N431 Care Plan #3

Lakeview College of Nursing

Jasmine Banks

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
11/26/2020	DT	72-years-old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Single	vitamin c, aspirin
Code Status	**Height**	**Weight**	
full code	170 cm	64.9 kg	

Medical History (5 Points)

Past Medical History: Allergic rhinitis, anxiety, depression, mild mental retardation, schizophrenia, GERD with esophagitis, BPH with urinary obstruction, central obesity, constipation, DM type II, HTN, hyperlipidemia

Past Surgical History: Cholecystectomy laparoscopic possible cholangiogram

Family History: N/A. The client is unable to state any pertinent family history.

Social History (tobacco/alcohol/drugs): The client is unable to state if he uses, or has used, alcohol, tobacco, or any other drugs.

Assistive Devices: None

Living Situation: The client resides in a nursing home**.**

Education Level: unknown (The client was unable to state his level of education.)

Admission Assessment

Chief Complaint (2 points): Cough

History of present Illness (10 points):

The client is a poor historian and unable to communicate effectively. The client was experiencing a bad cough. He was trying to clear the mucus from his throat but was unable to every time. He began to cough after he received his medication. He was experiencing a hacking cough that wouldn’t go away for about an hour. Nothing seemed to make it better because he

couldn't cough up the mucus. The nurse suctioned the client's mouth when he did cough up mucus.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Sepsis

Secondary Diagnosis (if applicable): Altered mental status

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

Sepsis is a life-threatening condition. Sepsis is caused by the body's response to an infection (Mayo Clinic, 2018). Sepsis usually develops when the chemicals that are released by the immune system to fight an infection cause inflammation throughout the body (O'Connell, 2018). More than a million cases of sepsis each year and kills more than 250,000 Americans a year (O'Connell, 2018). In severe cases, sepsis can lead to septic shock (O'Connell, 2018). Septic shock is a medical emergency.

There are a few things that could cause a client to develop sepsis. These causes include pneumonia and infection of the digestive system (Mayo Clinic, 2018). Infections of the kidney, bladder, and other parts of the urinary system, and bloodstream infections are also causes of sepsis (Mayo Clinic, 2018). My client experienced a urinary tract infection, which led to him developing sepsis.

When it comes to sepsis, there are a few risk factors. The risk factors include diabetes, cirrhosis, have wounds or injuries, have invasive devices, very young or old, or has a compromised immune system (Mayo Clinic, 2018). My client has a few of these risk factors. My client has diabetes, a chronic foley catheter, a urinary tract infection, and a wound on his buttocks.

There are a few signs and symptoms that are seen with sepsis. The signs and symptoms of sepsis are tachycardia, tachypnea, fever or hypothermia, confusion, disorientation, or hypotension (O'Connell, 2018). In severe sepsis cases, a client could experience decreased urination, low platelets, unconsciousness, extreme weakness, abnormal heart problems, or changes in mental ability (O'Connell, 2018). My client experienced confusion and disorientation. He experienced hypothermia, as well.

There are a few diagnostic tests that are done to diagnose sepsis. The diagnostic tests include blood tests, imaging tests, and other tests such as urinalysis (Mayo Clinic, 2018). The imaging tests include an x-ray, CT scan, ultrasound, and MRI (Mayo Clinic, 2018). The blood tests are completed to test for evidence of infection, electrolyte imbalances, clotting problems, and abnormal liver or kidney function (Mayo Clinic, 2018). My client underwent a urinalysis, blood tests, and an x-ray. The urinalysis confirmed he had a urinary tract infection.

When it comes to treatment options, there are a few things that are used to treat sepsis. A client with sepsis should seek immediate medical care (O'Connell, 2018). These treatment options include antibiotics, IV fluids, vasopressors, supportive care, or surgery (Mayo Clinic, 2018). My client is receiving antibiotics and IV fluids.

