N321 Care Plan # 1

Lakeview College of Nursing

Ashley Webber

Demographics (3 points)

Date of Admission 1/20/21	**Patient Initials** KH	**Age** 67	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired Social Worker	**Marital Status** Married	**Allergies** • Bee Pollen (Swelling, documented on 3/28/11) • Dicloxacillin (Rash, chart indicates the patient is not sure if this or Doxycycline, documented on 2/20/13) • Doxycycline (Rash, chart indicates the patient is not sure if this or Dicloxacillin, documented on 2/20/13) • Erythromycin (Rash, documented 3/3/11) • Naproxen (Rash, documented on 2/20/13)
Code Status Full Code	**Height** 162 cm	**Weight** 73.94 kg	

Medical History (5 Points)

Past Medical History:

- Atrial Fibrillation
- Diabetes Mellitus Type II
- Anticoagulant Therapy
- Cirrhosis of the liver
- Sleep Apnea
- Degenerative disk disease
- Restless leg syndrome
- Sink sinus syndrome

Past Surgical History:

- Gallbladder removed date not noted
- Tonsils removed date not noted
- Appendix removed date not noted

- Tubal ligation date not noted
- Pacemaker date not noted

Family History:

Patient states her parents both passed away from cancer, nothing was noted in chart. Patient showed signs of sadness so didn't push for more information of which types.

Social History (tobacco/alcohol/drugs):

Patient is a retired social worker for the Vermillion County Public Health Department. Patient quit smoking just over thirty years ago. Patient denies any drug usage and will occasionally have a glass of wine, the last one being on Thanksgiving. Patient indicates she has two children, one daughter and one son as well as a handful of grandchildren.

Assistive Devices:

Patient uses glasses and does not typically need assistance when walking but since admission has been using a walker

Living Situation:

Patient states she lives at home with her husband in the Danville area. Patient typically spends her day grocery shopping, cooking, cleaning the dishes, doing crossword puzzles as well as sudoku books. Patient's husband is present at bedside and states he still works during the week. Patient's children do live within 20-30 minutes of their house.

Education Level:

Patient graduated high school and college with a degree in social work.

Admission Assessment

Chief Complaint (2 points):

- Patient became weak, confused, had difficulty speaking and balancing. She is being seen this admission to rule out a stroke as well as addressing cellulitis in her right leg.

History of present Illness (10 points):.

- Patient reports she had similar symptoms back in October/November of 2020 and was admitted for stroke rule out. Per the patient the cause of those symptoms is still unknown. On 1/20 patient got up to go to the bathroom and became weak while walking back to living room. It became difficult for her to speak and she was confused. Her husband came home from work and brought her to the Emergency Room. Patient believes she has had a stroke as well as cellulitis in her right leg. Patient indicates onset occurred when she got up to walk on 1/20 her right foot/ankle hurts and noticed the calf region to be red. The pain is located in her lower right leg and is constant. Especially while the patient is up and putting pressure on leg or if she is dangling off the side of bed. Patient states characteristics of pain as a sharp shooting pain. Walking or dangling are the aggravating factors. The pain is relieved when sitting with legs elevated. Treatment was sought and patient is not receiving broad-spectrum antibiotics until urine culture is resulted.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):.

- Rule Out Stroke

Secondary Diagnosis (if applicable):.

- Cellulitis of Right Leg
- Urinary Tract Infection

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

In an ischemic stroke, there is a disruption of the cerebral blood flow due to obstruction of a blood vessel. The disruption of blood flow signals a complex series of cellular metabolic events referred to as the ischemic cascade (Hinkle, p. 2010). During the ischemic cascade events the patient may present with any of the symptoms listed, numbness or weakness of face, arm or leg, confusion or change in mental status, trouble speaking or understanding speech, visual disturbances, difficulty walking or loss of balance, and/or sudden severe headache (Hinkle, p. 2011). Lab tests that indicate a stroke would include complete blood count, serum electrolytes, thyroid panel, as well as cholesterol panel. Diagnostic tests performed to identify a stroke include computed tomography scan (CT scan) and electrocardiogram (EKG). Treatment for a stroke would include IV thrombolysis which would dissolve the clot that is blocking arterial blood flow and allows for reperfusion to occur (Capriotti, p. 816).

