N311 Care Plan #4

Lakeview College of Nursing

Anita Wilson

Demographics

Date of Admission	**Patient Initials**	**Age**	**Gender**
1014/2020	J.C.	10/1/1937 (83 years old)	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Black or African American	Retried	Single	No known allergies
Code Status	**Height**	**Weight**	**Assistive Device**
Full	5’5”	114 pounds (18.97 kg) BMI: 27.8	Walker
Primary Language	**Religion**		
English	Christian		

Medical History

Past Medical History:

Patient has a medical history of the following: carcinoma, hypertension, arthritis, asthma, congestive heart failure, COPD, diabetes mellitus, thyroid disease, malnutrition, urinary tract infection, lactic acidosis, c. diff. colitis and stroke.

Past Surgical History:

Colon surgery, appendectomy, biopsy of skin lesion, breast surgery, cardiac surgery procedure, exploratory of the abdomen, gastrectomy, joint replacement, kidney surgery, mastectomy, tonsillectomy, vascular surgery procedure, inguinal hernia repair

Family History:

No known family history; patient is unable to provide history due to poor memory.

Social History (tobacco/alcohol/drugs):

Patient denies alcohol consumption. Patient confirms that he smokes marijuana “occasionally”. Patient smokes cigarettes at least a pack a day. Patient states he is not ready to quit yet.

Admission Assessment

Chief Complaint:
Fall at home and unable to get up; concern for safety

History of present Illness:

J.C. is a 83 year old male who presented to the emergency department with complaints of falling at home and being unable to get up. Per report, patient was checked on by a neighbor and found in his bathtub at home, had apparently been unable to get up and had been lying in his bathtub since yesterday afternoon. Patient states that he lives alone, and falls all the time. Patient uses a walker for ambulation at home. He denies any past medical history aside from having cancer in his stomach that was removed a couple years ago. Patient states he does not take any medications at home, and has not seen a provider outpatient in a couple of years. He is a daily smoker, unsure of how much he smokes per day. Patient denies ETOH abuse or recreational drug use. States he has four children, but they do not live here and he does not want any of them called after asking him multiple times. Aside from not being able to get out of his tub and verbalizing multiple falls at home that occur frequently. Patient denies symptoms of fever, nausea, abdominal pain. When asked what year it is, patient stated “202” multiple times. He is otherwise able to provide his known medical history and how he was unable to get out of his tub since yesterday afternoon and has not eaten since. Patient does mention that a neighbor comes and checks on him every day. Patient’s neighbor heard shouting from his house and contacted the police. Patient’s neighbor also checked in on him and found him in his bathtub at home and found feces all over the house. Patient has not apparently evicted by his landlord as patient does not paying power and water bills because of which he does not have these services at home and there are feces all over the house.

Primary Diagnosis

Primary Diagnosis on Admission: Sepsis

Secondary Diagnosis: Fall

Pathophysiology of the Disease, APA format: Hypertension

Hypertension is the elevation of blood pressure to values that are correlated with cardiovascular damage. It is called the silent killer because it has no symptoms and can lead to fatal. It has been established that hypertension exists when two or more diastolic blood measurements on at least two or more clinical visits are 80 mm Hg or greater, or when the systolic blood pressure readings on two or more clinical visits are consistently 130 mm Hg or greater. Higher blood pressure is necessary in older adults for blood to reach the brain and other organs. As adults age, blood vessels become less elastic and stiffer, which physiologically raises blood pressure. Organ circulation requires higher pressure in older age adults. Therefore, the baseline recommendation for blood pressure for older adults is higher than older adults. Hypertension is one of the most common worldwide diseases (Capriotti, 2020). This is because of morbidity and mortality and the cost to society, it is an important public health challenge. Primary hypertension accounts for 90% to 95% of adult cases; a small percentage of patients have a secondary cause (Remick, 2007). Primary hypertension has no known cause. Secondary hypertension is a side effect of another systemic disorder such as Cushing's disease, kidney disease and hyperaldosteronism. Risk factors for hypertension is age, African American ethnicity, family history, obesity, diabetes mellitus, tobacco use, sedentary behavior, insufficient potassium in diet and excess alcohol. Hypertension has two negative effects on the cardiovascular system. It exerts high damaging forces against all the endothelial linings of the arteries. It also causes high resistance against the hearts left ventricle. Blood pressure in the aorta

