N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
2/20/2021	TL	34	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Disabled	single	Codeine, sulfa drugs
Code Status	**Height**	**Weight**	
Full code	160 cm.	52.5 kg	

Medical History (5 Points)

Past Medical History: Acute otitis media, acute UTI, cerebral palsy, cerumen impaction, chronic otitis externa, hyperlipidemia, hypertropia, hypertension, impetigo, kyphosis, morbid obesity, pressure ulcer, profound mental retardation, scoliosis, seizure disorder, xerosis of skin

Past Surgical History: No surgical history noted

Family History: No known family history

Social History (tobacco/alcohol/drugs): Patient could not respond, poor historian

Assistive Devices: No assistive devices noted

Living Situation: Group home

Education Level: Patient

Admission Assessment

Chief Complaint (2 points): Fever, vomiting, UTI

History of present Illness (10 points): The patient is a 34-year-old female with profound mental retardation, hypertension, hyperlipidemia, history of seizure disorder, and cerebral palsy. She was previously diagnosed with a UTI and treated with Keflex. She was administered the Covid vaccine on 2/18/2021. She presented to the outpatient clinic on the 19th with a fever of 101 F and vomiting. The outpatient clinic sent her to the ER for further testing. Initial labs obtained in the

ER showed chronically elevated liver function tests. A urinalysis was positive for UTI. Due to patient being a poor historian, subjective data was not able to be obtained.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Urinary Tract Infection

Secondary Diagnosis (if applicable): This patient does not have a secondary diagnosis

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

Pathophysiology

For a urinary tract infection (UTI) to occur, bacteria must gain access to the bladder and colonize the epithelium of the urinary tract to avoid washing out washed out whenever the individual urinates (Hinkle & Cheever, 2018). Most bacteria washes out of the urethra during urination (Capriotti & Frizzell, 2016). A majority of UTIs result from fecal organisms traveling from the perineum to the urethra and eventually making their way to the bladder (Hinkle & Cheever, 2018). Bacteria have three ways to enter the urinary tract. The first way is through the transurethral route, which is the most common. The other two methods are through the bloodstream or from a direct extension of a fistula in the intestine (Hinkle & Cheever, 2018). A women's short urethra does not provide enough resistance to bacteria's movement (Hinkle & Cheever, 2018). Activities such as sexual intercourse send the bacteria further into the bladder.

Signs and Symptoms

Signs and symptoms of a UTI depend on the location of the infection in the urinary tract (Hinkle & Cheever, 2018). Lower UTI symptoms include burning on urination, urinary frequency, urgency, nocturia, incontinence, and suprapubic pelvic pain (Hinkle & Cheever, 2018). This patient had a lower UTI. Even though she could not communicate her symptoms, she

likely was experiencing some listed above. Hematuria and back pain are also common symptoms of a UTI (Hinkle & Cheever, 2018). Broad-spectrum antibiotics cause UTIs to reoccur (Hinkle & Cheever, 2018). Catheter-associated UTIs are typically asymptomatic. However, if symptoms appear, the patient should be assessed for urosepsis (Hinkle & Cheever, 2018).

Expected Findings and Diagnostics

A urine culture is a standard test to determine a UTI. Cultures identify the exact organism that is causing the infection. A bacterium count of over 100,00 CFU/mL indicates an infection (Hinkle & Cheever, 2018). Any bacteria present from suprapubic needle aspiration, straight catheterization, or surgical cystoscopy is significant (Hinkle & Cheever, 2018). Patients with an acute UTI may also have hematuria present in their urine (Hinkle & Cheever, 2018). All patients with a UTI will have WBC in their urine, but it does not indicate a bacterial infection (Hinkle & Cheever, 2018). Dipsticks test for WBC's and nitrites (Hinkle & Cheever, 2018). This patient's WBC count was nine, and her leukoesterase count was 1+. It is also common to test for sexually transmitted infections when an individual presents with a UTI. Symptoms of a UTI and sexually transmitted infections are similar to each other (Hinkle & Cheever, 2018). Other diagnostic tests include x-rays, CT scans, ultrasonography, and kidney scans. This helps detect obstructions, abscesses, tumors, and cysts (Hinkle & Cheever, 2018).