Pathophysiology References (2) (APA):

Mayo Clinic. (2018, November 16). *Sepsis*. https://www.mayoclinic.org/diseases-conditions/sepsis/diagnosis-treatment/drc-20351219

O'Connell, K. (2018, August 31). *Sepsis*. Healthline. https://www.healthline.com/health/sepsis#symptoms

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	3.9-5	2.96	3.22	The client has a UTI (Capriotti, & Frizzell, 2016).
Hgb	12.15.5	8.9	9.7	The client has a UTI (Capriotti, & Frizzell, 2016).
Hct	35-45	25.5	27.3	The client has a UTI (Capriotti, & Frizzell, 2016).
Platelets	140-400	213	237	Within normal range
WBC	4-9	11.2	11.1	The client has sepsis (Farkas, 2020).
Neutrophils	40-70	82	77.3	The client has sepsis (Farkas, 2020).
Lymphocytes	10-20	9.3	11.2	The client has sepsis (Farkas, 2020).
Monocytes	0-0.9	6.8	5.8	The client has sepsis (Farkas, 2020).
Eosinophils	0-0.5	1.8	4.7	The client has sepsis (Farkas, 2020).
Bands	<10%			

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	138	Within normal range
K+	3.5-5.1	3.1	3.1	The client has diarrhea (Capriotti, & Frizzell, 2016).
Cl-	98-108	115	108	The client has sepsis (Capriotti, & Frizzell, 2016).
CO2	22-29	22	24	Within normal range
Glucose	70-99	85	86	Within normal range
BUN	6-20	11	4	The client has diarrhea (Capriotti, & Frizzell, 2016).

Creatinine	0.5-1	0.58	0.54	Within normal range
Albumin	3.5-5.2	2	2.1	The client has sepsis (Capriotti, & Frizzell, 2016).
Calcium	8.4-10.5	7.3	7.3	The client has diarrhea (Capriotti, & Frizzell, 2016).
Mag	1.5-4.5	1.4	1.8	The client has diarrhea (Capriotti, & Frizzell, 2016).
Phosphate	2.5-4.5			
Bilirubin	0.3-1	0.3	0.4	Within normal range
Alk Phos	35-105		72	Within normal range
AST	0-32	34	23	The client has sepsis (Capriotti, & Frizzell, 2016).
ALT	0-33	31	29	Within normal range
Amylase	23-85			
Lipase	0-160			
Lactic Acid	<2	1.4	0.8	Within normal range
Troponin	0-0.4	0.2	0.176	Within normal range
CK-MB	5-25		58.26	The client has sepsis (Capriotti, & Frizzell, 2016).
Total CK	22-198		874	The client has sepsis (Capriotti, & Frizzell, 2016).

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	l.81-1.2	1.22	1.3	The client has sepsis (Schnur, 2017).
PT	11.5-15	15.7	17.3	The client has sepsis (Schnur, 2017).
PTT	23.5-37.5		30.2	Within normal range

D-Dimer	<250			
BNP	<100		72	Within normal range
HDL	>40			
LDL	<100			
Cholesterol	<200			
Triglycerides	<150			
Hgb A1c	0-5.7			
TSH	0-5.5	2.27	0.81	Within normal range

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	Yellow/clear	dark yellow/turbid		The client has a UTI (Capriotti, & Frizzell, 2016).
pH	5-8	5.5		Within normal range
Specific Gravity	1.005-1.034	1.023		Within normal range
Glucose	Normal	normal		Within normal range
Protein	Negative	2+		The client has a UTI (Capriotti, & Frizzell, 2016).
Ketones	Negative	trace		The client has a UTI (Capriotti, & Frizzell, 2016).
WBC	<=5	>100		The client has a UTI (Capriotti, & Frizzell, 2016).
RBC	0-3	85		The client has a UTI (Capriotti, & Frizzell, 2016).
Leukoesterase	Negative	4+		The client has a UTI (Capriotti, & Frizzell, 2016).

