N441 Care Plan

Lakeview College of Nursing

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Demographics

Date of Admission 1/25/22 @ 0820	**Patient Initials** M.B.	**Age** 94 years old (8/31/1927)	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired (Former farmer)	**Marital Status** Widowed (Was married for 60 years)	**Allergies** According to the patient and his chart, she is allergic to Metronidazole and Nitrofurantoin. The patient states she when she takes both medications, she has ana allergic reaction such as rashes.
Code Status DNR/ DNI POA: Daughter	**Height** 5'3" 160.2 cm	**Weight** 178 pounds (80.7 kg) BMI: 31.5	

Medical History

Past Medical History:

According to the patient, she has a past medical history of coronary artery disease (since her early 50s). This patient was unable to provide an exact date as to when she was diagnosed with coronary artery disease. M.B. also stated she has a past medical history of neuropathy and hypertension. She was unable to provide an exact date to when she was diagnosed with both medication disorders, however she stated it was either when she was in her early or mid-fifties. When looking at her chart, I found that this patient also has a past medical history of hypothyroidism. When asked about her past medical history of hypothyroidism, the patient confirmed the diagnoses, but stated she is unsure to an exact date or age when each medical issue occurred. Patient stated a majority of her health issues begun "when I was older". The patient attributed the major change in health to her increase in a sedentary lifestyle. The patient stated

she use to work on a farm and was very active, but due to a combination of act and the passing of her husband 21 years ago, she no longer participates in farming.

Past Surgical History:

When asked about her past surgical history, M.B. state she had a hysterectomy when she was younger. This information was confirmed with her chart which stated her hysterectomy was surgical done when she was 36 years old. Other past surgery for this patient consist of a left knee replacement (7/2020), cholecystectomy (1996), appendectomy (1996). Both the patient and her charts confirmed that she has had a tonsillectomy. However, when asked what year this procedure was done, the patient stated she does not recall, but it was when she was much younger, maybe in grade school. The patient's chart did not provide more information as to the exact date of when the patient had a tonsillectomy. The patient also had a coronary artery bypass graft surgery in 2008.

Family History:

Patient has a family history that includes rheumatoid arthritis and osteoporosis with her mother and congestive heart failure with her father. The patient denies any other family history with her siblings, children, and other family members.

Social History:

Patient denies a history of smoking, alcohol use and illicit drug use. The patient continued to state that she never had interest in part taking in any of the following mentioned.

Assistive Devices:

Patient uses hearing aids bilaterally, but states that with them she still has a difficult time hearing. Patient uses glasses for long distance vision as well as reading. Patient denies the use of a wheelchair. The patient does admit to using a walker when ambulating outside of her room and

when she is in her room, she uses a cane. Patient states she uses a cane on left side occasionally prior to admission, but mainly ambulates with a walker. Patient uses partial dentures for her upper teeth.

Living Situation:

Patient currently lives in an assistive living home in an apartment by herself in Rantoul and has lived here for close to ten years. Prior to this, M.B. stated she lived at home alone after the passing of her husband. The patient stated she enjoys where she currently lives but does not enjoy the food that is serviced there. The patient states although she lives in an assist living facility, she still feels like she has her independence especially since she drives. Patient stated the reasoning for her transition to an assistance living facility is due to her slight increase in weakness periodically. Patient stated her children thought it would be safer for her to be somewhere where she would be able to get help whenever need be. Patient denies use of respiratory equipment at the assistance living facility. Patient states she drives.

Education Level:

Patient's education level extends to high school. Patient stated she did not go to college and had no plans or intentions in doing so. The patient stated that during that era, it was a major accomplishment to even graduate high school, so she was very proud of herself for doing so. The patient denies any learning barriers.

Admission Assessment

Chief Complaint: Dizziness and syncope

History of Present Illness:

M.B. presented from the assisted living facility. When talking to this patient, she stated that the onset of her dizziness and lightheadedness begun the previous night on 1/24 by around roughly 7pm after dinner. The patient continues to mention that her dizziness got worse over the night even after she walked the halls and did her laundry. The patient stated the location of her dizziness was throughout her entire body, but mostly felt in her eyes. The described this feeling as if she was “spinning around the room”. The patient stated she was unable to stand or walk. The patient stated the dizziness was so bad, she was unable to sleep well because of it. The patient stated the duration of her dizziness is still current at the time of this assessment. Nonetheless, the patient has stated that it has decreased a bit after she was administered normal saline 0.9% in the emergency room upon admission. From the patient’s perception, the cause of her dizziness is in direct correlation to her being dehydrated. The patient states her daughter is always encouraging her to increase her fluids, so she believes this is a result to her not being as compliant to drinking enough water. The patient denies ever experiencing similar symptoms prior to this occurrence. The patient denies any associating factors but stated that an aggravating factor for her dizziness was when she moved. The patient stated with movement, she would have increased dizziness. The patient stated that her dizziness is not fully resolved yet, however something that decreased some of her dizziness was when she was administered normal saline 0.9% in the emergency room. The patient is still undergoing evaluation to fully understand the treatment for her dizziness. Upon admission to the emergency department, the patient was administered 500 mL of sodium chloride 0.9% IV bolus and magnesium. The patient was

admitted the same day this assessment was done so her chart was not completely filled out yet. The patient is however, expected to be discharged with the same medication as wel as follow up with a cardiac physician. The patient stated although she did not experience any level of physical pain due to her dizziness, she did experience a lot of discomfort. When asked, the patient stated her discomfort level was an 8/10. The patient described her dizziness as being “ongoing” and constant.

