N321 Care Plan #2

Lakeview College of Nursing

Airelle Mitchell

Demographics (3 points)

Date of Admission **10/20/2021**	**Patient Initials** **J.L**	**Age** **93 years old**	**Gender** **Female**
Race/Ethnicity **Causcasian**	**Occupation** **Retired teacher**	**Marital Status** **Divorced**	**Allergies** **Metformin - reaction is severe diarrhea, Vicodin - reaction in nausea/vomiting, Oxycodone - reaction is nausea/vomiting, Pantoprazole - reaction is dizziness.**
Code Status **DNR**	**Height** **170 cm**	**Weight** **55 Kg**	

Medical History (5 Points)

Past Medical History: Diabetes, dizziness, fall risk, fracture of the right hip, hypertension, hyperlipidemia, and rectal bleeding.

Past Surgical History: Esophagogastroduodenoscopy biopsy (08/15/2021), arthroplasty hip total anterior approach (09/30/2020), open reduction internal fixation hip trochanteric nail fixation (TFN) (03/10/2020), bile duct stone removal, knee replacement, and cholecystectomy.

Family History: No known family history.

Social History (tobacco/alcohol/drugs): The client denied the use of any form of tobacco use or drug use in her life. The client states she has not drank any alcohol in the last few years. She said ever since she was diagnosed as a diabetic. When asked how long she has been drinking, she states, “I have been drinking for 65 plus years, I used to love my martinis, but I haven't had anything since being diagnosed with diabetes.”

Assistive Devices: The client requests a wheelchair, but can use a walker or cane. She always carried her glucose monitor with her.

Living Situation: The client lives in assisted living alone.

Education Level: She got her bachelor's degree in art and became a teacher at charleston high school and lakeland college as a professor. She quit half way through her masters degree program.

Admission Assessment

Chief Complaint (2 points): Diarrhea and hyperkalemia

History of present Illness (10 points): The client presented to the emergency room after seeking help through her primary care physician for having constant diarrhea. She had labs drawn and they were abnormal so the primary care physician sent her to the emergency room. She had a 6.1 potassium level, which is very high and problematic if not taken care of. The client had no pain, a 0 on a numeric scale of 0-10. Her diarrhea and potassium levels have been resolved during her stay, but she has had a UTI from unknown causes which then led to an acute kidney injury.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Urinary Tract Infection

Secondary Diagnosis (if applicable): Acute Kidney Injury

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

Urinary tract infections can be classified as lower or upper urinary infections and complicated or uncomplicated urinary tract infections (Hinkle & Cheever, 2018). The most

common type of urinary tract infection is the uncomplicated type. These can occur in people with acute kidney injuries or urological abnormalities (Hinkle & Cheever, 2018). A urinary tract infection is the most common type of bacterial infection in people, especially in women. The rectum is close to the urethra, which can cause a bacterial build-up (Hinkle & Cheever, 2018). The bacterium called *Proteus mirabilis* is located in the bowel and secretes ureases. Decreasing acidity enhances the ability of microorganisms to invade the bladder, creating an infection (Capriotti,2020). Stagnant urine is a building surface for bacteria growth, if not let out frequently or as needed. This can be normal flora like E. coli, which if gotten into the wrong area, can cause an infection. The immunoglobulin A is secreted by white blood cells that will prevent bacteria build up in the bladder (Capriotti,2020). Unfortunately, women are not secreters of this and decrease the fight against invaders to the bladder (Capriotti,2020). Frequently emptying the bladder is crucial to keeping the urinary tract free of infection.

When a client has a urinary tract infection, there can be many side effects that can go along with it. These signs and symptoms are pain, burning, frequency, urgency, dysuria, hematuria, inflammation, edema, and severe infections that can cause spasms (Capriotti,2020). My client felt the urgency and frequency when it came to needing to use the bathroom. In addition, this caused her to have urinary incontinence because she couldn't get to the toilet fast enough. She was able to receive a PureWick to suction the urine, so she did not have incontinence. Risk factors for a urinary tract infection are the inability to empty the bladder, female gender, diabetes, neurological disorders, kidney issues, and instrumentation of catheterization use (Hinkle & Cheever, 2018).