Treatment

The best treatment for UTI is antibacterial agents that rid the bacteria from the urinary tract (Hinkle & Cheever, 2018). Ideally, it is accomplished without affecting normal fecal and vaginal flora (Hinkle & Cheever, 2018). E. coli and fecal flora are two typical organisms responsible for UTIs. Bacterial agents should be effective against these (Hinkle & Cheever, 2018). There are different options for treatment regimens. They range from a single dose to

seven-day medications (Hinkle & Cheever, 2018). The patient must take the entire treatment course, even if symptoms are gone (Hinkle & Cheever, 2018). If the infection is severe enough, IVs and hospitalization are necessary (Hinkle & Cheever, 2018). Further treatment with antibiotics is required if infection reoccurs within two weeks (Hinkle & Cheever, 2018). If the infection persists, the patient needs a long-term antibiotic regimen. (Hinkle & Cheever, 2018). Nonpharmacological treatment for UTIs is a daily intake of cranberry juice. Daily consumption of cranberry juice controls and prevents UTI symptoms (Hinkle & Cheever, 2018).

Pathophysiology References (2) (APA):

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

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.9 – 5.0	3.83	4.17	This patient does not have any diagnoses that indicate low RBC. Low RBC, Hgb, and Hct all lead to anemia (Capriotti & Frizzell, 2016). It is possible that she has undiagnosed anemia. Dietary deficiency is also a reason for low RBC levels. The patient has been vomiting and not eating well (Capriotti & Frizzell, 2016).
Hgb	12.0-15.5	11.4	12.5	Low hgb levels are often due to anemia. With the combination of low RBC, Hgb, and Hct it is likely that the patient has anemia (Capriotti &

				Frizzell, 2016)
Hct	35-45%	33.7	37.0	Low hematocrit levels are most likely due to anemia. Due to low RBC, Hgb, and Hct, it is likely the patient had anemia (Capriotti & Frizzell, 2016)
Platelets	150,000-500,00	252,000	282,000	Normal lab value
WBC	4,500 – 11,000	6,100	8,800	Normal lab value
Neutrophils	45.3-79%	63.3	78.5	Normal lab value
Lymphocytes	11.8-45.9%	28.4	15.3	Normal lab value
Monocytes	4.4-12.0%	7.6	5.6	Normal lab value
Eosinophils	0.0-6.3%	0.1	NA	Normal lab value
Bands	0.0-5.0%	0.6	0.6	Normal lab value

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	134	137	The patients low sodium levels are related to inadequate sodium intake from vomiting and poor appetite (Capriotti & Frizzell, 2016).
K+	3.5-5.0	4.1	3.8	Normal lab value
Cl-	98-108	103	107	Normal lab value
CO2	22-29	23	22	Normal lab value
Glucose	70-100	111	96	Normal lab value
BUN	8-25	5	4	Low BUN levels are present in liver failure and malnutrition (Capriotti & Frizzell, 2016). The patient has elevated liver enzymes and has been vomiting, both of which are suspected reasons for her low BUN levels.
Creatinine	0.6-1.2	0.35	0.22	This patient has low levels of creatinine because of decreased muscles mass from cerebral palsy

				(Capriotti & Frizzell, 2016).
Albumin	3.5-5.0	4.0	NA	Normal lab value
Calcium	8.6-10.4	9.1	8.0	Normal lab value
Mag	1.6-2.4	NA	NA	NA
Phosphate	2.5-4.5	NA	NA	NA
Bilirubin	0.0-1.2	0.3	NA	NA
Alk Phos	35-105	142	NA	Hepatic problems cause increased alkaline phosphate (Capriotti & Frizzell, 2016). Her AST and ALT levels are elevated indicating issues with her liver.
AST	0-35	62	NA	Increased AST is an indication of liver disease (Capriotti & Frizzell, 2016).
ALT	24-36	64	NA	Increased ALT is an indication of liver disease (Capriotti & Frizzell, 2016).
Amylase	30-110	NA	NA	NA
Lipase	12-70	NA	NA	NA
Lactic Acid	0.5-2.2	1.3	NA	Normal lab value
Troponin	0-0.4	NA	NA	NA
CK-MB	0-4.9	NA	NA	NA
Total CK	22-198	NA	NA	NA

