

N321 Care Plan #1

Lakeview College of Nursing

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Demographics

Date of Admission 1/19/21	Patient Initials S.W.	Age 77 years old (9/23/1943)	Gender Female
Race/Ethnicity Caucasian	Occupation Retired; prior to that, patient owned a refrigerator business in Danville with her husband	Marital Status Widowed; husband passed away 5 years ago due to a heart attack; married for 53 years	Allergies Seasonal (sneeze)
Code Status FULL (No ACP docs)	Height 5'3"	Weight 178 pounds (81 kg) BMI: 31.36	

Medical History

Past Medical History: Patient has a past medical history of Asthma, moderate persistent (4/1/2019), breast cancer in situ (7/27/2011), COPD (8/21/2019), diabetes mellitus type 2, GERD, hiatal hernia, hypertension, osteopenia, skin cancer and sleep apnea with CPAP, pulmonary artery disease.

Past Surgical History: Patient has a past surgical history that includes breast biopsy (bilateral, 1991, 2008, 2012), lymph node dissection (left, 2008); dilation and curettage, joint replacement (right, 2/2011), Tah and Bso (8/2012), Rectocele Repair (08/2012), ankle surgery (left, 3/30/2017), hernia repair (9/18/2019) and malignancy skin lesion excision (dated not included).

Family History: Patient has a family history that includes cancer in her biological brother, heart disease on her father and mother's side of the family. Patient is unsure who exactly has it on her mother and father's side.

Social History (tobacco/alcohol/drugs): Patient reports that she quit smoking about 25 years ago. Patient has a 30 pack a year smoking history. She has never used smokeless tobacco. Patient reports that she does not drink alcohol or use drugs. Patient is currently retired. Prior to retirement, this patient owned a refrigerator business with her then husband at the time. Patient states she really enjoyed that. Patient stated she also worked on drafting in Danville as well as in an office. Patient lives alone in Danville, IL. Patient states she lived in a two-story house, but recently moved into a one-story house because her daughter was persistent in her getting a one-story house due to her surgery and not having the ability to go upstairs. Patient stated at first, she was reluctant and unhappy about the move, but it has grown on her and she really enjoys her new place. Patient joked that the upside of now having a one-story house very a two-story house is she has “less stuff to clean” and she is glad about that.

Assistive Devices: Patient uses glasses and hearing aids. Patient denies the use of a walker, wheelchair or cane.

Living Situation: Patient lives alone in a one-story house in close proximity to her daughter. Patient states she enjoys the community she lives in and her neighbor. She often times bakes for her neighbor.

Education Level: Patient’s education extends to 12th grade. Patient stated she started to work right away after high school and did not have the pressure or want to extend her education pass that due to her desire to want to work right away.

Admission Assessment

Chief Complaint: fever, fatigue, headache, urinary frequency of 5 days

History of present Illness: Patient is a 77 year old white female with history of hypertension, hyperlipidemia and COPD presents to the ER secondary to body aches, chills, fever, headache, urinary frequency, dark/ smelly urine since Friday. Patient stated she was “really sick with child with fever”. Patient goes on to state, “I thought I was going die. It was going on and one and wasn’t getting any better.” Patient has been tested 3 times for COVID and one time for the flu all of which have been negative. Patient denies any nausea, vomiting, diarrhea, constipation, chest pain, patient denies any hematuria. Does have history of right kidney stone and UPJ obstruction on CT abd in 2018.

Primary Diagnosis

Primary Diagnosis on Admission: Premature Ventricular Contractions (PVC)

Secondary Diagnosis: UTI

Pathophysiology of the Disease: Hypertension

Hypertension is the elevation of blood pressure to values that are correlated with cardiovascular damage. It is also commonly referred to as “silent disease” because many times it has no symptoms and can be fatal due to the impact it has on the heart. This can potentially be fatal due to it being “a significant risk factor for heart disease, stroke and other cardiovascular diseases and an estimated 970 million people worldwide suffer from the disease resulting in significant morbidity, mortality and financial burden globally” (Delacroix & Chokka, 2014).

The American Heart Association considers hypertension to exist when there are two or more diastolic blood pressure readings on at least two or more clinical visits of readings that are 80 mm Hg or greater for diastolic and when the systolic blood pressure reading of two or more clinical visits are consistently 130 mm Hg (Capriotti, 2020). A normal blood pressure reading is recommended to be less than systolic 120 and for diastolic should be less than 80. It is recommended that for older adults, their blood pressure should be less than 150/90. This recommendation comes from older adults most likely having a high blood pressure to attain cerebral perfusion and circulation to organs. Higher blood pressure is necessary in older adults for blood to reach the brain and other organs. As we age, “blood vessels become less elastic and stiffer, which physiologically raises blood pressure; organ circulation requires higher pressure in older age” (Capriotti, 2020).

Hypertension is described as being the most common worldwide disease. Although hypertension has no known cause, it accounts for 90% to 95% of adult cases (Capriotti, 2020). Hypertension can be secondary to many diseases and disorders like Cushing’s disease, pheochromocytoma, kidney disease or hyperaldosteronism, vasculitis, brain tumor, alcohol, cocaine, NSAIDs, oral contraceptives or obstructive sleep apnea.

There are many common hereditary and physical risk factors for high blood pressure. Risk factors of primary hypertension are mainly age, African American ethnicity, family history and obesity. Diabetes mellitus, tobacco use and excessive sodium in the diet followed by excessive alcohol and stress are also risk factors for hypertension. As shown, many of the risk factors for hypertension are modifiable and can be changed. An unhealthy diet, especially one high in sodium can be changed by patients making healthy food choices to help lower blood pressure. Being overweight or obese and carrying too much weight can put extra strain on the

heart which increases one's risk for cardiovascular disease, diabetes along with high blood pressure.

