

N431 Care Plan #1

Lakeview College of Nursing

Name: Richard Kumpi

Demographics (3 points)

Date of Admission 9/8/2021	Patient Initials P.W	Age 69	Gender Female
Race/Ethnicity White Caucasian	Occupation Retired	Marital Status Single	Allergies Penicillin V Potassium, Hydrochlorothiazide, Sulfa (sulfonamide)
Code Status Full code	Height 165.1 cm/ 5'5''	Weight 91.6 kg / 202 Lb	

Medical History (5 Points)

Past Medical History: Arthritis of lumbar spine, Atherosclerosis of abdomen Aorta, Bipolar 1 disorder, Cholelithiasis, Dyslipidemia, Kidney cyst, liver lesion, lymphedema, hepatomegaly, Hypertension, chronic venous hypertension, Heartburn, Thyroid lesion.

Past Surgical History: Hysterectomy (2008), PR Endovenous RF 1st vein left (2021).

Family History: cancer (mother, father, brother)

Social History (tobacco/alcohol/drugs): Never smoker, no alcohol or drug used.

Assistive Devices: none

Living Situation: lives at assisted living facility. She has a daughter who take care of her.

Education Level: has a high school diploma.

Admission Assessment

Chief Complaint (2 points): Altered mental status.

History of present Illness (10 points): On September 08th, 2021, a 69 y/o white, single female was brought to the E.R department of Carle Hospital for altered mental status that started earlier today. The confusion in her head has been going on for hours since this morning; the daughter said, "my Mom seemed to be a little bit off". The daughter said that the confusion was characterized by inappropriate acting, agitation, and inattention. She also

said that nothing could relieve her agitation. Patient is compliant with Coreg therapy. Patient denies nausea, vomiting, or pain. She presents no sign of shortness of breath. Patient had a high blood pressure with a systolic above 200 at admission to the ED. Patient has been given an injection of enoxaparin and olanzapine. A urine sample was collected for urinalysis and a chest X-rays has been done. Patient is alert but still confused.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute encephalopathy.

Secondary Diagnosis (if applicable): wound

Pathophysiology of the Disease, APA format (20 points): Acute encephalopathy is a clinical condition in which the functions of the brain have been temporarily or permanently affected due to different underlying diseases. It is a mental state, which if not treated can lead to brain damage (Malmo k., 2019). Encephalopathy refers to a group of medical disorders with many underlying causes. Those causes include both systematic and primary neurologic conditions (Erkkinen & Berkowitz, 2019). Encephalopathy has two major types: reversible such as hepatic encephalopathy caused by a malfunctioning liver that cannot remove toxic substance from blood, making the brain to work improperly. Another type is the metabolic encephalopathy, which happens when conditions such as kidney failure, heart failure, or diabetes hinder the brain's work. Infections of the brain such as meningitis and encephalitis or urinary tract infection can lead to encephalopathy (Erkkinen & Berkowitz, 2019). Irreversible encephalopathy includes chronic traumatic encephalopathy, which is caused by head injuries that damage the brain. Another irreversible encephalopathy is hypoxic-ischemic encephalopathy which happens when the

brain does not receive enough oxygen (Malmo k., 2019). Signs and symptoms of encephalopathy include confusion, personality changes, memory loss, disorientation, tremors, sleepiness, trouble speaking or swallowing... (Erkkinen & Berkowitz, 2019). At cellular level, encephalopathy affects the body in many ways depending on causative agents. A patient with severe high blood pressure can overwhelm the autoregulation mechanisms and causes a diffuse vasogenic edema; a cerebral ischemia may occur from brain vessel spasm due to hypertension (Barisavac. et al. 2017). Laboratory testing used to diagnose encephalopathy includes blood and urine tests, magnetic resonance imaging (MRI), chest X-ray, computed tomography (CT), electroencephalography (EEG) (Barisavac. et al. 2017). My patient's blood pressure was elevated with a systolic above 200, the arterial blood gas revealed elevated HCO₃ and pH. Her chest X-ray revealed enlargement of the cardiac silhouette. Treatment of encephalopathy depends on the underlying causes. It may include medications, oxygen therapy, bedrest. My patient is being treated with enoxaparin for her hypertension and olanzapine for her altered mental state.