Primary Diagnosis

Primary Diagnosis on Admission: Orthostatic hypotension

Secondary Diagnosis: bifascicular block, trigeminy, syncope, and hypomagnesemia

Pathophysiology of the Disease: Orthostatic Hypotension

Orthostatic hypotension is a form of low blood pressure that occurs when “a patient attempts to resume the upright position after a prolonged period of bedrest” (Capriotti, 2020, pp.66-7). There is more to this disease process than a sudden change in pressure. In the cellular level, after one is “an extended period in supine, their arterial baroceptors (pressure sensors that stimulate the sympathetic nervous system to vasoconstricts the arterial blood vessels) require time to readjust to the upright position” (Capriotti, 2020, pp. 66-7). Normal this does not occur for a typical person changing positions. As they change from a lying to standing position or a sitting up to standing position, the arterial blood still experiences a slight drop in blood pressure. The stimulating in the drop of blood pressure stimulates the baroreceptors inside the walls of the arteries to vasoconstrict arteries. This action results in an increase in heart rate. Due to the increase in heart rate, there is a decrease in blood pressure seen to “then readjusts to ensure cerebral perfusion” (Capriotti, 2020, pp. 66-7). With this particular patient along with many other individuals who deal with orthostatic hypotension, when they have a sudden change in

position like lying to standing, “there is a delay in arterial vasoconstriction, and the patient’s blood pressure temporality falls as he or she stands” (Capriotti, 2020, pp. 66-7). With this being said, it is clear to see that the effect of orthostatic hypotension is body wide and not just involving the blood pressure. It effects the entire body overall and each system. It effects the patient’s neurological status and function hence why the patient may complain of dizziness or weakness. The dizziness and weakness is a result of not enough cerebral perfusion that last long enough for the arteries to constrict occurs to increase blood pressure (Capriotti, 2020, pp. 66-7).

As mentioned above, the main sign and symptom that a patient with orthostatic hypotension may experience is a feeling of dizziness and weakness. For this particular patient, she states she felt dizzy and as if she was spinning in the room. She then went on to describe her symptoms as being weakness. Prior to her admission to the hospital, the patient stated she felt so weak that she was unable to stand or walk. Her symptoms left the patient unable to complete her daily activities like her laundry. Another common sign of orthostatic hypotension is the pressure to which the blood pressure falls. Someone’s blood pressure has to be at least a drop in 20 mm Hg for their systolic pressure or a diastolic blood pressure decrease at least 10 mm Hg within 3 minutes when going from a lying to a standing position (Capriotti, 2020, pp. 66-7). When the patient arrives on the unit, the physician ordered a set of orthostatic blood pressures to be taken on her to monitor if there has been improvement in her condition. Needless to say, the patient still displayed signs of orthostatic blood pressure. When she was at a lying position, it blood pressure read 160/82. When she is changing into a sitting up position at the side of the bed, she insistently complained of dizziness. When we took her blood pressure, there was much of a change in her diastolic pressure, however her systolic pressure dropped to 136. Lastly, when this patient was standing at the side of the bed, it blood pressure read 110/62. This is a classic sign of

orthostatic hypotension. A person with orthostatic hypotension may also experience blurry vision, confusion, nausea, and heart palpations (Conrad, 2021). This disorder is often times experienced by older adults or any individual on antihypertensive medications as well as dehydrated patients. The patient is also currently taking metoprolol succinate daily. This drug can cause orthostatic hypotension if one does not change positions slowly. Being that this occurs in individuals who are dehydrated, someone labs that could confirm dehydration for a patient experiencing orthostatic hypotension is an elevated in blood urea nitrogen, over 20 mg/dL. This patient's BUN was within normal level. Hers was 13 upon admission.

The diagnostic testing used to identify orthostatic hypotension is monitor a patient's blood pressure with the change of position. A doctor will diagnose a patient with this disease if they have a drop of 20 millimeters of mercury (mm Hg) in your systolic blood pressure or a drop of 10 mm Hg in your diastolic blood pressure within two to five minutes of standing, or if standing causes signs and symptoms. This is the main diagnostic tool utilized for orthostatic hypotension. It is also common for patients experience this to have an electrocardiogram, blood tests, echocardiogram and stress test done to rule out or further investigate the underlying cause of the disease (Conrad, 2021). In this particular patient's case, she has an electrocardiogram done due to her experience other heart issues.

For the treatment of orthostatic hypotension, doctors usually recommend lifestyle changes in conjunction with encouraging the patient to change positions slowly. Another there of several ways to manage or prevent orthostatic hypotension, most of these ways do not include the use of medications. Some lifestyle changes highly suggested for these patients are to keep hydrated at least 2-3 liters of fluids daily. It is also advised to avoid strenuous activity during hot weather and when getting out of bed to first sit on the edge of the bed for a couple minutes

before standing. For this patient, her treatment plan consist of her standing positions slowly. The patient was also administered normal saline upon administered just to help with hydrate.

Pathophysiology References (2):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives 2nd Edition* (2nd ed., p. 66-7). Philadelphia: F A Davis.

