N431 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
11/23/21	C.L.P	73 y/o	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Retired	Married	Otelza (unknown reaction) Penicillin (itching) Adhesive bandage (unknown reaction)
Code Status	**Height**	**Weight**	
Full code	160 cm	59.600 kg	

Medical History (5 Points)

Past Medical History: HTN, CAD, CKD, GERD, hyperlipidemia, aortic stenosis, A-fib, anxiety.

Past Surgical History: Phacoemulsification cataract with intraocular lens implantation (7/7/17), appendectomy, heart valve replacement, tubal ligation, carpal tunnel release.

Family History: Father (CAD, COPD, MI, cardiovascular disease, emphysema), mother (CAD, COPD, DM, MI, cardiovascular disease), sister (anxiety, arthritis, cardiovascular disease, DM)

Social History (tobacco/alcohol/drugs): Denies any of use of alcohol. Denies any use of recreational drugs. Former smoker. Smoked 1 pack per day from 13 y/o to 62 y/o for 49 years total.

Assistive Devices: Walker and gait belt.

Living Situation: Lives at home alone. Nephew lives across from patient and visits them often.

Education Level: Attended high school, some college.

Admission Assessment

Chief Complaint (2 points): Nausea and vomiting, and 50lb unintentional weight loss in less than one year.

History of present Illness (10 points): 73-year-old woman presented to the ED with the chief complaint of nausea and vomiting and a 50lb weight loss in less than a year. The patient stated that nausea and vomiting occur shortly after intake of both liquid and solid food and has started in the past few weeks. Upon presentation to the ED, the patient had coffee ground emesis after drinking water. Patient denies abdominal pain, dysphagia, cough, or chest pain. Patient reports that that nausea and vomiting is aggravated by oral intake. They have found no relief and has been progressively worsening as she has been losing weight. Upon testing, the patient was in sinus tachycardia and the UA were consistent with a urinary tract infection as supported by leukocytosis. The patient was given IV pantoprazole, aspirin, and started on IV ceftriaxone.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): n/a

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

A UTI is an infection of the urinary system due to uncontrolled bacterial growth, causing pain and inflammation in the kidney, ureters, bladder, and urethra. Women are at a higher risk of UTIs due to the urethra's proximity to the anus, facilitating the introduction of bacteria in the urinary system. The urinary system is sterile, and normal flora outside the urethral opening helps prevent pathogens from invading. The characteristics of urine, such as its high osmolarity, urea, and organic acid, reduce bacterial viability (Capriotti, 2020). However, obstruction of outflow and stasis of urine can create an optimal environment for bacterial growth. Many uropathogenic bacteria have capsules that protect them from the acidity of the urine, allowing them to stick and

multiply within the bladder wall. Secretions of cytotoxic necrotizing factors and hemolysin enable them to migrate up the urinary tract (Capriotti, 2020).

UTIs' signs and symptoms are difficulties during urination, such as burning or voiding small amounts frequently. The urine may appear dark, cloudy, tinged with blood, and a foul smell. Patients may experience abdominal pain, nausea, vomiting, and even confusion. Manifestation in older adults can mimic dementia-like symptoms (Mayo Foundation for Medical Education and Research, 2021). The patient presented at the ED complaining of nausea and vomiting; however, they did not report any other symptoms associated with a UTI.

The most common diagnostic test is a urinalysis that examines the urine for bacteria, white blood cells, leukoesterase, and nitrates, indicating a urinary tract infection (Capriotti, 2020). A urine culture identifies the pathogen for antibiotic therapy. The patient's urine sample was orange and turbid and had a high specific gravity of 1.048. WBC, RBC, and leukoesterase were present. The patient's urine culture was also positive for Escherichia coli, a common causative uropathogenic microbe, establishing the patient's diagnosis of a urinary tract infection.

Antibiotics such as Nitrofurantoin, ciprofloxacin, and trimethoprim-sulfamethoxazole (Bactrim) are the treatment choice for uncomplicated UTIs (Capriotti, 2020). The patient received 1000 mg of ceftriaxone IV.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

Mayo Foundation for Medical Education and Research. (2021, April 23). *Urinary tract infection (UTI)*. Mayo Clinic. Retrieved December 2, 2021, from https://www.mayoclinic.org/diseases-conditions/urinary-tract-infection/symptoms-

causes/syc-20353447.

