N431 Care Plan #1

Lakeview College of Nursing

Kathleen Serrano

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/14/2021	B.M.	38 y.o.	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Nurse	Married	Morphine sulfate, ragweed
Code Status	**Height**	**Weight**	
Full	5'1"	123 lbs.	

Medical History (5 Points)

Past Medical History: Patient reports a past medical history of hypertension, urinary tract infections (UTIs), kidney stones, and iron-deficiency anemia.

Past Surgical History: Patient has a past surgical history of cesarean section, and a cholecystectomy in 2012.

Family History: The patient's mother and brother both have a history of diabetes. The patient's father has a history of myocardial infarction (MI).

Social History (tobacco/alcohol/drugs): Patient reports being a current smoker, who smokes one pack per day. The patient states smoking for ten years. In addition, the patient states being a casual drinker for twenty years. Usually, the patient consumes one to two alcoholic beverages per month. The patient denies any previous or current drug use.

Assistive Devices: The patient reports not having any assistive devices.

Living Situation: The patient reports living at home with her husband and eight children.

Education Level: The patient reports completing all of high school, and four years of college. The patient has a Bachelor's degree in nursing (RN BSN)

Admission Assessment

Chief Complaint (2 points): Redness, swelling, and pain to the right lower extremity (RLE)

History of present Illness (10 points): O: On October 14th, 2021, a 38-year-old female presented to Sarah Bush Lincoln Hospital upon admission for increasing redness, swelling, and pain to the right lower extremity (RLE). Prior to admission, the patient states that she was playing with her children outdoors, tripped over a rock, feel, and skinned her right knee on the pavement. L: The patient reports pain, redness, and swelling in the right lower extremity. D: The patient reports constant pain, redness, and swelling of the right lower extremity. C: The patient does not report any characteristics about the pain in the right lower extremity other than redness and swelling. A: The patient reports no aggravating factors. R: The patient reports no alleviating factors. T: The patient reports doing nothing to treat the pain, redness, and swelling in the right lower extremity.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cellulitis

Secondary Diagnosis (if applicable): A secondary diagnosis is not applicable to the patient.

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

Cellulitis occurs when bacteria enters an open wound or area where there is a break in the skin (Capriotti & Frizzell, 2020). The skin protects bacteria from entering the body, but when there is skin breakdown or a wound the skin becomes compromised (Capriotti & Frizzell, 2020). Normally, the most common bacteria that causes cellulitis is Group A B-hemolytic streptococcus (Capriotti & Frizzell, 2020). As the bacteria invades the wound the body's immune system defensively sends white blood cells to the area which causes inflammation (Capriotti & Frizzell, 2020). The patient reported playing with her children, tripping, falling, and scraping the right leg on the pavement. It is evident that the abrasion to the right lower extremity is the cause of

cellulitis (Capriotti & Frizzell, 2020). Individuals with immunodeficiency and impaired circulation are at high risk for developing cellulitis (Capriotti & Frizzell, 2020). The patient has a past medical history of iron-deficiency anemia is at increased risk for cellulitis due to impaired circulation (Hinkle & Cheever, 2018).

Common signs and symptoms of cellulitis are erythema, edema, pain, fever, and hot temperature around wound (Hinkle & Cheever, 2018). The patient presents with redness, pain, and swelling related to cellulitis However, the patient had a normal temperature, and the wound was not hot to the touch. Normally, individuals with cellulitis may have increased heart rate, blood pressure, and temperature (Hinkle & Cheever, 2018). However, the patient's vital signs were stable. Expected lab findings are an increase in white blood cell count, erythrocyte sedimentation rate (ESR), and positive wound culture (Hinkle & Cheever, 2018). The patient only had an increase in white blood cell count related to cellulitis. Surprisingly, the patient did not have a wound culture completed. Other diagnostic tests the patient underwent included a chest X-ray, a right foot X-ray, electrocardiogram (EKG), and venous doppler test. All tests resulted in normal findings and no differences related to cellulitis. Cellulitis of the lower extremities increases the risk of thrombophlebitis in adults. The venous doppler test revealed a normal finding of no thrombosis (Hinkle & Cheever, 2018).

