N431 Care Plan 2

Lakeview College of Nursing

Tuan Nguyen

Demographics (3 points)

Date of Admission 10/30/2021	**Patient Initials** J. W	**Age** 81	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Married	**Allergies** Fish and sulfa drugs
Code Status Full	**Height** 156.7 cm (61.7 inches)	**Weight** 41.6 kg (91.5 lbs)	

Medical History (5 Points)

Past Medical History: Alzheimer's disease, chronic low back pain, recurrent major depressive disorder, vertigo, osteoporosis, hyperlipidemia, GERD, and basal cell carcinoma of left ear

Past Surgical History: Cystoscopy (11/28/2017), cholecystectomy (1/11/1998), appendectomy (1955)

Family History: Grandchild has a history of autism, the mother has a history of colon cancer and hyperlipidemia, brother has a history of heart attacks and hyperlipidemia.

Social History (tobacco/alcohol/drugs): The client's daughter stated that she does not use tobacco products or drugs and does not drink.

Assistive Devices: The client uses a gait belt, walker, in the hospital. The client's daughter stated that the provider had placed an order for a wheelchair for the client.

Living Situation: The client's daughter states that the client lives at home with her husband.

Education Level: The client's daughter stated that the client went and graduated from college. The daughter stated that the client did not have any learning disabilities until her Alzheimer's disease emerged.

Admission Assessment

Chief Complaint (2 points): Altered mental status

History of present Illness (10 points): An 81-year old female with a history of Alzheimer's disease came in on 10/30/2021 with a chief complaint of altered mental status. The change in mental status occurred in the evening of 10/30/2021 when she ran towards oncoming traffic after stating that she must visit her mother, who had been dead for years. The client has a UTI that she states do not cause her any discomfort anywhere, so the location of discomfort is unidentifiable. Her UTI and altered mental status are ongoing and have persisted since 10/30/2021. She is (ANO x1). No characteristics of discomfort or pain could be collected as the client denied any discomforts or pain. The client states that she feels fatigued and confused about where or why she is in the hospital. She sleeps to help her feel less fatigued. Haloperidol was used to relieve her agitation.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Urinary tract infection

Secondary Diagnosis (if applicable): Alzheimer's disease

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

A urinary tract infection (UTI) is an infection of the urinary system, including the kidneys, ureters, urethra, and bladder, caused by bacteria that travel up and through the urethra and into the bladder (Capriotti, 2020). Most UTIs manifest in the lower urinary tract, including the bladder and the urethra, but can proliferate up into the ureters and the kidneys (Capriotti, 2020). Clients experiencing a UTI may experience manifestations like frequency and urgency changes, pain or burning on urination, urinary retention, occasional hematuria, and bladder spasms in more severe cases (Capriotti, 2020). Confusion is another symptom of UTIs that commonly occur in the elderly population (Capriotti, 2020). The client, during clinical, stated

that she did not feel any discomfort or pain. She denied pain related to voiding or any frequency or urgency changes. The client was ANO x1 and experienced altered mental status and confusion during clinical, which may have been affected by the UTI.

UTIs can be diagnosed with a urinalysis and urine culture (Capriotti, 2020). The appearance of red blood cells on a urinalysis dipstick is an indicator of a UTI. Leukocyte esterase, nitrates, and WBC in the urinalysis are indications of a UTI (Capriotti, 2020). Urine cultures that reveal a growing colony larger than 10^5/mL are usually a sign of an infection as well as a count as low as 1,000 mL (Capriotti, 2020). The presence of a UTI can also impact vital signs. The client may become tachycardic and experience tachypnea which may reflect an elevated pulse and respiratory rate (Capriotti, 2020). The client, during clinical, had a urinalysis done as a diagnostic test, which revealed a 2+ value for leukoesterase and a positive value for WBC, which are indications for a UTI. The client also experienced an elevated blood pressure of 160/87 mmHg at 0825 hours. No cultures were
perfomred.

Antibiotcitc therapy is implemented for UTI They should be taken for a specified amount of days, depending on the severity of the infection (MedlinePlus, 2021). Severe UTIs may require hospitalization, where the client may be given antibiotics with IV fluids to help clear out the bacteria (MedlinePlus, 2021). A culture and sensitivity test done to determine the appropriate antibiotic (Capriotti, 2020). Nitrofurantoin and trimethoprim-sulfamethoxazole are typically given (Capriotti, 2020). To treat urinary tract pain, Phenazopyridine is given (Capriotti, 2020). The client, during clinical, was hospitalized and was given 1000 mg of ceftriaxone through IV piggyback every 24 hours to help clear out her UTI. The client was also encouraged to increase her fluid intake to help her stay hydrated and promote voiding, but she refused.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F. A. Davis.