is elevated when there is hypertension in the systemic arteries. High aortic pressure places an excessive work load on the heart's left ventricles, raising the intramyocardial wall tension in the ventricular muscle (Capriotti, 2020). Over time, this results in left ventricular hypertrophy as the muscle works harder to eject blood into the aorta. The enlarged left ventricle develops into a prominent muscle that requires increased circulation and oxygen. However, the coronary blood flow available is inadequate for the enlarged ventricular muscle. The enlarge left ventricle, which hypertrophied because of hypertension, becomes susceptible to ischemia, infraction and heart failure. Hypertension is silent, gradual process that most commonly has no symptoms until is causes dysfunction. The target organs of hypertension are the heart, brain, extremities, retina and kidney. Symptoms of chest pain, dyspnea on exertion, palpitations, headache, vision problems, dizziness, leg pain and edema. The patient should also be asked about diet, physical activity, smoking. Foods that are high in saturated fat and salt such as fast food and processed food raise blood pressure. Diagnostic evaluation of hypertension should rules out any potential causes of elevated blood pressure and determine if there is any target organ damage. Testing includes a ECG, urinalysis, CBC, blood glucose, serum potassium and BUN. Treatment is usually is diet, stress reduction, physical activity, smoking cessation and pharmacological treatment. Complications that could arise from hypertension is damage to the organs, heart, retina, kidney, brain and arteries if not well controlled. This relates to my patient because he has a history of hypertension due to smoking, food choice of diet and decreased physical activity and stress.

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.

Remick, D. G. (2007). Pathophysiology of Sepsis. *The American Journal of Pathology*, *170*(5), 1435–1444. https://doi.org/10.2353/ajpath.2007.060872

Laboratory Data

COMPLETE BLOOD COUNT

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RED BLOOD CELLS (carry oxygen)	M: 4.7-6.1	4.09	4.03	
HEMOGLOBIN (oxygen-carrying protein in RBCs)	M: 13.8-17.2	**12.6**	**12.3**	Patient has a history of chronic kidney disease. Healthy kidneys produce a hormone called EPO. EPO prompts the bone marrow to make RBCs, which then carry oxygen throughout the body. When the kidneys are disease or damaged, they do not make enough EPO. As a result, the bone marrow makes fewer RBCs causing anemia.
HEMATOCRIT (the proportion of RBCs to the fluid component, plasma in your blood)	M: 41-50	**37.5**	**37.0**	Patient has a history of chronic kidney disease. Healthy kidneys produce a hormone called EPO. EPO prompts the bone marrow to make RBCs, which then carry oxygen throughout the body. When the kidneys are disease or damaged, they do not make enough EPO. As a result, the bone marrow makes fewer RBCs causing anemia.
PLATELETS (help with blood clotting)	150,000-450,000	306,000	**491,000**	Infections are the most common cause of an elevated platelet.
WHITE BLOOD CELLS (fight infection)	4,000-10,000	**11,500**	**11,100**	Smoking; When you smoke, the number of white blood cells (the cells that defend your body from infections) stays high. This is a sign that your body is under stress, constantly fighting against the inflammation and damage caused by tobacco.
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	**83.5**	**62.3**	Neutrophils are the primary white blood cells that respond to a bacterial infection. The most common cause of marked neutrophilia is a bacterial infection. Neutrophils react within an hour of tissue injury and are the hallmark of acute inflammation.
LYMPHOCYTES (B cells: produce antibodies to attack bacteria T-cells: kill infected cells	20-40	**10.7**	28.3	Severe or chronic low counts can indicate a possible infection or other significant illness.
MONOCYTES	2-8	5.4	7.9	