Conrad, M. (2021, February 22). *Orthostatic Hypotension Symptoms, Signs & Causes*. MedicineNet.https://www.medicinenet.com/orthostatic_hypotension_symptoms_and_signs/symptoms.htm

Laboratory Data

COMPLETE BLOOD COUNT

Lab	Normal Range	Admission Value 1/25/22 @ 0820	Today's Value 1/25/21	Reason for Abnormal Value
RED BLOOD CELLS (carry oxygen)	F: 4.2-5.4	4.43	N/A	
HEMOGLOBIN (oxygen-carrying protein in RBCs)	F: 12-15.5	14.3	N/A	
HEMATOCRIT (the proportion of RBCs to the fluid component, plasma in your blood)	F: 36-44%	41.4	N/A	
PLATELETS (help with blood clotting)	150,000-450,000	244	N/A	
WHITE BLOOD CELLS (fight infection)	4,000-10,000	6.70	N/A	
NEUTROPHILS (type of WBC that the bone marrow creates; travel into blood stream and move to areas of infection and neutralize that area)	40-60	59.1	N/A	
LYMPHOCYTES (B cells: produce antibodies to attack bacteria T-cells: kill infected cells	20-40	29.8	N/A	

MONOCYTES (fight infection; help remove dead tissues; destroy cancer cells)	2-8	7.9	N/A	
EOSINOPHILS (participating in immediate allergic reactions)	0-4	2.1	N/A	
BANDS (immature form of neutrophils; produced in excess during infection to help fight disease)	3-7	N/A	N/A	

Chemistry

Lab	Normal Range	Admission Value 1/25/22 @ 0820	Today's Value 1/25/22	Reason For Abnormal
NA- (Control BP and blood volume; needed for muscle and nerves to work)	135-145	134	N/A	
K+ (helps your nerves to function and muscles to contract; heartbeat stay regular; move nutrients into cell and waste products out of cell)	3.5-5.0	3.8	N/A	
Cl- (helps keep the amount of fluid inside and outside of your cells in balance; maintain blood volume, BP and pH)	95-105	98	N/A	
CO2 (regulates the pH of blood, stimulates breathing, and influences the affinity hemoglobin has for oxygen)	23-30	26	N/A	
Glucose (for energy)	70-110	**126**	N/A	A reasoning for an increased glucose level could be stress from being hospitalization. Stress blocks your body from releasing insulin, and lets glucose pile up in your blood (Capriotti & Frizzell, 2019). If you're stressed for a long time, your sugar levels will keep building. Since this patient's blood glucose is slightly elevated, it is most likely due to her stress levels. It is not abnormal for hospitalized patients to experience high levels of glucose due to stress. Stress blocks your body from releasing insulin which causes

				glucose to build up in the blood (Yitshak-Sade et al., 2020). If stress is prolonged, glucose levels can continue to build up overtime.
BUN (measures the amount of nitrogen in your blood that comes from the waste product urea; indicates how well your kidney are working)	10-20	13	N/A	
CREATININE (to be filtered and eliminated in urine)	0.6-1.5	0.84	1.02	
ALBUMIN (helps keep fluid in your bloodstream so it doesn't leak into other tissues)	3.5-5.0	4.4	N/A	
CALCIUM (stored in bones and teeth; supports structure; carries massages between the brain and body parts)	8.5-10.0	9.4	N/A	
MAGNESIUM (required for energy production)	1.5-2.5	1.5 (I did not highlight or bold because this is still considered to be within the normal levels, despite her being medical treated for it.)	N/A	In this patient's chart, this level was flagged as being low. When I spoke with the patient's nurse, the nurse educate me that the reason for her getting magnesium sulfate premix 2g is because her magnesium is on a lower end of normal, so to get ahead of it being lower than the normal value, her doctor wanted to her to take magnesium for easily prevention of the result of magnesium deficiency. In this particular patient's case the cause of her magnesium being on the lower end of normal could be due to poor absorption or malnutrition. The patient did state she did not enjoy the food from her assisted facility.
PHOSPHATE (build and repair bones and teeth, help nerves function, and make muscles contract)	2.8-4.5	2.8	N/A	
BILIRUBIN (orange-yellow pigment that occurs normally when part	0.3-1.2	0.8	N/A	

of your red blood cells breaks down)				
ALK PHOS (mostly found in the liver, bones, kidneys, and digestive system. When the liver is damaged, ALP may leak into the bloodstream)	20-90	67	N/A	
AST Checks for liver damage	5-40	19	N/A	
ALT Test for liver cell damage	7-56	14	N/A	
Amylase Test for disease of the pancreas	30-110	N/A	N/A	
Lipase Helps your body digest fats; normal to have a small amount in body; protein that helps your body absorb fats (for pancreas)	0-160	N/A	N/A	
Lactic Acid Substance made by muscle tissue; high disrupt a person's acid pH balance; lactic acidosis caused by not enough oxygen in cells/ tissues	0.5-2.0	N/A	N/A	
Troponin	0-0.4	<0.030	N/A	
CK-MB	5-25	N/A	N/A	
Total CK	22-198	N/A	N/A	

