Bartlett Learning, 2019, p14).	Educate patient that he may bleed or bruise easily when taking enoxaparin (Jones & Bartlett Learning, 2019).	Instruct the patient to "report evidence of blood or dyscrasia" (Jones & Bartlett Learning, 2019, p.218)	Instruct the patient to "Immediately report signs of hypersensitivity, such as rash" (Jones & Bartlett Learning, 2019, p.902).	Instruct the patient "to take quetiapine with food to reduce stomach upset" (Jones & Bartlett Learning, 2019,

	The nurse should also assess when Hydrocodone-acetaminophen was last given.	Educate patient that he is at risk for bleeding and to notify is he experience any unusual bleeding (Jones & Bartlett Learning, 2019).	Educate the patient signs and symptoms of hypersensitivity reactions like "rash, itching skin, or hives" (Jones & Bartlett Learning, 2019, p.218)	The nurse should monitor if symptoms get better or worsen.	p.1045). Instruct the patient "not to stop quetiapine suddenly because doing so may exacerbate her symptoms" (Jones & Bartlett Learning, 2019, p.1045.

Medications Reference (APA):

Drugs.com. (2020). ***Imodium: Uses, Dosage & Side Effects.***

https://www.drugs.com/imodium.html

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** alert x2 **Orientation:** orient to place, person, and time. However, the patient has dementia and does not always recall memory. **Distress:** appears to be in no distress **Overall appearance:** well and appropriate.	
INTEGUMENTARY (2 points): **Skin color:** pink **Character:** dry and intact **Temperature:** warm, temperature between 97.1-97.5 F **Turgor:** rapid recoil, less than 3 seconds	

Rashes: no rashes or lesions noted **Bruises:** bruises are present on abdomen and arms from injections and blood draws **Wounds:** no wounds present **Braden Score: 13** **Drains present: Y☐ N ☒** **Type:**	
HEENT (1 point): **Head/Neck:** Normocephalic, no swollen lymph nodes noted. Carotid pulses present bilaterally. Trachea is midline. **Ears:** External ears appear to be clean with no drainage or erythema. **Eyes:** Eyelids clean, no drainage or crust present. Sclera is white. Conjunctiva is pink and moist. PERRLA and EOM's intact. Pt does not wear glasses for corrective vision. **Nose:** Septum is midline, sinuses nontender to palpitation. Membranes are pink and moist. No nasal drainage. **Teeth:** Patient has upper and lower dentures.	**Patient denies any pain in HEENT. Patient has tattoos on both arms, back, neck, and chest.**
CARDIOVASCULAR (2 points): **Heart sounds:** S1 and S2 noted, no presence of S3 or S4. PMI present. No gallops or murmurs. **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** Sinus bradycardia with sinus arrhythmia (EKG results on 10/15/2020). The patient was not on cardiac monitoring during this admission. **Peripheral Pulses:** all pulses are 2+ and present bilaterally **Capillary refill:** less than 2 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**Heart rate 67-72 bpm**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character:** Clear lung sounds bilaterally. No crackles, wheezes, or rubs.	**Patient denies any dyspnea or shortness of breath at rest or during activity.**

GASTROINTESTINAL (2 points): **Diet at home:** Regular **Current Diet:** Regular **Height:**154.9 cm **Weight:** 56.7 kg **Auscultation Bowel sounds:** All bowel sounds are normoactive in all four quadrants. **Last BM:**10/18/2020 **Palpation: Pain, Mass etc.:** No pain with palpation. No CVA tenderness. Abdomen is soft to palpation. **Inspection:** No presences of masses or organomegaly. **Distention:** No distention **Incisions:** Three incisions from the laparoscopic cholecystectomy **Scars:** small scar from tubal ligation **Drains:** no drains present **Wounds:** no wounds **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Patient denies any nausea, vomiting, or diarrhea. No blood in urine or stool. Patient rates pain during palpation 0/10.**
GENITOURINARY (2 Points): **Color:** yellow **Character:** cloudy, no odor **Quantity of urine:** good urine output. Patient voided X4 **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** Genitals clean. Excoriation of perineal area. Barrier cream is applied after perineal care. **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Patient denies any difficulty with urinating. No flank pain present.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** Alert and oriented to person, place, and time **ROM:** good ROM, completed range of motion independently. **Supportive devices:** no supportive devices needed	