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	0.86-1.14	NA	NA	NA

PT	11.9-15	NA	NA	NA
PTT	25-40	NA	NA	NA
D-Dimer	<500	NA	NA	NA
BNP	0-99	NA	NA	NA
HDL	40-80	NA	NA	NA
LDL	65-125	NA	NA	NA
Cholesterol	<170	NA	NA	NA
Triglycerides	50-150	NA	NA	NA
Hgb A1c	<6%	NA	NA	NA
TSH	0.5-5	NA	NA	NA

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	Yellow/clear	NA	Normal lab value
pH	5.0-8.0	8.0	NA	Normal lab value
Specific Gravity	1.005-1.034	1.029	NA	Normal lab value
Glucose	Normal	Normal	NA	Normal lab value
Protein	Negative	Trace	NA	Proteinuria is an indication of kidney disease (Capriotti & Frizzell, 2016). Depending on the location of the infection in the urinary tract, it is not uncommon to find protein in the urine of somebody who has a UTI (Capriotti & Frizzell, 2016).
Ketones	Negative	Negative	NA	Normal lab value
WBC	<5	9	NA	The patient has a UTI which is the reason for an abnormal amount of WBC in her urine (Capriotti & Frizzell, 2016).

RBC	0-4	3	NA	Normal lab value
Leukoesterase	Negative	1+	NA	A positive leukoesterase count indicates a UTI (Capriotti & Frizzell, 2016). The patient is positive for urinary tract infection.

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	NA	NA	NA
PaO2	80-100	NA	NA	NA
PaCO2	35-35	NA	NA	NA
HCO3	22-26	NA	NA	NA
SaO2	95-100	NA	NA	NA

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	>100,000 cfu/mL gram negative bacilli	>100,000 cfu/mL Escherichia coli	The patients urine culture is positive for both gram negative bacilli and Escherichia coli. These are the organisms responsible for her UTI (Capriotti & Frizzell, 2016).
Blood Culture	Negative	NA	NA	NA
Sputum Culture	Negative	NA	NA	NA
Stool Culture	Negative	NA	NA	NA

Lab Correlations Reference (1) (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1. Abdominal x-ray: Allows providers to get a better look inside the abdomen for causes of abdominal pain, blockages, masses, or holes in the intestine (Hinkle & Cheever, 2018). This test was ordered because the patient was vomiting and had stopped eating her normal amount of food.

Diagnostic Test Correlation (5 points):

1. Abdominal x-ray: The abdominal x-ray showed normal findings. The gas pattern was normal and there was no evidence of an obstruction. Congenital hypoplastic left hip was noted.

Diagnostic Test Reference (1) (APA):

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

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

Home Medications (5 required)

Brand/Generic	Keflex/ cephalexin	Pepcid/ famotidine	Baclofen/ baclofen tablets	Zofran/ ondansetron	Colace/ docusate sodium
Dose	500 mg	20 mg	10 mg	16 mg	100 mg
Frequency	BID	BID	TID	PRN	TID
Route	Oral	Oral	Oral	Oral	Oral

Classification	Chemical: first generation cephalosporin Therapeutic: antibiotic	Chemical: thiazole derivative Therapeutic: antiulcer agent, gastric acid secretion inhibitor	Therapeutic: muscle relaxant, antispasmodic	Chemical: carbazole Therapeutic: antiemetic	Chemical: anionic surfactant Therapeutic: laxative, stool softener
Mechanism of Action	Inhibits bacterial cell wall synthesis which prevents the growth of bacteria.	Reduces HCl formation by preventing histamines from binding with H2 receptors. This helps prevent peptic ulcers from forming and it also helps to heal already existing ones.	Inhibits reflexes at the spinal level through hyperpolarization of afferent terminals.	Blocks serotonin receptors in the intestine to reduce nausea and vomiting by preventing the release of serotonin and blocking signals to the CNS.	Softens stool by acting as a surfactant. It decreases surface tension between water and oil in feces.
Reason Client Taking	UTI	GERD	Spasticity from cerebral palsy	Nausea	Constipation and possibly hepatic disfunction. There is nothing noted in her past medical history about hepatic disfunction, but lab values indicate otherwise.