MedlinePlus (2021, November 2). *Urinary tract infection – adults.* https://medlineplus.gov/ency/article/000521.htm

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	3.80-5.41x10^6/mcL	4.09	N/A	N/A
Hgb	11.3-15.2 g/dL	13.1	N/A	N/A
Hct	33.2-45.3%	39.2	N/A	N/A
Platelets	149-393 K/mcL	287	N/A	N/A
WBC	4.0-11.7 K/mcL	8.6	N/A	N/A
Neutrophils	45.3-79.0%	59.8	N/A	N/A
Lymphocytes	11.8-45.9%	29.9	N/A	N/A
Monocytes	4.4-12.0%	6.0	N/A	N/A
Eosinophils	0.0-6.3%	3.7	N/A	N/A
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-	136-145 mmol/L	144	N/A	N/A

K+	3.5-5.1 mmol/L	3.5	N/A	N/A
Cl-	98-107 mmol/L	111	N/A	The client is dehydrated, as evidenced by no intake (Pagana, 2018).
CO2	21-31 mmol/L	27	N/A	N/A
Glucose	74-109 mg/dL	92	N/A	N/A
BUN	7-25 mg/dL	21	N/A	N/A
Creatinine	0.70-1.30 mg/dL	0.75	N/A	N/A
Albumin	3.5-5.2 g/dL	4.3	N/A	N/A
Calcium	8.6-10.3 mg/ dL	9.2	N/A	N/A
Mag	1.5-2.5 mg/dL	2.2	N/A	N/A
Phosphate	2.4-4.5 units/L	N/A	N/A	N/A
Bilirubin	0.3-1.0 mg/dL	0.3	N/A	N/A
Alk Phos	34-104 units/L	51	N/A	N/A
AST	13-39 U/L	20	N/A	N/A
ALT	7-52 U/L	18	N/A	N/A
Amylase	60-100 U/dL	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
Troponin	<0.03	N/A	N/A	N/A
CK-MB	3-5	N/A	N/A	N/A
Total CK	55-170 (Males)	N/A	N/A	N/A

	30-135 (Females)			

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	Less than 60 md/dL	N/A	N/A	N/A
LDL	Less than 100 mg/dL	N/A	N/A	N/A
Cholesterol	Less than 200 mg/dL	N/A	N/A	N/A
Triglycerides	Less than 150 mg/dL	N/A	N/A	N/A
Hgb A1c	Less than 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	Yellow, clear	Yellow and clear	N/A	N/A
pH	5.0 – 8.0	6.0	N/A	N/A
Specific Gravity	1.005 – 1.034	1.018	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	Negative	Positive	N/A	The client has a UTI (Pagana, 2018).
RBC	Negative	N/A	N/A	N/A
Leukoesterase	Negative	2+	N/A	The client has a UTI (Pagana, 2018).

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	N/A	N/A	N/A	N/A
PaO2	N/A	N/A	N/A	N/A
PaCO2	N/A	N/A	N/A	N/A
HCO3	N/A	N/A	N/A	N/A
SaO2	N/A	N/A	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):

Sarah Bush Lincoln Center Hospital System. Medical Values

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- Urinalysis panel – Results showed a positive presence of WBC and leukoesterase in the client's urinalysis.

Diagnostic Test Correlation (5 points):

- WBC and leukoesterase in the urinalysis indicates a potential bacterial infection (Capriotti, 2020).

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F. A. Davis.