KH presented to the Emergency Department with weakness in her legs, confused state, difficulty speaking and loss of balance. Computed tomography scan and electrocardiogram were both performed as well as labs drawn. Based on the results of all three it was determined KH did not suffer a stroke but rather has cellulitis in her right leg and a urinary tract infection which together formed her symptoms.

Cellulitis arises when an entry point through normal skin barriers allows bacteria to enter and release toxins into the subcutaneous tissues. The pathogen is classically either Streptococcus or Staphylococcus aureus (Hinkle, p881). Cellulitis will present with swelling, localized redness, warmth and painful. It could also include a fever, chills and/or sweating. Mild cases of cellulitis are often treated outpatient with antibiotic’s however the more severe cases require hospitalization with IV medications. Potential sites of bacterial entry include cracks and fissures

in the skin between toes, contusions, abrasions, ingrown toenails and hangnails (Hinkle, p881). All of these need to be assessed to find the portal of entry to ensure this doesn't occur again.

Upon admission to the Emergency Department, KH had redness and warmth to the touch of her right leg between knee and ankle region. Emergency room staff marked with skin marker the borders of the redness which were approximately one inch below the knee to one inch above the ankle. At time of student assessment, approximately twenty-four hours since arrival the redness has reduced to two inches below the knee and two inches above the ankle. KH was placed on broad-spectrum antibiotic which is why the redness has reduced.

A Urinary Tract Infection (UTI) is caused by pathogenic microorganisms in the urinary tract. For the infection to happen the bacteria must gain access to the bladder to attach to and colonize the epithelium of the urinary tract and avoid being washed out with voiding (Hinkle, p.1616). Bacteria can enter the urinary tract in three ways, ascending infection, hematogenous spread, or direct extension. An ascending infection would be by the transurethral route. Hematogenous spread is through the bloodstream. Direct extension would be a fistula from the intestine. Symptoms of a UTI include frequency, pain or burning on dysuria, urgency and at times hematuria (Capriotti, p. 552). A urinalysis and urine culture are collected to diagnose a UTI. Treatment would be to provide antibiotics depending on the severity the patient could take oral antibiotics and recover at home or in severe cases the patient is admitted and given intravenous antibiotics.

KH's urinalysis showed multiple abnormalities which would indicate the UTI. Her urine culture was not back at time student left the floor however she was started on a broad-spectrum antibiotic until results are finalized.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2020). *Pathophysiology Introductory Concepts and Clinical Perspectives* (2nd ed.). F.A. Davis Company.

Hinkle, J. & Cheever, K. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Wolters Kluwer.

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	3.8 - 5.3	5.42	5.28	Red blood cell counts are increased in patients with sleep apnea. Patient has a history of sleep apnea which is the cause of elevated sleep apnea. (Pagana, p. 418)
Hgb	12.0 – 15.8	16.8	16.3	Hemoglobin are elevated in patients that are dehydrated. KH is on IV fluids to ensure she stays hydrated and has improved her Hgb since fluids started. (Pagana, p. 419)
Hct	36 -47	48.6	47.3	Hematocrit is elevated in patients that are dehydrated. KH is on IV fluids to ensure she stays hydrated and has improved her Hct since fluids started. (Pagana, p. 419)
Platelets	140 - 440	184	166	-
WBC	4 - 12	15	12.30	White blood cell counts are elevated in patients who have an infection. KH has a urinary tract infection as well as cellulitis which is causing the elevation. (Pagana, p. 422)
Neutrophils	47 - 73	66.3	58.3	-
Lymphocytes	18 – 42	22.1	25.8	-
Monocytes	4 – 12	10.4	12.9	Monocytes are elevated when your body is fighting an infection. KH is fighting two infections which is the

				cause of elevation. (Pagana, p. 423)
Eosinophils	0 – 5	.5	1.9	-
Bands	N/A	N/A	N/A	-

