N431 Care Plan 1

Lakeview College of Nursing

Happy Kalavadia

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9/8/2021	SJ	64	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired (Walmart employee)	Married	None
Code Status	**Height**	**Weight**	
Full	5 feet	150 lb	

Medical History (5 Points)

Past Medical History:

Neuropathy, Anxiety, Kidney cancer , End stage renal disease and Lung Cancer.

Past Surgical History: Partial Nephrectomy and Hemicolectomy

Family History: None available (Patient did not want to describe)

Social History (tobacco/alcohol/drugs): None

Assistive Devices: Cane

Living Situation: Living by herself. Patient mentioned that she had been emotionally, physically and sexually abused by her husband.

Education Level: High school graduate

Admission Assessment

Chief Complaint (2 points): Lightheadedness and mild shortness of breath

History of present Illness (10 points):

Patient is 64 years old and came to the emergency department by air medical transport services due to mild shortness of breath and feeling of impending doom. She was in her home when she started having difficulty breathing and feeling of passing out after his breakfast. The onset of pain was about two hours after breakfast. There is no pain experienced by the patient, but she mentioned that she felt that she is going to die soon. The

patient mentioned that she did not have any pain . The duration of shortness of breath was few seconds before she called for emergency air medical services. She mentioned that she did not have any characteristics symptoms and any associated manifestations about her shortness of breath, she further stated that sitting up relieved her shortness of breath and she did not do any home intervention about her shortness of breath.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Metabolic acidosis due to end stage renal failure.

Secondary Diagnosis (if applicable): Lung cancer

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

End stage renal disease can be defined as loss of 90 % of kidney function (Capriotti and Frizzell, 2017). Kidney serve as major filtering organ where it filters organic waste and remove toxins from the body. Kidneys also serve as glands whose main function is to regulate blood pressure , enable production of red blood cells and aid in the formation of bone (Capriotti and Frizzell, 2017). Kidneys can no longer function on it own in end stage renal disease due to loss of glomerular function as well as tubules (End stage renal disease, 2021). The main treatment in end stage renal disease is hemoperitoneal dialysis and to eliminate waste and toxins from the body (Capriotti and Frizzell, 2017). The last resort of patients suffering from end stage renal disease is transplantation of kidneys, but it has very low success rates due to graft versus host diseases from the transplant (Capriotti and Frizzell, 2017).

The patient had loss of kidney function for 10 years and hence had nephrectomy before few years (Capriotti and Frizzell, 2017). The kidney is a unique organ where it can function if one of the kidneys is removed (Capriotti and Frizzell, 2017). The patient presented to ED with low CO2 levels and in a state of metabolic acidosis which was due to chronic end stage renal disease. There are several peculiar electrolyte changes in a patient with end stage renal failure such as low potassium levels, high albumin , creatinine and BUN levels . In addition, the body goes into metabolic acidotic stage where patient starts hyperventilating and excreting high amounts of CO2 levels. In addition, patient feels anxious, dizzy and may be presenting GI upset such as diarrhea.

The signs and symptoms of renal failure matches with patient's situation and her presenting symptoms. The patient had low PH due to acidosis and low CO2 levels because the patient is hyperventilating. In addition, patient had low levels of potassium levels, high BUN and creatinine levels which corelated to his chronic end renal kidney disease. Patient also had low hemoglobin and hematocrit levels due to less production of erythropoietin by the failing kidneys. In addition, patient had fecal occult blood in her stool and is another reason why she had low hemoglobin levels.

The main goal of treatment is to stabilize patient and improve her CO2 levels and pH levels. In addition, one-unit blood was transfused to patient due her blood loss in stool and low hemoglobin levels. IV fluids were also started to increase patient's blood pressure and to improve her hypotensive episodes.

The clinical data exactly correlated with the patient's symptoms because she low pH levels and CO2 levels in blood. In addition, hemoglobin and hematocrit levels are low due to fecal occult blood loss. The provider performed D dimer test to rule out clots due to

patients hyperventilating episode, but it was negative. CT chest was done without contrast to rule out any lung pathology as patient had history of lung cancer .

Hence in end stage renal disease, there is disruption of various electrolyte imbalances and patient starts to hyperventilate due to chronic metabolic acidosis.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2017). Pathophysiology: introductory concepts and clinical perspectives. Philadelphia: F.A. Davis Company.

End stage renal disease (esrd). Johns Hopkins Medicine. (n.d.). Retrieved September 11, 2021, from https://www.hopkinsmedicine.org/health/conditions-and-diseases/end-stage-renal-failure.