Hypertension has two major negative effects on the cardiovascular system. One of which, it exerts high damaging forces against all the endothelial linings of the arteries (Capriotti, 2020). This then causes high resistance against the heart's left ventricular being that the high amount of pressure is causing that ventricular to work harder and pump faster. This involves impairment of renal pressure natriuresis, the feedback system in which high blood pressure induces an increase in sodium and water excretion by the kidney that leads to a reduction of the blood pressure. Pressure natriuresis can result from impaired renal function, inappropriate activation of hormones that regulate salt and water excretion by the kidney (such as those in the renin-angiotensin-aldosterone system), or excessive activation of the sympathetic nervous system (Delacroix & Chokka, 2014).

Clinical manifestation is commonly referred to as a "silent killer" due to the gradual process that has no symptoms until it causes organ dysfunction. It is important for nurses for nurses to determine if any disorders are present within the patient's history that can predispose this individual to hypertension. Primary hypertension has no signs or symptoms until the disease advances to damaging organs. On a rare occasion, people complain of "headache, nosebleeds, blurred vision or palpitations" (Capriotti, 2020). A patient with hypertension will present with an elevated blood pressure. There should be no caffeine, exercise or smoking within 30 minutes of taking their blood pressure. The arm should be supported, and the cuff should be larger to cover about 80% of the upper arm. As mentioned above, at least two measurement should be taken and recorded as this is a determinant to diagnosing hypertension. A 24-hour ambulatory blood pressure monitoring is an effective measure of also measuring blood pressure. This is done until

a patient's daily living activities and sleep due to some patients having white coat hypertension from the nervousness of a healthcare provider. Fundoscopic examination can also be done to assess the retina and optic nerve. With hypertension, there are characteristic changes in the retinal vessels. A patient suspected to have hypertension should also have their arteries accessed. The nurse should do this by "the use of the stethoscope to listen for bruits over the aorta, carotid and renal arteries" (Capriotti, 2020).

Diagnostic evaluation of hypertension should be done to rule out any potential causes of an elevated blood pressure and determine if there is any organ damage. These tests can include ECG, urinalysis, CBC, glucose, potassium and creatinine.

Treatment of hypertension includes a change in diet that includes lower sodium options or the DASH diet. Stress reduction with the use of relaxation techniques and yoga can help reduce stress which is known to increase one's blood pressure. For physical activity, doing 30 minutes of vigorous physical activity at least 5 days a week is also known to lower someone's risk for hypertension. Smoking cessation is also highly encouraged to patients as smoking can raise blood pressure and increase resistance to blood flow in the heart. Drugs such as ACE inhibitors, CCBs, Diuretics, renin inhibitors all lower blood pressure by changing angiotensin I into angiotensin II in the RAAS. Beta blockers "diminish the effects the SNS on the heart and arteries, thereby decreasing HR and blocking vasoconstriction" (Capriotti, 2020).

Since S.W. was a smoker for close to 20 years and smoked 30 packs of cigarettes a day, this could be the reason this patient has hypertension along with her excessive intake of sodium and her poor weight management. Smoking over an extended period of time can cause "the left ventricle to contract greater thereby causing it to hypertrophy when there is arterial vasoconstriction; this causes the left ventricle to become exhausted by the high resistance it must

pump against the aorta” (Capriotti, 2020). Although this patient has not smoked for an extended amount of time, it does not change the factor that she still smoked for a long time and the damage persistent due to the length of time she was smoking for.

Although S.W. did not present with high blood pressure when admitted or has recently had an episode of hypertension, she still was diagnosed with hypertension and is currently taking metoprolol daily to help maintain and manage her blood pressure. Metoprolol helps with the elevation of blood pressure by “blocking catecholamine-induced increases in heart rate, in velocity and extent of myocardial contraction and in pressure, metoprolol reduces the oxygen requirement of the heart at any given level of effort, thus, making it useful in the long-term management of angina pectoris” (*Metoprolol 25MG*, n.d.). S.W.’s CBC did not show an elevation of potassium, sodium, creatine, glucose and cholesterol which are all labs used for hypertension. Had either of these lab values been elevated, it would have been consistent with a current issue with hypertension. However, this patient is on blood pressure medications daily to help manage that, so it is not surprising that she is not present with an elevated blood pressure at this time.

Pathophysiology References:

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and*

Clinical Perspectives 2nd Edition (2nd ed., p. 562). Philadelphia: F A Davis.

Delacroix, S., & Chokka, R. G. (2014). Hypertension: Pathophysiology and Treatment. *Journal of Neurology & Neurophysiology*, 05(06). doi:10.4172/2155-9562.1000250

Metoprolol 25MG. (n.d.). Dailymed.nlm.nih.gov. Retrieved January 22, 2021, from

<https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=8852c699-0885-20c3-e053-2a95a90a17ee&type=display>