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	7.35-7.45	7.28		The client has diarrhea (Capriotti, & Frizzell, 2016).
PaO2	75-100	193		The client has diarrhea (Capriotti, & Frizzell, 2016).
PaCO2	35-45	26.6		The client has diarrhea (Capriotti, & Frizzell, 2016).
HCO3	22-26	14.4		The client has diarrhea (Capriotti, & Frizzell, 2016).
SaO2	95-100	99		Within normal range

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	Negative	>100,000 cfu/ml enterococcus faecalis	>100,000 cfu/ml streptococcus species	The client has a UTI (Capriotti, & Frizzell, 2016).
Blood Culture	Negative	negative		Within normal limits.
Sputum Culture	Negative			
Stool Culture	Negative			

Lab Correlations Reference (APA):

Capriotti, T., & Frizzell, J. (2016). *Pathophysiology: Introductory concepts and clinical perspectives*. F. A. Davis Company.

Farkas, J. (2020, January 6). *Pulmcrit- Sepsis Special Edition & CBC To Diagnose Septic Shock*. Plumcrit EMCrit . https://emcrit.org/pulmcrit/cbc-sepsis/

Schnur, M. (2017, March 11). *Laboratory Signs Of Sepsis [Infographic]*. Lippincott Nursing Center. https://www.nursingcenter.com/ncblog/march-2017/laboratory-signs-of-sepsis

Diagnostic Imaging

All Other Diagnostic Tests (5 points): EC echo with contrast, CT brain/head without contrast, Chest x-ray

Diagnostic Test Correlation (5 points):

The chest x-ray visualizes any problems with the lungs and heart (Mayo Clinic, 2018). The echocardiogram assesses the heart and how well it is working. The CT scan visualizes the brain and any abnormalities in the brain. The chest x-ray showed clear lungs, the heart size mildly enlarged, and no acute cardiopulmonary process. The echocardiogram showed normal function, normal sinus rhythm, and an ejection fraction of 77%. The CT scan of the brain showed no acute intracranial abnormality and extensive volume loss.

Diagnostic Test Reference (APA):

Mayo Clinic. (2018, November 16). *Sepsis*. https://www.mayoclinic.org/diseases-conditions/sepsis/diagnosis-treatment/drc-20351219

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

Home Medications (5 required)

Brand/Generic	Docusate sodium/ Colace	Omeprazole/ Prilosec	Ondansetron / Zofran	Famotidine/ Pepcid	Finasteride / Proscar
Dose	100 mg	20 mg	8 mg	10 mg	5 mg
Frequency	BID	Daily	Q8H-PRN	BID	Daily
Route	PO	PO	PO	PO	PO

Classification	stool softener	Antiulcer	Antihistamine	Antiulcer agent, gastric acid secretion inhibitor	Benign prostatic hyperplasia agent, hair growth stimulant
Mechanism of Action	Act as a detergent to facilitate the admixing of fat and water in the stool.	Interferes with gastric acid secretion by inhibiting hydrogen potassium adenosine triphosphatase enzyme system, or proton pump, in gastric parietal cells	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine.	Reduces HCl formation by preventing histamine from binding with H2 receptors on the surface of parietal cells. By doing so, it helps prevent peptic ulcers from forming and helps heal existing ones	Inhibits 5-alpha reductase
Reason Client Taking	Used to treat occasional constipation	To treat GERD	Nausea	To treat GERD	To treat BPH
Contraindications (2)	Fecal impaction, acute abdominal pain	Hypersensitivity to drug or its components, cautious in liver disease	Concomitant use of apomorphine, hypersensitivity to drug or its components	Hypersensitivity to drug and its components, severe kidney impairment	Hypersensitivity to drug or its components, female clients
Side Effects/Adverse Reactions (2)	Diarrhea, abdominal cramping, rash	Hypoglycemia, chest pain, hypotension	Weakness, fever, SOB, hypotension	Fatigue, dry mouth, nausea	Hypotension, diarrhea, dizziness
Nursing Considerations (2)	-Should be taken with a full glass of water -Discontinue	-monitor urine output -if needed, open capsule and sprinkle	-monitor for signs and symptoms of hypersensitivity to the	-monitor for adverse effects -shake oral suspension	-client should have a urologic evaluation