Lab Test	Normal Range	Value on Admission 1/25/22 @ 0820	Today's Value 1/25/22	Reason for Abnormal
INR	0.8-1.1	N/A	N/A	
PT	11-13.5	N/A	N/A	
PTT	25-35	N/A	N/A	
D-Dimer	Negative	N/A	N/A	
BNP	Less than 100	N/A	N/A	
HDL	60	N/A	N/A	
LDL	Less than 100	N/A	N/A	
Cholesterol	Less than 200	N/A	N/A	
Triglycerides	Less than 150	N/A	N/A	
Hgb A1c	Below 5.7	5.7	N/A	
TSH	0.4-4	N/A	N/A	

Urinalysis

Lab Test	**Normal Range**	**Value on Admission** 1/25/22 0820	**Today's Value** 1/25/22	**Reason for Abnormal**
COLOR & CLARITY	Colorless-Yellow, Clear	N/A	N/A	This lab was now shown with in this patient's chart.
pH	6-8.0	N/A	N/A	
SPECIFIC GRAVITY (test compares the density of urine to the density of water; help determine how well your kidneys are diluting your urine)	1.005-1.030	N/A	N/A	
GLUCOSE	Negative	N/A	N/A	
PROTEIN	0-8	N/A	N/A	
KETONES (fuels for the body that are made when glucose is in short supply)	Negative	N/A	N/A	
WBC	0-4	N/A	N/A	
RBC	0-3	N/A	N/A	
LEUKOESTERASE	Negative	N/A	N/A	

Arterial Blood Gas

Test	Normal Range	Value on Admission 1/25/22 0820	Today's Value 1/25/22	Explanation of Findings
pH	7.35-7.45	N/A	N/A	
PaO2	80-100%	N/A	N/A	
PaCO2	35-45	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	92-100	N/A	N/A	

Cultures

Test	Normal Range	Value on Admission 1/25/22 0820	Today's Value 1/25/22	Explanation of Findings
URINE CULTURE	Negative	N/A	N/A	
BLOOD CULTURE	Negative	N/A	N/A	
SPUTUM CULTURE	Negative	N/A	N/A	
STOOL CULTURE	Negative	N/A	N/A	

Lab Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2019). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

Kathleen Deska Pagana. (2020). *Mosby's Diagnostic And Laboratory Test Reference.* Elsevier Mosby.

Yitshak-Sade, M., Mendelson, N., Novack, V., Codish, S., & Liberty, I. F. (2020). The Association Between an Increase in Glucose Levels and Armed Conflict-Related Stress: A Population-Based Study. *Scientific Reports*, *10*(1). https://doi.org/10.1038/s41598-020-58679-z

Diagnostic Imaging

All Other Diagnostic Tests:

1. Exam: X-Ray Chest Single View Portable on 1/25/22 @ 0844

Purpose: According to the patient chart, this particular diagnostic test was order for this patient because of her dizziness since the prior evening. The patient also has a history of coronary artery disease as well as coronary artery bypass graft surgery. An x-ray will allow professionals to visualize images of the heart and the structures and organs within the chest.

Findings:

According to the patient's chart, the finding of her x-ray is as followed:

1. The patient has a large body habitus, and the image is a lordotic projection.
2. The heart size is magnified with borderline enlargement and indistinctness of the inferior heart borders due to adjacent epicardial fat pads.
3. There is chronic elevation of the right hemidiaphragm remains indistinct.
4. No acute infiltrate, consolidation, hyperinflation, vascular congestion, pleural effusion, or pneumothorax is noted.

5. There is mild multilevel spondylosis of the thoracic spine.

Diagnostic Test Correlation:

Due to the detection of “chronic elevation of the right hemidiaphragm and indistinctness of the left hemidiaphragm” this indicates that one side of the diaphragm has become weaker from loss of innervation (Patel & Bechmann, 2021). This occurs primarily due to age and the decreased lung volume that occurs overtime with age. This type of impression is also seen with atelectasis and phrenic nerve palsy (Patel & Bechmann, 2021). This patient also has an extensive history of coronary heart disease, so this can play a factor. Heart disease can directly correlate with the respiratory system and “the way fluid is carried to away from the lungs” (Patel & Bechmann, 2021). Since the patient was experience periods of constant dizziness, a chest x-ray is pertinent to the client because it is important to rule out if the patient’s symptoms are in relation to any acute cardiopulmonary disease. This test ruled out acute cardiopulmonary disease for this particular patient.

2. Exam: Electrocardiogram on 1/25/22 @ 0844

Purpose: According to this patient’s chart, test was ordered for this patient due to her extensive history of coronary artery disease. It was also ordered to rule out a heart attack. With an EKG, it allows healthcare professionals to visualize and assess the functioning of the heart. This test gathers information about the electrical activity of the heart.

Findings:

According to the patient’s chart, the findings of her EKG is as followed:

1. Sinus rhythm with a ventricular rate of 93
2. First-degree AV block with occasional PVC
3. Right bundle branch block, left anterior fascicular block, bifascicular block

Diagnostic Test Correlation:

The patient has a history of heart disease, and it was determined upon admission that the patient also has an occasional premature ventricular contraction along with a first-degree AV block. The findings of the diagnostic test correlate with the patient's current condition. The patient is having slow conduction within the AV condition system is defined as a prolongation of the PR interval beyond the upper limit of what is considered normal (Holmqvist & Daubert, 2018). While this delay within the AV condition system, there is an extra heartbeat that begins in one of the heart's two ventricles (Holmqvist & Daubert, 2018). Individuals who experience an occasional PVC, may also experience a fluttering sensation in the chest along with weakness and dizziness due to the reduce in the heart's pumping ability (Holmqvist & Daubert, 2018). This directly correlate and could potentially explain why the patient was feeling dizziness. It could be due to her heart not being able to slow down the extra heartbeat long enough for the heart to fully pump.