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-	133 – 144	132	131	Decreased sodium levels are a complication of cirrhosis. KH has past medical history of cirrhosis and is the result of low sodium value. (Pagana, p. 444)
K+	3.5 – 5.1	3.7	3.3	Decreased potassium levels are a complication of cirrhosis. KH has past medical history of cirrhosis and is the result of low potassium value. (Pagana, p. 444)
Cl-	98 – 107	97	96	Decreased chloride levels are a complication of cirrhosis. KH has past medical history of cirrhosis and is the result of low chloride value. (Pagana, p. 446)
CO2	21 – 31	23	26	-
Glucose	70 – 99	178	230	Elevated glucose is sign of diabetes. KH has diabetes type II which is reason for elevated glucose. ((Pagana, p. 525)
BUN	7 – 25	24	25	-
Creatinine	0.5 – 1	1.2	.89	Increased creatinine levels are a complication of cirrhosis. KH has past medical history of cirrhosis and is the result of high creatinine value. (Pagana, p. 530)
Albumin	3.5 – 5	4		-
Calcium	8.8 – 10.2	9.4	8.6	Decreased calcium levels are a complication of cirrhosis. KH has

				past medical history of cirrhosis and is the result of low calcium value. (Pagana, p. 531)
Mag	1.6 – 2.6	1.7	1.6	-
Phosphate	N/A	N/A	N/A	-
Bilirubin	0.2 – 1.3	1.5		Elevated bilirubin levels are a complication of cirrhosis. KH has past medical history of cirrhosis and is the result of high bilirubin value. (Pagana, p. 527)
Alk Phos	38 – 126	89		-
AST	14 – 36	44		Increased AST levels are a complication of cirrhosis. KH has past medical history of cirrhosis and is the result of high AST value. (Pagana, p. 545)
ALT	0 – 34	23		-
Amylase	N/A	N/A	N/A	-
Lipase	N/A	N/A	N/A	-
Lactic Acid	N/A	N/A	N/A	-

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	N/A	N/A	N/A	-
PT	N/A	N/A	N/A	-
PTT	N/A	N/A	N/A	-
D-Dimer	>600	563		-

BNP	N/A	N/A	N/A	-
HDL	>40	45		Elevated HDL level indicates heart disease. KH had a pacemaker placed as her heart is weakened. (Pagana, p. 610)
LDL	<130	92		-
Cholesterol	<200	167		-
Triglycerides	<150	<150		-
Hgb A1c	4 – 6	14		Elevated A1c is a complication of diabetes mellitus. KH has type II diabetes and is the cause of elevated A1c. (Pagana, p. 526)
TSH	0.27 – 4.2	26.354		Elevated TSH is a complication of both diabetes mellitus and cirrhosis. KH is diagnosed with both and is the reason for elevated TSH. (Pagana, p. 618)

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	Golden Cloudy		Abnormal color and clarity or urine indicates an infection. KH has a UTI which is the cause of color and clarity in urine. (Pagana, p. 720)
pH	5 – 9	5.0		-
Specific Gravity	1.003 – 1.03	1.016		-
Glucose	Negative	Negative		-
Protein	Negative	Negative		-
Ketones	Negative	Trace		Ketones in urine is a complication of diabetes. KH has diabetes type II and is the cause of trace ketones. (Pagana, p. 721)
WBC	0 – 5	21 – 50		Elevated WBC is a complication of a UTI. KH has a UTI and is the

				cause of elevated WBC. (Pagana, p. 721)
RBC	0 – 2	0-2		-
Leukocyte esterase	Negative	3+		Elevated leukocyte esterase is a complication of a UTI. KH has a UTI and is the cause of presence in urine. (Pagana, p. 720)

Lab Correlations Reference (APA): .

Pagana, Kathleen Deska & Pagana, Timothy J. (2017). *Mosby's Manual of Diagnostic and Laboratory Tests.* (6th ed.) Elsevier.