Strength: strength is 5+ in all limbs, within normal limits **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 60 **Activity/Mobility Status:** Up with one assist with gait belt and walker. **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☒ **Needs support to stand and walk** ☐	**The patient needs help with dressing and toileting.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** to person, place, and time **Mental Status:** alert, within normal limits **Speech:** normal and clear **Sensory:** intact, follows commands, within normal limits **LOC:** alert and oriented	**The patient has a history of Alzheimer's disease and dementia. She has moments of confusions. She is a poor historian at times. She is alert and answers questions appropriately.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** Patient is accepting and cooperative with staff. **Developmental level:** appropriate developmental level **Religion & what it means to pt.:** Patient states "I am Christian and that's what it means" **Personal/Family Data (Think about home environment, family structure, and available family support):** Patient lives at Hawthorne Inn in Danville IL. Her son is her legal guardian. Her son states "the staff at Hawthorne take good care of her and know her really well".	.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1320	67	120/58	18	97.1 F	98% RA
1530	72	122/64	18	97.5 F	97% RA

Vital Sign Trends: Vital signs were in normal range, the diastolic of her first blood pressure was slightly under normal range, but not unstable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1320	0	NA	NA	NA	NA
1530	0	NA	NA	NA	NA

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:22 g **Location of IV:** lateral side of right arm **Date on IV:**10/18/2020 **Patency of IV:** patent, infusing without difficulty **Signs of erythema, drainage, etc.:** no erythema or drainage present. **IV dressing assessment:** dry and intact	Normal Saline running at 100 mL/hour. • 1215-1539 → 340 mL of Normal Saline fluids

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
200 mL – PO **240 mL – PO** **340 mL - IV**	**BM – 0** **Void x4**

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was waiting for COVID results before discharging. The patient finished IV fluids. Vital signs were performed. The patient ambulated in room. Up to bathroom. Son is at bedside.

Procedures/testing done: No procedures or test completed during shift

Complaints/Issues: No complaints or issues.

Vital signs (stable/unstable): Vital signs are stable

Tolerating diet, activity, etc.: Patient can bear weight and ambulate without support from staff member. The patient is up with a gait belt and walker. The patient is on a general diet. The patient is incontinent but can identify the urge to urinate. The patient is encouraged to call for assistance to help ambulate to bathroom as soon as the urge to urinate is present.

Physician notifications: None

Future plans for patient: Patient is going to discharge to Hawthorne Inn today. The plans for this patient is to encourage independence with self-care and providing teaching to help prevent infection.

Discharge Planning (2 points)

Discharge location: Patient is discharging to Hathorne Inn in Danville, IL.

Home health needs (if applicable): No home health needs

Equipment needs (if applicable): No equipment needed.

Follow up plan: The patient is discharging to Hawthorne Inn. The facility will set an appointment with primary care provider within one week.

Education needs: The patient is up independent at facility. The patient is encouraged to continue to ambulate to the bathroom to void and pass bowel movement. This will help reduce the risk of recurrent urinary tract infection. Proper perineal care teaching is provider as well. The patient had an acute cystitis that was caused by Escherichia coli which is a common bacterium found in the gastrointestinal tract. The patient was educated to wipe from front to back.

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. Infection related to improper toileting as evidence by mental status change, bacteriuria, presence of WBC and RBC in urine	**This nursing diagnosis is chosen because the patient was admitted and being treated for urinary tract infection**	**1. Educate and encourage to urinate every 2 hours** **2. Encourage the patient to increase fluid intake to 2-3 liters of fluids each day**	**The patient was accepting to these nursing interventions. The patient states that she probably will not drink 2 to 3 liters of water a day because she has a tiny bladder but will do her best. The patient was able to ambulate and use the bathroom (voided once). The patient finished 240 mL of water**
2. Acute confusion related to over the age of 60	**This nursing diagnosis is chosen because the patient has a**	**1. Cluster care to allow for appropriate sleep**	**The patient was accepting to the interventions set in place. The nurse and I**

