N321 Care Plan #1

Lakeview College of Nursing

Bailey Pierce

Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
6.17.21	L.W.	81	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Widowed	No Known Allergies (NKA)
Code Status	**Height**	**Weight**	
FULL CODE	5’8”	115	

Medical History (5 Points)

Past Medical History: Diabetes type II, Diabetic Ketoacidosis, Dementia (senile w/ behavioral disturbance), Paroxysmal A-fibrillation, Right lumbar radiolucency, Asthma without status asthmaticus or acute exacerbation, Major depressive disorder with partial remission, Mixed hyperlipidemia, Gastroesophageal reflux disease (GERD), Hypertension, Hypothyroidism, UTI with hematuria, Primary open-angle glaucoma, Supraventricular tachycardia, Clostridiodes difficile (C. diff), Non-ST elevation myocardial infarction (NSTEMI), Alzheimer’s disease.

Past Surgical History: Colonoscopy, Dental surgery (all dentition removed), cardiac catherization, Cardiac angioplasty.

Family History:

Mother- Stroke

Sister #1- Blood clots, Ovarian cancer, Stroke

Sister #2- “Died of a broken heart”, Stroke.

Sister #3- Breast cancer, Cancer

Social History (tobacco/alcohol/drugs): Pt reports no history of smoking, alcohol, or drug use.

Assistive Devices: Glasses, Dentures

Living Situation: Independent, assisted living, and memory care (Villas of Holly Brook). Pt was confused about where she lived, but chart indicated assisted living at Villas of Holly Brook.

Education Level: High school

Admission Assessment

Chief Complaint (2 points): “I can do it myself”. Referring to ambulating to the restroom on her own.

History of present Illness (10 points): Pt presents with unstable blood sugar after being found four days ago due to hypotension and hyperglycemia. The patient was brought the emergency from the Villas of Holly Brook. The pt was unresponsive upon arrival and was intubated w/ addition of a nasogastric tube immediately. Labs elevated glucose (941), potassium (6.5), and serum creatinine (2.54). The patient was given insulin and glucose readings dropped to 84 followed by 96. Glucose levels have since ranged from 143-301. This morning the patient given was 1 oz of vanilla pudding with her morning medication and her blood sugar rose from 226-290. The patient has a history of Diabetic Ketoacidosis and was treated 30 days ago for a similar incident. The patient is receiving both rapid, regular, and long-term insulin. The patient is also being treated for a urinary tract infection (UTI) and is receiving IV clindamycin. She is also being monitored for a possible acute kidney injury.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):

Diabetic Ketoacidosis with coma associated with type 2 Diabetes Mellitus

Secondary Diagnosis (if applicable): Possible acute renal injury, UTI

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

Diabetic Ketoacidosis (DKA) is a condition commonly associated with type 1 diabetes mellitus (T1DM). T1DM is characterized by an autoimmune response which destroys the beta cells of the islets of Langerhans (Capriotti, 2020). These beta cells are responsible for producing insulin which moves glucose into the cells so that the body may break it down and use it for energy. Due to the inability to move glucose into the cells, the body instead breaks down fat and protein for energy. The byproduct of this process produces ketones (Capriotti, 2020). Ketones are acidic and alter blood pH leading to metabolic acidosis (Capriotti, 2020). These ketones can be found in the urine when a urinalysis is performed and also contribute to the patient having fruity smelling breath (Capriotti, 2020).