(fight infection; help remove dead tissues; destroy cancer cells)				
EOSINOPHILS (participating in immediate allergic reactions)	1-4	**0.1**	**0.6**	An abnormally low eosinophil count can be the result of intoxication from alcohol or excessive production of cortisol, like in Cushing's disease. Cortisol is a hormone naturally produced by the body. Low eosinophil counts may also be due to the time of day. This patient has a history Cushing disease.
BANDS (immature form of neutrophils; produced in excess during infection to help fight disease)	3-7	N/A	N/A	

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	143	139	
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	**3.2**	4.3	
Cl- (helps keep the amount of fluid inside and outside of your cells in balance; maintain blood volume, BP and pH)	95-105	104	104	

CO2 (regulates the pH of blood, stimulates breathing, and influences the affinity hemoglobin has for oxygen)	23-30	27	25	
Glucose (for energy)	70-110	104	101	
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	**21**	**24**	Patient is dehydrated.
CREATININE (to be filtered and eliminated in urine)	0.6-1.5	0.95	0.83	
ALBUMIN (helps keep fluid in your bloodstream so it doesn't leak into other tissues)	3.5-5.0	3.6	3.8	
CALCIUM (stored in bones and teeth; supports structure; carries massages between the brain and body parts)	8.5-10.0	9.6	9.1	
MAGNESIUM (required for energy production)	1.5-2.5	1.6	2.0	
PHOSPHATE (build and repair bones and teeth, help nerves function, and make muscles contract)	2.8-4.5	N/A	N/A	
BILIRUBIN (orange-yellow pigment that occurs normally when part of your red blood cells break down)	0-0.3	0.1	0.3	

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	37	44	

Urinalysis

Lab Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Reason for Abnormal** *An updated urinalysis was not administered to this patient, besides the one taken upon admission to the ED on 10/14/20.*
COLOR & CLARITY	Colorless-Yellow, Clear	**Hazy/ Yellow**		Dehydration
pH	6-8.0	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	1.021		
GLUCOSE	Negative	Negative		
PROTEIN	0-8	0		
KETONES (fuels for the body that are made when glucose is in short supply)	Negative	Negative		
WBC	0-4	**11-20**		Bacterial infection; patient had a UTI
RBC	0-3	Negative		
LEUKOESTERASE	Negative	**+3**		Patient had a UTI

Cultures

Test	**Normal**	**Value on**	**Today's**	**Explanation of Findings**

	Range	Admission	Value	
URINE CULTURE	Negative	**Abnormal**	N/A	Patient had a UTI. Mixed growth of one or more distal urethral contaminants.
BLOOD CULTURE	Negative	Negative	N/A	No growth with 5 days.
SPUTUM CULTURE	Negative	None ordered	N/A	
STOOL CULTURE	Negative	**Positive**	Negative	Patient was positive for c. diff. colitis. Strain detected is negative for 027/ NAP1/ BI C. Diffcile.

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:

Viral AB-AG-DNA

Covid-19 (not detected)

Stool testing

C. diff. toxin B (positive)

Microbiology

- C. Diff. by PCR (10/18/20) 2355
- Culture blood (10/18/20) 1004
    - No growth with in 5 days
- Culture, urine (10/14/20) 1348
    - Mixed growth of one or more urethral contaminants

CT Head or brain without contrast (10/14/20) 0947

1. The ventricles are mildly dilated there is no midline shift.
2. Prominence of the cerebral cortex.
3. There are nonspecific white matter changes, most likely related to small vessel disease.
4. No mass lesions.
5. No extra axial fluid collections of evidence of intracerebral bleed.
6. Bone windows show no osseous abnormality.