Diagnostic Test Reference (1) (APA):

Holmqvist, F., & Daubert, J. (2018). First degree av block. *Annals of Noninvasive Electrocardiology : The Official Journal of the International Society for Holter and Noninvasive Electrocardiology, Inc*, *18*(3), 215–224. https://doi.org/10.1111/anec.12062

Patel, P., & Bechmann, S. (2021, August 1). *Elevated hemidiaphragm*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK559255/

Current Medications

Home Medications

Brand/Generic	**Amlodipine (Norvasc)**	**Acetylsalicylic Acid (Aspirin)**	**Gabapentin (Neurontin)**	**Levothyroxine (Synthroid)**	**Diphenhydramine (Benadryl)**
Dose	5 mg	81 mg	300 mg	88 mcg	25 mg
Frequency	Once Daily	Once Daily PRN	2x Daily	2x Daily (ever morning before breakfast)	Q8H PRN
Route	Oral	Oral	Oral	Oral	Oral
Classification	Calcium channel blocker and ACE inhibitor	non-steroidal anti-inflammatory drug and analgesic and antipyretic	Anticonvulsant and analgesic	Hormone	Antihistamine
Mechanism of Action	Relaxes the blood vessels so the heart does not have to pump as hard	Disrupts the production of prostaglandins throughout the body by targeting cyclooxygenase-and cyclooxygenase-2 (COX-2).	Reduces the excitability of nerve cells (neurons) in the brain	Increases the metabolic rate of cells of all tissues in the body producing thyroxine (T4) that is made and released by the thyroid gland	It works by blocking the action of histamine, a substance in the body that causes allergic symptoms.
Reason Client Taking	Lower blood pressure	Reduce fever or relieve mild to moderate pain	Pain	History of hypothyroidism	Seasonal Allergies
Contraindications (2)	Known hypersensitivity, cardiogenic stroke, unable angina	Low vitamin K levels, anemia or decreased blood platelets	Depression, decreased lung function	Diabetes, osteoporosis	Overactive thyroid gland, glaucoma, high blood pressure
Side Effects/Adverse Reactions (2)	Edema in the hands, feet or ankles and headache	Nausea, vomiting and heartburn	Drowsiness, weakness and headache	Weight gain or loss and changes in appetite	Dry mouth, nose and drowsiness, dizziness, nausea and vomiting
Nursing Considerations (2)	Monitor for chest pain. Monitor for shortness of breath.	Monitor pain 1 hour before giving medication. Monitor for interaction to warfarin.	Monitor for decreased LOC and dizziness. Monitor for suicidal thoughts	Promote rest for the patient. Monitor the patient's diet for increased fiber intake.	Monitor respiratory function at rest and during exercise. Monitor symptoms of seasonal allergies (sneezing,

					rhinitis, itching eyes, cough) or allergic skin reactions (rash, hives, itching)
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess blood pressure prior to and after administering of medication. Assess for musculoskeletal system (can cause weakness).	Assess renal and liver function. Assess for ototoxicity.	Use Glasgow Coma Scale for LOC. Assess for rash to sensitivity the medication.	Assess heart rate. Assess ECG. Assess heart sounds.	Assess blood pressure periodically Assess dizziness and drowsiness that might affect gait, balance, and other functional activities
Client Teaching needs (2)	Take as directed. Shake the suspension well before each use to mix medication evenly.	Swallow extended-release tablets whole with a full glass of water. Do not brush, crush or chew pill. Assess for bleeding or bleeding gums. Use gentle toothbrush.	Take within 2 hours of antacids. Take evenly spaced out throughout the day and night. Do not drive when taking this.	Take on an empty stomach with water (at least one hour before eating). Avoid external heart sources.	Take within 30 minutes before bedtime. Must chew the chewable tablet before you swallow it.

Hospital Medications

Brand/Generic	**Atorvastatin (Lipitor)**	**Enoxaparin (Lovenox)**	**Ondansetron (Zofran)**	**Omeprazole (Zegerid)**	**Metoprolol Succinate (Toprol)**
Dose	20 mg	40 mg	4 mg	20 mg	50 mg
Frequency	Daily	QHS (Once daily)	Q6 PRN	Once daily	Once daily
Route	Oral	Subcutaneous	IV Push	Oral	Oral
Classification	HMG-CoA reductase inhibitors and statins	anticoagulants and antithrombotic	Antiemetic and 5-HT_3 antagonists	Proton-pump inhibitors and antiacid	Beta blocker
Mechanism of Action	It works by slowing the production of cholesterol in the body to decrease the amount of cholesterol that may build up on the walls of the arteries and block blood flow to the heart, brain, and other parts of the body.	Potentiates the inhibitory effect of antithrombin on factor Xa and thrombin.	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine.	It works by decreasing the amount of acid made in the stomach.	It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure.
Reason Client Taking	Lowers cholesterol	Prevent blood clot (routine)	Nausea and vomiting	Heartburn	Lower blood pressure
Contraindications (2)	Active liver disease Decreased kidney function	Duodenal ulcers or major bleeding such as GI bleed	Concomitant use of apomorphine, hypersensitivity to ondansetron or its components	Liver problems and low amount of magnesium in the blood	Liver problems, congestive heart failure and thyroid disorder
Side Effects/Adverse Reactions (2)	Headache and sore throat	Dizziness or headache or insomnia	Hypotension, prolonged QT interval	Constipation and vomiting and headache	Diarrhea Depression
Nursing Considerations (2)	Monitor for dizziness and weakness. Monitor patient's gait and balance and other functional	Monitor for symptoms of DVT (pain, swelling or warmth) and monitor for shortness of	Dilute drug in 50mL of D5W or normal saline solution when indicated and monitor for serotonin	Monitor the patient for skin problems such as itching or rash. Monitor the patient's appetite.	Monitor for suicidal thoughts. Monitor for change in position to minimize orthostatic hypotension.