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	4.08	n/a	n/a
Hgb	12.0-15.5	11.8	n/a	The patient has reported vomiting for the past weeks prior to admission, hemoglobin and hematocrit will appear higher in those who are dehydrated (Capriotti, 2020).
Hct	35-45	31.7	n/a	The patient has reported vomiting for the past weeks prior to admission, hemoglobin and hematocrit will appear higher in those who are dehydrated (Capriotti, 2020).
Platelets	140-400	569	n/a	Thrombyctosis can occur during infections (Capriotti, 2020).
WBC	4.0-9.0	14.2	n/a	The patient has a urinary tract infection, leukocytosis is associated with infections and inflammation (Capriotti, 2020).
Neutrophils	40-70	80.1	n/a	The patient has a urinary tract infection, leukocytosis is associated with infections and inflammation (Capriotti, 2020).
Lymphocytes	10-20	11.7	n/a	n/a
Monocytes	4.4-12.0	7.5	n/a	n/a
Eosinophils	0-6.3	0.2	n/a	n/a
Bands	0-5.1	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	136	n/a	n/a

K+	3.5-5.1	3.6	3.3	Hypokalemia is an adverse effect of ceftriaxone (Jones & Bartlett Learning 2019).
Cl-	98-107	98	n/a	n/a
CO2	22-29	24	n/a	n/a
Glucose	70-99	79	n/a	n/a
BUN	6-20	22	n/a	The patient has CKD, creatinine and BUN will be increased in those with renal impairment (Capriotti, 2020).
Creatinine	.50-1.00	1.34	n/a	The patient has CKD, creatinine and BUN will be increased in those with renal impairment (Capriotti, 2020).
Albumin	3.5-5.2	3.3	n/a	n/a
Calcium	8.4-10	9.1	n/a	n/a
Mag	1.6-2.5	1.8	n/a	n/a
Phosphate	35-105	n/a	n/a	n/a
Bilirubin	.3-1.0	0.5	n/a	n/a
Alk Phos	30-120	62	n/a	n/a
AST	10-30	27	n/a	n/a
ALT	10-40	14	n/a	n/a
Amylase	30-110	n/a	n/a	n/a
Lipase	0-160	42	n/a	n/a
Lactic Acid	0.5-1	n/a	n/a	n/a
Troponin	0 – 0.04	0.061	0.029	Elevated troponin levels are commonly associated with myocardial infections, but can occur in sepsis, renal failure, and strokes (Capriotti, 2020). The patient has chronic kidney disease.

CK-MB	5 - 25	n/a	1.17	n/a
Total CK	22 - 198	n/a	32	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	n/a	n/a	n/a
PT	11-12	n/a	n/a	n/a
PTT	0.8-1.1	n/a	n/a	n/a
D-Dimer	11-13.5	n/a	n/a	n/a
BNP	30-40 sec	n/a	n/a	n/a
HDL	<250	n/a	n/a	n/a
LDL	<100	n/a	n/a	n/a
Cholesterol	>60	n/a	n/a	n/a
Triglycerides	<130	n/a	n/a	n/a
Hgb A1c	<200	n/a	n/a	n/a
TSH	<150	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	Pale yellow-deep amber/clear	Orange /turbid	n/a	Patient is diagnosed with a urinary tract infection, manifestations of a UTI include cloudy, blood tinged, foul smelling urine (Capriotti, 2020).
pH	5-8	6	n/a	n/a

Specific Gravity	1.005-1.034	1.048	n/a	The patient has reported vomiting for the past weeks prior to admission, high specific gravity is a sign of dehydration (Capriotti, 2020).
Glucose	negative	negative	n/a	n/a
Protein	negative	2+	n/a	The patient has CKD, proteinuria can occur in those with renal impairment (Capriotti, 2020).
Ketones	negative	trace	n/a	The patient is diabetic, and the presence of ketones is a manifestation of DKA (Capriotti, 2020).
WBC	negative	>100	n/a	The presence of a WBC is indicative of a UTI (Capriotti, 2020).
RBC	negative	3+	n/a	Patient is diagnosed with a urinary tract infection, manifestations of a UTI include cloudy, blood tinged, foul smelling urine (Capriotti, 2020).
Leukoesterase	negative	4+	n/a	The presence of a leukoestrease in the urine is manifestation of a UTI (Capriotti, 2020).