EKG 12 Lead (10/14/20) 0935

- Normal sinus rhythm
- Minimal voltage criterial for LVH
- Nonspecific T wave abnormality
- Abnormal ECG

Current Medications

Brand/Generic	**Amlodipine (Norvasc)**	**Famotidine (Pepcid)**	**Ferrous Sulfate**	**Tamsulosin (Flormax)**	**Magnesium Oxide**
Dose	1 tablet (5 mg)	1 tablet (20 mg)	325 mg	1 capsule (0.4 mg)	1 tablet (400 mg)
Frequency	Daily	Daily	2x daily	Daily every morning	Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Calcium channel blocker	H2- blockers or H2- receptor antagonists	Iron	Alpha blockers	Mineral
Mechanism of Action	It lowers blood pressure by relaxing the blood vessels so the heart does not have to pump as hard.	Works by decreasing the amount of acid produced by the stomach.	Iron combines with porphyrin and globin chains to form hemoglobin, which is critical for oxygen delivery from the lungs to other tissues.	Relaxes the muscles in the prostate and bladders so that urine can flow easily	An inorganic compound that occurs in nature as the mineral periclase. In aqueous media combines quickly with water to form magnesium hydroxide. It is used as an antacid and mild laxative and has many nonmedicinal uses.
Reason Client Taking	Blood pressure	GERD	Low blood levels of iron	Treat symptoms to an enlarged prostate	Acid indigestion, heartburn
Contraindications (2)	Severe hypotension, shock	Gastric cancer, infection, renal disease	Iron metabolism disorder, UC, an inflammatory condition of the intestines	Hepatic disease, prostate cancer	
Side Effects/Adverse Reactions (2)	Swelling, dizziness, flushing	Constipation, diarrhea, headache	Constipation, diarrhea	Drowsiness, dizziness	

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 African American male. He is alert and orientated to situation and person, time and place. Patient does not wear any assistive devices like glasses. Patient uses a walker, but no contacts or cane. Patient appears to be well groomed and in no acute distress, well-developed and not ill-appeared. Patient was calm and cooperative. Patient appears stated age. **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 or erythema. Patient has no drainage. Patient has no bruising to his skin. Patient is not pale or ashy. Patient's nails are without clubbing and cyanosis. Skin turgor normal mobility, quick to return to original state. Patient had no wounds at the time of this assessment. Patient has no drains. Patient's Braden score is a 19 (sensory perception 4 (moderately 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, no visible discharge in eye bilaterally. 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, oral mucous overall is moist and pink without lesions noted. Patient does not wear dentures. Patient's hair is thick, grey and even distribution. Oropharynx is clear. No discharge present right and left ear. External right and left ear normal. Normal range of motion and neck supple. **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 1+ throughout bilaterally. No edema observed or palpated bilaterally though out 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. Lung sounds are clear throughout bilaterally. No wheezes, crackles or rhonchi noted. Bilateral equal air entry. **Patient denies wheezing, cough, increase in sputum production. 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 ☒** **Type:**	Patient is on a cardiac diet and a low fat saturated diet while being hospitalized. Patient states he would describe his eating habits and diet at home to be "ok". Patient eats out a majority of the time. Patient is malnourished as evidenced by his weight and BMI and appearance. While hospitalized, 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 is 5'5". Patient weights 113 pounds. Patient's abdomen is soft, flat, nontender, no masses noted upon light and deep palpation of all the four quadrants. 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 swallows food without difficulty and has no indicators of nutrition risks. Patient's last bowel movement was 11/4/20. Patient described bowel movement as being brown. Patient stated he is not having any difficulty having a bowel movement. Patient describes his recent bowel movement as being "soft". Patient is passing flatus and tolerating full liquids well. **Patient denies nausea, vomiting, diarrhea, abdominal**