Routine laboratory tests with urinary tract infections can be seen through urinalysis and a urine culture test (Hinkle & Cheever, 2018). Also, cellular studies that can show a urinary tract infection is microscopic hematuria, pyuria which whight blood cells in the urine, leuk esterase can be seen, and other organisms. My client had a urinalysis laboratory test done after admission, and they were negative. Still, showed signs of a urinary tract infection, so they ordered another urinalysis and culture. Although her labs were negative, she was being treated with a urinary tract infection in the nursing home and had to finish out her antibiotics in the hospital. Vitals that can be seen with a urinary tract infection include tachycardia, fever, suprapubic tenderness, and flank pain (Capriotti, 2020). A CT scan can show a 3-D vision of the urinary tract, which can reveal tumors, stones, and cysts (Hinkle & Cheever, 2018).

Furthermore, treatment for the client can include antibiotics to fight the bacterial infection and can be determined by a culture and sensitivity test (Capriotti,2020). Drinking plenty of fluids is necessary to staying hydrated and limiting the risk of a urinary tract infection. Also, drinking cranberry juice has been thought to decrease the risk of a urinary tract infection by reducing the bacteria on the bladder wall (Capriotti, 2020). The client is taking two antibiotics called Ceftriaxone and Cefdinir to treat her bacterial infection. These should not be discontinued in the middle of treatment and should be completed in their entirety.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives.* Philadelphia: F.A. Davis.

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed). 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	**3.90-4.98 (mill/cumm)**	**3.49**	**3.50**	**Clients' decreased levels can be due to anemia by acute kidney disease (Pagana, 2018)**
Hgb	**12.0-15.5 (gm/dL)**	**10.2**	**10.2**	**Clients' decreased levels can be due to anemia acute kidney disease (Pagana, 2018).**
Hct	**35-45%**	**30.2**	**30.2**	**Decreased levels of hematocrit can be caused from acute kidney disease (Pagana, 2018).**
Platelets	**140-400 (1000/mm3)**	**215**	**213**	**N/A**
WBC	**4.0-9.0 (10 x 3/uL)**	**6.9**	**6.5**	**N/A**
Neutrophils	**40-70%**	**59.5%**	**57.0%**	**N/A**
Lymphocytes	**10-20%**	**27.2**	**27.4**	**Increased due to the clients' inflammation and infection of the acute kidney and urinary tract infection (Pagana, 2018).**
Monocytes	**5%**	**7.1**	**8.1**	**These can be high due to recovinger from an acute infection like an acute kidney injury from the urinary tract infection (Pagana, 2018).**
Eosinophils	**1-4%**	**5.1**	**6.2**	**Increased levels could be due to allergies (Pagana, 2018).**
Bands	**0.0-10.0%**	**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-	135-145 (mEq/L)	138	141	N/A
K+	3.5-5.1 (mEq/L)	6.1	4.5	Increased levels could be due to clients' dehydration and the possibility of eating too many foods rich in potassium (Pagana, 2018).
Cl-	98-107 (mEq/L)	100	112	Increased levels could be due to the clients' dehydration (Pagana, 2018).
CO2	21-31 (mEq/L)	23	26	N/A
Glucose	60-110 (mg/dL)	77	87	N/A
BUN	8-23 (mg/dL)	17	14	N/A
Creatinine	0.05-1.00 (mg/dL)	1.6	0.86	Creatine is increased upon admission due to acute kidney injury possibly from the urinary tract infection (Pagana, 2018).
Albumin	3.5-5.2 (gm/dL)	3.3	N/A	N/A
Calcium	8.4-10.0 (mg/dL)	8.2	8.0	Low calcium could be from not getting the nutrients of calcium or it could be from the acute kidney disease (Pagana, 2018).
Mag	1.3 - 2.1 (mg/dL)	N/A	N/A	N/A
Phosphate	2.5-5 (mg/dL)	N/A	N/A	N/A
Bilirubin	0.0-1.2 (mg/dL)	N/A	N/A	N/A
Alk Phos	35-105 (U/L)	N/A	N/A	N/A
AST	13-39 U/L	N/A	N/A	N/A