While DKA is most associated with T1DM, it can also occur in patients with type 2 diabetes mellitus (T2DM) (Capriotti, 2020). Patient L.W. is a type 2 diabetic. In T2DM, the patient produces insulin, but the cells are insulin resistant meaning they do not properly accept the glucose molecules. DKA is possible in T2DM with pancreatic beta cell failure (Capriotti, 2020). Signs and symptoms of DKA include dehydration, nausea, vomiting, weakness, abdominal pain, Kussmaul's respirations, lethargy, stupor, and comatose (Capriotti, 2020). The patient presented to the emergency room in a comatose state. She was intubated and a nasogastric tube was place with follow up Xray to confirm correct placement. Diagnostic labs correlating with DKA include blood glucose greater than 250 mg/dL (normal range 70-100), arterial pH lower than 7.3, serum bicarbonate lower than 18mEq/L, ketonuria, and ketonemia (Capriotti, 2020). The patient's blood glucose level was 941 mg/dL upon arrival and had ketones in her urine. Blood uric nitrogen (BUN), serum creatinine, serum sodium, potassium, and bicarbonate levels will also need assessed (Capriotti, 2020). The patient's BUN levels were 31, serum creatine (2.54), serum sodium (131), and potassium (6.5). All these labs are positive indicators of DKA. Before treatment, serum potassium levels may be elevated. This is a false high due to intracellular potassium moving into the extracellular compartment during acidosis (Capriotti, 2020). Hydrogen ions replace potassium within the cell shifting potassium into the blood (Capriotti, 2020). Once insulin is administered and the patient is no longer in acidosis, the potassium moves intracellularly where true potassium levels are indicative of hypokalemia (Capriotti, 2020). Potassium supplements are often needed to compensate (Capriotti, 2020). High

levels of glucose can cause damage to cardiovascular system damaging blood vessels (Cheever, 2020). This damages the vessels of many organs including the kidneys, eyes, and heart (Cheever, 2020).

DKA should be treated with fluid replacements and insulin. IV insulin is recommended until the patient's glucose readings are steadily under 250 mg/dL (Capriotti, 2020). The patient may be switched to sub q insulin once readings are in the 150-200 range (Capriotti, 2020). L.W. is currently receiving sub q rapid acting insulin, regular insulin, and long-acting insulin therapy. She was previously receiving IV fluids but was no longer receiving them as off 06/21/21.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: introductory concepts and clinical perspectives* (Second ed.). F.A. Davis Company.

Cheever, K. H., Hinkle, J. L. (2020). *Brunner and Suddarth's textbook of medical-surgical nursing*. 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	**Male: 4.7-6.1** **Female: 4.2-5.4**	**3.51**	**3.80**	These values are low and can be related to anemia, dietary deficiency, and renal disease (Pagana et al., 2016). Uncontrolled diabetes can lead to damage of the kidneys. The patient has a secondary diagnosis of possible acute kidney injury.
Hgb	**Male: 14-18g/dL** **Female: 12-16g/dL**	**10.9**	**11.8**	These values are low and can be related to anemia, dietary deficiency, and renal disease (Pagana et al., 2016). Uncontrolled diabetes can lead to damage of the kidneys. The patient has a secondary diagnosis of possible acute kidney injury.
Hct	**Male: 40-52%** **Female 36-47%**	**32.5**	**34.5**	These values are low and can be related to anemia, dietary deficiency, and renal disease (Pagana et al., 2016). Uncontrolled diabetes can lead to damage of the kidneys. The patient has a secondary diagnosis of possible acute kidney injury.

Platelets	**150-400 x 10^9/L**	**364**	**304**	
WBC	**5-10 x 10^9/L**	**21.7**	**9.4**	The initial value was low and can be related to infection, stress, and trauma (Pagana et al., 2016). Pt is currently being treated for UTI.
Neutrophils	**55-70%**	**88**	**70.3**	These values are high and can be related to trauma and bacterial infections (Pagana et al., 2016). The patient is currently being treated for a UTI.
Lymphocytes	**20-40%**	**5.4**	**20.4**	The initial value was low and that can be indicative of immunodeficiency (Pagana et al., 2016). If the patient's diabetes consistently uncontrolled this can lead to the body not working efficiently.
Monocytes	**2-8%**	**6.2**	**7.0**	
Eosinophils	**1-4%**	**0.1**	**1.0**	The initial value is low and can be consistent with increased adrenal steroid production (Pagana et al., 2016). With the increased stain of the patient's uncontrolled diabetes, the body would be in a constant state of stress and release of cortisol.
Bands	**0.5-1%**	**	**	