	pain, heartburn, jaundice, hematochezia, melena. Patient was unable to recall the last episode of nausea and/or vomiting. Patient is passing gas. Patient's last bowel movement was 11/4/2020. Patient's bowel movement was described as being brown and soft. ___
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 have episodes of incontinence. Patient voids spontaneous without difficulty. Patient voided once during my shift and was incontinent. Patient's urine was clear yellow, no malodor and not cloudy. Patient described his urine production as being good. Patient stated he has no difficulty in urinating. **Patient denies burning or pain, hematuria, incontinence, flank pain while urinating.**
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☐ X**	Patient appeared to be alert LOC. Patient arousal level was she opened his eyes spontaneously. Patient is a one assist with stand by assist. Patient demonstrated active range of motion bilaterally throughout. Patient fall risk score is a 16 (2 – age greater than 65, 2 – altered elimination, 8 – unsteady gait or weakness, 4 – history of fall (within 3 months). Patient's bed alarm, fall reduction program maintained, non-skid shoes/ slippers, when out of bed, ambulated encouraged and dorsiflexion/ plantar flexion and anticoagulant therapy initiated. Patient maintains good balance with a stand by assist and gait belt. Patient ambulated 50 feet in the hallway during the shift. Patient tolerated ambulation well. Patient showed no signs of difficulty breathing. Patient is a stand by assist. Patient needed no cueing and set up assistance. Patient was encouraged to engage in as much as he 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:** **Sensory:** **LOC:**	Patients speech was logical, well-paced, spontaneous and clear. Patient's mood and behavior was cooperative, calm and talkative. Patient's memory was normal. PERRLA bilaterally. Patient's hand grip and ankle strength were strong bilaterally. Patient is alert and orientated to situation and person, time and place. Patient is full concisions and alert. Patient displays no signs of confusion. CAM score negative. No acute, inattention, altered LOC, disorganized thinking.
PSYCHOSOCIAL/CULTURAL:	Patient states he copes with different stressor in his life by

Coping method(s): **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	just staying to himself and "not bothering no one and minding [his] business". Patient's developmental level is appropriate for his age. Patient stated he is a Christian. Patient states he enjoys when the hospital's pastor visits him and prays with him. Patient states he does have four children, but does not keep in close contact with him and they live further away from him. Patient is not married and is single. Patient states he does have a neighbor who checks on him every other day. Patient states he lives alone.

Vital Signs

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0751	62 (right radial)	139/82 (right arm;	18 (unlabored)	98.6 F (oral)	98% (room air)

		HOB 30)			

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
0951	2 out of 10	Lower back	Low intensity	"ok"	Patient stated he wanted to get back in bed to rest. When patient awoken from his nap, patient stated his back pain decreased and he felt better. Patient was able to ambulate in the halls approximately 50 ft and tolerated ambulation well.

Intake and Output

Intake (in mL)	Output (in mL)
200 mL (black/ plain coffee (no sugar or creamer)) 300 mL (water) 100 % break (2 slice of toast with butter and 2 pieces of turkey bacon) 100% snack (teddy graham crackers)	All of patient's urine throughout shift was yellow, clear urine, free of foul odor. Patient voided once during shift. Patient was incontinent of urine. Patient did not have a bowel movement during shift. **TOTAL: 1 occurrence**

Patient was encouraged to eat as much as tolerable to promote good and healthy healing.