Contraindications (2)	Hypersensitivity reactions Allergy to cephalosporin or its components	Hypersensitivity to famotidine Hypersensitivity to other H2 receptor antagonists	Hypersensitivity reactions Skeletal muscle spasms from rheumatic disorders	Concurrent use of apomorphine Congenital long QT syndrome	Fecal impaction Intestinal obstruction
Side Effects/Adverse Reactions (2)	Elevated liver enzymes vomiting	Seizures Elevated liver enzymes	Mood changes Tiredness	Agitation Anorexia	Vomiting Perianal irritation
Nursing Considerations (2)	Monitor BUN and serum creatinine levels to detect early signs of nephrotoxicity. Monitor for allergic reactions a few days after beginning therapy	Shake oral suspension for 5 to 10 seconds before administration. Pepcid AC chewing tablets contain aspartame which is dangerous for patients with phenylketonuria	It is important that patients are slowly withdrawn from the medication.	Do not give ondansetron in the same IV line as acyclovir alopurinol, aminophylline, amphotericin B, ampicillin, sulbactam, amacrines, cefepime, cefoperazone, furosemide, ganciclovir, lorazepam, methylprednisolone, mezlocillin, piperacillin, or sargramostim. Disintegrating tablets and oral soluble films should be placed on the patients tongue immediately after opening the package.	Long term use of docusate sodium will cause dependence to achieve bowel movements. Assess patient for laxative abuse syndrome.

Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Perform a culture and sensitivity test prior to prescribing the antibiotic.	Monitor patient's creatine clearance. A creatinine clearance less than 49 needs a lower dose.	Assess kidney function prior to medication therapy.	Monitor patient closely for serotonin syndrome	Monitor for electrolyte imbalance.
Client Teaching needs (2)	Instruct patient to complete prescribed course of therapy Shake oral suspension well before measuring each dose.	Do not take famotidine with other acid reducing medications. Keep the medication at room temperature and prevent from freezing.	Baclofen can make you drowsy. Be careful when operating vehicles or machinery. CNS effects may worsen when taking the medication with alcohol or other CNS depressants.	Immediately reports hypersensitivity signs such as a rash. Patient should seek immediate medical attention if symptoms are persistent, severe, unusual, or worsening.	Do not used docusate sodium with abdominal pain, nausea, or vomiting. Take medication with a full glass of water.

Hospital Medications (5 required)

Brand/ Generic	Lovenox/ enoxaparin sodium	Carbatrol/ carbamazepine	Flonase/ fluticasone	Cholac/ lactulose	Claritin/ loratdine
Dose	40 mg	200 mg	2 sprays (100 mcg)	10 g	10 mg
Frequency	Daily	Once daily	Daily	Daily	Daily
Route	SQ injectable	Oral	Nasal	PO	PO
Classification	Chemical: low molecular	Chemical: tricyclic iminostilbene	Chemical: trifluorinated corticosteroi	Chemical: synthetic disaccharid	antihistamine

	weight heparin Therapeutic: antithrombotic	derivative Therapeutic: analgesic, anticonvulsant	d Therapeutic: antiasthmatic, anti-inflammatory	e sugar Therapeutic: ammonia reducer, laxative	
Mechanism of Action	Allows antithrombin III to work by binding with it, allowing inactivation of clotting factors. It prevents fibrinogen from converting to fibrin which prevents clots from forming.	Prevents seizures by blocking sodium channels and preventing sodium from entering the cell. Keeping sodium out of the cell slows nerve impulse transmissions which also slows how quickly neurons fire	Inhibits cell that are involved in the inflammatory response of asthma. Prevents the production and secretion of chemical mediators like cytokines, histamines, and leukotrienes.	Breaks down into lactic acid, acetic acid, and formic acid and acidifies fecal contents. This increases osmotic pressure in the colon which increases stool water and softens stool. It also makes intestinal contents more acidic than blood, preventing ammonia diffusion from intestine into the blood. The trapped ammonia is converted into ammonia ions which	Relieve immediate hypersensitivity reactions. Can also be used as antiemetics, antidyskinetics, antitussives, sedatives, or pre/postop analgesia's.