ALT	**7-52 U/L**	**N/A**	**N/A**	**N/A**
Amylase	**60-100 U/L**	**N/A**	**N/A**	**N/A**
Lipase	**0-160 U/L**	**N/A**	**N/A**	**N/A**
Lactic Acid	**0.5-1.5 mEq/L venous**	**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 Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**1-2**	**N/A**	**N/A**	**N/A**
PT	**10-12 seconds**	**N/A**	**N/A**	**N/A**
PTT	**30-45 seconds**	**N/A**	**N/A**	**N/A**
D-Dimer	**Negative, less than 250 mg/mL**	**N/A**	**N/A**	**N/A**
BNP	**Less than 100 pg/mL**	**N/A**	**N/A**	**N/A**
HDL	**< 60 md/dL**	**N/A**	**N/A**	**N/A**
LDL	**< 100 mg/mL**	**N/A**	**N/A**	**N/A**
Cholesterol	**< 200 mg/dL**	**N/A**	**N/A**	**N/A**
Triglycerides	**< 150 mg/dL**	**N/A**	**N/A**	**N/A**
Hgb A1c	**< 5.7%**	**N/A**	**N/A**	**N/A**
TSH	**0.5-5.0**	**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	N/A	colorless clear	N/A	N/A
pH	5.0-8.0	5.0	N/A	N/A
Specific Gravity	1.005-1.034	<1.005	N/A	N/A
Glucose	Negative	Negative	N/A	N/A
Protein	Negative	Negative	N/A	N/A
Ketones	Negative	Negative	N/A	N/A
WBC	0-0.5	Negative	N/A	N/A
RBC	0-3	Negative	N/A	N/A
Leukoesterase	Negative	500 Negative	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	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Lakeview college of Nursing Diagnostic Lab Value Sheet

Sarah Bush Lincoln Center Hospital System. Medical Value

Pagana, K.D, Pagana, T. N. (2018). Mosby's diagnostic and laboratory test reference (6th ed.).

St. Louis, MO.: Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1. Chest X-ray - Routine check and she was negative for pneumonia.
2. EKG - Sinus rhythm with 1st degree AV block with premature supraventricular complexes.

Diagnostic Test Correlation (5 points):

1. An X-ray is a diagnostic test to show bone density, bone texture, fluids, erosion, and certain structures that need to be examined (Hinkle & Cheever, 2018). There are many different views from anterior body view, posterior body view, and lateral body views (Hinkle & Cheever, 2018). This particular x-ray was done to view the clients' chest to check due to routine in the emergency room. The clients' results showed no abnormal findings and she was negative for pneumonia.
2. An electrocardiogram is a monitor that is connected to the patient by electrodes and shows electrical impulses that travel through the heart (Hinkle & Cheever, 2018). Then it

shows up on a strip of paper that reflects specific waveforms of the heart (Hinkle & Cheever, 2018). These can produce immediate recordings and can show different sinus rhythms. The clients' electrocardiogram showed an abnormal delay in the AV node and a prolonged PR interval (Hinkle & Cheever, 2018). The client had a recording of sinus rhythm with 1st degree AV block with premature supraventricular complexes.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	**Eliquis/ Apixaban**	**Furosemide/ Lasix**	**Lisinopril/ Prinivil**	**Levothyroxine/ Levoxyl**	**Tylenol/ Acetaminophen**
Dose	**5 mg Tablet**	**20 mg Tablet**	**5mg Tablet**	**25 mcg Tablet**	**500 mg Tablet**
Frequency	**BID**	**Daily**	**Daily**	**Daily**	**PRN Q6H**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Factor Xa Inhibitor; Anticoagulant (Jones, 2021)**	**Loop diuretic; Antihypertensive, diuretic (Jones, 2021)**	**Angiotensin-converting enzyme inhibitor (ACE); Antihypertensive (Jones, 2021)**	**Synthetic thyroxine (T4); Thyroid hormone replacement (Jones, 2021).**	**Nonsalicylate, para aminophenol derivative; Antipyretic, nonopioid analgesic (Jones, 2021)**
Mechanism of Action	**Inhibits free and clot clot**	**This medication inhibits sodium**	**Reducing blood**	**Replaces endogenous**	**Inhibits cyclooxygenase**