Lastly, the treatment for cellulitis includes oral or intravenous penicillin, warm compresses at the wound site, pain medication as needed, and elevation of the infected extremity (Capriotti & Frizzell, 2020). The patient received 200 mg of clindamycin every six hours intravenously as initial treatment of cellulitis. Then, due to a pain rating of 6/10, the patient received 650 mg of Tylenol to relive pain. The provider prescribed hydrocodone/acetaminophen,

and hydromorphone for pain relief as needed. The nurse utilized warm compresses on the right lower extremity to provide nonpharmacological pain relief.

Pathophysiology References (2) (APA):

Capriotti, Theresa M. and Frizzell, Joan Parker. (2020). *Pathophysiology: Introductory Concepts and Clinical Perspectives* (2nd ed.). F.A. Davis Company.

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

Laboratory Data (15 points)

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

****Today's values were not taken.**

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**4.28-5.56**	**N/A**	**N/A**	
Hgb	**13.0-17.0**	**8.8**	**N/A**	**Due to the patient's history of iron-deficiency anemia and in combination with the inflammation in the right lower extremity, the hemoglobin levels are abnormally low (Hinkle & Cheever, 2018).**
Hct	**38.1-48.9%**	**N/A**	**N/A**	
Platelets	**149-393**	**N/A**	**N/A**	
WBC	**4.0-10.8**	**17.4**	**N/A**	**Due to the presence of inflammation and the onset of cellulitis from a skin abrasion led to a higher level of white blood cells (Hinkle & Cheever, 2018).**
Neutrophils	**45.3-79.0%**	**N/A**	**N/A**	
Lymphocytes	**11.8-45.9%**	**N/A**	**N/A**	
Monocytes	**4.4-12.0%**	**N/A**	**N/A**	
Eosinophils	**0.0-6.3%**	**N/A**	**N/A**	

Bands	**0-5%**	**N/A**	**N/A**	

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

****Today's values were not taken.**

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**135-145**	**138**	**N/A**	
K+	**3.5-5.1**	**3.6**	**N/A**	
Cl-	**98-107**	**N/A**	**N/A**	
CO2	**21-31**	**N/A**	**N/A**	
Glucose	**74-109**	**86**	**N/A**	
BUN	**7-35**	**10**	**N/A**	
Creatinine	**0.70-1.30**	**1.67**	**N/A**	**Creatinine level is elevated due to the potential risk of an acute kidney injury related to cellulitis (Hinkle & Cheever, 2018).**
Albumin	**3.5-5.2**	**N/A**	**N/A**	
Calcium	**8.6-10.3**	**N/A**	**N/A**	
Mag	**1.7-2.2**	**N/A**	**N/A**	
Phosphate	**2.5-4.5**	**N/A**	**N/A**	
Bilirubin	**0.3-1.0**	**N/A**	**N/A**	
Alk Phos	**34-104**	**N/A**	**N/A**	
AST	**13-39**	**N/A**	**N/A**	
ALT	**7-52**	**N/A**	**N/A**	

Amylase	**30-110**	**N/A**	**N/A**	
Lipase	**11-82**	**N/A**	**N/A**	
Lactic Acid	**0.5-2.0**	**N/A**	**N/A**	
Troponin	**0-0.04**	**N/A**	**N/A**	
CK-MB	**3-5%**	**N/A**	**N/A**	
Total CK	**22-198**	**N/A**	**N/A**	

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

****Values not taken for the other tests below.**

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**0.86-1.14**	**N/A**	**N/A**	
PT	**11.9-15.0**	**N/A**	**N/A**	
PTT	**25-35**	**N/A**	**N/A**	
D-Dimer	**<0.5**	**N/A**	**N/A**	
BNP	**100-400**	**N/A**	**N/A**	
HDL	**>40**	**N/A**	**N/A**	
LDL	**<100**	**N/A**	**N/A**	
Cholesterol	**125-200**	**N/A**	**N/A**	
Triglycerides	**<150**	**N/A**	**N/A**	
Hgb A1c	**<5.7%**	**N/A**	**N/A**	
TSH	**0.5-5.0**	**N/A**	**N/A**	

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

****Urinalysis lab values were not taken.**

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow; clear	N/A	N/A	
pH	5.0-8.0	N/A	N/A	
Specific Gravity	1.005-1.034	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	<5	N/A	N/A	
RBC	0-3	N/A	N/A	
Leukoesterase	Negative	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.

****Arterial blood gas lab values were not taken.**

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	N/A	N/A	
PaO2		N/A	N/A	
PaCO2		N/A	N/A	
HCO3		N/A	N/A	

SaO2	**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.