Laboratory Data

COMPLETE BLOOD COUNT

Lab	Normal Range	Admission Value 1/19/21 1548	Today's Value 1/21/21 0440	Reason for Abnormal Value
RED BLOOD CELLS (carry oxygen)	F: 3.80-5.30	4.73	4.60	
HEMOGLOBIN (oxygen-carrying protein in RBCs)	F: 12-15.8	13.8	12.8	
HEMATOCRIT (the proportion of RBCs to the fluid component, plasma in your blood)	F: 36-47	41.0	40	
PLATELETS (help with blood clotting)	150,000-450,000	217,000	215,000	
WHITE BLOOD CELLS (fight infection)	4,000-10,000	16.20	12,000	The term leukocytosis is used to describe an elevation in white blood cell counts. Leukocytosis is evident in the presence of infection. Patient was admitted for premature ventricular contractions, but it was later founded that she has a urinary tract infection. An infection multiple in the blood causing the bone marrow to produce more white blood cells to fight off the infection. Infection then causes inflammation which can turn into can increase number of white blood cells. After antibiotic administration, the white blood cell count has decreased although it is still not within the normal range.
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	81.9	50	Neutrophils are the main white blood cells that respond to infection. This patient had an infection in her urinary tract which can also result in activation of the inflammatory response system. As shown through her lab results, it has resolved since being hospitalized due to the decrease number in neutrophils in comparison to

				her admission date.
LYMPHOCYTES (B cells: produce antibodies to attack bacteria T-cells: kill infected cells)	20-40%	49	23	High lymphocyte blood levels indicates that the body is dealing with an infection and an inflammatory condition in this case, it's the patient UTI. Usually, a temporarily high lymphocyte count is a normal effect of the body's immune system working, however this patient had a urinary tract infection which coincides with the elevation of lymphocytes.
MONOCYTES (fight infection; help remove dead tissues; destroy cancer cells)	2-8	12.5	N/A	Monocytes are elevated within this patient's lab results due to her body fighting an infection in this case a urinary tract infection.
EOSINOPHILS (participating in immediate allergic reactions)	1-4	1.4	1	
BANDS (immature form of neutrophils; produced in excess during infection to help fight disease)	3-7	N/A	N/A	This lab was not shown within the patient's chart.

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	131	135	The reason for a slight decrease in sodium in this patient could be because of her diuretic use to help with her blood pressure. Diuretics affect the fluid and electrolyte balance because it "leads to negative sodium and fluid balance without primary effects on serum sodium concentration" (Pagana et al., 2019). It blocks the absorption of sodium and other electrolytes from being filtered in the kidney tubules.
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	3.7	3.9	

Cl- (helps keep the amount of fluid inside and outside of your cells in balance; maintain blood volume, BP and pH)	95-105	96	100	
CO2 (regulates the pH of blood, stimulates breathing, and influences the affinity hemoglobin has for oxygen)	23-30	24	26	
Glucose (for energy)	70-110	91	112	S.W. stated her blood glucose levels are for the most part managed well as home and are within normal range. So, I predict that the reasoning for a slight elevation of glucose could largely be due to stressors of being hospitalized. Stress blocks your body releasing insulin and that lets glucose pile up in the blood. Over a long period of time, your blood sugar levels will continue to increase.
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	22	18	This patient's BUN is increased most likely due to her diabetes along with hypertension and the direct effect it causes on the kidneys. This can result to low blood flow to the kidneys. High blood glucose levels can damage the blood vessels within the kidneys. When they are damaged, it decreases the ability for the kidney to work effectively and filter. Uncontrolled hypertension can cause arteries around the kidneys to narrow and weaken and eventually harden over time. These damaged arteries are not able to deliver enough blood to the tissue and poor perfusion to the kidney decreases its ability to filter.
CREATININE (to be filtered and eliminated in urine)	0.6-1.5	0.65	0.47	The slight decrease in creatine during hospitalization could be due to aging or a diet very low in protein. With older adults, there is a reduction in muscle mass which causes low creatine levels. This patient also has osteopenia which causes loss of bone mass and weakens the bone gradually.
ALBUMIN	3.5-5.0	3.9	3.3	The slight decrease in albumin is seen in

(helps keep fluid in your bloodstream so it doesn't leak into other tissues)				patients with inflammation. Inflammation increases capillary permeability and causes the body to lose albumin which is shown to shorten and decrease total albumin and since this patient had a UTI, Asthma, Hypertension and other commodities she is existing signs of inflammation
CALCIUM (stored in bones and teeth; supports structure; carries messages between the brain and body parts)	8.5-10.0	9.4	8.7	
MAGNESIUM (required for energy production)	1.5-2.5	1.9	2.1	
PHOSPHATE (build and repair bones and teeth, help nerves function, and make muscles contract)	2.8-4.5	N/A	N/A	This lab was now shown with in this patient's chart.
BILIRUBIN (orange-yellow pigment that occurs normally when part of your red blood cells break down)	0-0.3	0.8	0.1	This patient has a history of GERD which is known to correlate with bilirubin. A study found shocks that blocking stomach acid can lead to an overgrowth of intestinal bacteria that can lead to or contribute to liver inflammation and damage.
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	127	117	This patient has a history of cancer that has occurred three times. When abnormal bone tissue is formed by cancer cells, level of alkaline phosphate increase. Bone disorders like osteopenia can cause the bones to become abnormally weak and prone to fracture which results in moderately high levels of alkaline phosphate due to the increased bone cell activity.
AST Checks for liver damage	5-40	20	21	
ALT Test for liver cell damage	7-56	54	42	
Amylase Test for disease of the pancreas	30-110	N/A	N/A	This lab result was not present for this patient.
Lipase Helps your body digest	0-160	N/A	N/A	This lab result was not present for this patient.

fats; normal to have a small amount in body; protein that helps your body absorb fats (for pancreas)				
Lactic Acid Substance made by muscle tissue; high disrupt a person's acid pH balance; lactic acidosis caused by not enough oxygen in cells/ tissues	4.5-19.8	9	N/A	