****Lab not performed**

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-	**136-145 mEq/L**	**140**	**137**	**
K+	**3.5-5 mEq/L**	**6.5**	**3.2**	This value was high upon admission and can be consistent with infection, DKA, and dehydration (Pagana et al., 2016). The patient is currently being treated for a UTI. The patient's potassium levels are low today which can be consistent with DKA. Low levels typically follow a false high once potassium moves back into the cells (Capriotti, 2020). The patient is receiving potassium supplements that are being crushed. It is possible the patient is not consuming the full dose as well as she is resists when taking oral medications.
Cl-	**98-106 mEq/L**	**89**	**103**	This value was taken the day of admission and was low. This value can be consistent with nasogastric suctioning (Pagana et al., 2016). The patient had a nasogastric tube placed upon arrival.
CO2	**23-30 mEq/L**	**3**	**25**	**
Glucose	**74-106**	**941**	**227 (0724)**	The value on admission was extremely high and

	mg/dL		**290 (1115)**	consistent with her diagnosis of DKA (Pagana et al., 2016).
BUN	**10-20 mg/dL**	**31**	**13**	The value on admission was high and can be consistent with dehydration and renal impairment (Pagana et al., 2016). The patient's uncontrolled diabetes could be affecting her kidney function and has a secondary diagnosis of possible acute kidney injury.
Creatinine	**0.5-1.1 mg/dL**	**2.54**	**0.77**	The value on admission was high and can be related to diabetic neuropathy and nephritis. The patients uncontrolled diabetes could be affecting kidney function. The patient also has a secondary diagnosis of possible acute kidney injury.
Albumin	**3.5-5 mg/dL**	**4.1**	**	**
Calcium	**9-10.5 mg/dL**	**9.5**	**8**	Today's values were low and can be consistent with pancreatitis and vitamin D deficiency (Pagana et al., 2016). The patient has not been eating or drinking much since arriving. The patient's amylase levels are also high and consistent with DKA and pancreatitis (Pagana et al., 2016).
Mag	**1.3-2.1 mEq/dL**	**1.6**	**	**
Phosphate	**3-4.5 mg/dL**	**	**	**
Bilirubin	**0.3-1 mg/dL**	**	**	**
Alk Phos	**30-120 U/L**	**63**	**	**
AST	**0-35 U/L**	**	**	**
ALT	**4-36 U/L**	**	**	**
Amylase	**60-120 U/L**	**266**	**	This lab was only drawn on admission and was high. This can be consistent with DKA and pancreatitis (Pagana et al., 2016). The patient's calcium levels were also high and can be related to pancreatitis as well (Pagana et al., 2016).
Lipase	**0-160 U/L**	**66.1**	**	**
Lactic Acid	**0.5-2.2 mmol/L**	**3.4**	**	This lab was only drawn on admission and was high. This can be consistent with DKA due to inadequate tissue perfusion (Pagana et al., 2016).

****Labs not performed**

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	**0.8-1.1**	**1.0**	**	**
PT	**11-12.5 seconds**	**12.1**	**	**
PTT	**60-70 seconds**	**36**	**	This lab was only drawn upon admission and was low. Lack of one of the blood clotting factors could lead to this (Pagana et al., 2016). The patient is taking ticagrelor which is an antiplatelet medication and prevents platelet aggregation.
D-Dimer	**>0.4 mcg/mL >250 ng/mL**	**	**	**
BNP	**<100 pg/mL**	**113**	**	This lab was only taken at admission and was elevated. Systemic hypertension and Atrial fibrillation can be a cause for this (Pagana et al., 2016).
HDL	**Male: >45 mg/dL Female: >55 mg/dL**	**	**	**
LDL	**Adult: <130 mg/dL Child: <100 mg/dL**	**	**	**
Cholesterol	**<200 mg/dL**	**	**	**
Triglycerides	**40-180 mg/dL**	**	**	**
Hgb A1c	**<5.7%**	**11.0 (06/06/21)**	**	The patient did not have an A1c completed today, but did have one 06/06/21 and was at 11.0. This indicates that other the last 120 days the patient's blood glucose was uncontrolled and high. We would like to see our diabetic patients with an A1c below 7.
TSH	**2-10 mU/L**	**0.181**	**	This lab was only drawn upon admission and was low. This can be consistent with DKA which reduces T3, T4, and TSH levels (Mirboluk, 2017). These levels return to normal after DKA had been treatment (Mirboluk, 2017).