	bound and prothrombin activity. (Jones, 2021)	**and water absorption in the kidneys (Jones, 2021).**	**pressure by inhibiting angiotensin I to angiotensin II, (Jones, 2021).**	**thyroid hormone which can exert physiological effects by controlling DNA transcription (Jones, 2021).**	**by blocking prostaglandin production and interfering with pain impulse. (Jones, 2021)**
Reason Client Taking	**To reduce the risk of stroke and systemic embolism (Jones, 2021).**	**To manage hypertension (Jones, 2021).**	**To treat the patient's hypertension (Jones, 2021).**	**To treat hypothyroidism (Jones, 2021).**	**To relieve mild to moderate pain (Jones, 2021).**
Contraindications (2)	**Active pathological bleeding and severe hypersensitivity to this medication or its components (Jones, 2021).**	**Anuria and hypersensitivity to this medication (Jones, 2021).**	**Aliskiren in patients with diabetes and idiopathic angioedema (Jones, 2021).**	**Hypersensitivity to this medication or its components and uncorrected adrenal insufficiency (Jones, 2021).**	**Severe hepatic impairment, severe active liver disease. Inhibits sodium and water absorption in the kidneys (Jones, 2021).**
Side Effects/Adverse Reactions (2)	**GI bleeding or fresh bleeding from rectum (Jones, 2021).**	**Arrhythmias and azotemia (Jones, 2021).**	**Hypotension and acute renal failure (Jones, 2021).**	**Seizures and worsening of diabetes (Jones, 2021).**	**Hepatotoxicity and hypokalemia. (Jones, 2021).**
Nursing Considerations (2)	**Expect to discontinue medication 48 hours prior to surgery. Monitor closely for bleeding as this medication can cause severe life threatening bleeding (Jones, 2021).**	**Obtain a patient's weight during and prior to administration. Monitor renal function, hepatic function, and blood pressure. (Jones, 2021)**	**Monitor blood pressure often while taking lisinopril. Use cautiously in patients with impaired renal function. (Jones, 2021)**	**This medication should not be used for obesity and for weight loss (Jones, 2021).**	**Use cautiously in clients with hepatic impairment, alcoholism, and chronic malnutrition. (Jones, 2021)**

Hospital Medications (5 required)

Brand/Generic	**Cefdinir/ No brand name**	**Tramadol/ Ultram**	**Ceftriaxone/ No brand name**	**Pantoprazole / Protonix**	**Enoxaparin/ Lovenox**
Dose	**300 mg Tablet**	**5 mg Tablet**	**1 g - 1000 mg**	**40 mg tablet**	**40 mg**
Frequency	**Q12H**	**HS PRN**	**Q24H**	**BID**	**Daily**
Route	**PO**	**PO**	**IV piggyback**	**PO**	**Subcutaneous Injection**
Classification	**Third - generation cephalosporin; Antibiotic (Jones, 2021)**	**Opioid agonist; opioid analgesic (Jones, 2021)**	**Third - generation cephalosporin; Antibiotic (Jones, 2021)**	**Proton pump inhibitor; Antiulcer (Jones, 2021)**	**Low-molecular-weight heparin; Anticoagulant (Jones, 2021)**
Mechanism of Action	**Interfere with bacterial wall synthesis cross-linking peptidoglycan strands (Jones, 2021).**	**It binds with mu receptors and inhibits the reuptake of norepinephrine and serotonin (Jones, 2021).**	**Treats bacterial infection caused by Escherichia coli, Staphylococcus aureus, and streptococcus pneumoniae (Jones, 2021).**	**This medication decreases the amount of gastric acid produced by the stomach (Jones, 2021)**	**Enoxaporin rapidly binds and inactivates clotting factors (Jones, 2021).**
Reason Client Taking	**To treat uncomplicated UTI from soft tissue infections caused by**	**To relieve severe pain enough to require an opioid analgesic (Jones, 2021).**	**To cut down bacteria for the patient's UTI (Jones, 2021).**	**To treat GERD - gastroesophageal reflux disease (Jones, 2021).**	**To prevent a deep vein thrombosis after hip or knee replacement (Jones, 2021).**