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35 – 7.45	n/a	n/a	n/a
PaO2	40 - 50	n/a	n/a	n/a
PaCO2	35 – 45	n/a	n/a	n/a

HCO3	22 - 26	n/a	n/a	n/a
SaO2	92% - 100%	99%	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	Positive Escherichia coli	n/a	E.coli is a common causative pathogen of UTI (Capriotti, 2020).
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

Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

Jones & Bartlett Learning. (2019). 2019 Nurse's Drug Handbook. Burlington, MA

Lab Lakeview College of Nursing, "Tab: Diagnostics: Lab"

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

CT chest w/contrast**,** CT abdomen and pelvis w/contrast**,** Chest XR.

Diagnostic Test Correlation (5 points):

- CT chest w/contrast was indicated by nausea and vomiting. Results showed mild centrilobular emphysema and a 2cm cysts/cavity on the posterior of the right middle

lobe. This diagnostic test was done to rule any lung problems such as pneumonia, tuberculosis, or PE.

- CT abdomen and pelvis w/contrast was indicated due to nausea and vomiting. Results showed hepatic parenchymal density consistent with fatty liver. Punctuate calcification were visualized on the spleen and liver suggesting old granulomatous disease. This diagnostic test was done to visualize the abdominal cavity to diagnose inflammation infection, or injury that may be causing the patient's nausea and vomiting.
- Chest XR was indicated due to the patient's dyspnea occurring last night (11/28). Results suggest patchy atelectasis and pulmonary congestion. This diagnostic test was done to rule out any lung problems that may be causing the patients dyspnea.

Diagnostic Test Reference (1) (APA):

Capriotti, T., & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

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

Brand/Generic	Lipitor/ atorvastatin	Zofran/ ondansetron	Aspir 81/aspirin	Lasix/furosemide	Vitamin B12/ Cyanocobalamin
Dose	40 mg	4 mg	81 mg	20 mg	1,000 mcg
Frequency	daily	Q8H, PRN	daily	daily	1,000 mcg daily for 5 days, then weekly for 4 weeks, then monthly for 1 year
Route	PO	PO	PO	PO	IM

Classification	HMG reductase inhibitors, lipid lowering agents	Selective serotonin (5-HT3) receptor antagonist	Salicylate, NSAID, antiplatelet	Loop diuretic	Vitamins
Mechanism of Action	Decreases cholesterol production in the liver buy preventing the conversion of HMG-CoA reductase to mevalonate	Reduces nausea and vomiting by blocking serotonin receptors of the vagal nerve terminals in the intestines	Aspirin blocks cyclooxygenase suspending prostaglandins synthesis and an inflammatory response. Aspirin also impedes the production of thromboxane A2 inhibiting platelet aggregation	Blocks the absorption of sodium and water in the kidneys causing increase in output	Binds to transcobalamin I and transcobalamin II allowing absorption of Vitamin B 12 into cells
Reason Client Taking	To manage hyperlipidemia	To manage nausea and vomiting	To manage CAD	To manage HTN	To manage GERD, prevent malabsorption, Increase Vit B12
Contraindications (2)	Liver impairment, renal impairment	Hypokalemia, heart arrythmia	Coagulation disorders, gout	Dehydration, hypokalemia	Hypokalemia, optic atrophy
Side Effects/ Adverse Reactions (2)	Myopathy, rhabdomyolysis	Hypotension, bronchospasms	Nausea, vomiting	Dizziness, headache	Easy bruising, diarrhea
Nursing Considerations (2)	Monitor for muscle weakness, this medication can increase HgbA1c	Do not administer fast, avoid those with heart arrythmias	Implement bleeding precautions, may cause ototoxicity	Monitor I&O, monitor hydration status	Absorption of vitamin B12 may be decreased if there is a lack of intrinsic factor, antibiotics can decrease absorption of vitamin B12
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess AST/ALT, Assess bilirubin levels	Asses for frequency in nausea and vomiting, asses for abdominal pain	Assess coagulation studies, assess risk for bleeding	Assess electrolytes, assess BP	Assess for s/s for numbness or tingling of the hands, assess Hct/Hgb

Client Teaching needs (2)	Avoid grapefruit juice, notify provider immediately for unexplained muscle pain	Take with a full glass of water, can be taken with or without food	Educate of bleeding precautions/risks, avoid NSAIDs	Avoid getting up too fast, avoid alcohol	Eat foods high in Vit B12 such as beef, liver, and eggs, avoid alcohol

Home Medications (5 required)

Hospital Medications (5 required)