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

Home Medications (5 required)

Brand/ Generic	**Lorazepam ATIVAN**	**Ondansetron ZOFRAN**	**Amitriptyline ELAVIL**	**Pantoprazole PROTONIX**	**Acetaminophen TYLENOL**
Dose	**0.5 mg**	**8 mg**	**25 mg**	**2 mg**	**1000 mg**
Frequency	**Daily**	**Q8H PRN**	**Bedtime**	**Q4H PRN**	**Q6H PRN**

Route	**Oral**	**Sublingual**	**Oral**	**Oral**	**Oral**
Classification	**Pharmacologic Class: Benzodiazepine (Jones, 2020)** **Therapeutic Class: Anxiolytic (Jones, 2020)**	**Pharmacologic Class: Selective serotonin (5-HT_3) receptor antagonist (Jones, 2020)** **Therapeutic Class: Antiemetic (Jones, 2020)**	**Pharmacologic Class: Tricyclic antidepressant (Jones, 2020)** **Therapeutic Class: Antidepressant (Jones, 2020)**	**Pharmacologic Class: Proton pump inhibitor (Jones, 2020)** **Therapeutic Class: Antiulcer (Jones, 2020)**	**Pharmacologic Class:** Nonsalicylate, paraminophenol derivative (Jones, 2020) **Therapeutic Class:** Antipyretic, nonopioid analgesic (Jones, 2020)
Mechanism of Action	Gamma-aminobutyric acid (GABA) and other inhibitory neurotransmitters increase the effects by binding to specific benzodiazepine receptors. GABA inhibits excitatory stimulation, which controls emotional behavior (Jones, 2020)	This medication reduces nausea by blocking serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at the vagal nerve in the intestines (Jones, 2020)	**This medication blocks serotonin and norepinephrine reuptake and raises serotonin and norepinephrine levels, which elevates mood and reduce depression (Jones, 2020)**	This medication inhibits the final step in gastric acid production by blocking the exchange of intracellular H^+ and extracellular K^+, thus preventing H^+ from entering the stomach and additional HCl from forming (Jones, 2020)	This medication reduces pain sensation by inhibiting the enzyme cyclooxygenase, blocking prostaglandin production, and hindering pain impulse generation in the peripheral nervous system (Jones, 2020).
Reason Client Taking	**The client is taking this medication to control anxiety (Jones, 2020).**	The client is taking this medication to prevent nausea and vomiting (Jones, 2020).	**The client is taking this medication to relieve depression (Jones, 2020).**	The client is taking this medication as a prophylaxis to prevent short-term gastroesopha	The client is taking this medication as prophylaxis to relieve moderate pain (Jones, 2020).

				geal reflux disease (GERD) (Jones, 2020).	
Contraindications (2)	**Contraindications include hypersensitivity, and psychosis (Jones, 2020)**	Contraindications to this drug include hypersensitivity to ondansetron or its components and concomitant use of apomorphine or congenital long QT syndrome (Jones, 2020).	**Contraindications include hypersensitivity to the medication and MAO inhibitor therapy (Jones, 2020).**	**Contraindications for this drug include hypersensitivity to pantoprazole and concurrent therapy with rilpivirine-containing products (Jones, 2020).**	Contraindications to this drug include hypersensitivity to acetaminophen and severe hepatic impairment (Jones, 2020).
Side Effects/Adverse Reactions (2)	**Side effects include Suicidal ideation and respiratory depression (Jones, 2020)**	Side effects and adverse reactions include hypotension and arrhythmias (Jones, 2020).	**Side effects include hyperglycemia and suicidal ideation (Jones, 2020).**	Side effects include dyspnea and hypomagnesemia (Jones, 2020)	Side effects and adverse reactions include anxiety and hypertension (Jones, 2020).
Nursing Considerations (2)	**1. Monitor the client's respirations every 5 to 15 minutes and keep**	1) Correct any electrolyte imbalances such as hypokalemia or hyperkalemia	**1. Monitor blood pressure for hypotension or hypertension (Jones,**	1) Flush IV line with D_5W, normal saline solution, or lactate Ringer's	1) Administer cautiously in patients with hepatic impairment or alcoholism (Jones, 2020). 2) Monitor patient'

	emergency resuscitation equipment readily available (Jones, 2020). **2. Taper the dosage of this medication when discontinuing (Jones, 2020).**	before administering ondansetron (Jones, 2020) 2) Monitor clients for hypersensitivity reactions because they can be deadly (Jones, 2020).	**2020).** **2. Watch client closely for suicidal tendencies (Jones, 2020)**	injection before and after giving drug (Jones, 2020). 2) Monitor the client's PT or INR if the client takes oral anticoagulant (warfarin) (Jones, 2020).	s renal function on long-term therapy of acetaminophen (Jones, 2020).
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Ensure the client is already taking an antidepressant before administration of this medication due to the increased risk for suicidal**	Assess the client for the presence of prolonged QT intervals before administration of this drug, as it is a contraindication for ondansetron (Jones, 2020).	**Before administering this medication, the client can be assessed for suicidal ideation and a history of seizures, urine retention, or**	The client takes oral anticoagulants, so monitoring the client's PT or INR before the administration will provide a baseline as a reference	Monitor the client's AST, ALT, bilirubin levels and ensure they are within limits to prevent liver damage before administration (Jones, 2020).