Other Tests

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR Measures the time for the blood to clot	0.8- 1.1 2-3 is therapeutic range for people of warfarin	1.0	N/A	
PT Monitor blood-thinning medicines	10 to 12 seconds	12 seconds		
PTT Screening test that helps evaluate a person's ability to form blood clots; number of seconds it takes for a clot to form in a sample of blood	25-35 seconds	N/A	N/A	
D-Dimer Blood test used to rule out a blood clot; protein fragment from the breakdown of a blood clot	Negative	N/A	N/A	
BNP Measures protein that is made by your heart and blood vessels (higher in heart failure)	Less than 100	N/A	N/A	
HDL Measures the level of	60	N/A	27	This patient having low HDL cholesterol puts her at higher risk for heart disease.

good cholesterol in the blood				Hypertension and obesity (which this patient has a history of) can result in low HDL-cholesterol.
LDL Measures the amount of “bad” cholesterol in the blood; increases risk of hardening of the arteries	Less than 100	N/A	42	
Cholesterol	120- 200	N/A	93	
Triglycerides	Less than 150	N/A	122	
Hgb A1c Measures your average blood sugar levels over the past 3 months; commonly used to diagnose prediabetes and diabetes	Below 5.7%	5.4	5.7	
TSH Thyroid stimulating hormone; located near your throat; the thyroid makes hormones that regulate the way your body uses energy	0.4-4	N/A	N/A	

Urinalysis

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
COLOR & CLARITY	Colorless- Yellow, Clear	Yellow/ Hazy	Yellow/ Cloudy	This patient presented to the ED with yellow and hazy urine due to her urinary tract infection. Patient also stated she noticed the

				change in color in her urine accompanied by her foul-smelling urine. With a UTI, it is normal for patients to have hazy or cloudy urine. UTIs can cause cloudy or milky urine due to an excess of white blood cells used by the body to fight a UTI.
pH	6-8.0	6	7	
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	1.013	1.023	
GLUCOSE	Negative	Negative	Negative	
PROTEIN	0-8	Negative	Negative	
KETONES (fuels for the body that are made when glucose is in short supply)	Negative	Negative	Negative	
WBC	0-4	51-150	21-50	When the white blood cell count in urine is high, it may indicate that there is inflammation in the urinary tract or kidneys. In this patient's case, she did have a UTI which causes an infection and inflammation in the urinary tract due to bacteria.
RBC	0-3	0-2	0-2	
LEUKOESTERASE	Negative	Few	Few	This suggest that there are white blood cells in the urine which is indicative of a urinary tract infection which this patient presented with.

Cultures

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
URINE CULTURE	Negative	Greater than 100,00 CFU/ML Escherichia Coli	N/A	A culture of over 100,000 Escherichia coli were present in this patient's urine upon admission due to the incompletely treated infection or

				the urinary tract. E. Coli. Is the most common type of bacteria that cause a UTI in women due to a number of reasons but mainly dealing with improper hygiene wiping front to back after during the toilet.
BLOOD CULTURE	Negative	N/A	N/A	
SPUTUM CULTURE	Negative	N/A	N/A	
STOOL CULTURE	Negative	N/A	N/A	

Lab Correlations Reference: .

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):

1. Exam: Ultrasound Renal Complete (1/20/2021 1437)

Comparison: Unenhanced CT abdomen and pelvis

Findings:

The kidneys are prominent with normal echogenicity and without hydronephrosis or solid mass. There are possibly small, obstructing calculi bilaterally. The right kidney measures 5.6 x 7 x 13.2cm and has 2 small unilocular cysts and a small amount of perinephric fluid. The left kidney measures 7.4 x 5.2 x 13.8 cm. The urinary bladder is mildly distended with normal morphology and a measured volume of 61 mL. No significant wall thickening, mass, calculus, diverticulum, or adjacent fluid collection is noted. The anterior wall measures 3-4 mm in thickness. Of incidental note, there is fatty infiltrating of the liver.

2. Exam: X-RAY Chest Single View Portable

Findings:

- AP portable semi upright view of the chest.
- Cardiac silhouette and mediastinum: Unremarkable considering AP positioning and low lung volume. Atherosclerotic calcification of the thoracic aorta. Trachea projects midline. Pulmonary vessels and hila: unremarkable.
- Lungs: Elevation of the right hemidiaphragm. Right basilar calcification is unchanged. Mild interstitial prominence is unchanged. No focal consolidation.
- Pleura: No effusion or pneumothorax.
- Chest wall: Postsurgical changes of the left axilla.
- Degenerative changes of the spine. Impression was hypoinflated exam. No acute abnormality or significant change.

Diagnostic Test Correlation (5 points):

1. In this patient's chart, it stated an ultrasound of the kidneys, ureters and bladder was ordered to check for sepsis as well as there being a concern for hydronephrosis and pyelonephritis due to her then present UTI. If UTIs are frequent in individuals, which this patient stated she has had 4-5 UTIs prior before although her symptoms differed this time, "a doctor may order an ultrasound

to check for kidneys and bladder irregularities that may require treatment” (Alshamsan et al., 2009).

2. A single view chest x-ray was order for this patient due to her history of shortness of breath, fever with chills, history of COPD and diabetes, breast cancer, prior smoker. This patient also presented to the ED the day of admission with a reported fever. This test was ordered to monitor the progress of potentially medical conditions like heart failure.