Brand/Generic	Cardizem/diltiazem	Lexapro/ escitalopram	Antara/fenofibrate	Rocephin/ ceftriaxone	Protonix/ pantoprazole
Dose	360 mg	20 mg	145 mg	1,000 mg	10 mL
Frequency	daily	daily	daily	Q24H	BID
Route	PO	PO	PO	IV piggyback	IV push
Classification	Calcium channel blocker	Selective serotonin reuptake inhibitor (SSRI)	Fibric acid derivatives	Cephalosporin antibiotic	Proton pump inhibitor
Mechanism of Action	Prevents flow of calcium ions in the cardiac cells during depolarization resulting in smooth muscle relaxation	Inhibits the reuptake of serotonin on the monoamine transporter on the allosteric site	Activates peroxisome proliferator-activates receptors alpha inducing HDL synthesis	Inhibits bacterial cell wall synthesis by bindings to transamidases of the peptidoglycan polymers of the cell wall	Pantoprazole binds to the hydrogen and potassium ATP pump inhibiting gastric acid and basal acid secretion
Reason Client Taking	To manage hypertension	To manage anxiety	To manage hyperlipidemia	To treat UTI	To manage GERD
Contraindications (2)	Hypersensitivity, complete heart block	Hypersensitivity, MAOI use	Liver impairment, renal impairment	Hemolytic anemia, liver impairment	Hypersensitivity, lupus

Side Effects/Adverse Reactions (2)	Hypotension, bradycardia	Nausea, drowsiness	Myopathy, rhabdomyolysis	Headache, nausea	Headache, abdominal pain
Nursing Considerations (2)	This medication may increase risk for falls, use cautiously with renal insufficiency	This medication may increase risk for falls, use cautiously with renal insufficiency	Patients should be put on a low fat/cholesterol diet, monitor for jaundice	Monitor for hypersensitivity, monitor for watery, loose diarrhea suggestive of C diff associated diarrhea	Do not take with digoxin, do not take with methotrexate
Key Nursing Assessment(s) /Lab(s) Prior to Administration	Assess BP, assess HR	Assess for suicidal ideations, assess for hyponatremia	Assess ALT/AST, assess bilirubin levels	Assess WBC, assess BUN/creatinine	Assess for presence of stomach pain, assess for hypocalcemia
Client Teaching needs (2)	Notify provider immediately for unexplained muscle pain, avoid grapefruit juice	Notify provider if you are having symptoms of serotonin syndrome such as hallucinations, avoid using other herbal medicines with Lexapro	Take as prescribed, notify provider immediately for unexplained muscle pain	Avoid NSAIDs, avoid caffeinated drinks	Increase foods high in Vit B12, Increase food high in calcium

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). 2019 Nurse's Drug Handbook. Burlington, MA

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert and responsive A&O x4 No visible signs of distress Overall appearance was appropriate
INTEGUMENTARY (2 points): **Skin color:**	 Skin color is usual for ethnicity

Character: **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 19** **Drains present: Y☐ N ☒** **Type:**	Supple Warm Loose turgor No rashes observed No bruises observed No wounds observed 19 n/a
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Normocephalic, no deviation of trachea No drainage, grey-pink tympanic membrane No drainage, symmetrical, pink conjunctiva No septum deviation, polyps, turbinate Teeth intact, no visible dental caries
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/S2 heart sounds heard No murmur or gallops heard Normal steady rate and rhythm Peripheral pulses 3+ bilaterally, radial/dorsalis pedis 3+ bilaterally Capillary refill 3+hands bilaterally n/a
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	 Respiration pattern is regular Clear anterior/posterior bronchovesicular breath sounds heard bilaterally throughout all lobes Equal lung aeration
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 ☒**	 Regular diet at home Soft diet 160 cm 59.600 kg Active in all 4 quadrants 11/29 No pain/masses detected upon palpation Skin warm and color usual for ethnicity No distention observed No incision observed 2 – 3 cm scar on RLQ No drains observed No wounds observed

Nasogastric: Y ☐ N ☒ **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	 n/a n/a
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	 Light yellow Clear 500 mL Appropriate n/a n/a
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 60** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☒**	 Nail bed pink, capillary refill 3 sec, warm skin Active range of motion Walker, gait belt 4- active motion against some resistance (slight weakness) 60 Active ROM against some resistance (slight weakness)
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	 A&O x4 Normal cognition Clear Sensory perception appropriate Alert and responsive
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**	 Seeks support through family members Patient's developmental level is appropriate. Able to read and write. Patient is not affiliated with any religious group. Patient's main support system is nephew. Patient

available family support):	was seen talking on the phone with the nephew and is expecting a visit. Patient appears to be in a good supportive relationship as they are the patient's primary support person.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0706	62 bpm	121/82 mmHg	24 bpm	36.1 C	93%
1003	68 bpm	112/57 mmHg	20 bpm	26.1C	98%