	staphylococcus aureus (Jones, 2021).				
Contraindications (2)	**Hypersensitivity to cefdinir, other cephalosporins or its components (Jones, 2021).**	**Acute or severe bronchial asthma and significant respiratory depression (Jones, 2021).**	**Intravenous administered of this medication solutions with lidocaine or hypersensitivity to this medication and its components (Jones, 2021).**	**Rilpivirine-containing products or hypersensitivity to this product and its components (Jones, 2021)**	**Major bleeding and allergies to pork products or enoxaparin components (Jones, 2021).**
Side Effects/Adverse Reactions (2)	**Pseudomembranous colitis and anaphylaxis (Jones, 2021)**	**Seizures and adrenal insufficiency (Jones, 2021)**	**Acute renal failure and hepatic failure (Jones, 2021)**	**GI bleeding and nephritis (Jones, 2021).**	**Hyperkalemia and hepatocellular liver injury and malena (Jones, 2021).**
Nursing Considerations (2)	**Monitor patients with chronic GI conditions such as colitis. Assess for evidence of superinfection because it can cause perineal itching and loose foul smelling stools (Jones, 2021).**	**Monitor patients for respiratory depression. Make sure to have seizure precautions readily available (Jones, 2021).**	**Calcium products should noy be given within 48 hours of this medication. Nurses should protect the powder from light. (Jones, 2021)**	**No more than 90 mg should be given at any one time because of increased risk for severe effects on the kidneys. Monitor the patient for hypocalcemia (Jones, 2021).**	**Monitor potassium levels because of renal impairment. Keep protamine sulfate near just in case of an overdose. (Jones, 2021)**

Medications Reference (1) (APA):

Jones, D. W. (2021). *Nurse's drug handbook.* (A. Barlett, Ed.) (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The client was alert and oriented to person, place, time, and situation (x4). The client was not in any distress and was calm. Her appearance was appropriate. Her makeup was done and had her hair combed. She had good overall hygiene.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 19** **Drains present: Y☐ N X** **Type:**	Clients' skin is pale/pink, dry, warm and intact. Her skin turgor was greater than 3 seconds due to clients' dehydration and her skin was loose. Skin was absent of rashes, but did have bruising around her hands and legs. The client stated she bruises really easily. There were no wounds or drains present. Braden score of 19.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The clients' head was normocephalic and her neck was midline with no deviation. Her ears were intact, midline, and symmetrical. She has no hearing aids or hearing impairment. I was able to talk with a normal tone of voice and she could hear me. No drainage noted in her ears. The client's eyes were symmetrical, no conjunctivitis, and the sclera was white. Client exhibited PERLA and six cardinal fields. The client wears glasses, except when sleeping. The client's nose was midline. She had dentures in her upper teeth. Her tongue appeared to be pink, moist, and midline.

CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N X** **Edema Y ☐ N X** **Location of Edema: N/A**	S1 and S2 heard upon auscultation. No signs or murmur or S3 gallop. The client had a regular heartbeat with 77 bpm and 70 bpm. Peripheral pulses were strong 3+ bilaterally in upper and lower extremities with the radial, carotid, and dorsalis pedis arteries. Capillary refill was less than three seconds. No edema was noted in the upper or lower extremities. No neck vein distention noted.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N X** **Breath Sounds: Location, character**	No abnormal lung sounds heard upon assessment. Lung sounds were clear. Breathing was unlabored and no use of accessory muscles used and no chest deformities noted. Her chest raised and lowered evenly. The client had regular respirations of 18 bpm.
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 X** **Nasogastric: Y ☐ N X** **Size:** **Feeding tubes/PEG tube Y ☐ N X** **Type:**	Client's diet is diabetic, but she doesn't really care, she stated because of her age. In the hospital her diet is diabetic. She asked her dietician if she could have a slice of pecan pie and the dietitian said yes, just once slice, not a whole pie. She stated she was very happy. Height: 170 cm (5'5") Weight: 55 Kg (121.25 lbs) Last bowel movement was 10/22/2021. Clients' bowel sounds were hypoactive 5 - 10 sounds in all four quadrants. She is given Miralax or Colace for constipation. Client did not have abdominal distension or drains present. Client did have scars noted on the knees and hip from her past surgeries. There were no wounds, ostomy, nasogastric, or feeding tubes presented.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N X** **Dialysis: Y ☐ N X** **Inspection of genitals:** **Catheter: Y X N ☐** **Type: PureWick**	Urine was light yellow and clear. Client denied any pain or burning when urinating. 600 mL of urine in total during my shift. Client had an external catheter called PureWick due to her incontinence and she cannot make it to the bathroom fast enough. No dialysis.