	ideation (Jones, 2020).		**angle-closure glaucoma (Jones, 2020).**	during administration (Jones, 2020).	
Client Teaching needs (2)	**1. Instruct the client and family to take as prescribed and not stop without consulting the provider due to the risk of withdrawal symptoms (Jones, 2020).** **2. Advise the client or the client's family to**	1) Instruct the client or the client's family to immediately report signs of hypersensitivity, such as a rash (Jones, 2020). **2)** Instruct the client or the client's family to seek immediate medical attention if the client	**1. Instruct the family or caregiver to watch the client closely for suicidal tendencies, especially when therapy starts (Jones, 2020).** **2. Instruct the client or the client's family to avoid using alcohol or TOC**	1) Instruct the client or tell the client's family to have the client swallow the pantoprazole tablet whole and not to chew or crush them (Jones, 2020). 2) Advise the client to follow bleeding precaution	1) Tell the client or the client's family that the client should adhere to the recommended dosages to prevent overdose (Jones, 2020). 2) Educate the client or the client's family on the signs and symptoms of liver toxicity, such as bruising, malais

	avoid hazardous activities until the drug's CNS effects are known (Jones, 2020).	experiences persistent, severe, unusual, or worsening symptoms (Jones, 2020).	**drugs that contain alcohol during amitriptyline therapy (Jones, 2020).**	s and notify the prescriber immediately if bleeding occurs since he takes oral anticoagulants (warfarin) (Jones, 2020).	e, and bleeding (Jones, 2020).

Hospital Medications (5 required)

Brand/ Generic	**Ceftriaxone ROCEPHIN**	**Heparin**	**Haloperidol HALDOL**	**Megestrol MEGACE**	**Promethazine ANERGAN**
Dose	**1000 mg**	**5000 units/mL**	**5 mg**	**40 mg**	**12.5 mg**
Frequency	**Q24H**	**BID**	**Q4H PRN**	**BID**	**Q4H**
Route	**IV piggyback**	**SubQ**	**IM**	**Oral**	**IM PRN**

Classification	**Pharmacological Class: Third-generation cephalosporin (Jones, 2020)** **Therapeutic Class: Antibiotic (Jones, 2020)**	**Pharmacological Class: Anticoagulant (Jones, 2020)** **Therapeutic Class: Anticoagulant (Jones, 2020)**	**Pharmacological Class: Butyrophenone derivative (Jones, 2020)** **Therapeutic Class: Antipsychotic (Jones, 2020)**	**Pharmacological Class: Progesterone hormone (Jones, 2020)** **Therapeutic Class: Ovarian hormone (Jones, 2020)**	**Pharmacological Class: Phenothiazine (Jones, 2020)** **Therapeutic Class: Antiemetic, antihistamine, antivertigo, sedative-hypnotic (Jones, 2020)**
Mechanism of Action	It kills bacteria by interfering with bacterial cell wall synthesis (Jones, 2020)	**This medication binds with antithrombin III, enhancing its inactivation of coagulation enzymes thrombin (factor IIA) and factors Xa and Xia, which are needed to convert fibrinogen to fibrin; clots cannot form without fibrin (Jones, 2020).**	**This medication blocks postsynaptic dopamine receptors in the limbic system and increases the brain turnover of dopamine, producing an antipsychotic effect (Jones, 2020).**	**This medication reduces the availability or stability of the hormone-receptor complex, shutting off estrogen-responsive genes or causing a negative feedback mechanism that decreases the number of functioning estrogen receptors (Jones, 2020).**	**This medication competes with histamine for H_1-receptor sites, antagonizing histamine effects and reducing allergy signs and symptoms. This medication also decreases vestibular stimulation and labyrinthine function in the inner ear, which reduces vertigo (Jones, 2020).**