Pathophysiology References (2) (APA):

1. Berisavac, I. I., Jovanović, D. R., Padjen, V. V., Ercegovic, M. D., Stanarčević, P. D. J., Budimkić-Stefanović, M. S., Radović, M. M., & Beslač-Bumbaširević, L. G. (2017). How to recognize and treat metabolic encephalopathy in Neurology intensive care unit. *Neurology India*, 65(1), 123–128. <https://doi.org/10.4103/0028-3886.198192>
2. Erkkinen, M. G., & Berkowitz, A. L. (2019). A clinical approach to diagnosing encephalopathy. *The American journal of medicine*, 132(10), 1142–1147. <https://doi.org/10.1016/j.amjmed.2019.07.001>

3. Malmo k. (2019). What is encephalopathy? WebMD.

<https://www.webmd.com/brain/what-is-encephalopathy>

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	M:4.5-6 million F: 4-5.5 million	4.39	4.39	
Hgb	M: 14-16g/dl F: 12-15 g/dl	11.5	11.5	Hgb is decreased in situations involving chronic disease. Patient has a past medical of liver lesion and kidney cyst. (Van Leeuwen & Bladh, 2017)
Hct	M: 35-47% F: 42-52%	32.9	32.9	Hct are decreased in the presence of chronic disease. Patient has a past medical history of liver lesion and kidney cyst. (Van Leeuwen & Bladh, 2017)
Platelets	150,000-400,000 cells/mm ³	352	352	
WBC	4,500-11,000 cell/mm ³	26.50	26.50	WBC are higher in situation involving infection, stress, and Leukocytosis. Patient has wound at groins. Also leukocyte esterase found in her urine. (Hinkle & Cheever, 2018)
Neutrophils	45-75%	83.9	83.9	Neutrophil levels are elevated in the presence of infection, depression, stress, inflammation. Patient has hepatomegaly. She also was under stress and depressed at the admission. She has been given antidepressant meds. (Hinkle & Cheever, 2018)
Lymphocytes	20-40%	14.7	14.7	Lymphocytes are decreased in the

				presence of infections, cancerous agents, HIV/AIDS. Patient has hepatomegaly, thyroid lesion and wounds. (Van Leeuwen & Bladh, 2017).
Monocytes	4-6%	8.3	8.3	Monocytes are elevated in presence of chronic infections, autoimmune disease, leukemia, tuberculosis. My patient has a Hepatomegaly, kidney cyst, liver lesion which make her immunosuppressed. (Van Leeuwen & Bladh, 2017)
Eosinophils	< 7%	0.1	0.1	
Bands	<0-5%	Not drawn	Not drawn	

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145 mmol/L	139	139	
K+	3.5-5.0 mmol/L	3.6	3.6	
Cl-	97-107 mmol/L	97	97	
CO2	35-45 mm Hg	30	30	Carbon dioxide levels are decreased: metabolic acidosis, can be due to dehydration and anxiety, liver failure, kidney disease. Patient has chronic liver issues, kidneys disease, and also ketones are found in her urine. (Hinkle & Cheever, 2018)
Glucose	70-100 mg/dL	119	119	High levels of glucose can be seen in clients with kidney disease or liver disease. My Patient has a past medical history of hepatomegaly and chronic kidney disease. (Van Leeuwen & Bladh, 2017)
BUN	8-25 mg/dL	23	23	