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	4.0-4.9 10^6/ uL	N/A	2.49	Patient has low RBC due to chronic occult blood loss in stool also called hematochezia (Capriotti and Frizzell, 2017).
Hgb	12.0-16.0 g/dL	N/A	7.6	Patient had low hemoglobin levels due to decreased production of erythropoietin in chronic renal failure (Capriotti and Frizzell, 2017).
Hct	37.0-48.0%	N/A	25.1%	In chronic renal failure, there is decreased production of hematocrit due to insufficient production of erythropoietin (Capriotti and Frizzell, 2017).

Platelets	**150-400 10^3/uL**	**N/A**	**104**	**Patient has history of occult blood loss resulting in bleeding and eventually leading to loss of platelets (Capriotti and Frizzell, 2017).**
WBC	**4.1-10.9 10^3/uL**	**N/A**	**13.6**	**Patient had increased WBC due to potential chronic metabolic renal failure. (Capriotti and Frizzell, 2017).**
Neutrophils	**1.50-7.70 10^3/uL**	**N/A**	**1.51**	**Within normal range.**
Lymphocytes	**1.00-4.90 10^3/uL**	**N/A**	**2.80**	**Within normal range.**
Monocytes	**0.00-0.80 10^3/uL**	**N/A**	**0.20**	**Within normal range.**
Eosinophils	**0.00-0.50 10^3/uL**	**N/A**	**0.3**	**Within normal range.**
Bands	**N/A**	**N/A**	**N/A**	**N/A**

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**136-145 mmol/L**	**N/A**	**138**	**Within normal range.**
K+	**3.5-5.1 mmol/L**	**N/A**	**5.2**	**In patients with chronic renal failure, potassium levels are low because kidneys cannot reabsorb potassium. (Capriotti and Frizzell, 2017).**
Cl-	**98-107 mmol/L**	**N/A**	**100**	**Within normal range.**
CO2	**21.0-32.0 mmol/L**	**N/A**	**11**	**In metabolic acidosis, there is decreased level of CO2 as patient is hyperventilating (Capriotti and Frizzell, 2017).**
Glucose	**60-99 mg/dL**	**N/A**	**110**	**Patient has chronic renal failure and the metabolism of glucose decreases in chronic renal patients (Capriotti and Frizzell, 2017).**
BUN	**5-20 mg/dL**	**N/A**	**12**	**Within normal range.**
Creatinine	**0.5-1.5 mg/ dL**	**N/A**	**2.00**	**Patient cannot metabolize creatine in chronic renal failure who have**

				end stage kidney disease (Capriotti and Frizzell, 2017).
Albumin	**3.4-5.4 g/dL**	**N/A**	**5.6**	**Albumin is increased in patients with kidney disease due to impaired breakdown by kidneys in patients with renal failure (Capriotti and Frizzell, 2017).**
Calcium	**8.5-10.1 mg/dL**	**N/A**	**9**	**Within normal range.**
Mag	**1.6-2.6 mg/ dL**	**N/A**	**1.8**	**Within normal range.**
Phosphate	**- N/A**	**N/A**	**N/A**	**N/A**
Bilirubin	**Less than 0.3**	**N/A**	**N/A**	**N/A**
Alk Phos	**44-147 U/L**	**N/A**	**148**	**Patients has increased Alkaline phosphatase due to impaired excretion by kidneys in renal failure (Capriotti and Frizzell, 2017).**
AST	**14-36**	**N/A**	**134**	**Liver cannot metabolize AST due to renal failure (Capriotti and Frizzell, 2017).**
ALT	**0-35**	**N/A**	**55**	**Liver cannot metabolize ALT due to renal failure (Capriotti and Frizzell, 2017).**
Amylase	**N/A**	**N/A**	**N/A**	**N/A**
Lipase	**N/A**	**N/A**	**N/A**	**N/A**
Lactic Acid	**N/A**	**N/A**	**N/A**	**N/A**
Troponin	**N/A**	**N/A**	**N/A**	**N/A**
CK-MB	**N/A**	**N/A**	**N/A**	**N/A**
Total CK	**N/A**	**N/A**	**N/A**	**N/A**

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

Lab Test	Normal	Value on	Today's	Reason for Abnormal

	Range	Admission	Value	
INR	**N/A**	**N/A**	**N/A**	**N/A**
PT	**N/A**	**N/A**	**N/A**	**N/A**
PTT	**N/A**	**N/A**	**N/A**	**N/A**
D-Dimer	**N/A**	**N/A**	**N/A**	**N/A**
BNP	**N/A**	**N/A**	**N/A**	**N/A**
HDL	**N/A**	**N/A**	**N/A**	**N/A**
LDL	**N/A**	**N/A**	**N/A**	**N/A**
Cholesterol	**N/A**	**N/A**	**N/A**	**N/A**
Triglycerides	**N/A**	**N/A**	**N/A**	**N/A**
Hgb A1c	**N/A**	**N/A**	**N/A**	**N/A**
TSH	**N/A**	**N/A**	**N/A**	**N/A**