Reason Client Taking	To eliminate potential bacterial infection (Jones, 2020)	**The client is taking this medication as a prophylaxis to prevent blood clots (Jones, 2020).**	**The client is taking this medication to treat psychotic and nonpsychotic behavior disorders (Jones, 2020).**	**The client is taking this medication to stimulate her appetite (Jones, 2020).**	**The client is taking this medication to prevent vertigo (Jones, 2020).**
Contraindications (2)	Contraindications for this medication include calcium-containing IV solutions; solutions containing lidocaine (Jones, 2020)	**Contraindications include hypersensitivity to this medication and a history of heparin-induced thrombocytopenia (Jones, 2020).**	**Contraindications include hypersensitivity to the medication and Parkinson's disease (Jones, 2020).**	**Contraindications include hypersensitivity to the medication or active thromboembolic disorder (Jones, 2020)**	**Contraindications include hypersensitivity to this medication and coma (Jones, 2020).**
Side Effects/Adverse Reactions (2)	Side effects include Clostridium difficile-associated diarrhea; neutropenia (Jones, 2020)	**Side effects include Hemorrhage and asthma (Jones, 2020).**	**Side effects include seizures and laryngospasm (Jones, 2020).**	**Side effects include hypotension and clotting, and bleeding abnormalities (Jones, 2020).**	**Side effects include bradycardia and hypotension (Jones, 2020).**
Nursing Considerations (2)	1. Use cautiously in patients that are hypersensitive to penicillin due to cross-	**1. Alternate injection sites and watch for signs of bleeding and hemat**	**1. Monitor CBC, especially if the client has a low WBC or history of drug-**	**1. Use cautiously in clients with CNS disorders, such as depression or seizures (Jones,**	**1. Monitor respiratory function because the drug may suppress**

	sensitivity (Jones, 2020). 2. Monitor the BUN and serum creatinine levels to detect early signs of nephrotoxicity (Jones, 2020).	**oma (Jones, 2020).** **2. Check the client's hematocrit and platelet count during the entire course of heparin therapy (Jones, 2020).**	**induced leukopenia or neutropenia (Jones, 2020).** **2. Monitor for signs of neuroleptic malignant syndrome (Jones, 2020).**	**2020).** **2. Monitor the client for adrenal suppression, especially with megestrol therapy. Notify the prescriber if suspected (Jones, 2020).**	**the cough reflex and cause the thickening of bronchial secretions (Jones, 2020).** **2. Monitor the client for evidence of neuroleptic malignant syndromes, such as fever, hypertension or hypotension, mental**

					changes, tachycardia, and tachypnea (Jones, 2020).
Key Nursing Assessment(s) /Lab(s) Prior to Administration	Ask the client if an allergic reaction was ever experienced when taking other antibiotics (Jones, 20200	**Assess the client's risk for falls and bruising before administration of this drug due to the blood-thinning nature of heparin (Jones, 2020)**	**Assess the client for fall risks, such as elderly and those with conditions or disease, to take drugs that exacerbate central nervous system adverse effects such as motor instability and orthostatic hypotension before administration (Jones, 2020).**	**Assess if the client is allergic to peanut oil or sesame oil. If the client is allergic, she must contact the pharmacist to determine if the prescribed progestin contains peanut or sesame oil (Jones, 2020).**	**Assess the client's baseline respiratory rate because this medication can depress respirations (Jones, 2020).**
Client Teaching needs (2)	**1. Urge the client or the client's family to repor**	**1. Educate the client's family of the increased risk**	**1. Advise the client and family to take haloperido**	**1. Instruct the client or the client's family that administratio**	**1. Advise the client or the family to avoid OTC**

	t watery, bloody stools to the prescriber immediately, even up to 2 months after drug therapy has ended (Jones, 2020). **2. Advise the prescriber to stop taking the drug immediately and advise the client or the client's family to**	**for bleeding while taking this medication (Jones, 2020).** **2. Advise the client to wear or carry appropriate medical identification before therapy initiate (Jones, 2020).**	**l precisely as prescribed and not stop abruptly due to with drawal symptoms.** **2. Advise the client or the client's family to take the medication with food or a full glass of milk or water to reduce GI distress**	**n of this medication can increase the risk of dementia associated with progestin therapy (Jones, 2020).** **2. Emphasize the importance of good dental hygiene and regular dental checkups because elevated progestin levels increase the growth of normal oral flora (Jones,**	**drugs unless approved by the prescriber (Jones, 2020).** **2. Educate the client or the family to report to the prescriber immediately if the client experiences involuntary movements and restlessness (Jones,**

	report any hypersensitivity reactions, such as a rash, itching skin, or hives (Jones, 2020).		**(Jones, 2020).**	**2020).**	**2020).**