Diagnostic Test Reference:

Alshamsan, L., Al Harbi, A., Fakeeh, K., & Al Banyan, E. (2009). The value of renal ultrasound in children with a first episode of urinary tract infection. *Annals of Saudi Medicine*, 29(1), 46–49. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2813611/>

Current Medications

Brand/Generic	Acetaminophen (Tylenol)	Atorvastatin (Lipitor)	Ceftriaxone (Rocephin)	Enoxaparin (Lovenox)	Montelukast (Singular)
Dose	650 mg (tablet)	5 mg per half tablet	2 g	40 mg	10 mg
Frequency	Every 24 hours PRN	Daily	Every 24 hours	Every 24	Every evening

				hours	
Route	Oral	Oral	IV	SubQ injection	Oral
Classification	Analgesic, Antipyretics	HMG-CoA reductase inhibitors; statins	Antibiotics	Anticoagulants	Anti-inflammatory; LTRAs
Mechanism of Action	Inhibits the COX pathway in the central nervous system but not peripheral tissues	Prevents the conversion of HMG-CoA to mevalonate, statin medications decrease cholesterol production in the liver	Selectively and irreversibly inhibits bacterial cell wall synthesis by binding to transpeptidases	Binds and accelerates the activity of antithrombin III, an enzyme which causes blood to clot by acting on a blood protein called fibrogen. It also inhibits coagulation factors Xa and IIa	Works by blocking the action of substances in the body that causes symptoms of asthma and allergic rhinitis
Reason Client Taking	Mild or severe pain	Used along with a proper diet to help lower LDL and triglycerides and raise HDL in the blood	Treat bacteria from UTI	Prevent formation of blood clot while being hospitalized due to decrease mobility	Asthma
Contraindications (2)	Acute liver failure, caloric undernutrition, inflammation of the liver due to hepatitis c virus	Liver failure, alcoholism, untreated decreased level of thyroid hormones, decreased kidney function	Diarrhea from an infection with C. diff., liver problems, disease of the gallbladder, renal impairment	Bleeding Operation on the spine Eye surgery	Suicidal thoughts, depression, inflammation of blood vessels in the skin, anxiety disorder
Side Effects/Adverse Reactions (2)	Nausea, stomach pain, itching	Joint pain, nausea, stomach pain or discomfort	Rash, vomiting, dizziness, headache	Pain, bruising, fever, bleeding	Headache, stomach pain, cough

Nursing Considerations (2)	Consult physician if needed for longer than 10 days Avoid using multiple preparations containing acetaminophen	Monitor liver function test prior to initiation of therapy Monitor renal function	Watch for seizures Monitor for diarrhea	Monitor for signs of bleeding Administer in subcutaneous tissue	Assess respiratory status Should only be taken once daily at night because of higher plasma concentration at the moment
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Brand/Generic	Ropinirole (Reequip)	Ondansetron (Zofran)	Magnesium Hydroxide (milk to magnesia)	Insulin Lispro (Humalog)	Glucose (glucose)
Dose	0.5 mg tablet	4 mg	30 mL	2-12 units	15 g
Frequency	Every night	Every 12 hours	Daily	4x daily with meals and nightly	PRN
Route	Oral	Injection	Suspension	Injection	Oral gel
Classification	Dopamine agonists	5-HT ₃ antagonist	Laxative	Insulin	Glucose-elevating agent
Mechanism of Action	Stimulates dopamine D ₂ receptors within the caudate putamen in the brain	Serotonin receptors of 5-HT ₃ type are present both peripherally on vagal nerve terminals and centrally in the chemoreceptor trigger zone of the area postrema	Draws water into the intestine, an effect that helps to cause movement of the intestine	Lowers blood glucose by stimulating peripheral glucose uptake by skeletal muscle and fat, and by inhibiting by skeletal muscle and hepatic glucose production	Used to increase the blood sugar when it is falling too low
Reason Client Taking	Patient has a history of restless leg syndrome	PRN nausea	Upset stomach and indigestion	Diabetes type 2 to lower blood sugar	Hypoglycemia
Contraindications (2)	Orthostatic hypotension, drowsiness, hallucinations, dyskinesia	Fever, serotonin syndrome, neuroleptic malignant syndrome	Dehydration, kidney function, seizures, appendicitis	Hepatic disease, hypoglycemia, hypokalemia	OTC medicine

Side Effects/Adverse Reactions (2)	Nausea, stomach pain, constipation, diarrhea	Headache, constipation, weakness, tiredness, chills	Diarrhea, stomach cramps, vomiting	Nausea, hunger, sweating	Cough, itching, difficulty swallowing
Nursing Considerations (2)	Use gait training Coordination exercise should be implemented in therapeutic exercise	Can cause balance problems (fall risk) Monitor for decreased bowel activity	Should be taken 1-2 hours before meals Do not use long term or excessively	Give 15 minutes before meals or immediately after meals Rotate sites	Should not be used at or around the time of eating Education patient not to drink or smoke