Creatinine	0.6-1.3 mg/dL	0.85	0.85	
Albumin	3.5-5.2 mg/dL	Not drawn	Not drawn	
Calcium	8.6-10 mg/dL	8.9	8.9	
Mag	1.3-2.3 mEq/L	Not drawn	Not drawn	
Phosphate	2.5-4.5 mg/dL	Not drawn	Not drawn	
Bilirubin	0.1-1.4 mg/dL	Not drawn	Not drawn	
Alk Phos	44-147 U/L	Not drawn	Not drawn	
AST	10-30 U/L	Not drawn	Not drawn	
ALT	10-40 U/L	Not drawn	Not drawn	
Amylase	30-110U/L	Not drawn	Not drawn	
Lipase	0-160 U/L	Not drawn	Not drawn	
Lactic Acid	0.5-2.2 mmol/L	Not drawn	Not drawn	
Troponin	0-0.04ng/mL	N/A	N/A	
CK-MB	26-174 U/L	196>	196>	Elevated levels of CK in blood sample destruction of muscles by an abnormal process such as inflammation or muscular dystrophy, thyroid disorders, seizures. Patient has atherosclerosis of abdominal aorta, her chest X-ray revealed enlargement of cardiac silhouette and possible pleural effusion (Hinkle & Cheever, 2018).
Total CK	26 - 174 U/L	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 Range	Value on Admission	Today's Value	Reason for Abnormal
INR	2-3	Not drawn	Not drawn	
PT	M:9.6-11.8 sec F:9.5-11.3 sec	Not drawn	Not drawn	
PTT	30-40 sec	Not drawn	Not drawn	
D-Dimer	< 250 ng/mL	Not drawn	Not drawn	
BNP	< 100 ng/L	Not drawn	Not drawn	
HDL	>60	Not drawn	Not drawn	
LDL	< 130 mg/dL	Not drawn	Not drawn	
Cholesterol	< 200 mg/dL	Not drawn	Not drawn	
Triglycerides	< 150 mg/dL	Not drawn	Not drawn	
Hgb A1c	4-5.6 %	Not drawn	Not drawn	
TSH	0.5-5.0 mIU/L	Not drawn	Not drawn	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Colorless-yellow, clear	Hazy, yellow	Hazy, yellow	Abnormal urine color and clarity, like hazy is seen in patients who are dehydrated or have kidney diseases. Liver diseases may also play a role. My patient has a history of chronic kidney diseases and liver diseases. She was likely dehydrated when the sample was taken. (Van Leeuwen & Bladh, 2017)
pH	4.5-8	8.0	8.0	

Specific Gravity	1.005-1.035	1.014	1..014	
Glucose	none	none	none	
Protein	none	30	30	Protein in urine may indicate kidney disease. (Hinkle & Cheever, 2018)
Ketones	none	20	20	Ketones in urine indicate diabetic ketoacidosis. It can also be caused by dehydration, poor diet in carbs. My patient may have been dehydrated when brought to the hospital (Hinkle & Cheever, 2018).
WBC	None or rare	5	5	Presence of WBC in the urine may be due to leukocytosis, inflammation in the urinary tract, liver disease, or kidneys. My patient has a kidney disease and hepatomegaly that may cause elevated WBC in the urine. (Van Leeuwen & Bladh, 2017)
RBC	None or rare	46	46	Elevated values of RBC in the urine are seen in patients who have inflammation in the urinary tract, kidney disease or liver disease. Patient has a liver lesion, hepatomegaly, and kidney disease that would contribute to the cause of elevation of RBC in the urine. (Van Leeuwen & Bladh, 2017)
Leukoesterase	none	Moderate		The presence of leukocyte esterase in the urine indicates the presence of WBCs, which indicate inflammation of the kidneys or urinary tract caused by bacterial infection. Patient has kidney diseases and elevated levels of WBCs in the urine (Van Leeuwen & Bladh, 2017).

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	7.43	7.43	
PaO ₂	80-100 mmHg	81	81	O ₂ is within normal range but stands to the lowest extremity. The patient's chest X-ray showed enlargement of the cardiac silhouette. Also, a patient has a history of kidney disease that can cause low O ₂ saturation. Patient has been put on 3L O ₂ .
PaCO ₂	35-45	30	30	Carbon dioxide levels are decreased: metabolic alkalosis, can be due to dehydration and anxiety, liver failure, kidney disease. Patient has chronic liver issues, kidneys disease, and also ketones are found in her urine. (Hinkle & Cheever, 2018)
HCO ₃	22-26	32.1	32.1	HCO ₃ is elevated to compensate metabolic alkalosis caused by kidney disease (Hinkle & Cheever, 2018).
SaO ₂	95-100 %	N/A	N/A	

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		Results not available	Results not available	
Blood Culture		Not drawn	Not drawn	
Sputum Culture		Not drawn	Not drawn	
Stool Culture		Not drawn	Not drawn	

Lab Correlations Reference **(1)** (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of Medical Surgical Nursing*. 14th Wolters Kluwer.