Vital Sign Trends:

The patients' morning vital signs were stable and within defined limits. The patients' blood pressure slightly decreased after administration of diltiazem, however it did so slightly. The patients' blood pressure along with other vital signs are still within expected ranges.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0815	numeric	n/a	0/10	n/a	n/a
1003	numeric	n/a	0/10	n/a	n/a

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock

Size of IV:	22 gauge
Location of IV:	Right antecubital
Date on IV:	11/28
Patency of IV:	Aspirated and flushes easily
Signs of erythema, drainage, etc.:	No phlebitis/infiltration observed
IV dressing assessment:	Dry, intact

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
None reported/observed	500 mL urine

Nursing Care

Summary of Care (2 points)

The patient was assessed and given medications as prescribed. The patient is eating well, is currently on a soft diet, and is seen ambulating between the chair and bed. The patient complains of no pain, and vital signs are well within expected limits. The patient had no procedures or testing done today; however, the patient is still being monitored due to new-onset A-fib occurring the night before. A cardiac consult was encouraged due to the elevation of troponin.

Discharge Planning (2 points)

The patient currently lives at home by themselves, with the occasional supervision of their nephew. Still, they are now waiting on acceptance to a nursing home around the area. Home health or equipment is not needed. A cardiac consultation was encouraged, and the patient will return to their primary care physician after one week for follow-up. The patient will need education on preventive measures concerning UTIs, such as avoiding urine stasis, wiping front to back, and increasing fluid intake.

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. Risk for imbalanced fluid volume related to prolonged vomiting as evidenced by increased Hgb and Hct.	The patient reported nausea and vomiting shortly after oral intake ongoing for several weeks. The patient cannot take anything by mouth, putting them at risk for dehydration.	**1.**Monitor hydration status: VS Q2H, I/O, electrolytes, and for signs and symptoms of dehydration such as tachycardia, hypotension. **2.**Administer IV fluids as prescribed. Administering IV solutions will replace lost liquids, preventing dehydration by promoting fluid shifts into the intravascular space.	1. The patient's vital signs were stable. No signs of dehydration were present. Electrolytes remained within expected limits. The patient's intake and output were equivalent indicating fluid balance. 2. The patient's fluid volume was replenished. The patient stayed hydrated. Pink, moist mucus membranes were observed.
2. Imbalanced nutrition less than the body requirements related to prolonged nausea and vomiting as evidenced by unintended 50lb weight loss in less than one year.	The patient reported that they've lost 50lbs in less than a year and have nausea and vomiting after they eat. The patient's consumption is disturbed, and absorption of nutrients cannot occur, causing weight loss.	1. Provide the patient with soft diet orders. Determine the patient's food preference, ensuring that it aligns with the food order. Promoting a non-stressful environment and providing food that that patient enjoys will encourage nutritional intake. **2.**Offer 6 frequent	1. The patient ate preferred food of soft tuna and mashed potatoes. The patient enjoyed their meal and consumed more than 75% of their meal. 2. The patient gained 2lbs in a week. The patient ate six small, nutrient-dense meals. The patient did not vomit during feedings. The patient increases their nutritional intake and will continue eating small frequent meals after

		small nutrient-dense meals throughout the day to reduce the feeling of fullness and the risk for vomiting.	discharge to increase absorption.
3. Impaired urinary elimination related to the presence of protein, ketones, RBC, and leukoesterase, as evidence by increase BUN and creatine.	The patient has chronic kidney disease, and their GFR and creatinine is elevated, indicating reduced renal function. The kidneys cannot filter the blood and excrete and concentrate urine properly.	1. Monitor hydration status such as I/O. Close monitoring of intake and output assess that the patient's fluid regulation. 2. Avoid alcohol, caffeine, and NSAIDs (unless needed). The patient should avoid hard substances on the kidneys to prevent further damage.	1. The patient's intake was 500 mL and output were 500 mL and determined to be equivalent, indicating fluid balance. 2. The patient's creatine and BUN decreased within acceptable values per provider. The patient's kidney function improved, and UA showed no presence of protein or RBC.
4. Deficient knowledge related to infection of the urinary tract system as evidenced by orange, turbid urine.	The patient is at risk for UTI's being a woman of older age. The patient's kidney function is also impaired. Primary health promotion should be taught to decrease the re-occurrence.	1**.** Educate the client on proper perineal hygiene of wiping front to back to prevent the re-occurrence of urinary tract infection. 2 Educate the client to urinate as soon as they need to. Teach the client about the importance of avoiding urinary stasis.	1. The patient had no difficulty urination, no frequency, urgency, or burning. No signs and symptoms of infection were present. 2. The patient voided as soon as they felt the urge. The patient's urine was yellow and clear. The patient prevented urinary stasis and the development of bacterial growth in the urine.