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

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient is an elderly Caucasian female. She appears to be alert and orientated to situation and person, time and place. When asked what year and month it was, the patient answered correctly. Patient knew exactly where she was and for what. Patient does assistive devices like glasses and hearing aids bilaterally for the past 14 years. Patient denies the use of any other assistive devices like a walker, wheelchair or cane. Patient appears to be well groomed and in no acute distress, well-developed and not ill-appeared. Patient was calm and cooperative.</p>
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	<p>Patient appears stated age.</p> <p>Patient denies fatigue, weight changes, fevers, chills, night sweats currently.</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Patient’s skin is warm, pink and dry. No rashes or lesions or erythema. Patient has no drainage. Patient has no bruising to her 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 3 (slightly limited), moisture 4 (rarely moist), activity 3 (walks occasional), mobility 3 (slightly limited), nutrition 3 (adequate), friction shear 3 (no apparent problem).</p> <p>Patient denies dryness, rashes, lesions, non-healing sores, hair changes, purities.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>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 states she has never worn braces and explains that good dentation runs in her family. Both her parents did not wear dentures towards their later years of their life and had few missing teeth. 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 does wear a hearing aid and has for the past 14 years. Patient states that each year, her doctor has to increase the strength of her hearing aid due to her poor hearing. Patient states even with hearing aids in, she still has a difficult like hearing people and this has heightened due to her mask regulations. Patient states she does notice that people have to talk to her laughter and clearer in her left ear being that that is the hear she has more decreased hearing in compared to her right ear.</p> <p>Patient denies experiencing headaches, head injury, blurry vision, double vision, earache, drainage, nasal congestion, nose bleeds, nasal drainage, dry mouth, sore throat, swallowing difficulty at the time of the assessment.</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill:</p>	<p>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. Patient does present with edema in her lower extremities at the time of this assessment. Patient’s edema was a +1 (trace) in her ankle, leg and foot bilaterally throughout. Patient’s extremities appeared to have no discoloration. Edema was both observed and palpated</p>

<p>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema: legs, foot and ankle bilaterally through out</p>	<p>bilaterally in leg, foot and ankle throughout 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.</p> <p>Patient denies chest pain, palpitations, diaphoresis, dyspnea, PND, Orthopnea, claudication.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>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.</p> <p>Patient denies wheezing, cough, increase in sputum production. Anterior, lateral, clear and equal bilaterally.</p>
<p>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 <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Patient is on a consistent carb diabetic while being hospitalized. Patient states she would describe her eating habits and diet at home to be “good”. Patient goes on to state she “doesn’t eat hamburger every day” and has a balance between vegetables and fruits. She states she loves to cook, but especially bake for her neighbors. Patient states she is just like her mother in the case that she considers herself an “old fashion cook”. Patient also stated she watches what she eats daily because she watches the amount of sugar she consumes. Patient states although this is not often, she enjoys eating steak, baked potatoes or a stir fry and casserole for dinner. Patient is considered overweight as evidenced by her BMI of 31.36 and appearance.</p> <p>While hospitalized, eats well and shows no signs of difficulty eating. Patient uses no assistive devices to aide in eating. Patient does not require set up help with each meal. Patient is 5’3”. Patient weights 178 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 1/20/21. Patient described bowel movement as being brown and “normal for me”. Patient stated she is not having any difficulty having a bowel movement. Patient describes her recent bowel movement as being “soft”. Patient is passing flatus and tolerating full liquids well.</p> <p>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 1/20/21. Patient’s bowel movement was described as being brown and soft. _____</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Patient’s urine appears to be yellow, clear and absent of foul odor. Patient has a normal stream of urine and consent flow. Patient’s genitals appear to be intact, no abnormalities noted. Patient does not have episodes of incontinence. Patient voids spontaneous without difficulty. Patient voided twice during my shift and was not incontinent. Patient’s urine was clear yellow, no malodor and not</p>

<p>Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>cloudy. Patient described her urine production as now being good since being hospitalized and getting her UTI resolved. Patient stated she has no difficulty urinating or starting urinary flow.</p> <p>Patient denies burning or pain, hematuria, incontinence, flank pain while urinating.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> X Needs support to stand and walk <input type="checkbox"/></p>	<p>Patient appeared to be alert LOC. Patient arousal level was she opened her eyes spontaneously. Patient is a one assist with stand by assist. Patient required no queing or set up assistance. Patient demonstrated active range of motion bilaterally throughout. Patient’s fall risk score is a 10 (2 – age greater than 65, 8 – unsteady gait or weakness). Patient’s bed alarm is 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 standby assist and gait belt. Patient ambulated approximately 5 feet to and from the bathroom to her recliner. Patient tolerated ambulation well. Patient tolerated ambulation well. Patient showed no signs of difficulty breathing.</p> <p>Patient is a standby assist. Patient needed no cueing and set up assistance. Patient was encouraged to engage in as much as she can independently, all personal objects within reach. Patient’s general motor response was normal. At home, patient is completely independent with ambulating, feeding, dressing, bathing and all activities of daily living.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>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.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>Patient states she is not really a stressed-out person and rarely deals with stressors in her life, so she has no active coping methods. Patient states she enjoys baking and spending time with her 2 children, her daughters who both live close by to her in the Danville area. Patient’s developmental level is appropriate for her age. Patient stated she is a Bethlehem Lutheran. Patient goes on to state she “never saw a day you couldn’t go to church”. Patient states her and her siblings grew up in church and her parents always thought them the importance of religion and God. When asked what her religion means to her, the patient stated it “means a lot to me and I believe in God, I have to have that”. Patient lives alone and is widowed. Patient states she has no plans of remarrying. Patient maintains a healthy relationship with her two daughter who are her only children. Patient states they have a close relationship and talk to one another every day. Patient states she also maintains a close relationship with her 2 adopted teenager grandchildren. Her primary source of support/ comfort is extended family. Again, patient lives alone with no caregiver needed. Patient</p>

	states she lives in a nice neighborhood by the lake where her neighbors are close and check in on one another. She goes on to state she enjoys baking for them and they enjoy her food. Patient is very pleased with where she resides and states she feels safe.
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Vital Signs

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0734	79 (left radial)	123/72	18 (unlabored)	97.1 (oral)	93% (room air)
1045	76 (left radial)	121/73	14 (unlabored)	98.0 (oral)	94% (room air)

