N321 Care Plan # 2

Lakeview College of Nursing

Name: Richard Kumpi

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2/13/21	R.K	76	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
With Caucasian	Former truck driver	Divorced	No known
Code Status	**Height**	**Weight**	
full	5’ 8”	214lb	

Medical History (5 Points)

Past Medical History: anasarca, atrial fib, (HCC), chronic kidney disease, hypertension, liver cirrhosis.

Past Surgical History: hernia repair, lap, inguinal hernial reaper, colonoscopy.

Family History: father died during WW II and mother died of breast cancer.

Social History (tobacco/alcohol/drugs): former smoker of cigarette, 0.5/ day for 3 years. So the client is a 1.5 year smoker. He quit since high school. Never used drugs but used to drink one box of beer per week for 18 years.

Assistive Devices: walker.

Living Situation: he is divorced and lives at a nursing home, has a daughter who takes care of him.

Education Level: High School Diploma.

Admission Assessment

Chief Complaint (2 points): fall

History of present Illness (10 points): On February 13th, 2021, a 76 y/o white divorced man was brought to the ED at OSF Sacred Heart Medical Center for falling around noon at home. Patient stated that he felt dizzy and fell in the kitchen while he was trying to find food for lunch. He called 911 and the ambulance came to pick him up, says the patient.

When incident occurred, he had bruises over the body from falling, he had pain all over the body and was given pain medications to relieve his pain. Today patient report no pain. Patient is in bed rest, lowered to the ground with bed alarm to keep him from falling. MRI brain, TTE, and other tests have been ordered for further diagnoses.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):acute metabolic encephalopathy

Secondary Diagnosis (if applicable):N/A

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

Acute metabolic encephalopathy is a clinical condition in which the functions of the brain are temporarily or permanently disturbed due to different underlying diseases or medical toxicity in the body that cause imbalanced chemicals in the blood and impaired cerebral metabolism which affects the brain. This condition may be overturned if the preexisting conditions are quickly diagnosed and treated. otherwise, it may result damaged brain (Karthik Kumar, 2020). At cellular level, metabolic encephalopathy affects the body in many ways depending on causative agents. A patient with diabetes, when blood sugar goes too high leading to confusion or coma, the brain loses its abilities to work, therefore the body is affected as neurophysiologic mechanisms regarding cognitive, awareness, and arousal will be impaired. A cerebral ischemia may result from brain vessel spasm causing vasogenic edema due to hypertension (Barisavac. et al.2017).

Clinical presentation of acute metabolic encephalopathy is associated with the level of gravity of the metabolic conditions that caused it. Signs and symptoms include ataxia (a

difficulty coordinating with motor tasks such as walking, and other daily activities), dementia, agitation, decreased consciousness, illusions, disorientation to surroundings, heart rhythm disorders, difficulty breathing, hallucinations, vision changes, thoughts and memory disorders, and delirium, which is the most common symptom characterized by confusion, impaired speech, and disrupted attention (Karthik Kumar, 2020).

The common causes of metabolic encephalopathy are any metabolic disturbances, which can be due either to medical and substance toxicity such as sedatives, antidepressants, alcohol, heavy metal or impaired function of organs such as chronic liver diseases like cirrhosis, impaired thyroid, chronic renal disease, heart failure, pancreatitis, brain tumors. Other causes include diabetes, infections, dehydration, high blood pressure, hypoxia (Barisavac, et al.2017).

A patient with metabolic encephalopathy will mostly present with hypo/hypernatremia, elevated uric acid, CT or MRI scan will show damage or abnormalities in the brain, respiration distress, hypertension (Barisavac, et al.2017). Laboratory testing used to diagnose the disease include CBC, BUN, CT scan, MRI of the brain, EKG (Karthik Kumar, 2020). My patient's MRI brain showed moderate cerebral atrophy. He was diagnosed with elevated protein in urine, high creatinine, chloride serum, and low Calcium.

Treatment of metabolic encephalopathy consist of treating the underlying conditions causing the disease. Patient should be given medication for delirium, monitor patient's respiration, circulatory functions, fluids and electrolytes balance, encourage bedrest. Some medications are haloperidol, quetiapine, olanzapine, lorazepam, midazolam.