	drug if rectal bleeding, cramping, nausea or vomiting occurs	enteric-coated granules on applesauce or yogurt. Give immediately.	medication -monitor client's EKG as prescribed.	vigorously for 5 to 10 seconds before administration	prior to starting and periodically throughout therapy -expect client to have a digital rectal examination of the prostate before and periodically during therapy
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Assess for abdominal distention -monitor bowel sounds	-monitor I&Os and daily weights for fluid retention	-monitor closely for serotonin syndrome	-monitor for adverse effects	-assess the client's I&Os, fluid intake, and labs for kidney, and bladder function
Client Teaching needs (2)	-Encourage increase of fiber intake -Regular physical activity -Drink 6 to 8 glasses of water per day	-take drug before eating, usually before breakfast, and swallow delayed-release capsules whole. -avoid alcohol, aspirin products, ibuprofen, and foods	-immediately report signs of hypersensitivity -reassure client that if transient blindness occurs, it will return within a few minutes to 48 hours	-caution client to avoid alcohol and smoking -inform the client to notify the provider if they develop pain, has trouble swallowing, or if they have bloody vomit or black stools	-explain how to take drug and urge clint to follow instructions that accompany it. -Inform the client to inform the provider if they experience

		that may increase gastric secretions			any severe adverse effects

Hospital Medications (5 required)

Brand/Generic	Enoxaparin/ lovenox	benztropine mesylate/ Cogentin	Pantoprazole / Protonix	levofloxacin /Levaquin	potassium chloride
Dose	40 mg	0.5 mg	40 mg	750 mg	40 mEq
Frequency	Daily	BID	Daily	Every 48 hours	BID
Route	SubQ	PO	PO	IV	PO
Classification	**A**ntithrombotic/ Antiplatelet	Anti-parkinsonian, central-acting anticholinergic	Antiulcer, gastric acid secretion inhibitor	antibiotic	Electrolyte replacement
Mechanism of Action	Binds with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors	Blocks acetylcholine's action at cholinergic receptor sites. This restores the brain's normal dopamine and acetylcholine balance, which relaxes muscle movement and decreases drooling, rigidity, and tremors.	Interferes with gastric secretion by inhibiting the hydrogen-potassium-adenosine triphosphatase enzyme system, or proton pump, in gastric parietal cells	Interferes with bacterial cell replication by inhibiting the bacterial enzyme DNA gyrase, which is essential for repair and replication of bacterial DNA.	Helps maintain electroneutrality in cells by controlling exchange of intracellular and extracellular ions. Helps maintain normal renal function and acid-base balance.
Reason Client Taking	To prevent DVT. To prevent	To treat anxiety	Indigestion	To treat sepsis	To treat hypokalemia

	ischemic complications				
Contraindications (2)	Hypersensitivity to drug or its components, active major bleeding	Hypersensitivity to drug or its components, megacolon	Hypersensitivity to drug or its components, concurrent therapy with rilpivirine-containing products	Hypersensitivity drug or its components, myasthenia gravis	Acute dehydration, hypersensitivity to drug or its components
Side Effects/Adverse Reactions (2)	Vomiting, nausea, headache, fever	Confusion, hypotension, constipation	Headache, dyspnea	Confusion, dizziness	Confusion, bloody stools
Nursing Considerations (2)	-Do NOT give IM injection -keep protamine sulfate close in case of overdose.	-Give drug before or after meals based on client's need and response -Monitor client's movements closely for weakness and inability	-flush IV line with D5W, NS solution, or lactated ringer's injection before and after giving drug -monitor client's urine output	-monitor blood glucose levels -monito renal function	-administer oral potassium with or immediately after meals -monitor serum creatinine level and urine output
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-monitor platelets	-monitor client's strength and movements	-monitor client's urine output and for diarrhea	-expect to obtain culture and sensitivity tests before treatment starts	-monitor serum potassium before and during therapy
Client Teaching needs (2)	-Educate on adverse effects from the medication -notify provider if bruising, dizziness,	-Caution against driving and similar activities until the drug's effects are known	-notify provider if diarrhea occurs and becomes prolonged or severe -notify provider if	-avoid excessive sun exposure and wear sunscreen -caution client to avoid hazardous	-instruct client o take drug with or right after food -teach how to take radial

	loss of consciousness, or bloody stool occurs	-Warn client that drug has a cumulative effect, increasing risk of adverse effects and overdose	he is experiencing a decrease in the amount of urine voided or if there's blood in the urine	activities until drug's CNS effects are known.	pulse, and advise him to notify prescriber about significant changes in heart rate or rhythm

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 nurse's drug handbook* (18th ed.). Jones & Bartlett Learning.