	activities.	breath and chest pain	syndrome		
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess liver panel. Assess kidney function (creatinine)	Assess for signs of bleeding and peripheral edema; monitor potassium (hyperkalemia)	Assess lung sounds and monitor improvement of GI symptoms (decreased N/V	Assess living function panel. Assess skin for irritation.	Assess EKG. Assess circulation (such as peripheral pulses).
Client Teaching needs (2)	Take as directed. Continue to take even if you feel well. Do not open or chew tablet. Take at night.	Rotate site or don't expel bubbles prior to administration or report signs of bleeding, bruising or pain	maintain adequate fluid intake and avoid OTC medications	Avoid alcohol and foods that increase GI irritation. Report weakness to provider. Take before a meal in the morning (on an empty stomach).	Do not break or chew (take whole). Avoid driving or other activities that require alterness unit response to the drug is known.

Medications Reference (1) (APA):

Institute for Safe Medication Practices: ISMP Medication Safety Alert

http://www.ismp.org/. Jones & Bartlett Learning. (2019). 2019 Nurse's Drug

Handbook. Burlington, MA

Assessment

Physical Exam

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is an elderly Caucasian female. She appears to be alert and orientated to situation and person, time and place. When asked what year and month it was, the patient answered correctly. Patient knew exactly where she was and for what. Patient uses of hearing aids in both ears. Patient uses glasses for reading her books and newspapers and distance. Patient uses partial dentures in her upper teeth. Patient uses assistive devices like a walker and cane. Patient used a cane and a walker prior to hospitalization. Patient appears to be well groomed and in no acute distress, well-developed and not ill-appeared and awake. Patient opens eye spontaneous. Patient's speech is clear. Patient was calm and delightful. Patient appears stated age. Patient's mood and behavior is normal. **Patient denies fatigue, weight changes, fevers, chills, night sweats at the time of this assessment.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** Stage 2 pressure ulcer on sacrum **Braden Score:** 16 **Drains present: Y☐ N ☒** **Type:**	Patient's skin is warm, pink and dry. Patient does not have a foley catheter or any other drainage in place at the time of this assessment. Patient has bruises on the top of her left hand from an IV attempt on admission. There is a band aide on it. The dressing is dry and intact and without redness surrounding the dressing. Patient is not pale or ashy. Patient's nails are without clubbing and cyanosis. Skin turgor normal mobility, quick to return to original state. The patient does have a stage 2 pressure ulcer on her sacrum. The stage states that the wound is healing. According to the patient chart and progression pictures, it appears that it wound is healing nicely. The wound is cover with a dressing. The dressing is dry and intact without redness surrounding the dressing. The patient had no other rashes or lesions or erythema. Patient's Braden score is an 16. **Patient denies rashes, lesions, non-healing sores, hair changes, purities.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head and neck are symmetrical. Trachea is midline without deviations, thyroid is not palpable, no nodules noted at the time of assessment. Bilateral carotid pulses are palpable and strong. No swollen lymph nodes in the head or neck region. Bilateral sclera white, bilateral cornea clear. Bilateral conjunctiva pink, no visible discharge in eye bilaterally. Bilateral lids are pink and dry without lesion. PERRLA bilaterally. Septum is midline. Bilateral frontal sinuses are nontender and to palpation. Bilateral auricles moist and pink without lesions noted. Dentition is good, oral mucous overall is moist and pink without lesions noted and intact. Patient uses partial dentures in her upper teeth. Patient's hair is thick, shoulder length, white and even distribution. Oropharynx is clear. No discharge present right and left ear. External right and left ear normal. **Patient denies experiencing headaches, head injury, blurry vision, double vision, earache, drainage, nasal congestion, nose bleeds, nasal drainage, dry**