				is expelled in the feces.	
Reason Client Taking	Blood clot prevention	Seizure	Allergic rhinitis	Constipation	Allergic rhinitis
Contraindications (2)	Active or major bleeding History of HIT or immune mediated HIT	Concurrent therapy with other non-nucleoside reverse transcriptase inhibitors. History of bone marrow depression	Hypersensitivity to fluticasone or milk proteins. Untreated nasal mucosa infection	Hypersensitivity reaction Low galactose diet	Patients taking drugs that prolong the QT interval. Hypersensitivity reactions to antihistamines or their component.
Side Effects/Adverse Reactions (2)	Elevated liver enzymes Dyspnea	Vomiting Hyponatremia	Chest congestion Restlessness	Hyperglycemia Hypovolemia	Dry mouth Nosebleed
Nursing Considerations (2)	Do not give drug by IM injection Use with caution in patients with increased risk of hemorrhage from ulcerative GI disease.	Use cautiously in patients with impaired hepatic functioning. Do not crush or chew ER capsules. If unable to swallow capsules whole, open them and sprinkle contents on food.	Use cautiously inpatients with ocular herpes simplex, pulmonary tuberculosis, untreated systemic bacterial, fungal, parasitic, or viral infections. If bronchospasm occurs, administer a fast-acting bronchodilator and	Replace fluids if frequent bowel movements cause hypovolemia. Monitor for hyperglycemia because the medication contains galactose and lactose.	Use carefully in patients with history of glaucoma, peptic ulcer, or urine retention. Monitor patients' blood pressure because it can cause hypertension.

			expect to stop fluticasone therapy.		
Key Nursing Assessment(s) /Lab(s) Prior to Administration	Do not mix enoxaparin with other IV fluids or drugs	Monitor liver function tests	Monitor patient at the start of therapy, especially if the patient has an allergy to milk.	Check serum electrolyte level of debilitated patients who are on the medication for longer than 6 months.	Assess patient for hypokalemia and correct the imbalance before administration of the medication
Client Teaching needs (2)	Inform patient that taking aspirin or other NSAIDS can increase risk of bleeding. Patient may be more susceptible to bruising and bleeding. Important to review bleeding precautions with the patient.	Take the medication with food. Report bruising, fever, mouth ulcers, rash, or unusually bleeding to healthcare provider.	Use regularly as prescribed and inform the patient that the medication is not to be used for bronchospasm. Remind the patient to shake the canister before administering the medication.	Take medication with food or dilute with juice to help with the sweet taste. Do not take other laxatives while taking lactulose	Avoid alcohol and other CNS depressants while using this medication. Take the medication with food because it can cause GI upset.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). *Nurses drug handbook*

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was awake and alert but was not oriented to time, place, and situation (ANO x 0). The patient was unable to respond to questions asked but did not seem to be in any distress. Her overall appearance was good.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Braden Score: 9 (very high risk) Her skin was normal for ethnicity. It was intact, warm, and dry with good skin turgor. The patient had some rashes/wounds near her left jaw line and her left antecubital area. No drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patients head was normocephalic and midline with no deviations. Trachea was midline. Her pupils were equal, round, reactive to light, and accommodate. The tympanic membrane was pearly grey, intact, and without drainage bilaterally. There was no sign of a deviated septum. Turbinates were equal. Her oral mucosa was pink and moist with no abnormalities noted on her teeth. .
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:**	S1 and S2 was present, and she had a regular rhythm and a heart rate of 87. Peripheral pulses were palpable and strong at a 3+. Capillary refill less than 3 seconds. There was no neck vein distention or edema noted.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The patient had increased respiratory rate at 22 breaths per minute. However, there were no signs of accessory muscle use. Regular breath sounds were noted in all posterior and anterior lobes, bilaterally. Respirations were regular in rhythm and appeared non labored. No cough noted during assessment. SpO2 is 96% on room air.
GASTROINTESTINAL (2 points):	Due to patient being a poor historian, home diet