RxList. (2020). *Drugs A-Z list.* https://www.rxlist.com/drugs/alpha_a.htm

Assessment

Physical Exam (18 points)

GENERAL (1 point):	
Alertness:	A/O x 1
Orientation:	awake, confused; disoriented
Distress:	No acute distress
Overall appearance:	Confused
INTEGUMENTARY (2 points):	
Skin color:	usual for ethnicity; pink
Character:	dry
Temperature:	warm
Turgor:	elastic
Rashes:	none
Bruises:	none
Wounds: .	buttocks
Braden Score:	12
Drains present: Y☐ N ☐	No
Type:	
HEENT (1 point):	
Head/Neck:	Normocephalic
Ears:	Normal; TM pearly gray bilateral, non-tender
Eyes:	PERLA, EOMI
Nose:	Clear, intact, no mucus

Teeth:	Some rotten
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	 Normal sinus rhythm; S1/S2 heard; no murmur or gallop auscultated 3+ radial/brachial bilateral; 3+ dorsalis pedis bilateral <3 seconds No No
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	 No Clear, diminished, bilateral; anterior and posterior
GASTROINTESTINAL (2 points): **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:**	 Regular Caffeine free 170 cm 64.9 kg active; diminished in all quadrants 11/30/2020 soft, no tenderness, masses or pain upon palpation no no no no buttocks no no no
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	 Yellow Clear 620 mL No No N/A Yes Foley

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MUSCULOSKELETAL (2 points): **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☐**	 Active ROM None Equal; bilaterally No Yes 50 Yes Yes
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	 Yes Yes Yes A/O x 1 awake, confused; disoriented expressive language difficulty/gargled equal; bilateral Awake; confused
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	 Unable to state coping mechanisms. He likes to watch television. Developmental delay Unable to communicate effectively to receive answers. Unable to communicate effectively to receive answers.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0916	82	142/85	16	35.7	95
1118	82	117/80	16	36.6	97

Vital Sign Trends: The client's vital signs are within normal range except for the blood pressure and temperature. The client's blood pressure was elevated but decreased within normal range after a few hours. The client's temperature was decreased but increased within normal range after a couple hours.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0916	numeric	n/a	0	n/a	n/a
1118	numeric	n/a	0	n/a	n/a

IV Assessment (2 Points)

IV Assessment	**D5 ½ NS/100 mL, meropenum**
Size of IV:	20 gauge
Location of IV:	right peripheral forearm
Date on IV:	11/30/2020
Patency of IV:	infusing without difficulty, flushes easily
Signs of erythema, drainage, etc.:	no erythema, drainage, phlebitis, infiltration
IV dressing assessment:	dry, intact, transparent

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
220 (IV and oral intake)	620 mL (urine)

Nursing Care

Summary of Care (2 points)

The client was A/Ox1 and was not able to communicate effectively. He seemed confused and disoriented. Vital signs were obtained around 0900 and again around 1100. Both sets of vital signs were within normal limits except for blood pressure and temperature at 1100. Pain assessments were obtained around 0900 and again around 1100. The client experienced no pain at either of these times. The client received medications by mouth, and D51/2NS, and meropenem via IV. The client began experiencing a hacking cough without the production of mucus. The speech therapy came to see the client and sat with him as he ate lunch. Wound care visited the client and cared for the wound on his buttocks.

Procedures/testing done: No procedure to testing was done. A stress test was scheduled but cancelled due to the client's low potassium levels.

Complaints/Issues: None

Vital signs (stable/unstable): The client's vital sign was stable expect for blood pressure and temperature at 0916.

Tolerating diet, activity, etc.: caffeine free diet

Physician notifications: N/A

Future plans for patient: A stress test to be completed when his potassium levels are within normal range.

Discharge Planning (2 points)

Discharge location: Nursing home where he resides.