Size: One size	
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y X N ☐** **Fall Risk: Y X N☐** **Fall Score: 45** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Neurovascular status is intact and she is incontrol of her senses. The clients' pain was a 0 out of 10. Pallor was pale pink and appropraire for her ethnicity. Paralysis was not noted. Client had no sign of paresthesia. Passive range of motion. She has a strength of 3 out of 5 on strength scale bilaterally. The client is able to perform ADL' with assistance of gait belt, walker, or a wheelchair. The client is up ad lib, but during my shift she was in bed. The client has a fall risk score of 45.
NEUROLOGICAL (2 points): **MAEW: Y X N☐** **PERLA: Y X N☐** **Strength Equal: Y X N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The client moves her upper and lower extremities well. The client exhibited PERLA. She does need assistance with ADLs. The client is oriented to person, place, time, and situation (x4). Clients' cognitive and mental status is within normal range for her age with some memory loss due to age. Her speech was clear, soft, and verbal. Level of consciousness was alert - awake and answered 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):**	The client loves to watch football and talk with others. Her developmental level is appropriate for her age. She is a christain. She said she does not have any more aunts, uncles, mom, dad, or grandparents alive. She does not have any kids, but does have cousins that have kids and they reach out to her all the time. She does have family support available.

Vital Signs, 2 sets (5 points)

Time	**Pulse**	**B/P**	**Resp Rate**	**Temp**	**Oxygen**
0830	**77 bpm**	**113/61** **mmHg**	**18 rpm**	**36.5 C**	**99% on room** **air**

1000	**70 bpm**	**121/67 mmHg**	**18 rpm**	**36.9 C**	**98% on room air**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	**Numeric 0-10**	**N/A**	**0 - No pain**	**N/A**	**If in pain, client can have tramadol or tylenol.**
1000	**Numeric 0-10**	**N/A**	**0 - No pain**	**N/A**	**If in pain, client can have tramadol or tylenol.**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Client has a 20 gauge peripheral IV in the midline upper left arm. IV was placed on 10/20/2021. The IV is transparent and infusing without any difficulty. The IV is patent with no erythema or drainage noted. It is dry and intact. She has continuous infusion of sodium chloride 0.9% IV solution with an IV drip rate of 1000 mL at 75 mL/hr. A new bag of fluids started at 0700 10/25/2021.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600 mL **Ate all of her breakfast which consisted of** **eggs, bacon, and a piece of toast.**	**600 mL Urine**

Nursing Care

Summary of Care (2 points)

Overview of care: During the client's care I was able to give her medications, help her move up in bed multiple times due to her constantly sliding, and give her company. I was able to do vitals, assess her pain, and do a head to toe assessment. She was told by the doctor that she should be discharged today, but she wasn't sure.

Procedures/testing done: The client had a urinalysis done with on the

Complaints/Issues: The client complained about the eggs during breakfast because they were terrible, she said. The client was complaining about her purewick not functioning properly because it was leaking constantly on sunday 10/24/2021. There were no other complaints including pain during my shift.

Vital signs (stable/unstable): The vitals are stable when checked during both vital assessments during 0830 and 1000.

Tolerating diet, activity, etc.: During my shift, the client did not get out of bed to ambulate or use the toilet. She did have an external catheter in, which led her to stay in bed. I did move her every two hours and as needed because she was sedentary. The client's diet was diabetic. She ate all of her breakfast that included eggs, bacon, and a piece of toast.