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
0710	Number (numeric rating scale) Patient stated pain was a 5 out of 10.	Lower back	Sore, severe intensity	Sharp, persistent	Medication: patient stated it was effective
1100	Number (numeric rating scale) Patient stated pain was a 0 out of 10.	Patient stated she is currently in no pain what so ever.	N/A	N/A	N/A

IV Assessment

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	Peripheral IV Line – Single Lumen 1/19/21 median cubital vein (antecubital fossa) left 18 gauge; 1 in length Site preparation/ miniatous: dressing, dry intact Indication/ daily review: medication therapy Securement: sterile tap strips Flushed without difficulties No signs or symptoms of erythema, drainage, infiltration

Intake and Output

Intake (in mL)	Output (in mL)
400 mL – water Patient did not have an IV solution running at the time of assessment.	Patient voided twice during the shift from 0715-1200. Patient’s urine was clear and yellow, no foul odor. Patient denies any difficulties with voiding. Patient voided in the toilet (amount was unmeasured). Patient is not on strike input and output.

Nursing Care

Summary of Care

Overview of care:

Patient up in chair a majority of the shift. Patient ambulated to the bathroom at 0715 with no difficulties. Patient’s urine was yellow and clear and no foul odor present. Patient remained up in the chair watching television. Patient’s vitals were then obtained at approximately 0745.

Procedures/testing done:

Patient's blood sugar was obtained by the prior shift. Patient's lab values show improve in the patient's infection. Although of the patient's lab values are considered to be elevated if looking at the normal range, it is still decreased and a major improved in comparison to her lab values upon admission. For example, the patient's overall WBC has decreases dramatically, but still remains elevated and will probably persist until her antibiotic treatment is fully completed.

Complaints/Issues:

patient complained of pain in her lower back when getting out of bed, however 30 minutes after given a pain medication, patient stated her pain was resolved and decreased to a 1 out of 10 on a numerical pain scale.

Vital signs (stable/unstable):

Patient's vital signs were within normal range, there were no abnormalities present.

Tolerating diet, activity, etc.:

Patient shortly after ate breakfast. Patient required no assistance with feeding. Patient tolerated food good. Patient ate 75% of meal and drank 300 mL of water.

Physician notifications:

Last physician update 1/20/21 @ 0726: "S.W. was seen on morning rounds and says she feels overall better and has her appetite back. Patient did mention an episode of night sweats one night ago."

Future plans for patient:

Patient has to be seen by occupational therapy 3-4 weeks to address impairment and functional limitations.

Discharge Planning**Discharge location:**

Upon discharge, patient will be returning to her one-story house, which is closely located to her 2 daughters, whom she mentioned will be checking on her more physically.

Home health needs (if applicable):

Patient will not require home health care upon discharge, as she is fully independent in her care along with her having the assistance of her daughters if she does happen to require more assistance.

Equipment needs (if applicable):

Patient will not require equipment needs upon discharge.

Follow up plan:

Post discharge for this patient will include a follow up phone call along with follow up with primary doctor. Referral needs respiratory needs

Education needs:

Glucose monitoring, dietary restriction (low sodium diet) and blood pressure monitoring, when to seek medical attention for new symptoms, how to take new medications or home medication and side effects or changes, safe medication disposal, fall risk prevention, increase fluid to prevent another UTI, sleep and rest

Nursing Diagnosis

Nursing Diagnosis	Rational	Intervention	Evaluation
1. Infection related to	This patient is at an increased risk of	1.Observe and report signs of infection such	<ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan. 1. Goal met. Patient displayed no signs

<p>hyperglycemia, impaired healing, circulatory changes, failure to consume adequate nutrition, damage to neutrophil function, decreased leukocyte function as evidenced by prolong wound healing, current presents of infection, elevated WBC count both in urine and blood, edema</p>	<p>developing an infection due to her already presenting with a small wound on her left leg. Wounds are prone to infection and that risk increases with hospitalization. Patient also was +1 pitting edema in her lower extremities in her legs, ankles and foot. Edema occurs when the heart is unable to circulate an adequate supply of blood throughout the body which causes it to collect in the lower extremities which impairs circulatory function. This patient also has a present infection of the urinary tract that is being resolved. Upon admission, this patient presented with an elevated WBC of 16.20, neutrophils 81.9 and lymphocytes of 49% along with an elevated WBC in urine with 51-150. Although all of these labs have seen been decreased since the start of her antibiotic therapy this still posts a risk for infection.</p>	<p>as redness, warmth, discharge and increased body temperature throughout shift from 0715 to 1200 on 1/21/21.</p> <p>2. All staff will use appropriate hand hygiene by using hand washing or the use of alcohol-based hand rubs throughout shift from 0715 to 1200 on 1/21/21 to prevent the exposure of infection to this patient.</p>	<p>of redness, warmth, discharge or an increased body temperature throughout shift on 0715 to 1200 on 1/21/21. At 0715, patient's vital signs were taken, and her temperature was 97.1 oral and taken again at 1100 and was 98.1 oral.</p> <p>2. Goal met. Staff use alcohol-based rub prior to entering the patient's room as well as leaving the patient's room throughout shift on 0715 to 1200 on 1/21/21.</p>
<p>2. activity intolerance related to fatigue, energy</p>	<p>This is in relation to the patient having Asthma. Patient</p>	<p>1. Schedule and provide rest periods in a calm peaceful</p>	<p>1. Goal accomplished. Patient look a</p>