Home health needs (if applicable): n/a

Equipment needs (if applicable): Catheter

Follow up plan: n/a

Education needs: The client needs to be educated on catheter care and signs and symptoms of an infection.

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

Nursing Diagnosis ● Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** ● Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1.Risk for shock related to sepsis as evidenced by client's elevated blood pressure, disorientation and confusion, and decreased temperature.	The client was A/Ox0 and was unable to verbalize his name, where he was, or when it was. He appeared confused and disoriented. His blood pressure and temperature were not within the normal range.	1. Monitor vital signs, especially blood pressure and temperature. 2. Assess respiratory rate, rhythm, and quality. 3. Monitor heart rate and rhythm	The client will be A/Ox4. The client's vital signs will be within normal range. The client's will be normal with no gallop or murmur. The client respiratory rhythm and quality are good.
2. Potential for delayed wound healing related to diabetes as evidenced by a wound on his buttocks.	The client has diabetes, and he has wound on his buttocks which puts him at an increased risk for delayed wound heling.	1. Ensure good hand hygiene and use universal precautions with wound care. 2. Monitor the wound for signs of infections and delayed wound healing.	The client's wound exhibits signs of healing.
3. Hypothermia related to sepsis as evidenced by the client's temperature below normal limits.	The client's temperature was 35.7 C.	1.Frequently assess the client's temperature. 2.Frequently assess client's mental status	The client's temperature will be within normal limits. The client's mental status will be appropriate.

		3. Initiate slow rewarming with warm blankets, raising the room temperature and warm fluids.	
4. Risk for electrolyte imbalance related to diarrhea as evidenced by decreased potassium levels.	The client has diarrhea and is experiencing hypokalemia with a potassium level of 3.1.	1.Monitor heart rate and rhythm and respiratory rate, depth, rhythm and quality. 2. Monitor level of consciousness and neuromuscular function.	The client potassium level will be within normal limits. The client's heart rate and rhythm will be normal. The client's respiratory rate and rhythm will be normal. The client will display any cognitive impairment or muscle weakness.

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. Elsevier.

Concept Map (20 Points):

Subjective Data

There is no subjective data because the client was unable to communicate effectively.

Nursing Diagnosis/Outcomes

Risk for shock related to sepsis as evidenced by client's elevated blood pressure, disorientation and confusion, and decreased temperature.
The client will be A/Ox4. The client's vital signs will be within normal range. The client's will be normal with no gallop or murmur. The client respiratory rhythm and quality are good.
Potential for delayed wound healing related to diabetes as evidenced by a wound on his buttocks.
The client's wound exhibits signs of healing.
Hypothermia related to sepsis as evidenced by the client's temperature below normal limits.
The client's temperature will be within normal limits. The client's mental status will be appropriate.
Risk for electrolyte imbalance related to diarrhea as evidenced by decreased potassi
The client potassium level will be within normal limits. The client's heart rate and rhythm will be normal. The client's respiratory rate and rhythm will be normal.

Objective Data

Client had a persistent, unproductive cough
The client's temperature was 35.7
The client's blood pressure was 142/85
The client has a wound on his buttocks
The client was confused and disoriented
The client's potassium level was 3.1
The client RBCs, hgb, and hct were decreased
WBCs were elevated
The client's urinalysis indicated a UTI
The client's urine culture showed enterococcus faecalis and streptococcus species

Patient Information

D.T. is a 72-year-old male with a history of diabetes and hypertension was admitted with sepsis and altered mental status.

Nursing Interventions

1. Monitor vital signs, especially blood pressure and temperature.
2. Assess respiratory rate, rhythm, and quality.
3. Monitor heart rate and rhythm
1. Ensure good hand hygiene and use universal precautions with wound care.
2. Monitor the wound for signs of infections and delayed wound healing.
1.Frequently assess the client's temperature.
2.Frequently assess client's mental status
3. Initiate slow rewarming with warm blankets, raising the room temperature and warm fluids
1.Monitor heart rate and rhythm and respiratory rate, depth, rhythm and quality.
2. Monitor level of consciousness and neuromuscular function.