Physician notifications: N/A

Future plans for patient: The client will be discharged to her assisted living after her stay in the hospital.

Discharge Planning (2 points)

Discharge location: The client will be discharged back to her assisted living facility.

Home health needs (if applicable): Since the client will be discharged to a home health facility, she will have home health needs.

Equipment needs (if applicable): Equipment that she will need is a wheelchair, walker, and a gait belt.

Follow up plan: The clients' follow up plans should be to contact her primary care provider and make a follow up appointment.

Education needs: The client should be educated on her diet to increase her fluid intake to prevent dehydration and a possible urinary tract infection.

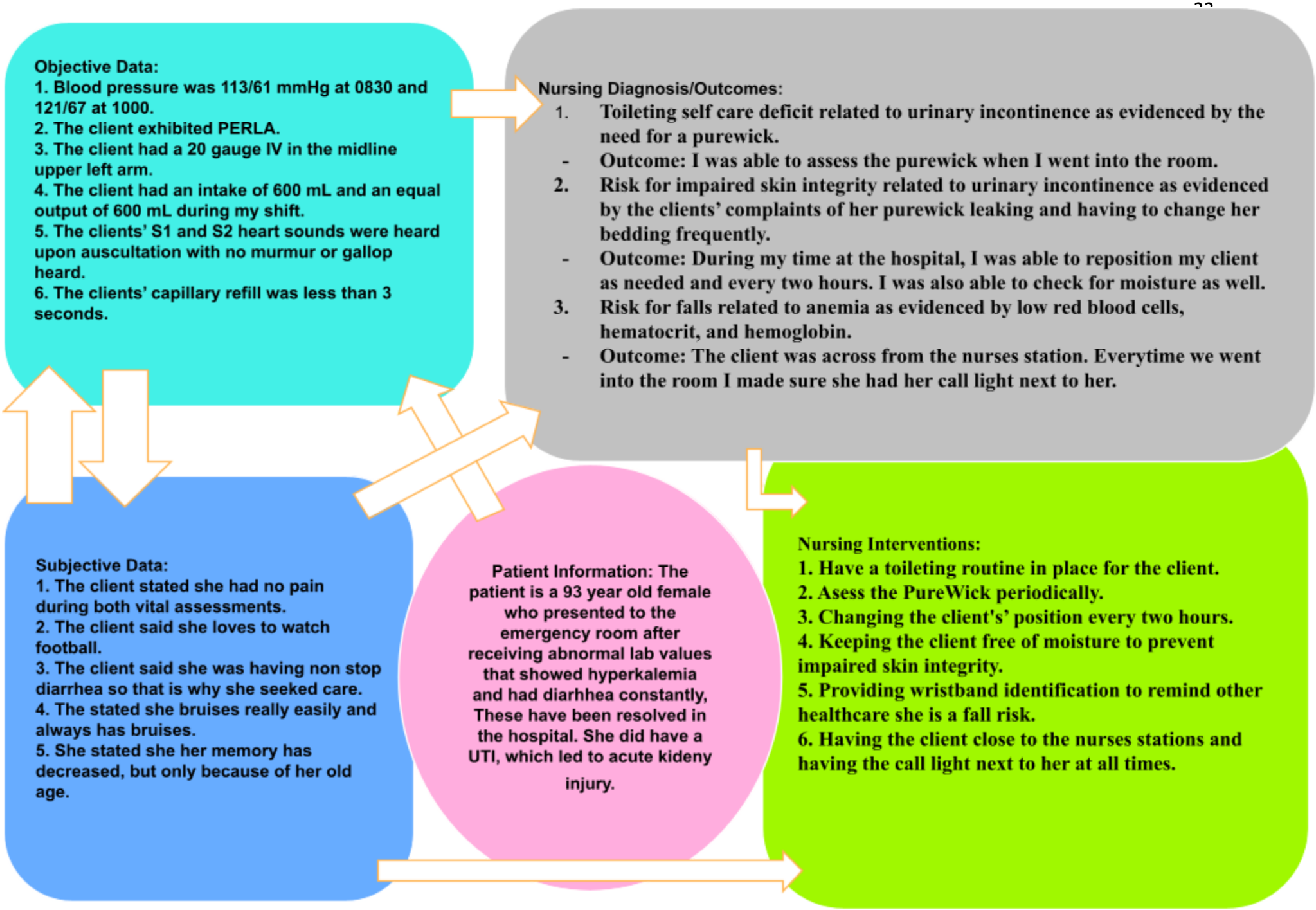
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Toileting self care deficit related to urinary incontinence as evidenced by the need for a purewick.	**She does not have control over her urination which can lead to a urinary tract infection and skin breakdown.**	**1. Have a toileting routine in place for the client.** **2. Assess the PureWick periodically.**	**Goal not met: I was not able to educate the client on a toileting routine for when she was discharged.** **Goal Met: I was able to assess the purewick when I went into the room.**
2. Risk for impaired skin integrity related to	**Moisture causes skin breakdown and the clients**	**1. Changing the clients' position every two hours.**	**Goal Met: During my time at the hospital, I was able to reposition**