Nursing Diagnosis

Nursing Diagnosis	Rational	Intervention	Evaluation

1. injury **related to** fall within last 3 months, needing assistance with ambulation **as evidenced by** use of walker, fall score of 19, living alone, stating he falls all the time, age older than 65, medication use.	Patient was admitted for falling again at home and being unable to get up. This is not the first time that the patient has fell as home and has been unable to get bed. Patient states his is something that occurs often.	1. Move patient's items within easy reach such as his call light, urinal, water, telephone and tv remote 7:30a-12:45pm on 11/5/20 so the patient remains free from falls. 2. All staff will ensure the beds are at the lowest possible position and bed alarm is enable 7:30a-12:45p on 11/5/20.	1. Goal met. Patient maintained free of falls during shift on 11/5/20 from 7:30am to 12:45pm. Patient had all of his personal belongings near him. if his items were far away from the patient, this may cause hazard and contribute to falls. 2. Goal met. Patient's bed remained in the lowest position during shift on 11/5/20 from 7:30am to 12:45pm when not being used. Keeping the bed closer to the floor reduces the risk of the patient getting injured.
2. Impaired skin integrity **related to** fecal and urinary incontinence, immobility, moisture, imbalance nutrition state **as evidenced by** having episodes of incontinence, malnourished, BMI of 18, wearing incontinence pads, requiring assistance with care and ambulation and Braden score of 19.	This patient is incontinent of urine and sometimes bowel which puts the patient at risk for impaired skin integrity. J.C. requires assistance with changing his depends and ambulating to the bathroom. This patient also spends a majority of his time in bed. Other risk factors are environmental moisture and inadequate nutrition.	1. Assess over condition of the patient's skin to establish baseline. Patient will have good skin turgor, be warm and dry to touch and free from any wounds and outbreaks during shift from 7:30a to 12:45pm on 11/5/20. 2. Encourage the patient to change position every 2 hours and change chair position every hour from 7:30a to 12:45pm on 11/5/20.	1. Goal was met. Patient was free of any wounds and outbreaks during shift on 11/5/20. Patient had good skin turgor and no moisture or thinning or the epidermis. 2. Goal is met. Patient changed positioned every 2 hours while in bed and changed position every hour while in his chair from 7:30a to 12:45pm on 11/5/20.

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 fell within the last 3 months at home

- According to patient this is something that occurs often

- Patient lives alone, but requires more

- Patient admits to having an unsteady gait so that's why he uses his walker at home

OBJECTIVE DATA

- Braden score of 19

- Gait characteristics is impaired

- Ambulatory aide required (walker)

Patient Information

J.C. is a 83 year old male who presented to the emergency department with complaints of falling at home and being unable to get up. Per report, patient was checked on by a neighbor and found in his bathtub at home, had apparently been unable to get up and had been lying in his bathtub since yesterday afternoon. Patient states that he lives alone, and falls all the time. Patient uses a walker for ambulation at home.

NURSING DIAGNOSIS/OUTCOMES

1. injury **related to** fall within last 3 months, needing assistance with ambulation **as evidenced by** use of walker, fall score of 19, living alone, stating he falls all the time, age older than 65, medication use.
- Goal met. Patient maintained free of falls during shift on 11/5/20 from 7:30am to 12:45pm. Patient had all of his personal belongings near him. if his items were far away from the patient, this may cause hazard and contribute to falls.
- Goal met. Patient's bed remained in the lowest position during shift on 11/5/20 from 7:30am to 12:45pm when not being used. Keeping the bed closer to the floor reduces the risk of the patient getting injured.

2. Impaired skin integrity **related to** fecal and urinary incontinence, immobility, moisture, imbalance nutrition state **as evidenced by** having episodes of incontinence, malnourished, BMI of 18, wearing incontinence pads, requiring assistance with care and ambulation and Braden score of 19.
- Goal was met. Patient was free of any wounds and outbreaks during shift on 11/5/20. Patient had good skin turgor and no moisture or thinning or the epidermis.
- Goal is met. Patient changed positioned every 2 hours while in bed and changed position every hour while in his chair from 7:30a to 12:45pm on 11/5/20.

NURSING INTERVENTIONS

1. Move patient's items within easy reach such as his call light, urinal, water, telephone and tv remote 7:30a-12:45pm on 11/5/20 so the patient remains free from falls.

2. All staff will ensure the beds are at the lowest possible position and bed alarm is enable 7:30a-12:45p on 11/5/20.

1. Assess over condition of the patient's skin to establish baseline. Patient will have good skin turgor, be warm and dry to touch and free from any wounds and outbreaks during shift from 7:30a to 12:45pm on 11/5/20.

2. Encourage the patient to change position every 2 hours and change chair position every hour from 7:30a to 12:45pm on 11/5/20.