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	**Light yellow**	**N/A**	**N/A**	**N/A**
pH	**5.0-7.0**	**N/A**	**N/A**	**N/A**
Specific Gravity	**1.003-1.030**	**N/A**	**N/A**	**N/A**
Glucose	**negative**	**N/A**	**N/A**	**N/A**
Protein	**negative**	**N/A**	**N/A**	**N/A**
Ketones	**negative**	**N/A**	**N/A**	**N/A**
WBC	**0-25 /ul**	**N/A**	**N/A**	**N/A**
RBC	**0-25/ul**	**N/A**	**N/A**	**N/A**
Leukoesterase	**negative**	**N/A**	**N/A**	**N/A**

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	N/A	7.32	PH is low in acidosis (Capriotti and Frizzell, 2017).
PaO2	80-100	N/A	70	In renal failure patient has hypoxia and low Pao2 levels due to decreased oxygenation of tissues (Capriotti and Frizzell, 2017).
PaCO2	35-45	N/A	21	Paco2 is low in metabolic acidosis (Capriotti and Frizzell, 2017).
HCO3	22-26	N/A	22	Within normal range.
SaO2	92-100	N/A	89	Patients who are hyperventilating have decreased oxygen saturation and reduced hemoglobin levels (Capriotti and Frizzell, 2017).

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	**N/A**	**N/A**	**N/A**	**N/A**
Blood Culture	**N/A**	**N/A**	**N/A**	**N/A**
Sputum Culture	**N/A**	**N/A**	**N/A**	**N/A**
Stool Culture	**N/A**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2017). Pathophysiology: introductory concepts and clinical perspectives. Philadelphia: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

D- dimer test showed negative tests.

CT chest with contrast showed diffuse centrilobar atelectasis and emphysema.

Diagnostic Test Correlation (5 points):

D- dimer test is a one of confirmatory to rule out pulmonary embolism in patient who has risk or history of blood clots. The patient d- dimer is negative which confirms absence of clot.

CT chest reveled atelectasis and centrilobular emphysema. The test was performed due to patient's low CO2 levels and her history of lung cancer.

Diagnostic Test Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2017). Pathophysiology: introductory concepts and clinical perspectives. Philadelphia: 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)

Generic/ Brand	**Duloxetine/ cymbalta**	**Gabapentin / neurontin**	**Magnesium/ Mag-Tab SR.**	**Potassium chloride(Klor-con)**	**Pyridoxine/(Vit B-6)**
Dose	**20 mg**	**600 mg**	**250 mg**	**20 meq**	**100 meq**
Frequency	**1 cap**	**1 tablet**	**1 tablet**	**1 tablet**	**1 tablet**
Route	**Oral once daily**	**Three times daily**	**Once daily**	**Once daily**	**Once daily**
Classification	**Antidepressent**	**Gabapentinoids**	**Minerals**	**Mineral**	**Vitamins**
Mechanism of Action	**Inhibits the reuptake of serotonin and norepinephrine in the central nervous system.**	**It inhibits the alpha 2-delta subunit of voltage-gated calcium channels**	**It increases the magnesium which is a mineral.**	**It increases potassium levels in body**	**It increases vitamin B12 levels in body**
Reason Client Taking	**Age related depression**	**Due to peripheral neuropathy related to vitamin B12 deficiency**	**Due to renal insufficiency. As kidneys does not produce adequate magnesium.**	**In renal failure , potassium levels are low.**	**Due to deficiency of vitamin B12 secondary to renal failure.**
Contraindications (2)	**Manic behavior Suicidal thoughts**	**Depression COPD**	**Allergy Hypermagnesemia**	**Allergy Hyperkalemia**	**Allergy Jaundice**
Side Effects/Adverse Reactions (2)	**Felling dizzy Blurry vision**	**Hypotension Tremor**	**Nausea Dizziness**	**Diarrhea Lethargy**	**Diarrhea Loos of taste**
Nursing Considerations (2)	**Remain alert for signs of anaphylactic reaction Monitor for**	**Do not lie down immediately after taking the**	**Monitor for fall episodes. Take with meal to prevent**	**Monitor for rash Take without**	**Take without food to prevent diarrhea.**

	hepatotoxicity.	**drug to prevent hypotension** **Monitor for fall episodes**	**nausea.**	**food to prevent acid reflux**	**Drink plenty of fluids**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**None**	**None**	**None**	**None**	**None**
Client Teaching needs (2)	**Take after evening meals and before going to bed to prevent dizziness.** **Take at same time every day for maximal effect**	**It can be taken with or without food.** **Swallow the tablet and do not crush it .**	**Take with meal to prevent nausea.** **Increases fiber in diet to prevent constipation.**	**Take before food to prevent diarrhea.** **Increase the amount of fluid intake.**	**Take without food to prevent diarrhea** **Take at same time every day for maximal absorption**

Hospital Medications (5 required)

There were only two medications prescribed by her provider in the ER.