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	**Clear,**	**Yellow,**	**	This lab was only taken on admission and

	Amber/Yellow	**Cloudy**		cloudiness can be indicative of infection.
pH	**4.6-8 Average: 6**	**5.0**	**	**
Specific Gravity	**1.005-1.03**	**1.012**	**	**
Glucose	**30-300 mg/day**	**3+**	**	This lab was only taken on admission and was elevated. This is consistent with the patient's diagnosis of DKA (Pagana et al., 2016).
Protein	**0-8 mg/dL**	**2+**	**	This lab was only taken on admission and was elevated. This is consistent with the patient's diagnosis of DKA (Pagana et al., 2016).
Ketones	**Negative**	**2+**	**	This lab was only taken on admission and was elevated. This is consistent with the patient's diagnosis of DKA and can also be related to dehydration (Pagana et al., 2016).
WBC	**0-4 per low-power field** **Negative for cast**	**11-20**	**	This lab was only taken on admission and was elevated. This is consistent with the urinary tract infection the patient is being treated for.
RBC	**Less than or equal to 2** **Negative for cast**	**6-10**	**	This lab was only taken upon admission and was elevated. This can be consistent with renal trauma (Pagana et al., 2016). The patient's secondary diagnosis is possible acute renal injury.
Leukoesterase	**Negative**	**1+**	**	This lab was only taken upon admission and was elevated. This can be consistent with a UTI, which the patient is currently being treated for.

**** Lab not performed**

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: Less than 10,000 mm/U**	**	**	**
Blood Culture	**Negative**	**Negative**	**	**
Sputum Culture	**Normal Upper RT**	**	**	**
Stool Culture	**Normal intestinal flora**	**Negative**	**	**

Lab Correlations Reference (1) (APA):

Mirboluk, A. A. (2017, April 15). *Thyroid function test in diabetic ketoacidosis*. PubMed. https://pubmed.ncbi.nlm.nih.gov/28545910/

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2016). *Mosby's diagnostic and laboratory test reference* (13th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Xray of chest. Single View. Portable

Impression: there is interval insertion of the endotracheal tube and nasogastric tube. Both are in satisfactory position. No infiltrates.

Diagnostic Test Correlation (5 points):

The chest Xray was taken to confirm placement of the intubation and nasogastric tube (Cheever, 2020). The patient was brought in unresponsive with an insufficient airway.

Diagnostic Test Reference (1) (APA):

Cheever, K. H., Hinkle, J. L. (2020). *Brunner and Suddarth's textbook of medical-surgical nursing*. Wolters Kluwer.

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

Home Medications (5 required)

Brand/ Generic	atorvastatin (Lipitor)	levothyroxine (Synthroid)	ticagrelor** (BRILINTA)	metoprolol-succinate (Toprol-XL)	mirtazapine (Remeron)
Dose	40 mg	175 mcg	90 mg	25 mg	15 mg
Frequency	Nightly	Every morning before breakfast	2x daily	Daily	Nightly
Route	PO	PO	PO	PO	PO
Classification	Antihyperlipidemic (Jones & Bartlett Learning, 2019)	Thyroid hormone replacement (Jones & Bartlett Learning, 2019)	Antiplatelet (Jones & Bartlett	Beta 1 adrenergic blocker (Jones & Bartlett	Antidepressant (Jones & Bartlett Learning, 2019)

			Learning, 2019)	Learning, 2019)	
Mechanism of Action	Reduces plasma cholesterol and lipoprotein levels by inhibiting the HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on the liver cells to enhance LDL uptake and breakdown. (Jones & Bartlett Learning, 2019)	Replaces endogenous thyroid hormone, which may exert its physiologic effects by controlling DNA transcription and protein synthesis. (Jones & Bartlett Learning, 2019)	Reversibly interacts with the platelet P2Y12 ADP-receptor to prevent platelet aggregation. (Jones & Bartlett Learning, 2019)	Inhibits stimulation of beta 1 receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand. (Jones & Bartlett Learning, 2019)	May inhibit neuronal reuptake of norepinephrine and serotonin, increasing the action of these neurotransmitters**.** (Jones & Bartlett Learning, 2019)
Reason Client Taking	Mixed hyperlipidemia	hypothyroidism	Paroxysmal A-fibrillation	Hypertension	Depression
Contraindications (2)	active hepatic disease, Hypersensitivity to atorvastatin or its components (Jones & Bartlett Learning, 2019)	Acute MI, hypersensitivity to levothyroxine or its components (Jones & Bartlett Learning, 2019)	Active bleeding, sever hepatic impairment. (Jones & Bartlett Learning, 2019)	Acute heart failure, pheochromocytoma (Jones & Bartlett Learning, 2019)	use withing 14 days of an MAO inhibitor, hypersensitivity to mirtazapine or its components. (Jones & Bartlett Learning, 2019)
Side Effects/ Adverse Reactions (2)	Lack of coordination, glaucoma (Jones & Bartlett Learning, 2019)	increased blood pressure and pulse, worsening of diabetic control. (Jones & Bartlett Learning, 2019)	Hypotension (may be severe), Elevated serum creatine level. (Jones & Bartlett	Orthostatic hypotension, diarrhea (Jones & Bartlett	Hypotension, dehydration (Jones & Bartlett Learning, 2019)