****Culture lab values were not taken.**

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**Negative**	**N/A**	**N/A**	
Blood Culture	**Negative**	**N/A**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Lakeview College of Nursing. *Tab: Diagnostics: Lab*. Paper.

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X-ray: The chest X-ray revealed a negative result for any acute abnormalities.

EKG: The electrocardiogram showed a normal sinus rhythm and no noted abnormalities.

Right foot X-ray: The X-ray of the right foot revealed a negative result for any acute abnormalities.

Venous Doppler RLE: The venous doppler of the right lower extremity showed a negative result for deep vein thrombosis (DVT).

Diagnostic Test Correlation (5 points): All the diagnostic tests revealed no abnormalities and no signs of infection related to cellulitis such as tachycardia, and the spread of bacteria in the chest or right foot (Hinkle & Cheever, 2018) A chest X-ray and right foot X-ray were taken to assess the presence of bacteria in the chest and right foot where the cellulitis is (Hinkle & Cheever, 2018). An electrocardiogram was necessary to observe for an abnormal heart rate and rhythm related to cellulitis and the potential spread of infection (Hinkle & Cheever, 2018). Lastly, the venous doppler showed a negative result for deep vein thrombi, which usually occurs with the presence of cellulitis (Hinkle & Cheever, 2018).

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	**loratadine (Claritin)**	**Prenatal vitamin (Mega Food Baby and Me)**	**lisinopril (Prinivil)**	**tamsulosin (Flomax)**	**ferrous sulfate (Feosol)**
Dose	**10 mg**	**2 chewable gummies**	**20 mg**	**0.4 mg**	**325 mg**
Frequency	**Once daily**	**Once daily**	**Once daily**	**Once daily**	**Three times daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Pharmacological: antihistamine**	**Pharmacological: vitamins and**	**Pharmacological: ACE inhibitor**	**Pharmacological: alpha adrenergic antagonist**	**Pharmacological: hematinic**

		minerals	**Therapeutic: antihypertensive**	**Therapeutic: benign prostatic hyperplasia agent**	**Therapeutic: antianemic**
Mechanism of Action	**Reduces the effects of natural chemical histamine in the body related to the allergic reaction response caused by allergens such as pollen or dust**	**Prenatal vitamin helps treat or prevent vitamin deficiency by consisting of a combination of multivitamins and iron product related to poor diet, or an illness like iron-deficiency anemia**	**Reduces high blood pressure by inhibiting angiotensin I from converting to angiotensin II.**	**Blocks alpha adrenergic receptors in the prostate, which inhibits smooth muscle contraction that improves uterine flow and reduces BPH symptoms.**	**Normalizes red blood cell production by binding to hemoglobin.**
Reason Client Taking	**To treat the patient's allergies**	**To help replace low iron levels, and prevent iron deficiency anemia and the manifestations of iron deficiency anemia**	**To treat patient's hypertension**	**To treat kidney stones**	**To prevent iron deficiency anemia**
Contraindications (2)	**Asthma, kidney disease**	**Hypersensitivity to prenatal vitamins**	**Hypersensitivity to lisinopril, concurrent aliskiren use in patients with diabetes or**	**Hypersensitivity to tamsulosin, hypersensitivity to quinazolines**	**Hemochromatosis, hemolytic anemias**

			patients with renal impairment		
Side Effects/Adverse Reactions (2)	**Tachycardia, severe headaches**	**Anaphylaxis, urticaria**	**Hypotension, arrhythmias**	**Respiratory impairment, angioedema**	**Hypotension, hemolysis**
Nursing Considerations (2)	**Monitor BUN, creatinine, and liver enzymes to observe for kidney or liver issues caused by loratadine.** **Monitor patient for adverse reactions such as urticaria, tachycardia, and respiratory distress.**	**Identify the other drugs the patient is taking including prescription, over-the-counter medicines, and herbal products to watch out for interactions or adverse effects.** **Monitor the patient's serum iron levels.**	**Be aware that lisinopril should not be given to patients who are unstable following an MI.** **Monitor patients for anaphylaxis.**	**Give drug approximately thirty minutes after the same meal each day.** **Know if drug is taken on an empty stomach, that blood pressure should be monitored for orthostatic hypotension.**	**Give iron tablets with a gull glass of water.** **Administer iron with a straw to prevent teeth staining.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Assess patient for signs and symptoms of allergies such as nasal congestion, watery eyes, and sneezing.** **Auscultate both lungs to monitor for respiratory changes**	**Check serum iron levels to get a baseline before administering prenatal vitamins.**	**Obtain baseline blood pressure.**	**Assess patient for the presence of kidney stones.**	**Monitor patient for manifestation of iron-deficiency anemia.**