Organ transplant such as liver can be considered in a patient with liver cirrhosis (Karthik Kumar, 2020). My patient is being treated with Metoprolol Succinate for his hypertension, Allopurinol for lowering uric acid, and Citalopram for depression.

Pathophysiology References (2) (APA):

Karthik Kumar, M.B.B.S. (2020, October 1). ***What Is Metabolic Encephalopathy?*** **https://www.medicinenet.com/what_is_metabolic_encephalopathy/article.htm.**

Berisavac, I. I., Jovanović, D. R., Padjen, V. V., Ercegovac, M. D., Stanarčević, P. D. J., Budimkić-Stefanović, M. S., Radović, M. M., & Beslać-Bumbaširević, L. G. (2017). How to recognize and treat metabolic encephalopathy in Neurology intensive care unit. ***Neurology India*****, 65(1), 123–128. https://doi.org/10.4103/0028-3886.198192**

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	**M:4.5-6 million F: 4-5.5 million**	**3.74L**	**2.97L**	Red blood cell counts are decreased in situations involving chronic disease. Patient has a PMH of liver cirrhosis and C.K.disese. This is the cause of a low RBC value. (Van Leeuwen & Bladh, 2017)
Hgb	**M: 14-16g/dl F: 12-15 g/dl**	**12.5 L**	**11.7L**	Hgb is decreased in situations involving chronic disease and cirrhosis. Patient has a past medical of CKD and liver cirrhosis. (Van Leeuwen & Bladh, 2017)
Hct	**M: 35-47% F: 42-52%**	**38.5**	**30.9L**	Hct are decreased in the presence of chronic disease and cirrhosis. Patient has a past medical history of CKD and liver cirrhosis. (Van Leeuwen & Bladh, 2017**)**

Platelets	**150,000-400,000 cells mm3**	**59 L**	**59L**	Low platelets, thrombocytopenia is present in chronic conditions. The patient has a past medical history of liver cirrhosis and chronic kidney disease. (Van Leeuwen & Bladh, 2017)
WBC	**4,500-11,000 cell/mm3**	**4.10**	**2.50L**	Leukopenia, a low level of WBC is mostly caused by bone marrow issues, cancers or treatment such as chemotherapy and radiation (Van Leeuwen & Bladh, 2017) but none of these is the case for my patient. His low WBC might be due to the chronic liver cirrhosis.
Neutrophils	**45-75%**	**85.1H**	**71.4**	Neutrophil levels are elevated in the presence of infection, stress, depression or inflammation. Probably patient was under stress and depression at the admission. Also, patient has a PMH of chronic liver cirrhosis, which causes neutrophil to go high. Neutrophil value is back to normal after admission to the hospital. (Van Leeuwen & Bladh, 2017)
Lymphocytes	**20-40%**	**7.5L**	**17.9 L**	Lymphocytes are decreased in the presence of immunosuppression, HIV/ AIDS, bone marrow suppression. Patient has a PMH of chronic liver cirrhosis that can cause immunosuppression. Lymphocyte is still low but has begun to rise after admission. (Van Leeuwen & Bladh, 2017)
Monocytes	**4-6%**	**8.1**	**5.6**	Monocytes are elevated in presence of chronic infections, autoimmune disease, leukemia, tuberculosis. My patient has a PMH of multiple organ failure such as liver cirrhosis, kidney disease which make him immunosuppressed. After admission monocyte level is back to normal (Van Leeuwen & Bladh, 2017)
Eosinophils	**¿ 7%**	**1.1**	**1.9**	
Bands	**¿ 0-5%**	**0.7**	**0.7**	