			Learning, 2019)	Learning, 2019)	
Nursing Considerations (2)	Monitor pt.'s blood glucose levels because atorvastatin therapy can affect blood glucose levels, notify prescriber immediately if pt develops an acute condition suggestive of myopathy (unexplained muscle pain, tenderness or weakness, especially if accompanied by elevated CPK level, fever, or malaise) (Jones & Bartlett Learning, 2019)	Monitor pt of patient who is taking anticoagulants. May require dosage change. Monitor blood glucose levels of diabetic pt as levothyroxine may worsen glycemic control and result in increased need for insulin. (Jones & Bartlett Learning, 2019)	Medication may be crushed. Avoid abruptly stopping ticagrelor due to increased risk of myocardial infarction, stent thrombosis, and death. (Jones & Bartlett Learning, 2019)	Check for signs of poor glucose control in patients with diabetes mellitus. May interfere with the therapeutic effects of insulin and masks evidence of hypoglycemi a. Expect to taper dosage over 1-2 weeks when drug is discontinued; stopping abruptly can cause myocardial ischemia, MI, and severe hypertension. (Jones & Bartlett Learning, 2019)	Administer mirtazapine before bedtime, use cautiously w/ the elderly and those taking concurrent medication known to cause hyponatremia because drug may lower serum sodium level in pt. (Jones & Bartlett Learning, 2019)

Hospital Medications (5 required)

Brand/Generic	glucagon injection	potassium	pantoprazole	brimonidine	(Humalog)

	SOLR (GlucaGen)	chloride SA (KLor Con)	(Protonix)	(Alphagan0.2%)	
Dose	1 mg	10mEq	40 mg	1 gtt	Sliding scale
Frequency	PRN	2x daily w/ meals	Daily	2x daily	Before meals
Route	Sub Q/ IM	PO	PO	Eye drop (both eyes)	Sub-Q
Classification	Antihypoglycemic (Jones & Bartlett Learning, 2019)	Electrolyte replacement (Jones & Bartlett Learning, 2019)	Antiulcer (Jones & Bartlett Learning, 2019)	Ophthalmic glaucoma agents, A2 adrenergic agonist (Jones & Bartlett Learning, 2019)	Fast acting insulin (Islam et al., 2020)
Mechanism of Action	Increases production of adenylate cyclase, which catalyzes conversion of adenosine triphosphate to cAMP, a process that in turn activates phosphorylase. (Jones & Bartlett Learning, 2019)	Helps maintain electroneutrality in cells by controlling the exchange of intracellular and extracellular fluids as well as aiding in nerve impulse transmission and cardiac and skeletal muscle contraction. (Jones & Bartlett Learning, 2019)	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphate enzyme system, or proton pump, in gastric parietal cells. (Jones & Bartlett Learning, 2019)	Inhibits the activity of adenylate cyclase reducing cAMP and aqueous humour production by the ciliary body. (Jones & Bartlett Learning, 2019)	Lower blood glucose by stimulating peripheral glucose uptake by skeletal muscle and fat and by inhibiting hepatic glucose production. (Islam et al., 2020)
Reason Client Taking	Low blood sugar	Low Potassium levels	GERD	Open angle glaucoma	Diabetes Mellitus Type 2
Contraindications (2)	Hypersensitivity to glucagon or its components, pheochromocytoma (Jones & Bartlett Learning, 2019)	Acute dehydration, hypersensitivity to potassium salts (Jones & Bartlett Learning, 2019)	concurrent therapy with rilpivirine containing products, hypersensitivity to pantoprazole. (Jones & Bartlett Learning, 2019)	Hypertension interacts with some medications used to treat depression and Parkinson's disease. (Jones & Bartlett Learning, 2019)	Hypoglycemia, Hypersensitivity to insulin lispro or one of its ingredients. (Islam et al., 2020)
Side Effects/Adverse	Hypotension, Hypertension	Confusion, Fever	Hyperglycemia, C. diff	Dry mouth, Burning eyes	Hypoglycemia, hypokalemia