	after administration of the drug.				
Client Teaching needs (2)	**Teach client to take the drug with a full glass of water.** **Advise client to report any signs of anaphylaxis like urticaria, difficulty breathing, or swelling of the face.**	**Teach client to stick to the prescription and dosage directions of two gummies per day to avoid overdose.** **Advise the patient to keep prenatal vitamins out of the reach of children.**	**Caution patient to not utilize salt substitutes that contain potassium.** **Advise patient to change positions slowly to avoid orthostatic hypotension.**	**Advise patient to change positions slowly.** **Instruct patient not to chew, crush, or open tamsulosin.**	**Instruct patient to not chew any solid form of iron.** **Urge patient to avoid foods that impair iron absorption.**

Hospital Medications (5 required)

Brand/Generic	**clindamycin (Cleocin)**	**acetaminophen (Tylenol)**	**Hydrocodone/ acetaminophen (Hydrela)**	**hydromorphone (Dilaudid)**	**Docusate**
Dose	**200 mg**	**650 mg**	**5/325 mg**	**0.5 mg**	**100 mg**
Frequency	**Every six hours**	**Every six hours as needed**	**Every four hours as needed**	**Every four hours as needed**	**Twice daily as needed**
Route	**IV**	**Oral**	**Oral**	**IV**	**Oral**
Classification	**Pharmacological: lincosamide**	**Pharmacological: nonsalicyate**	**Pharmacological: opioid Therapeutic: opioid analgesic**	**Pharmacological: opioid** **Therapeutic:**	**Pharmacological: surfactant**

	Therapeutic: antibiotic	**Therapeutic: antipyretic**		**opioid analgesic**	**Therapeutic: laxative**
Mechanism of Action	**Inhibits bacterial protein synthesis, which causes bacterial cell death**	**Inhibits cyclooxygenase and interferes with the pain impulse of the peripheral nervous system**	**Binds and activates opioid receptors to produce pain relief**	**Binds and activates opioid receptors to produce pain relief**	**Acts as a surfactant that softens stool**
Reason Client Taking	**To treat serious respiratory infections**	**For mild pain, fever**	**For moderate pain**	**For severe pain**	**For constipation**
Contraindications (2)	**Hypersensitivity to clindamycin, hypersensitivity to lincomycin**	**Hypersensitivity to acetaminophen, diazepam use**	**Acute or severe bronchial asthma, hypercarbia**	**Acute asthma, paralytic ileus**	**Fecal impaction, nausea and vomiting**
Side Effects/Adverse Reactions (2)	**Hypotension, neutropenia**	**Hypotension, stridor**	**Coma, seizures**	**Respiratory depression, hepatotoxicity**	**Palpitations, syncope**
Nursing Considerations (2)	**Expect to obtain a culture specimen and sensitivity before administration of first dose.**	**Use acetaminophen cautiously with liver impairment.** **Confirm that dose is based on**	**Monitor patient for evidence of physical dependency on drug.** **Monitor patient's vital signs.**	**Monitor patient for evidence of physical dependency on drug.** **Monitor patient's vital signs.**	**Expect excessive or long-term use of docusate.** **Assess for laxative abuse syndrome.**

		patient's weight.			
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Obtain for signs of infection before administration**	**Monitor liver enzymes to observe for hepatic impairment.**	**Obtain baseline respirations before administration.** **Obtain baseline**	**Obtain baseline respirations before administration.** **Obtain baseline**	**Assess stool patterns and habits before administration.**
Client Teaching needs (2)	**Teach client to complete full course of antibiotic.** **Educate patient to correctly pay attention to dosage.**	**Inform patient that acetaminophen may cause reduced fertility,** **Caution patient to not exceed prescribed dose.**	**Caution patients to avoid the consumption of alcohol.** **Avoid women of childbearing age to notify if pregnancy occurs.**	**Caution patients to avoid the consumption of alcohol.** **Avoid women of childbearing age to notify if pregnancy occurs.**	**Advise patient to not take docusate with nausea and abdominal pain.** **Advise patient to take docusate with a full glass of water.**