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 mmol/L**	**139**	**139**	
K+	**3.5-5.0 mmol/L**	**4.9**	**4.5**	
Cl-	**97-107 mmol/L**	**110 H**	**111H**	Elevated chloride values are related to excess sodium chloride infusion with water loss, diarrhea, dehydration, metabolic acidosis, respiratory alkalosis, medication. Patient has chronic kidney disease, which may potentially cause high chloride. Patient also has turbid urine lab (Van Leeuwen & Bladh, 2017).
CO2	**35-45 mm Hg**	**Not drawn**	**Not drawn**	
Glucose	**70-100 mg/ dL**	**114 H**	**100**	High levels of glucose can be seen in clients with kidney disease or liver disease. My Patient has a past medical history of liver cirrhosis and chronic kidney disease. (Van Leeuwen & Bladh, 2017)
BUN	**8-25 mg/dL**	**23**	**21**	
Creatinine	**0.6-1.3 mg/ dL**	**3.15 H**	**2.61H**	Creatine values are increased in patients who are dehydrated, patient with kidney disease Patient has chronic kidney disease. (Van Leeuwen & Bladh, 2017)
Albumin	**3.5-5.2 mg/ dL**	**3.0 L**	**Not drawn**	Albumin levels are decreased in patients with liver disease. My patient has a past medical history of cirrhosis of the liver. (Van Leeuwen & Bladh, 2017)
Calcium	**8.6-10 mg/dL**	**8.1 L**	**8.1L**	Calcium levels decrease in patients with liver disease. My patient has a past medical history of liver cirrhosis. Also pt is taking miralax. (Van Leeuwen & Bladh, 2017).

Mag	**1.3-2.3 mEq/L**	**Not drawn**	**Not drawn**	
Phosphate	**2.5-4.5 mg/ dL**	**Not drawn**	**Not drawn**	
Bilirubin	**0.1-1.4 mg/ dL**	**Not drawn**	**Not drawn**	
Alk Phos	**44-147 U/L**	**67**	**Not drawn**	
AST	**10-30 U/L**	**Not drawn**	**Not drawn**	
ALT	**10-40 U/L**	**Not drawn**	**Not drawn**	
Amylase	**30-110U/L**	**Not drawn**	**Not drawn**	
Lipase	**0-160 U/L**	**Not drawn**	**Not drawn**	
Lactic Acid	**0.5-2.2 mmol/L**	**Not drawn**	**Not drawn**	

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	**2-3**	**1.1**	**1.1**	**INR is used to test the effectiveness of oral anticoagulant. The pt has low INR this means the oral anticoagulant is not effective (Van Leeuwen & Bladh, 2017)**
PT	**M:9.6-11.8 sec F:9.5-11.3 sec**	**13.2 H**	**13.5 H**	**PT values are increased in patients with liver disease. The liver plays an important role in the process of blood clotting. Patient has a past medical history of liver cirrhosis. (Van Leeuwen & Bladh, 2017)**
PTT	**30-40 sec**	**30**	**30**	
D-Dimer	**¿ 250 ng/mL**	**Not drawn**	**Not drawn**	
BNP	¿100 *ng/L*	**Not**	**Not**	

		drawn	**drawn**	
HDL	**> 60**	**Not drawn**	**Not drawn**	
LDL	¿ 130 *mg*/*dL*	**Not drawn**	**Not drawn**	
Cholesterol	¿ 200 *mg*/*dL*	**Not drawn**	**Not drawn**	
Triglycerides	**¿ 150 mg/dL**	**Not drawn**	**Not drawn**	
Hgb A1c	**4-5.6 %**	**Not drawn**	**Not drawn**	
TSH	**0.5-5.0 mlU/L**	**Not drawn**	**Not drawn**	

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	**Colorless-yellow, clear**	**Turbid / amber**	**Clear/y**	**Abnormal urine color and clarity, like amber and cloudy, are seen in patients who are dehydrated or have kidney diseases. Liver cirrhosis may also play a role. My patient has a PMH of chronic kidney diseases and liver cirrhosis. He was likely dehydrated when the sample was taken. (Van Leeuwen & Bladh, 2017)**
pH	**4.5-8**	**5.0**	**6.0**	
Specific Gravity	**1.005-1.035**	**1.015**	**1.015**	
Glucose	**none**	**neg**	**neg**	
Protein	**none**	**2+**	**1+**	**Protein in urine may indicate kidney disease. My patient has a chronic kidney disease. (Van Leeuwen & Bladh, 2017)**
Ketones	**none**	**trace**	**none**	**Ketone in urine indicates diabetic ketoacidosis. Can also be caused by dehydration due to vomiting disorders. My patient may have been dehydrated when brought to the hospital.**