<p>shift to meet muscle needs for breathing to over air way obstruction as evidenced by current diagnoses of asthma, stated she sometimes feel short of breath and tired after ambulating periodically</p>	<p>states every once in a while, she does become short of breath when ambulating for a long distance or period of time. Patient does have an inhaler that she uses when this occurs.</p>	<p>environment during care throughout shift from 0715-1200 on 1/21/21 to promote adequate rest and decrease stimuli.</p> <p>2. Assess the patient's baseline cardiopulmonary status by checking her heart and pulse oximetry before initiating activity on 1/21/21 by 0715 to assess if there is an increase in oxygen demands during physical activity.</p>	<p>break in recliner after washing up and brushing her teeth during morning care at 0800 on 1/21/21. Patient stated although she was not severely short of breath at that present moment, taking a break really helped her regard her breath.</p> <p>2. Goal met. Patient's vital signs (pulse oximetry, heart rate and respiration) were within normal range after starting morning care on 1/21/21 at 0800.</p>
<p>3. Ineffective health maintenance related to deficient knowledge regarding methods to treat and prevent urinary tract infections as evidence by 4-5 reoccurring UTIs in the pass 5 years and unfamiliarity with nature and treatment of UTI, multiple questions</p>	<p>This is in relations to this patient stated she has had 4-5 UTIs in the past 5 years. Patient stated her symptoms have worsen with age and she did not experience his put pain with her previous UTIs. Patient states she was informed by her doctor this could largely be due to the progressive of age. Patient stated she is still very unclear to have to she has had so many within the past 5 years. Frequent recurrence of UTIs may</p>	<p>1. Explain to the patient about UTI risk factors and preventions by the ending of the shift at 1200 on 1/21/21.</p> <p>2 Encourage the patient to finish all prescribed antibiotics when if she notices symptoms have decreased or resolved by 1200 on 1/21/21.</p>	<p>1. Goal met. Patient was able to verbalize back to me that wearing constricting undergarments and improper perineal hygiene especially after a bowel movement can increase the risk of her developing another UTI by the end of the shift on 1/21/21.</p> <p>2. Goal met. Patient agreed she will finish all of her prescribed home medication upon discharge even if she starts feeling better. Patient</p>

	indicate that the patient has no understanding of the disease and its management.		stated this by the end of the shift at 1200 by 1/21/21.
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Other References (APA):

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

Concept Map

Subjective Data

- Patient stated periodically she feels “short of breath and tired when I walk for a long time or for a long time”
- “I have had 4-5 UTIs in the past 5 years.”
- Patient stated she is unsure the cause of her recurrent UTIs in the past 5 years.
- Patient states symptoms of her UTI this time have elevated and was worse in comparison to previous UTIs.

Objective Data

- History of Asthma
- Uses an inhaler for Asthma
- Currently hospitalized and receiving antibiotics for UTI the is reoccurring
- Small wound in lower extremity (left lower leg) the is unhealed
- +1 edema in legs, ankles and foot
- WBC elevation in blood of 16.20
- WBC elevation in urine 51-150
- Neutrophils elevation in blood 81.9
- Lymphocytes elevated of 49% in the blood

Patient Information

Patient is a 77-year-old white female with history of hypertension, hyperlipidemia and COPD presents to the ER secondary to body aches, chills, fever, headache, urinary frequency, dark/ smelly urine since Friday. Patient stated she was “really sick with child with fever”. Patient goes on to state, “I thought I was going die. It was going on and one and wasn’t getting any better.” Patient has been tested 3 times for COVID and one time for the flu all of which have been negative. Patient denies any nausea, vomiting, diarrhea, constipation, chest pain, patient denies any hematuria. Does have history of right kidney stone and UPJ obstruction on CT abdomen in 2018.

Nursing Diagnosis/Outcomes

1. Activity intolerance **related to** fatigue, energy shift to meet muscle needs for breathing to over air way obstruction **as evidenced by** current diagnoses of asthma, stated she sometimes feel short of breath and tired after ambulating periodically
 - a. Goal accomplished. Patient look a break in recliner after washing up and brushing her teeth during morning care at 0800 on 1/21/21. Patient stated although she was not severely short of breath at that present moment, taking a break really helped her regard her breath.
 - b. Goal met. Patient’s vital signs (pulse oximetry, heart rate and respiration) were within normal range after starting morning care on 1/21/21 at 0800.
2. Infection **related to** hyperglycemia, impaired healing, circulatory changes, failure to consume adequate nutrition, damage to neutrophil function, decreased leukocyte function **as evidenced by** prolong wound healing, current presents of infection, elevated WBC count both in urine and blood, edema
 - a. Goal met. Patient displayed no signs of redness, warmth, discharge or an increased body temperature throughout shift on 0715 to 1200 on 1/21/21. At 0715, patient’s vital signs were taken, and her temperature was 97.1 oral and taken again at 1100 and was 98.1 oral.
 - b. Goal met. Staff use alcohol-based rub prior to entering the patient’s room as well as leaving the patient’s room throughout shift on 0715 to 1200 on 1/21/21. Patient was also able to verbalize the importance of adequate hand hygiene to prevent another UTI and infection.

Nursing Interventions

- 1a. Schedule and provide rest periods in a calm peaceful environment during care throughout shift from 0715-1200 on 1/21/21 to promote adequate rest and decrease stimuli.
- 1b. Assess the patient’s baseline cardiopulmonary status by checking her heart and pulse oximetry before initiating activity on 1/21/21 by 0715 to assess if there is an increase in oxygen demands during physical activity.
- 2a. Observe and report signs of infection such as redness, warmth, discharge and increased body temperature throughout shift from 0715 to 1200 on 1/21/21.
- 2b. All staff will use appropriate hand hygiene by using hand washing or the use of alcohol-based hand rubs throughout shift from 0715 to 1200 on 1/21/21 to prevent the exposure of infection to this patient.