Medications Reference (1) (APA):

Jones, D. W. (2020). *Nurse's drug handbook*. (A. Barlett, Ed.) (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The client was not alert and slept throughout the clinical. She woke up at around 0950 hours and was only oriented to herself (x1). She was responsive, calm, and displayed a friendly demeanor but became agitated and uncooperative when asked to perform tasks. The client stated that she was not in distress or pain. She did not appear in distress and appeared well-groomed and clean. The client's daughters stated they wanted the client to shower since she has not showered and has been wearing the same clothes for two weeks.
INTEGUMENTARY (2 points): **Skin color:** **Character:**	The client’s skin was dry, warm, and intact. Her skin turgor was elastic and returned to its original position in less than 3 seconds. She does not have

Temperature: **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score: 21** **Drains present: Y☐ N ☒** **Type:**	any rashes, bruises, or wounds upon inspection. Her daughters stated that the client bruises easily and tends to bump her head often. The client has a Braden score of 21, which puts her at no risk for pressure ulcers. Client does not have any drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The client's head is normocephalic and displayed symmetrical facial and skull features. Her head is midline to her neck, which exhibited visible movement upon swallowing. No tracheal deviations, swollen lymph nodes, or thyroid were palpable. The client's ears were bilaterally intact, symmetrical, and exhibited no drainage. Her ear canal and tympanic membrane appeared to be intact and gray bilaterally upon inspection. The client's eyes were symmetrical and exhibited PERRLA bilaterally. Her eyes exhibited bilateral white sclera and pink conjunctiva. She has glasses but did not wear them during clinical. The client's nose was intact, midline to face, clear and patent, with no signs of bloody discharge, sneezing, or nasal drainage. The client has an entire row of teeth on the top and bottom jaw that appear clean.
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:**	The client's S1 and S2 were audible, with no murmurs or gallops heard upon auscultation. The client's carotid pulses were +3 bilaterally, +3 bilaterally in her radial pulses, +3 bilaterally in her dorsalis pedis, and +3 bilaterally in her posterior tibialis. Her capillary refill was less than three seconds bilaterally in her fingernails and toenails. There was no neck vein distention observed upon inspection.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The client's breath sounds were audible, clear, and regular upon bilateral auscultation of four spots anteriorly and six spots posteriorly on the client's back. No crackles, wheezes, or rhonchi were heard upon auscultation. No accessory muscle use, pursed lips, or tripod positioning was observed upon inspection. The client has unlabored breathing and states that she has no

	difficulty breathing. She experiences bilateral symmetrical rise and fall of her chest with no deformities.
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:**	The client's daughter states that she has a regular diet at home but is on a heart-healthy diet during the hospital stay. The daughter states that the client eats all her food "most" of the time. The client's height is 156.7 cm (61.7 inches). The client's weight is 41.6 kg (91.5 lbs). The client has active bowel sounds in all four quadrants with 5 to 30 gurgles a minute. The client's daughter states that the client's last BM was about 3 days ago. No tenderness, pain, or masses were palpated upon light and deep palpation of the abdomen and all four quadrants. No abdominal distention, incisions, scars, drainage, or wounds were observed upon inspection. The client does not have an ostomy, NG tube, or feeding tubes.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The client's urine was yellow, clear, and odorless. An accumulated 300 mL of urine was collected by the end of clinical at 1050 hours. The client states that she does not experience pain with urination. Her daughter states that she has had a UTI for the past three days. The client does not have dialysis or an inserted catheter.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 50** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐**	The client's capillary refill was less than 3 seconds bilaterally in her fingernails and toenails. There were no signs of cyanotic or pallor pigmentation in her fingernails and toenails bilaterally. Toes and fingers were warm and pink bilaterally. The client was able to move her fingers and toes bilaterally without pain or tingling—no signs of bilateral pulselessness in fingers and toes. The client can actively move all extremities with bilateral +4 strength in her upper extremities and