				(Van Leeuwen & Bladh, 2017)
WBC	**None or rare**	**3+**	**trace**	**Presence of WBC in the urine may be due to leukocytosis, inflammation in the urinary tract or kidneys or, cancer. Since my patient has a chronic kidney disease that may cause elevated WBC in the urine. (Van Leeuwen & Bladh, 2017)**
RBC	**None or rare**	**packed**	**21-50**	**Elevated values of RBC in the urine are seen in patients who have coagulation issues. Patient has an elevated PT. This would contribute to the cause of elevation of RBC in the urine. (Van Leeuwen & Bladh, 2017)**
Leukoesterase	**none**	**Not drawn**	**Not drawn**	

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	**≥ 100,000/ml**	**Not drawn**	**Not drawn**	
Blood Culture		**Not drawn**	**Not drawn**	
Sputum Culture		**Not drawn**	**Not drawn**	
Stool Culture		**Not drawn**	**Not drawn**	

Lab Correlations Reference (1) (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). ***Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications*** **(7 ed.). Philadelphia, PA: F.A. Davis Company.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points): TTE (transthoracic echo): mitral valve appears thick. EKG: atrial fibrillation with rapid ventricular responses, low voltage QRS, abnormal T wave. MRI brain: moderate cerebral atrophy noted, no hemorrhage intracranial.

Diagnostic Test Correlation (5 points): TTE: a test to check for any abnormality in the heart, also visualizes any problems in the blood vessels around the heart. Patient has a past medical history of atrial fibrillation, kidney disease, and hypertension, this test was ordered with the EKG in combination with the incidence of fall to evaluate the structure of the heart and its function. To see if any fluids around the heart or any new input to the heart (Van Leeuwen & Bladh, 2017). The note from the physician reported that the patient's mitral valve thick meaning that they may fuse together, narrowed and can reduce blood flow to left ventricle (Van Leeuwen & Bladh, 2017). The EKG showed irregular and fast heartbeats, which correlates with the patient's history of hypertension. MRI of brain: the rational for ordering this test was probably because the fall as the patient presented to the ER with bruises from heard to toes. They wanted to rule out potential traumatic brain injury due to fall, or to rule out any potential stroke, tumors, infections, or any disorders that can lead to problems with balance, movement, or mental functioning. Physician noticed a moderate cerebral atrophy, which is a gradual damage of cells of the brain, reducing the size of the brain a cause of loss of the neurological function. (Van Leeuwen & Bladh, 2017).

Diagnostic Test Reference (1) (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). ***Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications*** **(7 ed.). Philadelphia, PA: 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	**Lorazepam Ativan (Jones & Bartlett, L, 2020)**	**Acetaminophen/ Tylenol (Jones & Bartlett, L, 2020)**	**Ondansetron/ Zofran (Jones & Bartlett, L, 2020)**	**Polyethylene glycol/ Miralax (Jones & Bartlett, L, 2020)**	**Tamsulosin/ Flomax (Jones & Bartlett, L, 2020)**
Dose	**2mg**	**650 mg**	**4mg tablet**	**17g**	**0.4mg capsule**
Frequency	**Twice daily. Prn**	**Every 4 hrs**	**every 12hrs, prn**	**Daily**	**daily**
Route	**Injection**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**benzodiazepine**	**Nonopioid analgesics and antipyretics**	**Selective serotonin receptor antagonist/ antiemetic.**	**Osmotic laxative**	**Alpha adrenergicantagonist, BPH agent**
Mechanism of Action	**Depresses CNS**	**Inhibit the production of prostaglandins in the brain**	**Blocks serotonin receptors centrally in the chemoreceptor trigger zone to reduce nausea &vomiting.**	**retains water into the bowel lumen to cause elimination of watery stool.**	**Blocks alpha1 adrenergic receptors in the prostate to inhibit smooth muscle contraction in the bladder neck and prostate to improve the rate of urine flow and reduce symptoms of BPH.**
Reason Client Taking	**Withdrawal symptoms**	**Pain and fever**	**Nausea and vomiting**	**Constipation**	**To prevent symptoms of BPH and improve voiding.**
Contraindications (2)	**Hypersensitivity to benzodiazepines, acute narrow-**	**Active alcoholism, increase risk of hepatotoxici**	**Concomitant use of apomorphine, Congenital**	**Pt with low calcium Pt with severe**	**Hypersensitivity to tamsulosin Quinazolines or their components.**

