Nursing Diagnosis and Outcomes

Subjective Data

Patient was asked about the chief complaint and her reason for admission in her own words. Pt demonstrates disorganized speech patterns and is making nonsensical clang-like utterances. Pt unable to communicate effectively due to cognitive communication deficits.

Electrolyte imbalance related to diuretic use as evidenced by low potassium, calcium, and chloride
Elevate calcium levels to at least 8.8, potassium to 3.5 mEq/L and chloride to 98.
Impaired gas exchanged related to COPD as evidenced by CO2 value greater than 45%
Lower CO2 value to 31% or below
Risk for falls related to urinary incontinence as evidenced by high morse fall scale
Pt will have no falls during admission.

Medical Interventions and Nursing Interventions

Objective Data

Abnormal Labs:
CO2 greater than 45.
Calcium 8.7, chloride 81, K+ 3.2.
Assessment: Pt has coarse breath sounds in lower R lobe. Nasal cannula 2L/min.
Pt has bruising bilaterally on arms and legs extensively. Morse fall scale: 55 (high fall risk)
Borderline abnormal vitals: @1101 SpO2 95%
Diagnostics: X-ray finding bilateral pleural effusions, Pt then got a R thoracentesis. CT chest w/ contrast reveals 750ml moderate effusions on R side, small effusions on L lung. Portable XR found bilateral pleural effusion, atelectasis R lower lobe.

This 85-year-old caucasian female was admitted 6/16/2021 for COPD exacerbation x 1 day.
PMH: COPD, cognitive communication deficit, Urinary incontinence.

Patient Information

Medical
Administer electrolytes as ordered
Request BMP
Medical
Repeat X-ray to check on effusions
Refer to respiratory therapy
Medical
Refer to physical therapy
Administer Vitamin D as ordered
Nursing
Supplement pt with calcium, potassium, and chloride rich foods.
Monitor electrolyte levels
Nursing
Monitor ABGs as ordered
Monitor SpO2
Nursing
Identify factors that increase fall risks
Answer call light as soon as possible