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 **Alert, responsive, and oriented to time, place, and person; oriented to person, place, situation, and time, x4** **No acute distress** **Well-groomed and appropriately dressed**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 **Appropriate and normal for ethnicity.** **Skin character is dry and** **Skin temperature is warm** **Skin turgor is edematous in right lower extremity, but normal skin turgor of less than 1.5 seconds.** **No bruises or rashes present, but abrasion located on the right lower extremity.** **18**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 **Head is normocephalic; head and neck are symmetrical; neck is symmetrical, active, and equal movement, and no abnormalities detected in the trachea, thyroid, vessels, or lymph nodes. Ears free of any discharge and hearing appropriate and equal in both ears. Eyes symmetrical and good extra ocular movement; nose symmetry, no deviation, and no nasal drainage or discharge present; teeth well-maintained and no signs of decay**
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:**	 **Normal S1 and S2 auscultated, no murmurs, no gallops or rubs detected** **Cardiac rhythm is normal sinus rhythm** **Radial, brachial, carotid, femoral, popliteal, dorsalis pedis, tibialis posterior and abdominal aorta all palpated; all peripheral pulses were**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Regular and unlabored respirations, and clear breath sounds auscultated in both lungs bilaterally, in upper and lower lobes both anteriorly and posteriorly.**

	Lung aeration is equal in both lungs bilaterally, in both upper and lower lobes, and anteriorly and posteriorly.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Regular diet at home.** **Current diet is regular.** **Height is 5'1".** **Weight is 123 lbs.** **Normoactive bowel sounds auscultated in all four quadrants of the abdomen; last bowel movement was 10/18/2021. Palpation of the stomach revealed soft, non-tender abdomen, no guarding present, and no masses found. Upon inspection no abnormalities such as distention, incisions, scars, drains, and wounds were found.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Yellow** **Clear** **1,750 mL of urine over a four-hour period**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	**Nail bed is pink, clean, and well-maintained, extremities are well-groomed, maintained, and skin is appropriate for ethnicity; Temperature is warm.** **Patient has active and equal range of motion in all extremities.** **Patient has no assistive devices. Adequate strength in all extremities, upper and lower.** **Morse fall risk score is 0.** **Patient is independent, or up ad lib.** **Patient does not need any assistance with equipment or 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:**	**Cognitive and oriented to person, place, situation, and time, x4; Patient is adequately cognitive and mature** **Articulative and clear speech** **Alert** **No gross focal neurological deficits. Patient is alert, awake and able to answer questions appropriately**
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 copes through the support of her husband and their eight children. Mature for development age. Patient is able to read, write and form full structured sentences according to developmental age' Patient is fully capable of making informed decisions. Patient reports no religious affiliation or preference. Patient lives with her husband and eight children, and will discharge back home with them.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	**76**	**126/68**	**16**	**36.5**	**98%**
1100	**68**	**118/62**	**16**	**36.8**	**97%**

Vital Sign Trends: Vital sign trends are consistent and within normal range minus a slightly high systolic pressure of 126. However, vital signs will still need continuous monitoring.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	**Numeric**	**Right lower extremity**	**6/10**	**Generalized pain**	**Tylenol administered**
1100	**Numeric**	**Right lower extremity**	**2/10**	**Generalized pain**	**No intervention at this time**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	20 gauge Left antecubital IV inserted 10/14/2021 IV is patent and adequate. No complications or abnormal signs of erythema, drainage, etc. present Dressing is clean, dry, and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
400 mL of normal saline **240 mL of tea at breakfast** **120 mL of apple juice with breakfast** **In total, the patient's intake was 760 mL.**	**Voided 1,750 mL of urine over four hours** **Passed two stools**

Nursing Care

Summary of Care (2 points)

Overview of care: The patient had a lot of diagnostic tests like a chest X-ray, right foot X-ray, EKG, and venous doppler test. All resulted with normal findings and no issues related to cellulitis. Patient had a pain rating of 6/10 at 0700 that was relieved with the administration of Tylenol. Vital signs are all consistent and stable minus a slightly high systolic pressure of 126. The patient is up ad lib with no ambulation issues even in the right lower extremity. Anticipate client going for a routine checkup with primary physician in approximately one week.