Other References (APA):

1. Monitor hydration status: VS Q2H, I/O, electrolytes, and for signs and symptoms of dehydration such as tachycardia, hypotension
2. Administer IV fluids as prescribed. Administering IV solutions will replace lost liquids, preventing dehydration by promoting fluid shifts into the intravascular space.
3. Provide the patient with soft diet orders. Determine the patient's food preference, ensuring that it aligns with the food order. Promoting a non-stressful environment and providing food that that patient enjoys will encourage

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier

Concept Map (20 Points):

Subjective Data

Nausea after oral intake
0/10 pain

Objective Data

Coffee ground emesis
50lb weight loss
Sinus tachycardia
Hgb 11.8
Hct 31.7
Platelets 569
WBC 14.2
Neutrophil 80.1
K+ 3.3
BUN 22
Creatinine 1.34
Troponin 0.061, 0.029
Orange/turbid urine
UA specific gravity 1.048
UA protein 2+
UA WBC >100
UA RBC 3+
Leukoesterase 4+
Urine culture Positive
Escherichia coli
CT chest: mild centrilobular emphysema and a 2cm cysts/cavity on the posterior of the right middle lobe.
CT abdomen/pelvis: hepatic parenchymal density, Punctuate calcification
CXR: pulmonary congestion
500 mL urine output

Patient Information

A 73 y/o female with a medical history of HTN, CAD, CKD, GERD, hyperlipidemia, aortic stenosis, A-fib, anxiety presented to the ED of nausea and vomiting, and a 50lb unintentional weight loss over the past year. Patient reported that she started feeling symptoms these past weeks and occurs after oral intake. Patient has no other accompanying symptoms. Patient found no relief and has been progressively worsening. Upon testing patient's UA were consistent with a UTI. Ceftriaxone was given

1. Risk for imbalanced fluid volume related to prolonged vomiting as evidenced by increased Hgb and Hct.
- The patient's vital signs were within expected limits. No signs of dehydration were present. Electrolytes remained within expected limits. Pink, moist mucus membranes were observed.
2. Imbalanced nutrition less than the body requirements related to prolonged nausea and vomiting as evidenced by unintended 50lb weight loss in less than one year.
- The patient consumed 75% of their meal. The patient gained 2lbs in a week. The patient did not vomit during feedings.
3. Impaired urinary elimination related to the presence of protein, ketones, RBC, and leukoesterase, as evidence by increase BUN and creatine.
- The patient's intake was 500 mL and output were 500 mL and determined to be equivalent, indicating fluid balance. The patient's creatine and BUN decreased within acceptable values per provider. No protein, RBC found in UA
4. Deficient knowledge related to infection of the urinary tract system as evidenced by orange, turbid urine.
- The patient's urine was yellow and clear. No protein, RBC found in UA. The patient had no difficulty urination, no frequency, urgency, or burning.

Nursing Interventions

1. Monitor hydration status: VS Q2H, I/O, electrolytes, and for signs and symptoms of dehydration such as tachycardia, hypotension
2. Administer IV fluids as prescribed.
3. Provide the patient with soft diet orders. Determine the patient's food preference, ensuring that it aligns with the food order. Promote a non-stressful environment.
4. Offer 6 frequent small nutrient-dense meals throughout the day to reduce the feeling of fullness and the risk for vomiting
5. Monitor hydration status such as I/O
6. Avoid alcohol, caffeine, and NSAIDs (unless needed). The patient should avoid hard substances on the kidneys to prevent further damage
7. Educate the client on proper perineal hygiene of wiping front to back to prevent the re-occurrence of urinary tract infection
8. Educate the client to urinate as soon as they need to. Teach the client about the importance of avoiding urinary stasis.