Reactions (2)	(Jones & Bartlett Learning, 2019)	(Jones & Bartlett Learning, 2019)	associated diarrhea. (Jones & Bartlett Learning, 2019)	(Jones & Bartlett Learning, 2019)	(Islam et al., 2020)
Nursing Considerations (2)	Administer by slow I.V. injection to decrease risk of tachycardia and vomiting. Place unconscious patient on their side before injecting glucagon to prevent aspiration of vomitus when he regains consciousness. (Jones & Bartlett Learning, 2019)	Administer w/ food to avoid gastric irritation, Caution pt not to crush or chew E.R. forms unless instructed otherwise. (Jones & Bartlett Learning, 2019)	Flush I.V. line with D5W, normal saline, or lactated Ringer's injection before and after giving drug. Expect to monitor pT or INR during therapy if patient takes an oral anticoagulant. (Jones & Bartlett Learning, 2019)	Wait 5 minutes after administering drops to administer any additional eye drop medications, Interactions between antihypertensives and Alphagan can lead to orthostatic hypotension. Monitor pt during sudden positioning changes. (Jones & Bartlett Learning, 2019)	Closely monitor glucose as hypoglycemia may occur. Monitor injection site for sings of lipodystrophy. (Islam et al., 2020)

Medications Reference (1) (APA):

Islam, N., Khanna, N. R., & Zito, P. M. (2020, September 20). *Insulin Lispro*. NCBI.

https://www.ncbi.nlm.nih.gov/books/NBK507840/

Jones & Bartlett Learning. (2019). *2020 Nurse's Drug Handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 AxO x2: person, place Pt shows no signs of distress, but is pleasantly confused. Well-groomed and dressed appropriately.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Ivory Lentigo generalized, delicate. Warm to touch Normal skin turgor. No rashes observed. Bruising to the lower abdomen consistent with insulin injections. 3 skin tears on the L forearm. Actively healing. 15
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Symmetric, free of lesions Symmetric, dry skin around auricles. No drainage Symmetric, sclera white, conjunctive pink, cornea clear, no lesions on the lids. No drainage observed. Septum is midline w/o deviation. Edentulous, mucosa pink and moist. Pt states she wears a top and bottom denture, but they were with her upon arrival to the emergency room.
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:**	 Clear s1 and s2 sounds without gallops, murmurs, or rubs. N/A Bilateral radial pulses 2+, Bilateral dorsalis pedis 1+. Capillary refill of fingers and toes 3+ bilaterally. No edema present
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	 Clear anterior and posterior lung sounds bilaterally. No wheezes, crackles, or rhonchi noted. Respirations were observed and documented at 17 and 20 per minute. They were unlabored and within the normal range (12-20).
GASTROINTESTINAL (2 points): **Diet at home:**	 Regular