Procedures/testing done:

Complaints/Issues:

Vital signs (stable/unstable):

Tolerating diet, activity, etc.:

Physician notifications:

Future plans for patient:

Discharge Planning (2 points)

Discharge location: Patient plans to discharge back home with her husband and eight children. No noted home health needs or case management concerns. No noted home health needs or case management concerns. The patient will discharge on oral antibiotics and follow up with an appointment with the patient's primary care physician in one week. Emphasize the importance of completing full antibiotic therapy to the patient.

Home health needs (if applicable):

Equipment needs (if applicable):

Follow up plan:

Education needs:

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. At risk for sepsis related to impaired skin integrity as evidenced by pain, swelling, and redness in the patient's right lower extremity.	**Due to the skin breakage and bacteria invading the open wound, the patient is at increased risk for sepsis, or an infection of the blood. Sepsis is a very serious condition that can lead to serious issues including death if left untreated.**	**1. Monitor vital signs every four hours for signs of infection.** **2. Administer antibiotics one time.**	**1. Patient and family responds well to intervention. Vitals taken every four hours. Goal met. No modifications needed.** **2. Patient and family responds positively to intervention. Antibiotics administered. Goal met. No modifications needed.**
2. At risk for impaired skin integrity related to accidental skin abrasion as evidenced by pain, swelling, and redness in the patient's right lower extremity.	**The patient scraped their right leg on the pavement and caused on abrasion to occur in the right lower extremity. The abrasion led to cellulitis which resulted in pain, redness, and swelling.**	**1. Assess right lower extremity every two hours for any changes.** **2. Keep RLE clean and dry to prevent further skin breakdown.**	**1. Patient and family responds well to intervention. RLE assessed every two hours, no changes noted. Goal met. No modifications needed.** **2. Patient and family responds well to intervention. RLE kept clean and dry. Goal met. No modifications needed.**
3. At risk for deficient knowledge related to cellulitis in right lower extremity as evidenced by patient confusion and	**The patient needs education on the new diagnosis of cellulitis in the RLE to improve patient understanding and to help the patient treat**	**1. Educate patient on the pathology and cause of cellulitis.** **2. Educate patient to observe for worsening of cellulitis such as purulent drainage,**	**1. Patient and family responds well to intervention. Cellulitis education successful. Goal met. No modifications needed.** **2. Patient and family responds positively to intervention. Education**

questions.	**cellulitis to the best of the patient's ability.**	**further skin break down, and increased swelling.**	**successful. Goal met. No modifications needed.**
4. At risk for deficient knowledge about antibiotic related to cellulitis treatment as evidenced by patient confusion and questions.	**The patient needs education on the treatment of cellulitis, which is antibiotic therapy. The education about proper antibiotic therapy is imperative for successful treatment and relief of cellulitis.**	**1. Educate the patient to complete full course of antibiotic therapy.** **2. Educate patient to take antibiotics as prescribed.**	**1. Patient and family responds positively to intervention. Education successful. Goal met. No modifications needed.** **2. Patient and family responds positively to intervention. Education successful. Goal met. No modifications needed.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

Patient states that she was playing with her children outdoors and tripped over a rock, fell, and skinned her knee on the pavement. Patient reports no alleviating factors and no precipitating factors.

Nursing Diagnosis/Outcomes

At risk for sepsis related to impaired skin integrity as evidenced by pain, swelling, and redness in the patient's right lower extremity.
At risk for impaired skin integrity related to accidental skin abrasion as evidenced by pain, swelling, and redness in the patient's right lower extremity.
At risk for deficient knowledge related to cellulitis in right lower extremity as evidenced by patient confusion and questions.
At risk for deficient knowledge about antibiotic related to cellulitis treatment as evidenced by patient confusion and questions.

Objective Data

Vital signs all consistent. Chest X-ray, right foot X-ray, EKG, and venous doppler tests all resulted in normal findings with no changes. White blood cells elevated.

Patient Information

38-year-old female was admitted for cellulitis in the right lower extremity with pain, swelling, and redness.

Nursing Interventions

1. Monitor vital signs every four hours for signs of infection.
2. Administer antibiotics one time.
1. Assess right lower extremity every two hours for any changes.
2. Keep RLE clean and dry to prevent further skin breakdown.
1. Educate patient on the pathology and cause of cellulitis.
2. Educate patient to observe for worsening of cellulitis such as purulent drainage, further skin break down, and increased swelling.
1. Educate the patient to complete full course of antibiotic therapy.
2. Educate patient to take antibiotics as prescribed.