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): chest x-ray single view portable, stable bibasilar airspace opacities, atelectasis. Stable enlargement of the cardiac silhouette. Increase of left hemidiaphragm, possible trace of pleural effusion.

Diagnostic Test Correlation (5 points): A chest x-ray single view portable was ordered to rule out any potential infectious process in the heart and lungs in relation with the data.

The results are positive confirming bibasilar atelectasis.

Diagnostic Test Reference **(1)** (APA):

Hinkle, J.L., & Cheever, K.H. (2018). *Brunner & Suddarth's textbook of Medical Surgical Nursing*. 14th Wolters Kluwer.

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

Home Medications (5 required)

Brand/Generic	Albuterol sulfate	Sinemet levodopa	Calcium carbonate/	Carvedilol/ Coreg	Fluoxetine/ Prozac
Dose	2,5 mg/3ml	100 mg tablets	500 mg	6.25 mg Tablets	40 mg capsules
Frequency	Two puffs Every 6 PRN	3 times/day	Every 8 hours PRN	2 times/day	2 capsules /Day
Route	inhaler	P. O	P. O	P. O	P. O
Classification	Bronchodilator	Decarboxylate	Antiacid	Antihypertensive & heart failure treatment	Antidepressant

Mechanism of Action	Albuterol attaches to beta2 receptors on bronchial cell membranes, which stimulate the intracellular enzymes adenylate cyclase to convert ATP to cAMP.	Converting dopamine by DOPA decarboxylase and cross blood-brain barrier to stimulate dopaminergic receptors.	Increase levels of intracellular and extracellular calcium, which plays role to maintain homeostasis in nervous and musculoskeletal system.	Reduce cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance, which reduces blood pressure.	Inhibits reuptake of the neurotransmitter serotonin by central nervous system neurons and increase the amount of serotonin available.
Reason Client Taking	Atelectasis underlying pneumonia.	Treat Parkinson symptoms like tremor, poor muscle control, spasm, and stiffness.	To relieve heartburn and upset stomach.	Hypertension	depression
Contraindications (2)	Hypersensitivity to albuterol & its components	Hypersensitivity to drugs & narrow-angle glaucoma.	Hypercalcemia & hypophosphatemia	Asthma & cardiogenic shock	Concurrent use with pimozide & MAO inhibitor.
Side Effects/Adverse Reactions (2)	Dizziness & drowsiness.	Lightheadedness & dyskinesias	Hypotension & hypercalcemia	Heart failure & renal insufficiency	Seizure & serotonin syndrome.
Nursing Considerations (2)	Use caution for clients with hypertension & cardiac disorders.	Monitor for hemolytic anemia & report skin issue to the provider.	Keep patient in recumbent position & IV administer by IV infusion solution.	Do not stop the drug abruptly & do not give before major surgery.	Monitor depression & GI bleeding.
Key Nursing	Monitor	Monitor for	Monitor	Monitor	Monitor

Assessment(s)/ Lab(s) Prior to Administration	serum potassium & drug tolerance	blood dyscrasia	serum calcium and Chvostek's and trousseau's signs	blood pressure	serotonin syndrome
Client Teaching needs (2)	Wash mouthpiece & teach patient how to use inhaler and wait 1 min before the second dose if prescribed.	Educate patient about the medication & report side effect.	Shake the bottle & limit alcohol.	Monitor blood glucose during treatment & swallow extended- release capsules.	Observe serotonin syndrome & family should closely observe patient for suicidal ideation.