Current Diet:	Dysphagia (soft foods)
Height:	5'8"
Weight:	115
Auscultation Bowel sounds:	Normoactive bowel sounds in all 4 quadrants.
Last BM:	Observed 06/21/21.
Palpation: Pain, Mass etc.:	Abdomen is nontender. No palpable masses. No costovertebral (CVA) tenderness.
Inspection:	
Distention:	No distention present.
Incisions:	No incisions present.
Scars:	No scars present.
Drains:	No drains present.
Wounds:	3 small skin tears to the L forearm.
Ostomy: Y ☐ N ☒	
Nasogastric: Y ☐ N ☒	
Size:	
Feeding tubes/PEG tube Y ☐ N ☒	
Type:	
GENITOURINARY (2 Points):	
Color:	Yellow
Character:	Clear
Quantity of urine:	400 mL of output observed. Patient also had 1 damp attend.
Pain with urination: Y ☐ N ☒	
Dialysis: Y ☐ N ☒	
Inspection of genitals:	
Catheter: Y ☐ N ☒	No abnormalities observed while changing attend.
Type:	
Size:	
MUSCULOSKELETAL (2 points):	
Neurovascular status:	
ROM:	Full range of motion in all extremities.
Supportive devices:	Patient is a 1 assist with gait belt.
Strength:	Pt has generalized weakness but is able to make slight adjustments in position using arms and legs.
ADL Assistance: Y☒ N ☐	
Fall Risk: Y ☒ N☐	
Fall Score:	85
Activity/Mobility Status:	
Independent (up ad lib) ☐	No
Needs assistance with equipment ☐	Yes, Pt is a 1 assist with gait belt. Pt has generalized weakness and is unsteady on her feet.
Needs support to stand and walk☐	Yes, pt is unsteady on her feet due to generalized weakness and forgetful of limitations.
NEUROLOGICAL (2 points):	
MAEW: Y ☒ N☐	
PERLA: Y ☒ N☐	Pupils are equal, round, reactive to light, and able to accommodate.
Strength Equal: Y ☒ N ☐ if no - Legs ☐	Equal strength of the hands and feet when performing hand grips
Arms ☐ Both ☒	

Orientation: **Mental Status:** **Speech:** **Sensory:** **LOC:**	and pedal pushes/pulls. A & O x2: Person, place Alert and pleasantly confused. Comprehendible, but not always relevant due to confusion. No sensory deficits. No
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):**	 Pt states she likes to pray and talk to her sister when she is sad. Appropriate for age. "I like my church. I go to….". Pt could not recall name of church. Pt is widowed and living in an assisted living home. Two of her four siblings are deceased. One sister and a niece come to visit her. She never had children. When asked about her living arrangements she believe she still lived in Georgetown in her home.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0724	80	134/84 (sitting)	17	97.9	98
1322	72	91/50 (lying with head of bed elevated)	20	97.5	98

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0740	1-10	Pt reports no pain	0	Pt reports no pain	No interventions needed

1420	1-10	Pt reports no pain	0	Pt is not in any pain	No interventions needed

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	22 gauge
Location of IV:	underside R arm, median vein
Date on IV:	06/21/21 (19:50)
Patency of IV:	Flushes without difficulty.
Signs of erythema, drainage, etc.:	No signs or erythema or drainage.
IV dressing assessment:	Clean and intact

Intake and Output (2 points)

Intake (in mL): 600 mL	Output (in mL): 400 mL + 1 damp attend + 1 stool
240 mL **240 mL** **120 mL diet soda**	**200 mL (on commode)** **200 mL (on commode)** **1 damp attend** **1 stool**

Nursing Care

Summary of Care (2 points)

Overview of care: I helped the patient to and from the commode. Changed patients attend when soiled. Bed sheets were changed, and call light was moved within patients reach. Administered medication under observation of my instructor. Performed a head-to-toe assessment. Monitored blood glucose readings and vitals. Vitals were stable. Blood glucose readings are still high. See below. Administered 4 units of insulin before lunch. Chatted with the patient about the weather and plan of care for the morning.

Procedures/testing done: Glucose monitoring was performed two times during my rotation. Glucose is unstable. Readings from the past 24 hours from most recent include 290, 226, 324, 301, 143.

Complaints/Issues: Pt had no complaints or issues that required intervention.

Vital signs (stable/unstable): Vitals were stable.

Tolerating diet, activity, etc.: Pt was moved from a regular diet to a dysphagia diet due to not having dentures. Pt was not eating most of her meals. Speech therapy attributed that to not being able to chew her foods properly. Pt is tolerating physical therapy well. It has been she continues physical therapy upon her return to the Villas of Holly Brook.

Physician notifications: Doctor was not notified during rotation.

Future plans for patient: Pt's glucose will continue to be monitored until she is stable enough to return to Villas of Holly Brook.

Discharge Planning (2 points)

Discharge location: Pt will be return to the Villas of Holly Brook.

Home health needs (if applicable): N/A

Equipment needs (if applicable): Gait belt for assistance ambulating.

Follow up plan: Follow up pending discharge date. No plans have been made yet.