Generic/Brand	**Odansetron/ Zofran**	**Lorazepm/Ativan**			
Dose	**8mg**	**50 mg**			
Frequency	**twice daily**	**Once daily**			
Route	**Oral**	**Oral**			

Classification	**Antiemetic**	**Benzodiazepines**			
Mechanism of Action	**It prevents nausea by blocking 5Ht3 antagonist receptor in brain**	**It enhances the inhibits effects of GABA**			
Reason Client Taking	**Nausea**	**Due to anxiety**			
Contraindications (2)	**Allergy diarrhea**	**Allergy Sedation**			
Side Effects/Adverse Reactions (2)	**backpain uneasiness**	**Sedation Bad taste in mouth**			
Nursing Considerations (2)	**Eat with food to prevent GI upset** **Take the pill in semi flower's position**	**Monitor for fall risk.** **Take tablet after evening meals and before bedtime.**			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Nothing**	**None**			
Client Teaching needs (2)	**Take with food to prevent any GI problem.** **Do not immediately lie down after taking the medications.**	**Take with evening meals to prevent sedation.** **Do not drive if taking this medication.**			

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:**	**Patient appears to be anxious, not alert and disoriented . She is aware of her surroundings and not in distress. She is pleasant to talk and not diaphoretic.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 12** **Drains present: Y☐ N ☒** **Type:**	**Multiple ecchymosis present in lower legs, back and arms. No wounds are present. Skin is pink and moist. Skin turgor is normal.**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head and neck symmetrical, trachea midline no deviation, thyroid palpable, no noted nodules. Bilateral carotid pulses palpable. Nose septum midline turbinate's moist and pink.** **•Eyes bilateral sclera white, bilateral cornea foggy, conjunctive pink, slight drainage in left eye. Dentures noted upon oral examination.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):**	. **Clear S1 and S2 heard without gallops or rubs. Pt in normal sinus rhythm with PVC'S, Peripheral pulses palpable. Capillary refill less**

Peripheral Pulses: **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**then 3sec. No murmur heard.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Depth, rate, rhythm of respiration is normal. No use of accessory muscle noted.**
GASTROINTESTINAL (2 points): **Diet at home: Renal diet** **Current Diet** **Height: 5 feet** **Weight: 150 lb** **Auscultation Bowel sounds:** **Last BM: Today** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention: None** **Incisions: None** **Scars: None** **Drains: None** **Wounds: None** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Bowel sounds are present and normoactive in all four quadrants .Abdomen is soft, symmetric with no pain or tenderness. Aorta is midline with bruit or visible pulsation. No hepatomegaly or splenomegaly noted. Diet is NPO upon admission to ED.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine: 20 ml** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Patient does have urgency or frequency. The color of urine is dark yellow . Urine culture is not obtained as patient is not symptomatic.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices: Cane** **Strength:** **ADL Assistance: Y☒ N ☐**	**Patient is stable but not independent to walk. She requires support of assistive devices and assistance with equipment.**

Fall Risk: Y ☒ N☐ **Fall Score: 8** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☐**	
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 alert, awake and oriented to place ,person and time. Motor function is normal with muscle strength 5/5 bilaterally. Reflexes 2+ bilaterally. No gait abnormalities are noted.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Patient is living alone in her home by herself . She has a neighbor and her relationship is good with her as she came to give her medication to nurse. She mentions that she is not not coping with life very well and is out of food since few days.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
10: 00 am	**60**	**100/80**	**16**	**98.3**	**89**
11: am	**70**	**80/90**	**18**	**97.8**	**88**

Vital Sign Trends:

Blood pressure and oxygen saturation rates are dropping due to volume deficit related to diarrhea and chronic renal failure.

Pain Assessment, 2 sets (2 points)

Patient mentioned that she does not have any pain.