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	Collected but pending	N/A	N/A	Results not back yet
Blood Culture	N/A	N/A	N/A	
Sputum Culture	N/A	N/A	N/A	
Stool Culture	N/A	N/A	N/A	

Lab Correlations Reference (APA): N/A

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- Computerized Tomography (CT) Scan Head/Brain without contrast on 1/20/21

- A Computerized tomography without contrast is performed to show if the patient is having a stroke (Capriotti, p. 814). KH presented to the ED with weakness, confusion difficulty speaking and balancing. CT Scan was ordered to rule out or diagnosis stroke. Per the radiologist note the brain showed no acute infarction or acute hemorrhage. No mass effect or midline shift present. Ventricles were normal in caliber with basal cisterns clear. Bones/Joints were intact with no acute fractures. Soft tissues and scalp intact. Sinuses were scattered mild mucoperiosteal thickening with bilateral maxillary antrectomy change. Mastoid air cells clear and orbits within normal limits.

- MRI was discussed but not ordered.
  - Patient has a pacemaker that is not compatible with MRI machine.
- Electrocardiogram (ECG)
  - A 12 lead ECG was performed in the emergency room to provide a view of the heart's electrical forces from a different position (Capriotti, p. 372). The cardiologist's note indicates right ventricular hypertrophy, left axis deviation, atrial flutter with variable A-V block, septal infarct with age undetermined, ST & T wave abnormality which they consider lateral ischemia. When compared to a previous EKG performed on 9/1/20, the cardiologist indicates no additional significant damage since then.

Diagnostic Test Correlation & References (5 points):

Capriotti, T., & Frizzell, J. P. (2020). *Pathophysiology Introductory Concepts and Clinical Perspectives* (2nd ed.). F.A. Davis Company.

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

Home Medications (5 required)

Brand/ Generic	Eliquis (Apixaban) (Jones & Bartlett, p. 77-78)	Cymbalta (Duloxetine) (Jones & Bartlett, p. 379-380)	Tambocor (Flecainide) (Jones & Bartlett, p. 504-505)	Synthroid (Levothyroxine) (Jones & Bartlett, p. 697-698)	Lopressor (Metoprolol Tartrate) (Jones & Bartlett, p. 794-795)
Dose	5 mg	30 mg	100 mg	200 mg	75 mg
Frequency	BID	BID	BID	Daily at Breakfast	BID
Route	PO	PO	PO	PO	PO
Classification	Factor Xa inhibitor Anticoagulant	Selective serotonin and norepinephrine reuptake inhibitor Antidepressant, neuropathic and musculoskeletal pain reliever	Benzamide derivative Class IC antiarrhythmic	Synthetic thyroxine Thyroid hormone replacement	Beta 1 adrenergic blocker Antianginal, antihypertensive

Mechanism of Action	Inhibits free and clot-bound factor Xa and prothrombinase activity. By inhibiting factor Xa, apixaban decreases thrombin generation and thrombus development.	Inhibits dopamine, neuronal serotonin and norepinephrine reuptake to potentiate noradrenergic and serotonergic activity in CNS	Achieves antiarrhythmic effect by inhibiting fast sodium channels of myocardial cell membranes	Replaces endogenous thyroid hormone	Inhibits stimulation of beta1 receptor sites located mainly in the heart. These effects help minimize cardiac tissue damage
Reason Client Taking	To reduce the risk of systemic embolism	Treat major depressive disorder	Prevent and suppress ventricular tachycardia	Treat mild hypothyroidism	Manage hypertension
Contraindications (2)	Active pathological bleeding Hypersensitivity	Cirrhosis Hypersensitivity	Cardiogenic shock Hypersensitivity	Acute MI Hypersensitivity	Acute heart failure Cardiogenic shock
Side Effects/Adverse Reactions (2)	Excessive bleeding Angioedema	Seizures Bleeding episodes	Arrhythmias Heart failure	Arrhythmias Heart failure	Arrhythmias Heart failure
Nursing Considerations (2)	Monitor closely for bleeding Ensure patient uses soft bristle toothbrush	Monitor hepatic function Monitor serum sodium level	Monitor urine pH Check blood pressure, fluid intake/output and weight regularly	Monitor blood glucose level Perform thyroid function tests	Assess ECG as may be risk for AV block Check for signs of poor glucose control as patient is diabetic