Education needs: Facility will need to be reminded of the importance of monitoring pts blood glucose and need for insulin. This has been to the hospital repeated time for DKA and needs blood glucose monitored routinely.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing	Rational • Explain why	Intervention (2 per dx)	Evaluation • How did the

diagnosis with "related to" and "as evidenced by" components	**the nursing diagnosis was chosen**		**patient/family respond to the nurse's actions?** • **Client response, status of goals and outcomes, modifications to plan.**
1. Unstable glucose levels related to Diabetes Mellitus type 2 as evidence by glucose readings of 290, 226, 324, 201, and 143 over the last 24 hours. (Ackley et., 2019)	Patients blood glucose levels remain unstable despite receiving insulin as prescribed.	1. Administer insulin as prescribed and as needed. 2.Monitor glucose levels.	I administered 4 units of insulin. Patient's blood glucose rose from 226 to 290. Pt did eat one oz of vanilla pudding within that hour. Glucose levels were taken twice during my rotation. Patients blood glucose levels continued to rise.
2. Ineffective therapeutic regimen management related to dementia as evidence by resistance when trying to administer oral medications. (Ackley et., 2019)	Patient resists during admission of oral medications. All her morning medications were mixed into one oz of vanilla pudding. Without persistence, the patient would not have received her full course of medications.	1.Consult with the Dr./pharmacists about alternate routes of medicine administration due to patient resistance to oral medications. 2 Therapeutic communication to encourage the patient to finish her medications.	The patient's potassium chloride tablet was crushed and mixed into 1 oz of pudding. The patient was able to take all medications. The patient was reluctant to finish off pudding with medications, but with the help of my instructor the patient willingly finished taking her medications to help me "pass my class".
3. Fall risk related to dementia as evidence of patient forgetting limitations and trying to ambulate without assistance and morse fall score of 85.	Patient repeatedly attempted to get out of bed to use the restroom. UTI can also increase confusion in the elderly.	1. Place chair alarm under patient during meals. 2.Use gait belt when ambulating.	Patient tried to get up several times during her breakfast. Alarm was able to alert us of this activity and we were able to get her back into her chair. Gait belt was successfully used to ambulate the patient to and from the commode.

(Ackley et., 2019)			

Other References (APA):

Ackley, B.J., Ladwig, G.B., Makic, M.B.F., Martinez-Kratz, M., & Zanotti, M. (2019). *Nursing diagnosis handbook* (12th edition). Elsevier Gozondlheidszorg.

Concept Map (20 Points):

Subjective Data

"I can do it." – when attempting to get out of bed on her own.

"I'm glad you passed your test." Pts statement after thanking her for taking all her medications.

Objective Data

81-year-old, caucasian, female, widowed, full code, 5'8", 115 lbs.; DKA, Dementia, UTI, No pain

BP 134/84, 91/50
Pulse 80, 72
Resp 17, 20
Temp 97.9, 97.5
O2 98, 98

Blood glucose (over 24 hrs):
290, 226, 324, 201, 143

AxO x2 (person, place)
Pain @ 0 on a scale of 0-10
Morse Fall 85
Uranalysis: elevated RBC, WBC, and glucose. Ketones and Leukoesterase present.

Patient Information

Nursing diagnosis/outcomes

1. Unstable glucose levels related to Diabetes Mellitus type 2 as evidence by glucose readings of 290, 226, 324, 201, and 143 over the last 24 hours.
   a. Goal: Pt glucose will remain below 300 during this student's rotation.
2. Ineffective therapeutic regimen management related to dementia as evidence by resistance when trying to administer oral medications.
   a. Goal: Pt will take all medications prescribed during medications
3. Fall risk related to dementia as evidence of patient forgetting limitations and trying to ambulate without assistance.
   a. Goal: Pt will transfer with assistance and have no falls during this student's rotation.

Nursing Interventions

1. A. monitor signs of hyperglycemia including thirst, hunger, and increased urination.
   B. monitor blood glucose levels before and after meal.
2. A. Develop a plan where the patient is rewarded for successful follow through.
   B. Recognize what forms of therapeutic behaviors have the most successful outcome.
3. A. Respond to call light quickly.
   B. Keep bed in lowest position when not