	angle glaucoma.	**ty**	**long QT syndrome**	**ulcerative colitis.**	
Side Effects/ Adverse Reactions (2)	**-Respiratory depression -Ataxia**	**Hypotension Hepatotoxicity**	**Ataxia, Cardiac arrhythmias**	**Nausea Diarrhea**	**Atrial fibrillation Dizziness**
Nursing Considerations (2)	**Monitor patient's resp.every 5 to 15 min, use extreme caution when giving Lorazepam to elderly pts, especially those with compromised resp. functions**	**Use cautiously in pts with hepatic impairment or active hep disease. Monitor renal function in pts in long term therapy.**	**Place disintegrating tablet or oral soluble film on pt's tongue immediately after opening package as it dissolves in seconds. Monitor pt closely for S/S of hypersensitivity to ondansetron.**	**Assess pt for abdominal distention Assess color, consistency, amount of stool produced.**	**Give drug about 30 min after the same meal each day If pt takes drug on an empty stomach his BP sould be monitored because of the increased risk of orthostatic hypotension.**

Hospital Medications (5 required)

Brand/ Generic	**Metoprolol Succinate Toprol-XL (Jones & Bartlett, L,**	**Allopurinol Zyloprim (Jones & Bartlett, L,**	**Apixaban / Eliquis (Jones & Bartlett, L, 2020)**	**Atorvastatin/ Lipitor (Jones & Bartlett, L,**	**Citalopram / Celexa (Jones & Bartlett, L, 2020)**

	2020)	**2020)**		**2020)**	
Dose	**12.5 mg**	**100mg tablet**	**2.5 mg tablet**	**Tab 40 mg**	**20 mg tablet**
Frequency	**Daily**	**Daily**	**1t daily**	**Nightly**	**Daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Beta1 adrenergic blocker Antianginal, antihypertensive**	**Xanthine oxidase inhibitor, Antigout**	**Anticoagulant**	**HMG-CoA reductase Antihyperlipidemic**	**SSRI Antidepressant.**
Mechanism of Action	**Inhibits stimulation of beta1 receptor sites in the heart to reduce cardiac excitability and cardiac output, reduce BP**	**Inhibits uric acid production by inhibiting xanthine oxidase the enzyme that converts hypoxanthine and xanthine to uric acid.**	**Inhibits free and clot-bound factors Xa and prothrombinase activity.**	**Reduces plasma cholesterol and lipoprotein levels by increasing the number of LDL receptors on the liver cells to enhance LDL breakdown.**	**Blocks serotonin reuptake by adrenergic nerves, increasing serotonin levels at nerve synapses, which may elevate mood and reduce depression.**
Reason Client Taking	**To control BP and reduce cardiac excitability. Pt has A-fib and hypertension.**	**To reduce patient's uric acid.**	**To prevent deep vein thrombosis and PE.**	**To control lipid levels, to reduce risk of acute cardiovascular events. pt has a history of A-fib.**	**To treat depression.**
Contraindications (2)	**Acute heart failure Hypersensitivity to metoprolol or other beta**	**Hypersensitivity to allopurinol or its components. Chronic heart failure.**	**Active pathological bleeding Hypersensitivity to apixaban or its**	**Active hepatic disease Hypersensitivity to atorvastatin**	**Hypersensitivity to citalopram or its components. Pimozide**

	blockers		**components.**	**or its products.**	**therapy.**
Side Effects/ Adverse Reactions (2)	**CVA Bronchospasm**	**Drowsiness Thrombocytopenia.**	**Hemorrhage Anaphylaxis.**	**Dizziness Headache**	**GI bleeding, Heart failure.**
Nursing Considerations (2)	**Use with extreme caution in pt with bronchospastic disease Before starting therapy for heart failure, expect to give an ACE inhibitor, digoxin and diuretic to stabilize pt.**	**Obtain baseline CBC and uric acid level and review results of renal and liver function before and during allopurinol therapy Maintain a fluid intake to produce a daily urinary output of 2 L daily.**	**Expect apixaban to be discontinued 48 hrs before an invasive procedure or surgery. Monitor pt closely for bleeding as apixaban may cause life-threatening bleeding.**	**Monitor diabetic patient's blood glucose levels. Use atorvastatin with caution in pt with a history of liver disease.**	**Monitor patient for possible serotonin syndromes. Use citalopram cautiously in patient with other cardiac conditions. Monitor the patient's QT interval and detect the development of serious arrhythmia.**