Hospital Medications (5 required)

Brand/Generic	Enoxaparin/ Lovenox	Olanzapine/ Zyprexa			
Dose	40 mg	2.5 mg			
Frequency	daily	One time			
Route	Subcutaneous	IM			
Classification	Anticoagulant	Antipsychotic			
Mechanism of Action	Acts as antithrombin III, a coagulation that rapidly inactivates clotting factors.	May achieve antipsychotic effects by antagonizing dopamine and serotonin receptors.			

Reason Client Taking	Atherosclerosis of abdominal of the aorta	Bipolar			
Contraindications (2)	Active major bleeding & hypersensitivity to drug.	Cerebral arteriosclerosis & hepatic disfunction			
Side Effects/Adverse Reactions (2)	Confusion & edema	Dizziness & fatigue			
Nursing Considerations (2)	Use caution with client with risk of hemorrhage & hepatic or renal impairment	Caution in patient with hepatic impairment & cerebrovascular diseases.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	PTT, CBC, and platelet count. Check for the previous dose and site of administration.	Monitor blood pressure, daily weight, blood glucose, and tardive dyskinesia.			
Client Teaching needs (2)	Avoid NSAIDs & teach client how to use enoxaparin at home.	Avoid alcohol & smoking during treatment.			

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:	Well developed, appears unamused, speaks difficulty with low tone and voice.
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<p>Orientation: Distress: Overall appearance:</p>	<p>Alert Confused Patient appears distressed well groomed</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Pink Moisture, skin damaged Warm to touch Slow Rashes at posterior back, blisters on both legs No bruises Wounds on groins 9</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck symmetrical, normal cephalic. Ears are symmetrical and free of discharge, no hearing deficiencies, no hearing aids. Eyes are symmetrical, wears eyeglasses. Nose septum midline, no drainage or bleeding. Patient has natural teeth, no dentures.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	<p>Normal S1 and S2 with murmur/ swishing.</p> <p>Peripheral pulses are 2+ slightly more diminished through bilateral Weak, 1+</p> <p>Edema inspected and palpated in both lower extremities.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Crackles or rales noted in the left lung. No accessory muscle use, patient is on 2L oxygen therapy.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds:</p>	<p>Regular diet Regular diet 165.1 cm 91.6 kg Bowel sounds are present in all 4 quadrants</p>

<p>Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Earlier today in the morning Patient denies any pain, but masses noted above the umbilical region.</p> <p>No distension No incisions or scars noticed. No drains Wounds at groins</p>
<p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Yellow Hazy 340ml</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 18 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Edema on both lower extremities. Passive ROM upper and lower extremities No supportive devices Weak strength both upper and lower bilateral. Patient is at fall risk and is under supervision with need of support to stand or walk. Patient needs assistive devices for gait at hospital and at home.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory:</p>	<p>Patient is awake in bed, fatigued, and confused. Patient speaks difficultly and looks altered mentally.</p>

LOC:	
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 unamused and sleepy; she is cooperative and calm. Patient never smoke or use drugs. Patient has a high school diploma Patient states she has no religious preferences. Patient lives at assisted living, she has a good support from her daughter who takes care of her.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0245	74	189/106	16	98.1	92/ nasal cannula
0450	89	162/78	16	97.8	98/ nasal cannula

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0245	Numeric Scale 0/10	Patient denies pain	Patient denies pain	Patient denies pain	No interventions implemented
0450	Numeric Scale 0/10	Patient denies pain	Patient denies pain	Patient denies pain	No interventions implemented

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 G
Location of IV:	Left antecubital
Date on IV:	9/8/21
Patency of IV:	Lack of saline
Signs of erythema, drainage, etc.:	No sign of erythema
IV dressing assessment:	clean

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
520ml	340ml

Nursing Care

Summary of Care (2 points)

Overview of care: client is alert but still a little bit confused. Nursing is monitoring the client’s vital signs. Patient is at bedrest and nursing is monitoring the client for fall risk and her BP, which is still elevated but is dropping to normal. Client’s fluid intake is sufficient, and no IV supplementation of fluids is being provided at this time. Client is on 3L Oxygen therapy.