and dementia as evidenced by patient stating "I'm not sick, I am just here"	**history of dementia and Alzheimer's disease. The patient has confusion throughout the day but is easy to reorient. Her risk for infection is high and can cause further confusion**	**2. Give patient simple directions and allow time for the patient to respond.**	**were able to complete assessment and toileting to allow the patient to rest before discharge. The patient was able to get a few hours of rest before discharge. When providing discharge instructions, the nurse and I were able to give her simple directs and she responded appropriately.**
3. Impaired urinary elimination related to urination frequency and urgency as evidence by incontinence due to decreased mobility and has had 3 incontinence episodes	**This nursing diagnosis is chosen because the patient has been incontinent during this hospital stay. The facility that the patient lives at states that she is up independently. With a decrease in mobility and frequent urination, incontinence is a risk for her and can cause an infection and skin break down.**	**1. Provide proper perineal care** **2. Apply barrier cream to prevent skin break down from the urines acidity**	**The patient was accepting to these nursing interventions. The patient received proper perineal care after incontinence and barrier cream was applied to precent further skin break down. The patient has some excoriation to perineal area and the goal is that the excoriation will not get worse.**
4. Deficient knowledge related to unfamiliarity to urinary tract infection as evidenced by the patient not asking questions	**This nursing diagnosis was chosen because the patient was not involved in her care during my clinical. When the patient was asked about**	**1. Educate the patient about urinary tract infections, risk factors, and prevention.** **2. Teach the**	**The patient acknowledges the teaching about urinary tract infection, risk factors, and prevention. She understands that she is at risk for UTIs because of her gender and inability to properly clean perineal**

about infection	**perineal care the patient states "I just wipe". The patient is at risk for another urinary tract infection and needs further educated.**	**patient proper perineal hygiene**	**area. She was attentive when I was teaching proper perineal hygiene. The patient was able to identify that she was at risk for reoccurring the patient was able to teach back the proper steps to perineal hygiene.**

Other References (APA):

Swearingen, P.L., & Wright, J. D. (2019). ***All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health.*** **St. Louis, MO: Elsevier.**

Concept Map (20 Points):

Subjective Data

The patient was unresponsive to staff at Hawthorne Inn. Unable to collect data from the patient. Appeared to arrive with altered mental status.

Nursing Diagnosis/Outcomes

Infection the patient will urinate q2 hours and increase fluids to flush bacteria from urethra and prevent infection
Acute confusion the nursing staff will cluster care, give simple directions, and allow the patient to respond. This will allow the patient to get adequate rest and to fully understand task and information that is being provided.
Impaired urinary elimination the nursing staff will provide proper perineal care and apply barrier to prevent further skin breakdown from impaired urine elimination.
Deficient knowledge the patient is provided education about urinary tract infections and how to perform proper perineal care. The patient will teach back information about urinary tract infection and the proper perineal care to help reduce her risk of urinary tract infection.

Objective Data

Did not respond to verbal stimuli
Glasgow scale = 8
Urinalysis WBC -12-50, RBC 6-10, Leukoesterase 2+, cloudy, trace of blood in urine, bacteria present in urine.
Urine culture greater than 100,000 CFU/mL of Escherichia coli.
BUN: 23

Patient Information

80-year-old female with a history dementia, allergic rhinitis, Alzheimer's disease, anxiety, dehydration, failure to thrive, functional dyspepsia, gastroesophageal reflux disease, hypocalcemia, hypercalcemia, mood disorder, muscle weakness, vitamin deficiency, infective urethritis, encephalopathy, and acute metabolic encephalopathy. She arrived in the emergency department on 10/15/2020 and diagnosed with acute cystitis and cholecystitis.

Nursing Interventions

Infection toilet Q2 hours and increase fluids to 2-3 L/day
Acute confusion cluster care, give simple direction, and allow time for patient to ask questions and understand what task are being performed
Impaired urinary elimination provide proper perineal care when incontinent and apply barrier cream to prevent skin break down
Deficient knowledge educate the patient about urinary tract infections, causes, and preventions. Educate the patient how to perform proper perineal care independently.

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