urinary incontinence as evidenced by the clients' complaints of her purewick leaking and having to change her bedding frequently.	**skin is often moist due to her PureWick not absorbing properly. Also, her laying in wet clothes and bed causes moisture build up and can cause skin breakdown.**	**2. Keeping the client free of moisture to prevent impaired skin integrity.**	**my client as needed and every two hours.** **Goal Met: The nurse and I were able to check for wet clothes or sheets to avoid moisture build up and to protect her skin integrity.**
3. Risk for falls related to anemia as evidenced by low red blood cells, hematocrit, and hemoglobin.	**She is a fall risk, has level 3 strength, orthostatic hypotension from dehydration, and previous history of hip replacement.**	**1. Providing wristband identification to remind other healthcare she is a fall risk.** **2. Having the client close to the nurses stations and having the call light next to her at all times.**	**Goal Met: The client had fall risk signs implemented for other healthcare personnel to be reminded the client is a fall risk.** **Goal Met: The client was across from the nurses station. Everytime we went into the room I made sure she had her call light next to her.**

Other References (APA):

Concept Map (20 Points):


Objective Data:
1. Blood pressure was 113/61 mmHg at 0830 and 121/67 at 1000.
2. The client exhibited PERLA.
3. The client had a 20 gauge IV in the midline upper left arm.
4. The client had an intake of 600 mL and an equal output of 600 mL during my shift.
5. The clients' S1 and S2 heart sounds were heard upon auscultation with no murmur or gallop heard.
6. The clients' capillary refill was less than 3 seconds.
Nursing Diagnosis/Outcomes:
1. Toileting self care deficit related to urinary incontinence as evidenced by the need for a purewick.
- Outcome: I was able to assess the purewick when I went into the room.
2. Risk for impaired skin integrity related to urinary incontinence as evidenced by the clients' complaints of her purewick leaking and having to change her bedding frequently.
- Outcome: During my time at the hospital, I was able to reposition my client as needed and every two hours. I was also able to check for moisture as well.
3. Risk for falls related to anemia as evidenced by low red blood cells, hematocrit, and hemoglobin.
- Outcome: The client was across from the nurses station. Everytime we went into the room I made sure she had her call light next to her.
Subjective Data:
1. The client stated she had no pain during both vital assessments.
2. The client said she loves to watch football.
3. The client said she was having non stop diarrhea so that is why she seeked care.
4. The stated she bruises really easily and always has bruises.
5. She stated she her memory has decreased, but only because of her old age.
Patient Information: The patient is a 93 year old female who presented to the emergency room after receiving abnormal lab values that showed hyperkalemia and had diarhhea constantly, These have been resolved in the hospital. She did have a UTI, which led to acute kideny injury.
Nursing Interventions:
1. Have a toileting routine in place for the client.
2. Asess the PureWick periodically.
3. Changing the client's' position every two hours.
4. Keeping the client free of moisture to prevent impaired skin integrity.
5. Providing wristband identification to remind other healthcare she is a fall risk.
6. Having the client close to the nurses stations and having the call light next to her at all times.