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:**	could not be determined. Her current diet is honey thickened, puree diet. She is 160 cm and 62.5 kg. Bowel sounds were present and active in all 4 quadrants. Her last bowel movement was on 1/21/202 with slight smears. Abdomen was soft with no distention, incisions, scars, drains, or wounds. The patient had no ostomy, NG tube, or feeding tubes present. No discomfort was noted during assessment.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patients' urine was clear with a yellow/green color. Patient was incontinent so quantity could not be measured. Due to patient being a poor historian pain could not be assessed. No distention of the bladder noted. Patient was not on dialysis and did not have a catheter in place.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Fall score: 70 (high risk) Patient was alert, but ANO x O. Patient is unable to perform active range of motion. She is able to perform limited passage range of motion. Patient needs maximum assistance with all activities of daily living. Strength was difficult to assess due to positioning and bilateral contractures. No equipment was noted during assessment; however, I determine the patient will need a wheelchair or other form of assistance for movement.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -**	The patient cannot move all extremities well due to bilateral contractures in all 4 extremities. Her pupils were equal, round, reactive to light, and accommodate. Strength was difficult to assess

Legs ☐ Arms ☐ Both ☒ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	due to contractures. She has profound mental retardation and is nonverbal. Sensory is intact. When spoken to, she will make eye contact and can follow simple commands such as “open your mouth.”
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):**	Psychosocial and cultural could not be assessed due to patient being a poor historian.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0952	87	132/81	18	37.6	96%
1100	83	115/81	20	37.6	97%

Vital Sign Trends: The patient’s pulse, respirations, temp, and O2 saturation are all within normal limits. During the first set of vitals the patients systolic and diastolic pressures were both elevated. During the second set of vitals, the systolic had decreased to within normal limits, but the diastolic pressure was slightly elevated. Administration of blood pressure medication is responsible for the decrease in blood pressure.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0952	FLACC	Unable to assess	0	Unable to assess	No interventions needed
1100	FLACC	Unable to	0	Unable to	No

		assess		assess	interventions needed

IV Assessment (2 Points)

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:**	22-gauge saline lock in the left hand started on 2/19/2021. The IV is patent and flushes with no signs of drainage noted. The dressing is clean, dry, and intact.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
The patient at 25% of her meal.	Patient voided 1 time during my care. Amount was unable to be assessed due to patient being incontinent.

Nursing Care

Summary of Care (2 points)

Overview of care: After report, the nurse contacted the patient's doctor to restart her on her seizure medications after possibly having a seizure throughout the night. The patient was given her morning medications at 0830. She had difficulty swallowing the medications and vomited during administration. After medications were given, the patient was cleaned up and provided peri care from being incontinent. A head-to-toe assessment was performed. During the assessment, vitals were taken, and her blood pressure was elevated at 132/81. A last set of vitals were performed at 1100. Her blood pressure improved to 115/81.

Procedures/testing done: There were no procedures or testing done during clincal.

Complaints/Issues: Prior to clinical, the patient had a suspected seizure. It was determined that she had not been administered her antiseizure medications during her hospitalization. The nurse contacted to doctor and she was restarted on her seizure meds during morning medication administration.

Vital signs (stable/unstable): The patients vital signs were stable other than her blood pressure. She has a history of high blood pressure, so this is to be expected.

Tolerating diet, activity, etc.: The patient struggled with eating. It was noted that she vomited during both medication administration and when being fed breakfast.

Physician notifications: The physician was notified about seizure medications. He restarted her medications and performed a bedside assessment during his morning rounds.

Future plans for patient: The goal for the patient is to improve her urinary tract infection and improve vomiting and lack

Discharge Planning (2 points)

Discharge location: The patient will be discharged to her group home where she currently resides.

Home health needs (if applicable): There is a nurse in the group home that needs communication about medication changes. Adhering to her medication regimen will be of utmost importance to improve her UTI.

Equipment needs (if applicable): There are no equipment needs necessary.

Follow up plan: The patient will need to follow up with primary care physician for continued monitoring of UTI.

Education needs: Due to patients' inability to communicate any education needs to be addressed with the nurse in her group home.