Medications Reference (1) (APA):

Jones & Bartless Learning. (2020). 2020 Nurse's drug handbook (19th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**well developed, appears pleasant, speaks with less discomfort, no SOB.** **Patient is alert** **Oriented to person, time, day, and current event** **No acute distress** **Well groomed**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 **Pink** **Mist/ normal** **Warm to touch** **Normal turgor 2+** **No rashes noted** **multiple bruises noted in the body.** **No wounds noted** **18**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 **Head and neck symmetrical, normal cephalic.** **Ears are symmetrical and free of discharge, no hearing deficiencies, no hearing aids.** **Eyes are symmetrical, wears eyeglasses.** **Nose septum midline, no drainage or bleeding.** **Patient has natural teeth, no dentures.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒**	.**Normal heart sound S1 and S2 heard without murmur.** **Normal cardiac rhythm noted** **Pulses are 2+throught bilaterally** **Normal, 2+** **Normal less 3 seconds**

Edema Y ☐ N ☒ **Location of Edema:**	**No edema inspected or palpated in all extremities**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Non labored breathing, no rhonchi, no wheezes, or crackles noted. Normal respiration noted.**
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** **regular** **5'8''** **214Lb** **Bowel sounds present in all 4 quadrants** **1515** **No pain but masses noted at the umbilical region.** **No rashes** **Distended abdomen** **Small visible incisions from hernia repair** **Unnoticeable scars** **No drains** **No wounds**
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** **260 mL**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:**	**No edema, no neurovascular deficits noted** **Active ROM upper and lower extremities** **supportive devices (walker)** **Equal strength both upper and lower bilateral** **Patient is a fall risk and has a history of falls** **20** **Patient is under supervision with need of support to stand or walk.**

Independent (up ad lib) ☐ **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Needs assistive devices for gait at hospital or at home.**
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 but drowsy and fatigued. He is A&O x4. Patient speaks English well and at a normal pace. Patient MAEW for current age and condition. Patient's strength is bilaterally equal. Patient appears to be lethargic and annoyed; he shows signs of altered mental although he speaks at normal pace but has some uncorrelated thoughts.**
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 presents fatigued and asked for time to sleep. Patient is cooperative and calm. Patient acknowledges past tobaccos use to deal with stress. Patient states he completed high school. Patient states he has no religious preferences. Patient lives at a nursing home. His daughter comes to visit him. Patient states he has good support from his family. Patient is unemployed, he is a former truck driver.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0305	**94**	**117/68**	**18**	**98.1**	**98**
0515	**90**	**115/69**	**16**	**97.6**	**97**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0305	Numeric Scale 0/10	Patient denies pain	Patient denies pain	Patient denies pain	Patient denies pain
0515	Numeric Scale	Patient denies pain	Patient denies pain	Patient denies pain	Patient denies pain

	0/10				

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	N/A
Location of IV:	N/A
Date on IV:	N/A
Patency of IV:	N/A
Signs of erythema, drainage, etc.:	N/A
IV dressing assessment:	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
630mL	**260mL**

Nursing Care

Summary of Care (2 points)

Overview of care: patient is alert and tolerates diet and treatment well. Nursing is monitoring the client's BP, promoting his safety. Patient is dependent and is under close supervision. No incidence of fall noted today.

Procedures/testing done: TTE, EKG, and MRI brain.

Complaints/Issues: patient had 3 watery BM without asking to go to the toilet.

Vital signs (stable/unstable): patient's vital signs are stable, no complaint of pain or discomfort.

Tolerating diet, activity, etc.: yes, patient tolerates diet and other activities.