Hospital Medications (5 required)

Brand/ Generic	Protonix (Pantoprazole) (Jones & Bartlett, p. 950-951)	Mirapex (Pramipexole) (Jones & Bartlett, p. 1016-1017)	Urocit-K (Potassium Citrate) (Jones & Bartlett, p. 1008-1009)	Bayer (Aspirin) (Jones & Bartlett, p. 97-98)	Rocephin (Ceftriaxone) (Jones & Bartlett, p. 214-215)
Dose	40 mg	0.25 mg	10 mEq	81 mg	1 g
Frequency	Daily	Daily at Bedtime	BID	Daily	Every 24 hrs for 3 days
Route	PO	PO	PO	PO	IV piggyback Administer over 30 minutes
Classification	Proton pump inhibitor Antiulcer	Nonergoline dopamine agonist Anti-parkinsonian	Electrolyte cation Electrolyte replacement	Salicylate NSAID	Third generation Cephalosporin Antibiotic
Mechanism of Action	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphatase enzyme system in gastric parietal cells	Stimulate dopamine receptors in the brain	Acts as major cation in intracellular fluid, activating many enzymatic reactions essential for physiologic processes	Blocks activity of cyclooxygenase the enzyme needed for prostaglandin synthesis	Interferes with bacterial cell wall synthesis by inhibiting cross-linking of peptidoglycan strands

Reason Client Taking	Treat gastroesophageal reflux disease short-term	Treat Parkinson's disease	Prevent/Treat hypokalemia in patients who are losing potassium because of condition (cirrhosis)	Reduce risk of ischemic attacks or ischemic stroke	Treat infections
Contraindications (2)	Concurrent therapy with rilpivirine containing products Hypersensitivity	Hypersensitivity No others listed	Acute dehydration Hypersensitivity	Active bleeding Hypersensitivity	Calcium-containing IV solutions Hypersensitivity
Side Effects/Adverse Reactions (2)	Hypomagnesemia Hyponatremia	Cardiac failure Abnormal behavior	Arrhythmias Cardiac arrest	GI Bleeding Bronchospasm	Seizures Acute Renal Failure
Nursing Considerations (2)	Monitor urine output Monitor patient for bone fracture	Assess patient for skin changes regularly Monitor patient for postural deformity months after therapy has been initiated	Administer oral med with or immediately after meals Monitor serum creatinine level and urine output	Monitor for signs of tinnitus Do not crush time-release or controlled release tablets	Obtain culture and sensitivity results Monitor BUN and serum creatinine levels to detect early signs of nephrotoxicity

Medications Reference (APA):

Jones & Barlett (2020). *Nurse's Drug Handbook.* (19th ed.). Ascend Learning Company.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and orientated to person, place and time. Pt appears in no acute distress and well groomed.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 19** **Drains present: Y☐ N ☒** **Type:**	Patient's skin is fair tone with normal elasticity and warm to touch. No abnormal texture. Cellulitis is present on right calf region. Normal quality, distribution and texture of hair. Nails without clubbing or cyanosis. No notable skin turgor. No bruises. Patient has an IV in left forearm with 0.9% Sodium Chloride running at 75 ml/hr continuous. Braden Score: 19
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head is symmetrical, trachea is midline with no deviations. Thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and strong. Hair is white. Ears show no abnormal drainage. Bilateral sclera white, bilateral corneas clear, bilateral conjuctive pink, no visible drainage from eyes. Bilateral lids are moist and pink without lesions or discharge. PERRLA is noted bilaterally. Patient uses glasses regularly. Nose shows septum is midline, turbinates are moist and pink bilaterally. No visible bleeding or polyps. Bilateral frontal sinuses are nontender to palpation. Oral mucosa is pink and moist with no abnormalities. Uvula is midline, soft palate rises and falls symmetrically. Patient's teeth present and yellow to white in color.