	mouth, sore throat, swallowing difficulty at the time of the assessment.
CARDIOVASCULAR: **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:**	Clear S1 and S2 sounds heard without the presence of murmurs, gallops or rubs. PMI at 5th intercostal space at MCL. All extremities warm, pink and dry. Patient's peripheral pulses are present throughout bilaterally. Patient's carotid pulses are 3+ bilaterally throughout. Patient's radial and ulnar pulses are 3+ bilaterally throughout. Patient's brachial pulse is 3+ bilaterally throughout. Patient's posterior tibial pulse and dorsalis pedis pulse are 3+ bilaterally. Capillary refill less than 3 seconds bilaterally throughout. Patient denies shortness of breath with activity. Patient denies use of oxygen. Patient denies dry mucous membranes. Patient does have dizziness that increases with movement. The patient is also on a telemetry monitoring device. **Patient denies chest pain, palpitations, diaphoresis, PND, Orthopnea, claudication.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **RESPIRATORY:** **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** none **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	Respirations are regular, even, and symmetrical and nonlabored bilaterally. Lung sounds are clear throughout bilaterally. No wheezes, crackles or rhonchi noted. Bilateral equal air entry. Patient does not have an ET tube at the time of this assessment. **Patient denies wheezing, cough, increase in sputum production. Anterior, lateral, clear, and equal bilaterally.**
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:**	The patient would describe her diet at the assistive living facility as being somewhat okay. The patient stated she does not particularly enjoy the food that she is served there. She goes on to mention that she tries to follow a low sodium diet. The patient enjoys drinking diet Pepsi but admits that she does not drink enough fluids as she should. The patient also says she enjoys salad with some sort of meat in it. The patient's current diet while being hospitalized is a cardiac diet. The patient's height is 5'3" and she weights 178 pounds. This patient is considered to be obese with a BMI of 31.5. Patient shows no indicators for nutrition risk. Patient requires no feeding assistance and tolerances meals well. Patient's abdomen shows no sign of masses noted upon light and deep palpation of all the four quadrants. The patient denies tenderness when palpating her

Scars: **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	abdomen. The patient's last bowel movement was on 1/24/22. The patient stated she had two bowel movements that day and mentioned this is normal for her and she described her bowel movement that day as being normal for her. Patient stated her stool was a medium amount. Patient is passing flatus. Patients' bowel sounds are hypoactive in all four quadrants. Abdomen appeared to be not protruding/ distended and nontender throughout abdomen. No incisions, scars, drains or wounds present on this patient's abdomen. **Patient denies nausea, vomiting, diarrhea, abdominal pain, heartburn, jaundice, hematochezia, melena at the time of the assessment.** **Patient's last bowel movement was 1/24/22.**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **CAUTI prevention measures:**	Patient's urine appears to be yellow, clear and absent of foul odor. Patient's genitals appear to be intact, no abnormalities noted. Patient denies episodes of incontinence. Patient voids spontaneous without difficulty. Patient voided 500 mL during my shift. Patient is continent of urine and stool. Patient's urine was clear yellow, no malodor and not cloudy. Patient stated she has no difficulty urinating or starting urinary flow at the time of this assessment. Patient denies use of depend at night due to incontinence at the time of this assessment. **Patient denies burning or pain, hematuria, flank pain while urinating.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** active **Supportive devices:** walker **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** 6 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **X** (stand by assist due to increase levels of dizziness) **Needs support to stand and walk** ☐	Patient appeared to be alert LOC. Patient arousal level was she opened her eyes spontaneously. Patient is fully independent and up ab lid prior to admission. The patient is now a stand by assist due to her experiencing dizziness. Patient demonstrates active range of motion bilaterally throughout. Patient's fall risk score is a 6. Patient is currently a stand by assistant with ADLs and hygiene, transfer, bathing, dressing and eating. Patient uses the assistance equipment to support to stand and walk like a walker and cane occasionally. The patient does have SCDs bilaterally when patient is not ambulating or up in his chairs with her legs elevated. Patient's general motor response was normal. Hand grip was equal bilaterally. Patient's dorsiflexion was equal bilaterally. The patient's plantar flexion was equal bilaterally. Patient's bed alarm was utilized and activated. Patient had on yellow nonskid socks. Patient's call light was within reach.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:**	Patient's speech was logical, well-paced, spontaneous and clear. Patient's mood and behavior was cooperative, calm and talkative. Patient's memory was normal. PERRLA bilaterally. Patient's hand grip and ankle strength were strong bilaterally. Patient is alert and orientated to situation and person, time and place. Patient is full concisions and alert. Patient displays no signs of confusion. CAM score negative. No acute, inattention, altered LOC, disorganized thinking.

Sensory: **LOC:**	
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient copes with anxieties, fears and concerns by watching TV and spending time with her four grandchildren. Patient stated both of her daughters are a good support and highly participate in her care. The patient states that her daughter is a nurse and helps a lot with educating her about her care. Patient's developmental level is appropriate for her age. Patient stated she is Christian. Patient states at the assistant living facility on Sundays, she attends the church services and enjoys it. Patient stated her religion means a lot of her, as she grew up supported by religion. Patient states she considers her two children and five grandchildren to be a part of her support team. Patient states they have all been supportive of her care and live close by so they visit her at the assistive facility especially during the holidays. Patient stated the would like to have a visit from the hospital appointed Chaplin to pray with her.

Vital Signs

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0858	87 bpm (right radial)	148/74 (right arm; HOB elevated 60)	16 (unlabored)	97.6 F (oral)	98% (room air)
1100	77 bpm (right radial)	155/75 (right arm; HOB elevated 60)	18 (unlabored)	97.8 (oral)	96% (room air)

Vital Sign Trends/Correlation:

The patient has an extensive history of hypertension. When first taking the patient's blood pressure, it was elevated and when taken two hours later her blood pressure started to slightly elevate. The patient stated that since she came to emergency department early in the morning, she did not take her morning medications yet. This could potentially explain why the patient's blood pressure is elevated. Another reason for the slight elevation in the patient's blood pressure could be due to the pain or discomfort she is experiencing. The patient also stated that the vital signs mentioned above were somewhat within the normal range. The paint stated her normal systolic pressure usually runs low to mid 140s and her diastolic is roughly mid to high 70s. Her pulse, respirations, temperature, and oxygen are all within normal range for her age and conditions. The patient's vital signs will continue to be monitored every four hours throughout the shift.