Needs support to stand and walk☒	bilateral +3 in her lower extremities. She can move all extremities with a full range of motion without pain. The client's daughter states that the client usually needs a one-person assist with getting up and walking since she states that the client's gait is "a little wobbly." The client's fall score is 50, which puts her at a fall risk.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The client does not move all extremities well. She exhibits PERRLA but does not exhibit equal strength within her lower extremities compared to her upper extremities; the client has bilateral +4 strength in her upper extremities and bilateral +3 strength in her lower extremities. The client was asleep for most of the clinical until 0950 hours. She was only oriented to self (x1). She listens to most commands but refuses all commands towards eating, drinking, and self-care. She responds to questions appropriately. Her daughter states that the client has Alzheimer's, and her cognition is impaired. The client has bilateral sensory in her fingers and toes. The client's speech is clear and audible due.
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 slept throughout most of the clinical. Her two daughters visit and spend time with her every other day in the hospital. The client can speak in full-formed sentences but cannot make her own decisions, but she can refuse offered care. The daughter states that the client lives at home with her husband, but he is thinking about finding a nursing home since he cannot take care of her anymore.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0825	80 bpm	160/87 mmHg	16 respirations/minute	98.7 F (37.1 C)	100%
1100	80 bpm	145/74	16	N/A	98%

		mmHg	respirations/minute	The client was combative	

Vital Sign Trends: The client's vital signs remained stable throughout clinical, except for her blood pressure, which was elevated at 160/87 mmHg at 0825 hours. She was given 5 mg of haloperidol at around 0750 hours, which calmed her down, lowered her blood pressure, and made her less irritable. Her vital signs stabilized throughout the day, and her blood pressure decreased to 145/74 mmHg at 1100 hours. She became irritated when attempts at getting a temperature reading were made and scheduled to be done later after clinical.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0149	FLACC	N/A	0	N/A	Keep acetaminophen on standby
1030	FLACC	N/A	0	N/A	Keep acetaminophen on standby

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:**	The client has a 20-gauge peripheral IV inserted in the right forearm that was placed on 10/30/2021. IV is clear and patent upon assessment. IV site was absent of erythema and drainage. IV dressing was dry and intact. IV is saline locked.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

0 mL **Total = 0 mL**	300 mL – Void **Total = 300 mL**

Nursing Care

Summary of Care (2 points)

Care during clinical shift consisted of monitoring the client's vital signs, giving medications as needed, providing general bedside care, and tending to the needs of the client's two daughters who were present to take care of the client. No procedures or testing were done during the clinical shift. The client complained and refused a shower at the request of her daughters. The client stated that she does not want a shower despite not showering for two weeks, as stated by her daughters. The client's vital signs were stable except her blood pressure which was 160/87 mmHg at 0825 hours. At 1100 hours, her pulse, respiration, oxygen, remained stable and her blood pressure stabilized to 145/74 mmHg. A temperature reading could not be acquired because the client became increasingly agitated and combative when getting a temperature reading. Another attempt was rescheduled to be done after clinical. The client's daughter stated that the client has been on bed rest throughout clinical, eats all of her meals, but refuses to shower. There were no notifications from the client's provider during clinical, and there were no determined plans for the client at this time.

Discharge Planning (2 points)

The client's daughters stated that the client's husband is planning on finding a nursing home to take care of her after discharge at this time. She does not need any home health needs but should be given a walker or wheelchair once discharged for her wobbly gait, as reported by

her daughters. Education should be given to the client's daughters on ways to prevent falls, such as clearing clutters in the room, making sure the room is well lit, and clearing cords or carpets that can be a slip risk as related to the daughters' concerns for the client is easily bruised. No follow-up plans determined at this time.

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. Acute confusion related to Alzheimer's disease as evidenced by medical history of Alzheimer's and chief complaint of altered mental status.	**The client has Alzheimer's disease and UTI. She was admitted for altered mental status when she was stated to have attempted to run towards oncoming traffic to visit her deceased mother, who she thought was still alive. The client is ANO x1, and her altered mental status is possibly affected by her**	**1. Check on the client at least every 30 minutes and reorient to baseline mental status as indicated.** **2. Have the client's significant other talk with the client by phone or come in and sit with the client if the client's behavior requires checking more often than every 30 minutes.**	**1. Goal met: The client was checked every 30 minutes. She remained asleep until 0950 hours. She then reluctantly took her medication after a couple of minutes of reorienting and convincing.** **2. Goal met: The client was agitated and refused to take her scheduled medication. The client's daughter assisted in calming her down and convinced her to take her medications.**