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:**	Patient was on telemetry monitor until 1644 when order was discontinued. Heart sound auscultated in 5 locations (APETM). S1, S2 heart sounds noted, no murmurs, rubs, or gallops. Radial and pedal pulses assessed. Pulses graded 2+ and present bilaterally. Capillary refill less than 3 seconds fingers and toes bilaterally. No signs of edema present. Negative for neck vein distention.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular and even nonlabored bilaterally. No accessory muscle used when breathing. Patient denies being short of breath. Anterior and posterior lung sounds auscultated. Lungs sounds clear equal bilaterally, no wheezes, crackles or rhonchi noted.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** 162 cm **Weight:** 73.94 kg **Auscultation Bowel sounds:** **Last BM:** 1/20/21 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** N/A **Incisions:** N/A **Scars:** On chest/abdomen from previous surgeries. **Drains:** N/A **Wounds:** N/A **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Patient is on a diabetic diet. Scar on left chest and in in both lower quadrants from previous surgeries. Abdomen is soft, nontender, no masses upon palpation of all four quadrants. Bowel sounds present in all four quadrants. Patient denies pain on palpation. No masses present. No ostomy, nasogastric tubes, PEG tubes, or drains. Patient states last BM was yesterday morning. Patient has lost over 50 lbs over past year.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:**	Patient able to ambulate to bathroom with walker and student. No dialysis or catheter. No genital abnormalities noted. Urine is dark yellow and no abnormal odor. Patient denies pain, hesitancy or urgency on urination.

Size:	
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 15 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Patient able to show range of motion bilaterally in upper and lower limbs. Patient shows no sign of neurovascular deficit. Patient is a fall risk and is up with walk and standby assistance from staff/ student. Patient denies using walker, wheelchair, or cane at home Fall Risk Score: 15
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is awake in bed. She is alert and orientated x4. Patient speaks English and at a normal pace and volume. Patient moves all extremities well and has good hand grip strength bilaterally. Patient shows no signs of neurological damage or deficit.
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):**	Patient is awake and talking with husband upon student's entry to room. Patient denies drug use and states she drinks occasionally a glass of wine with the last time being on Thanksgiving. Patient quit smoking over thirty years ago. Patient completed high school and college. Patient lives with her husband and has good family support in place. Patient is retired. When asked what a typical day is like for her, she replied, "I grocery shop, cook, clean, do crossword books and sudoku books."

Vital Signs, 2 sets (5 points)

Time	**Pulse**	**B/P**	**Resp Rate**	**Temp**	**Oxygen**
1400 (by student)	60	108/58	18	97.7 f	96%
1630 (by student)	62	112/62	16	97.9 f	97%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1430	Numeric Scale 0-10 0	Patient denies pain	Patient denies pain	Patient denies pain	No interventions implemented.
1450 (PT walking patient)	Numeric Scale 0-10 8	Lower Right leg	Severe	Shooting, sharp	Back to bed with leg elevated and pain level decreases to 0

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g **Location of IV:** Left forearm **Date on IV:** 1/20/21 **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Left forearm IV placed on 1/20/21 in emergency room is stable, with no complications. Patient denies pain at site. No evidence of erythema, drainage or swelling. Dressing intact. IV flushes easily for RN prior to student arrival on unit. Continuous Infusion of 0.9% Sodium Chloride 1200ml at 75ml/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
IV Fluids 1300-1800 = 325 ml PO intake 1300-1800 = 240 ml Total intake = 565 ml	400 ml

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was awake most of the afternoon and visiting with her husband. Patient remained on the floor throughout the day. Patient's abnormal lab values are consistent with her diagnosis and past medical history. A urine culture was still pending results. Patient complied with the treatment plan and dietary restrictions.

Procedures/testing done: N/A

Complaints/Issues: Pain in right leg when walking or dangling leg off the bed.