Time	Scale	Location	Severity	Characteristics	Interventions
10:00 am	**0** **Numeric scale**	**None**	**None**	**None**	**None**
11:00 am	**0** **Numeric scale**	**None**	**None**	**None**	**None**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22 **Location of IV: Left arm** **Date on IV: 9/6/2021** **Patency of IV: patent** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: clear and dry**	Unit of blood NS I bag

Intake and Output (2 points)

Intake (in mL) None	Output (in mL)
Patient is NPO – 0 ml	**20 ml**

Nursing Care

Summary of Care (2 points)

Overview of care: The goal is to improve patient's CO2 levels and monitor for any hypotensive episodes.

Procedures/testing done: ABG analysis which revealed severe metabolic acidosis secondary to renal failure.

Complaints/Issues: Patient constantly complied of feeling of impending doom.

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

Tolerating diet, activity, etc.: Patient needs support to use bedside commode

Physician notifications: Monitor for hypotension and her saturation levels.

Future plans for patient: The plan is to prevent future hypotensive episodes and teach patient about its management at home.

Discharge Planning (2 points)

Discharge location: ED, Carle Urbana

Home health needs (if applicable): Patient would benefit from regular visits by a health nurse .

Equipment needs (if applicable): None

Follow up plan: None

Education needs: The patient needs to educated on using oxygen cylinder at home as her provider is planning to discharge him with oxygen cylinder due to her hyperventilative episode.

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. Fluid volume deficit related to diarrhea as evidenced by frequent bowel	**Patient had frequent BM due to diarrhea and is a risk for fluid volume deficit.**	**1.Drink plenty of fluids to replenish the fluid lost .** **2. 2. Drink electrolyte-based**	**Patient agreed to the plan of action and described that she felt much better after the interventions.**

movement.		**fluids , for example, Gatorade.**	
2. Impaired gas exchange related to chronic anemia as evidenced by decreased hemoglobin and hematocrit levels.	**Patient had very low hemoglobin due to renal failure .**	**1. Patient was transfused a unit of blood.** **2.Patient also given IV fluids to improve her fluid imbalance**	**Patient reported that she feels better now after blood transfusion and does not feel dizziness . She also does not have any shortness of breath .**
3. Decreased blood pressure related to frequent falling episodes as evidence by decrease in systolic and diastolic blood pressure.	**Patient had hypotensive episode at home and hence fell in her home.**	**1. Patient was given salt water to improve her blood pressure.** **2 Patient was placed in semi flowers position to improve her blood pressure**	**Patient mentioned that she is feeling less dizziness after drinking salt water and head of bed elevation.**
4. Fall risk due to chronic blood loss in stool as well as hypotension as evidenced by anemia , occult blood in stool and low blood pressure.	**Patient is fall risk due to feeling dizzy all the time due to low blood pressure and anemia.**	**1. Patient was place in semi flowers position which helped her in her dizziness** **2. Bed in lowest position and her room is clutter free to prevent fall. Call light is within reach as well.**	**Patient mentioned that she falls frequently at home but semi flower's position helped her in her dizziness which will prevent fall risk.**

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 presents with difficulty in breathing and fall episode in her home after having breakfast. She feels dizzy and feeling of impending doom.

Nursing Diagnosis/Outcomes

l volume deficit related to diarrhea as evidenced by frequent bowel movement.
Outcome- Drink plenty of fluids to replenish fluid lost.

2.Impaired gas exchange related to chronic anemia as evidenced by decreased hemoglobin and hematocrit levels.
Outcome: Patient given oxygen at four liters.

3.Decreased blood pressure related to frequent falling episodes as evidence by decrease in systolic and diastolic blood pressure.
Outcome: Patient given normal saline to increase blood pressure.

4.Fall risk due to chronic blood loss in stool as well as hypotension as evidenced by anemia , occult blood in stool and low blood pressure.
Outcome: Patient's bed is in lowest position and cal light with thin reach.

Objective Data

Patient ABG revealed metabolic acidosis and very low CO2. Patient also had occult blood in her stool and severe anemia secondary to blood loss and chronic renal failure.

Patient Information

Patient is 68 year female, 5 feet and 150 lb. she is full code and with severe hypotension and frequent falling episodes. She has low Co2 levels due to metabolic acidosis.

Nursing Interventions

1.Drink plenty of fluids to replenish the fluid lost .

.2. Drink electrolyte-based fluids , for example, Gatorade.
3.Patient was transfused a unit of blood.

4..Patient also given IV fluids to improve her fluid imbalance

5.Patient was given salt water to improve her blood pressure.

6. Patient was placed in semi flowers position to improve her blood pressure.

7. Patient was place in semi flowers position which helped her in her dizziness

8. Bed in lowest position and her room is clutter free to prevent fall. Call light is within reach as well.