	UTI and Alzheimer's and is still an ongoing issue.		
2. Caregiver role strain related caregiver fatigue as evidenced by client statement, "we do not have the time to take care of her anymore. Our father is looking for a nursing home for her".	**The client's condition is too much of a burden on her husband and two daughters, who have stated to no longer have the time to take care of her. Her husband stated that he could no longer keep up with her running off on her own and would instead send her to a nursing home.**	**1. Assess the caregiver's physical/emotional/spiritual condition and the present caregiving demands.** **2. Encourage the caregiver to discuss coping skills used to overcome similar stressful situations in the past.**	**1. Goal met: The client's daughter stated that it is challenging to take care of her since they do not have time to care for her. The daughters stated that their father could not run fast enough to catch the client whenever she ran off and could no longer care for her.** **2. Goal met:** The student nurse allowed the daughters to express their concerns and think about coping skills.
3. Self-care deficit related to Alzheimer's disease as evidenced by the client statement, "she has not showered and has been wearing that shirt for about two weeks now."	**The client's altered mental status interferes with her decision-making, and she refuses to shower and brush her teeth. Her daughters stated that she had not showered in two weeks and had expressed their concern for her.**	**1. Provide physical assistance, supervision, simple directions, reminders, encouragement, and support as needed.** **2 Promote independence but intervene when the client is not able to carry out self-care activities.**	**1. Goal met: The student nurse gave the client general bedside care and gave her medication. The student nurse offered the client's daughter help whenever they needed it.** **2. Goal met: The student nurse respected the client's autonomy and decision to refuse medication and shower.**

1. Risk for falls related to altered mental status as evidenced by fall score of 50 and client statement of "she is a little wobbly when she walks."	**The client's daughters have stated that her gait is wobbly and unsteady and tends to bump her head onto things. The client also has a fall score of 50.**	**1. Assess gait and monitor for weakness, difficulty with balance, tremors, spasticity, or paralysis.** **2. Clear out any clutter and remove all potentially hazardous items that may cause falls.**	**1. Goal partially met: The student nurse was unable to assess the client's gait but was able to ask the daughters. They stated that her gait was wobbly and unsteady.** **2. Goal met: The client's room was cleared of clutter, and pathways were cleared for more space to ambulate.**

Other References (APA):

Phelps, L. L. (2020). *Spark's and Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

The client's daughter stated that she ran out towards oncoming traffic to visit Massachusetts and visit her deceased mother.
The client's daughters stated that the client has not showered or changed clothes for two weeks.
The client's daughters stated that their father could not keep up with the mother as she ran towards traffic.
The client's daughters stated that the client's gait is wobbly and unsteady.

Nursing Diagnosis/Outcomes

confusion related to Alzheimer's disease as evidenced by medical history of Alzheimer's and chief complaint of ed mental status.
The client will state that she feels calm by the end of the clinical.

Self-care deficit related to Alzheimer's disease as evidenced by the client statement, "she has not showered and has been wearing that shirt for about two weeks now."
The client will take one shower and change into a new gown by the end of clinical.

Caregiver role strain related caregiver fatigue as evidenced by client statement, "we do not have the time to take care of her anymore. Our father is looking for a nursing home for her".
The client's caregivers will be able to identify which stressors they can and cannot control.

Risk for falls related to altered mental status as evidenced by fall score of 50 and client statement of "she is a little wobbly when she walks."
The client and family will identify factors that increase the potential for falls.

Objective Data

Vital signs
BP: 160/87 mmHg (0825)

Urinalysis lab values
WBC: 12 (elevated)
Leukoesterase: 2+

The client did not have any labs or bloodwork done on the day of clinical.

Patient Information

The client is an 81-year-old female with Alzheimer's, and a UTI came in for altered mental status. She has been on bed rest throughout clinical and denies any pain or discomfort. Her two daughters are present to take care of her. She has refused care given to her, including a shower, medications, and tooth brushing.

Nursing Interventions

1. Check on the client at least every 30 minutes and reorient to baseline mental status as indicated.
2. Have the client's significant other talk with the patient by phone or come in and sit with the client if the client's behavior requires checking more often than every 30 minutes.
3. Assess the caregiver's physical/emotional/spiritual condition and the present caregiving demands.
4. Encourage the caregiver to discuss coping skills used to overcome similar stressful situations in the past.
5. Provide physical assistance, supervision, simple directions, reminders, encouragement, and support as needed.
6. Promote independence but intervene when the client is not able to carry out self-care activities.
7. Assess gait and monitor for weakness, difficulty with balance, tremors, spasticity, or paralysis.
8. Clear out any clutter and remove all potentially hazardous items that may cause falls.