Physician notifications: continue monitoring his BP and his level of consciousness until he is discharged. Have the patient ambulate to monitor his gait.

Future plans for patient: continue with allopurinol to regulate patient uric acid, Tamsulosin/ Flomax to prevent symptoms of BPH and improve voiding.

Discharge Planning (2 points)

Discharge location: Arcadia nursing home

Home health needs (if applicable): not applicable patient will benefit supervision and care from nursing home.

Equipment needs (if applicable): walker.

Follow up plan: no follow up plan

Education needs: instruct patient to daily use his walker for a stable gait and prevent falls. Educate patient about healthy eating for fluid and electrolytes balance.

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 injury related to illusions and hallucinations as evidenced by patient having	**Safety is most important in a patient with impaired gait and history of falls due to impaired cerebral function.**	**1.promote patient's safety e.g., side rails, padding, call light, close supervision, assistant devise.** **2. maintain a calm and comfortable environment.**	**Patient was cooperative, he stayed in bed and used call light for assistance when he needed to get up. No falls registered as he uses a walker. Patient and family members were satisfied**

impaired gait and series of falls.			**about care provided to the patient for being provided an appropriate and comfortable environment.**
2. Disturbed thought processes related to delusional thinking/ changes in the level of consciousness as evidenced by patient diagnosed with moderate cerebral atrophy.	**With delusional thinking or impaired consciousness a patient will have disturbed thoughts, but cognition/ thinking may improve after treating the underlying medical or psychiatric problems. This will prevent further deterioration and maximize level of function.**	**1. check the status of neurology until a stable state.** **2.assist with treatment for underlying problems, such as dehydration.**	**Patient was given meds to treat underlying conditions and was able to take them. His thinking and consciousness are restored, patient is able to make correlated thoughts.**
3. Impaired memory related to cognitive impairment as evidenced by patient diagnosed with moderate cerebral atrophy.	**A patient with metabolic encephalopathy has impaired memory and will need to be reoriented. Inability to maintain orientation is an indication of deterioration of cerebral function.**	**1. reorient the patient** **2Assess the patient' s level of memory, have the patient write names of things periodically or have him work on puzzles to improve the memory. Keep the record for comparison and report changes.**	**Patient is able to follow directions and instructions as being reoriented. He is making great improvement for his memory as he still working on some IQ activities. He is able to write his name over and over, building puzzles.**

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

Patient stated that he felt dizzy and fell in the kitchen while he was trying to find food for his lunch.

Nursing Diagnosis/Outcomes

Risk for injury related to illusions and hallucinations as evidenced by patient having impaired gait and history of falls.
Disturbed thought processes related to delusional thinking/ changes in the level of consciousness as evidenced by patient diagnosed with moderate cerebral atrophy.
Impaired memory related to cognitive impairment as evidenced by patient diagnosed with moderate cerebral atrophy.
Patient was cooperative, he stayed in bed and used call light for assistance when he needed to get up. No falls registered as he uses a walker.
Patient and family members were satisfied about care provided to the patient for being provided an appropriate and comfortable environment.

Patient is able to follow directions and instructions as being reoriented. He is making great improvement for his memory as he still working on some IQ activities. He is able to write his name over and over, building puzzles

Objective Data

RBC counts are decreased in situations involving chronic
disease. Patient has a PMH of liver cirrhosis and C.K.D.
Cl- Elevated values are related to excess sodium chloride infusion with water loss, diarrhea, dehydration, metabolic acidosis, respiratory alkalosis, medication. Patient has chronic kidney disease, which may potentially cause high chloride.
MRI brain: moderate cerebral atrophy noted, no hemorrhage intracranial. This is due to impaired organ function

Patient Information

On February 13th, 2021, a 76 y/o white divorced man was brought to the ED at OSF Sacred Heart Medical Center for falling around noon at home.

Nursing Interventions

promote patient's safety e.g., side rails, padding, call light, close supervision, assistant devise.

Maintain a calm and comfortable environment.

Check the status of neurology until a stable state.

Assist with treatment for underlying problems, such as dehydration,

Reorient the patient

Assess the patient' s level of memory, have the patient write names of things periodically or have him work on puzzles to improve the memory. Keep the record for comparison and report changes.