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. Imbalanced nutrition related to anorexia, nausea, and malabsorption as evidence by decreased apetite and vomiting.	The patient's intake has been significantly less than normal, and she is experiencing vomiting as well.	**1.**Assess and record intake and output, weigh the patient daily. **2.**Administer parenteral or enteral nutrition if prescribed	**Goal:** The patient's goal is to increase intake and decrease episodes of vomiting.
2. Risk for trauma related to oral, musculoskeletal, and airway vulnerability occurring with seizure activity as evidence by seizure activity throughout the night.	The patient had a possible seizure throughout the night and has been off her seizure medication since admission to the hospital.	**1.** Assess patients' environment. Pad side rails with blankets or pillows, keep side rails up and bed in its lowest position when patient is in bed. Keep bed locked. **2.**Consider a saline lock for IV access for high-risk patients	**Goal:** The goal is to provide a safe environment in case the patient were to have another seizure. Preventing further injury is important.
3. Impaired skin integrity related to inadequate peripheral flow as evidence by open sore on coccyx.	The patient has an open sore on her coccyx from immobility due to cerebral palsy.	**1.** Assess for environmental moisture (wound drainage, excessive perspiration, high humidity)	**Goal:** The patient's goal is to improve open sore on coccyx by reducing the amount of moisture and keeping the injured area off of a surface.

		2. Assess the surface that the patient spends a majority of time on.	
4. Dysfunctional gastrointestinal motility constipation related to immobility as evidence by decreased bowel movements	The patient has been experiencing a decrease in bowel movements. Even with her medications, she has had minimal bowel movements within the past few days. She is also experiencing vomiting.	**1.** Assess patient's bowel function by auscultating for bowel sounds, inspecting for presence of distention, and monitoring nausea and vomiting, and impaction. Notify healthcare of significant findings. **2.** Assess and document patient's bowel movements, diets, and I&O.	**Goal:** The patient's goal is to return to normal bowel patterns and decrease vomiting.

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

Subjective data could not be determined due to patient being a poor historian.

Objective Data

Vomiting
Incontinent
Open sore on coccyx
Cerebral palsy
Bedrest
Lack of bowel movement
Not eating
UTI
Contractures

Patient Information

The patient is a 34-year-old female with profound mental retardation, hypertension, hyperlipidemia, history of seizure disorder, and cerebral palsy. She was previously diagnosed with a UTI and treated with Keflex. She was administered the Covid vaccine on 2/18/2021. She presented to the outpatient clinic on the 19th with a fever of 101 F and vomiting. The outpatient clinic sent her to the ER for further testing. Initial labs obtained in the ER showed chronically elevated liver function tests. A urinalysis was positive for UTI. Due to patient being a poor historian, subjective data was not able to be obtained.

Nursing Diagnosis/Outcomes

Imbalanced nutrition related to anorexia, nausea, and malabsorption as evidence by patient not eating and vomiting.
Outcome: The patient's goal is to increase intake and decrease episodes of vomiting.
Risk for trauma related to oral, musculoskeletal, and airway vulnerability occurring with seizure activity as evidence by seizure activity throughout the night.
Outcome: The goal is to provide a safe environment in case the patient were to have another seizure. Preventing further injury is important.
Impaired skin integrity related to inadequate peripheral flow as evidence by open sore on coccyx.
Outcome: The patient's goal is to improve open sore on coccyx by reducing the amount of moisture and keeping the injured area off of a surface.
Dysfunctional gastrointestinal motility constipation related to immobility as evidence by decreased bowel movements
Outcome: The patient's goal is to return to normal bowel patterns and decrease vomiting.

Nursing Interventions

Assess and record intake and output, weigh the patient daily.

2.Administer parenteral or enteral nutrition if prescribed

Assess patients' environment. Pad side rails with blankets or pillows, keep ide rails up and bed in its lowest position when patient is in bed. Keep bed cked.

Consider a saline lock for IV access for high-risk patients
Assess for environmental moisture (wound drainage, excessive perspiration, high humidity)

Assess the surface that the patient spends a majority of time on.
Assess patient's bowel function by auscultating for bowel sounds, inspecting for presence of distention, and monitoring nausea and vomiting, and impaction. Notify healthcare of significant findings.

. Assess and document patients bowel movements, diets, and I&O.