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

Tolerating diet, activity, etc.: Patient tolerating dietary restrictions.

Physician notifications: Order for telemetry motor expired at 1600, per physician patient does not need a new order and telemetry can be discontinued.

Future plans for patient: Continue antibiotic and rest prior to being discharged.

Discharge Planning (2 points)

Discharge location: Patient will be discharged home with her husband. Since the patient's husband still works, she may benefit from assistance from case management.

Home health needs (if applicable): N/A

Equipment needs (if applicable): Patient indicates she has a walker currently at home. She does believe she needs shower grab bars as she has become weak in the shower before and the grab bars would be nice. Patient and husband will be purchasing prior to discharge.

Follow up plan: Patient will be seen outpatient by physical therapy to ensure she regains her strength and is able to go back to being independent.

Education needs: Patient needs educated on the first signs of an infection to ensure proper treatment is sought immediately.

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 bleeding related to portal hypertension and altered clotting factors as evidenced by patient having cirrhosis (Swearingen, 2016, p. 406)	This is in relation to patient having cirrhosis and has been placed on blood thinners in prior years. Patient's current medications put her at higher risk for bleeding.	**1.** Assess patient for signs of bleeding **2.** Inspect stools for presence of blood	Patient and husband in agreeance of interventions, goals and outcomes. Appreciative of nurse's actions and plan of care.
2. Imbalanced Nutrition related to malabsorption and nausea as evidenced by patient stating when she feels nauseous, she doesn't eat. (Swearingen, 2016, p. 404-405)	This is in relation to patient having cirrhosis and at times skipping meals. Patient stated that when she is nauseous, she does not eat.	**1.** Encouraged small, frequent meals. **2.** Encouraged abstinence of alcohol	Patient and husband agreeable to eating small frequent meals to ensure patient stay nourished. Patient voiced understanding of importance to remain abstinence with alcohol.
3. Deficient	This is in	**1.** Assess patient's	Patient and husband

	Knowledge related to unfamiliarity of dietary precautions as evidenced by patient's husband bringing in outside food for her to eat. (Swearingen, 2016, p. 354-355)	relation to the patient have diabetes mellitus type II. Patient asked her husband to bring fast food choices to the hospital instead of eating off of the diabetic diet provided by hospital.	health care literacy and culturally specific information needs. **2.** Educate patient on signs, symptoms, and reasons for hyperglycemia and hypoglycemia.	understand the signs, symptoms and reasons for hyperglycemia and hypoglycemia. Both voice understanding in what to look for in each and how to treat should patient become one.

Other References (APA):

Swearingen, Pamela. (2016). *All-In-One Nursing Care Planning Resource* (4th ed.). Elsevier

Concept Map (20 Points):

Subjective Data

Patient states "she wants to get better so she can go home."

Patient's symptoms when arrived to hospital included confusion, weakness, difficulty speaking and understanding words.

Patient indicates pain when walking in lower right leg.

Nursing Diagnosis/Outcomes

Patient was diagnosis with cellulitis in her right leg and as having a urinary tract infection.

Patient acknowledges she is at risk for bleeding.

Patient understands she is not eating a balanced nutrition.

Patient has a knowledge deficient when it comes to dietary precautions.

Objective Data

Patient's urinalysis results were abnormal and showed signs of urinary tract infection.

Patient's lab results revealed an infection, consistent with urinary tract infection and cellulitis of right lower leg.

Patient Information

KH is a 67 year old female who presented to emergency room for rule out stroke. She has a past medical history that includes atrial fibrillation, diabetes mellitus type II, cirrhosis, anticoagulant therapy, and sleep apnea.

Nursing Interventions

Patient will be sure to assess and monitor for signs of bleeding and will inspect stool for presence of blood.

Patient agrees to eat small frequent meals to help ensure she is eating a nutritionally balanced diet. Patient will avoid alcohol use.

Patient was assessed for literacy level in order to provide education. Patient will monitor self at home to ensure she does not become hyperglycemic or hypoglycemic.