Procedures/testing done: X-ray chest, urinalysis, and other lab tests.

Complaints/Issues:

Vital signs (stable/unstable): unstable, her PB is still high.

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

Physician notifications: Patient will be admitted to medical surgical unit for further care.

Future plans for patient: continue with fluoxetine, enoxaparin, and Coreg.

Discharge Planning (2 points)

Discharge location: Nursing home

Home health needs (if applicable): not applicable

Equipment needs (if applicable): no equipment needed

Follow up plan: client will need to follow up with the physician for evaluation of mental status and atherosclerosis of aorta.

Education needs: follow healthy diet, eat low sodium and fat foods.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Intervention (2 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for impaired gas exchange related to bibasilar atelectasis as evidence by X-rays.</p>	<p>This diagnosis was chosen because client exhibit signs of respiratory distress such as shortness of breath.</p>	<p>1. Monitor pulmonary status as directed and needed</p> <p>2. Instruct client in effective coughing and deep breathing.</p>	<p>Client was excited after deep breathing and coughing because it did improve her oxygen from 81- 94 %</p> <p>Lungs are expended to capacity.</p>
<p>2 Ineffective cerebral tissue perfusion related to disruption of</p>	<p>This diagnostic was chosen because the patient’s blood pressure was too</p>	<p>1. Administer oxygen therapy</p> <p>2. Monitor and record blood</p>	<p>The client is active in the plan of care. BP are dropped to normal</p>

<p>blood flow as evidence by increasing Systolic blood pressure over 200.</p>	<p>high.</p>	<p>pressure, epical pulse and temperature every 2-4 hours</p>	
<p>3 Risk for impaired skin integrity related to the presence of inadequate tissue perfusion as evidenced by wound at groin and rashes on the lower back.</p>	<p>The diagnosis was chosen because the client’s skin is damaged with rashes on the lower back and wound on the groin.</p>	<p>1. Encourage frequent position change, assist in active and passive range of motion</p> <p>2Provide frequent skin care to minimize contact with moisture and excretion.</p>	<p>Client was able to move from side to side without help to maintain skin integrity</p>
<p>4 Impaired memory related to cognitive impairment as evidenced by confusion</p>	<p>A patient with encephalopathy has impaired memory and will need to be reoriented. Inability to maintain orientation is an indication of deterioration of cerebral function.</p>	<p>1. reorient the patient</p> <p>2Assess the patient’s level of memory, have the patient write names of things periodically or have him work on puzzles to improve the memory. Keep the record for comparison and report changes.</p>	<p>Patient is able to follow directions and instructions as being reoriented. He is making great improvement for his memory as he still working on some IQ activities. He is able to write his name over and over, building puzzles.</p>

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.**

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

Concept Map (20 Points):

Subjective Data

The client's daughter said, "my Mom seemed to be a little bit off since this morning". The confusion was characterized by inappropriate acting, agitation, and inattention

Nursing Diagnosis/Outcomes

Risk for impaired gas exchange related to bibasilar atelectasis as evidence by X-rays.
Ineffective cerebral tissue perfusion related to disruption of blood flow as evidence by increasing systolic blood pressure over 200.
Impaired memory related to cognitive impairment as evidenced by confusion.
Client was excited after deep breathing and coughing because it did improve her oxygen from 81- 94 %

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

Objective Data
Crackles or rales noted in the left
Urine yellow
Ketone 2+
CO2 30
Neutrophil 83.9
Increasing systolic blood pressure over 200
chest x-ray single view portable: stable bibasilar airspace opacities, atelectasis, stable enlargement of the cardiac silhouette.

Patient Information

On September 08th, 2021, a 69 y/o white, single female was brought to the E.R department of Carle Hospital for altered mental status that started earlier today.

Nursing Interventions

Monitor and record blood pressure, epical pulse and temperature every 2-4 hours
Assess the patient's level of memory, have the patient write names of things periodically or have him work on puzzles to improve the memory. Keep the record for comparison and report changes
Monitor pulmonary status as directed and needed