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
0858	Numeric	N/A	0/10	N/A	N/A
1100	Numeric	N/A	0/10	N/A	N/A

The patient denied being in any pain when doing a pain assessment on both occasions. The patient's first pain assessment was first done when the patient first arrived on the unit. The

second pain assessment was done after the patient was able to eat lunch and take a short nap. She experienced that she had no pain at all and had a decrease in dizziness. Upon admission, the patient stated she never had pain, but instead a lot of discomfort due to the dizziness. The patient did express that the only time she felt a slight discomfort was when she was changing from a lying to sitting up position to eat her lunch. The patient's pain will continue to be monitor throughout the shift. The patient was encouraged to report pain if present.

IV Assessment

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 patient does not have any PICC, port or central line present at the time of the assessment. **CUROS caps in place: Y ☐ N ☒** **CLABSI prevention measures:**	Placement date/ time was 1/25/22 upon admission for surgery Location: forearm right angiocath secured with transparent tape Gauge/ length: 22 gauge According to the patient's chart she has this IV for fluid therapy and medication therapy. Upon admission, I flushed her IV and assessed the site. The dressing appeared to be dry, clean, and intact. It was also able to flush without difficulties. I also asked the patient if her IV site hurt or burned when I flushed with the normal saline through, and he denied any pain or burning sensation. The patient's IV site showed no signs or symptoms of phlebitis and infiltration, drainage, or redness. The patency of this patient's IV was verified and documented during shift.

Intake and Output

Intake (in mL)	**Output (in mL)**
Patient is on a strict intake and output. Patient is ordered to be on a cardiac diet. For lunch, the patient had two slice of wheat bread with strawberry jelly. She also had grapes and pineapples. The patient also had 200 mL in water alongside her lunch. The patient was encouraged to continue drinking water with each encounter. At the	The patient voided a measurable amount once during on shift on 1/25/22. Patient was instructed to not flush after voiding or having a bowel movement so it can be assessed. The patient voided 200 mL of urine. The patient did not have a bowel movement. Patient's urine was clear, yellow and feel of foul odor. Patient denies

time of my assessment and during my shift, the patient was not receiving any IV fluids. The patient completed the 500 mL normal saline 0.9% when she was at the emergency room. The patient ate 100% of her meal. The patient said her meal tasted nice. **Total Intake: 700 mL**	any burning with urination. Patient did not have any emesis. **Total Intake: 200 mL from urine**

Nursing Care

Summary of Care

Overview of care:

The patient is up and able to ambulate without assistance with a standby assist to the feeling dizzy. At the beginning of my shift, I first started by taking this patient's vitals and assisting the nurse in assessing the patient's level of dizziness by taking her orthostatic hypotension. I also assisted with obtain the patient's weight and belonging that she brought with

her. I was able to witness the patient's admission process. I also evaluated the patient's pain, to which he denied having any pain and rated it a 0/10 on a numeric scale. The patient expressed interest in getting someone to eat but was reminded that the diet order needed to be put in by the provider prior to that. The patient was then able to order something to eat and ate 100% of her lunch and was encouraged to increase her fluid. The patient then took a nap to help with her dizziness. I then followed up with the patient's vital signs as well as pain. At the time of this assessment, the patient's medication had not been delivered to the floor, so I was unable to be present while her IV bag was hung.

Procedures/testing done:

The patient was not scheduled for any procedures or testing to be done today or during my shift. The patient did not have any lab drawn ordered in yet. The patient got her labs drawn in the emergency department upon admission. The patient is scheduled to have her labs drawn the following morning to check for improvement of her magnesium. The patient is also scheduled for another EKG the following day to assess her heart function. Although it was not stated in the patient's chart, I suspect orthostatic hypotension vitals will be routine for this patient to monitor for improvement of her dizziness.

Complaints/Issues:

The patient is not express any complaints or issues throughout my shift. He did mention on two different occasions that she felt dizzy, one when we were transferring her to the bed and then another when she stood up to obtain her weight. The patient expressed how thankful she was for the staff being so kind and the quality of care they have provided she since being admitted. After lunch, the patient did express that she was happy to be able to eat a meal that was somewhat enjoyable.

Vital signs (stable/unstable):

The patient has a history of hypertension which was shown when taking her morning vitals. The patient did not take her metoprolol prior to admission which could be the reasoning for elevation in her blood pressure. Her first set of blood pressure was 148/74 and her second set was 155/75. Despite the elevation, the patient stated these were not out of range from her day-to-day vital signs. The patient states that at the assisted living facility they take her temperature and blood pressure daily.

Tolerating diet, activity, etc.:

The patient is independent with a standby assist all activities of daily living and tolerates them well with slow movement and change in position. The patient was able to ambulate to the bathroom and walk without issues or pain when ambulating slowly. The patient is tolerating her diet well.

Physician notifications/ Future plans for the client:

According to the patient's chart, the pain for this patient is to be discharged back to the assisted living facility. The anticipated discharge date for this particular patient is unknown at the moment. When speaking to the nurse, she mentioned she thinks she will probably be discharged by the end of the week if everything goes well, and the patient is showing improvement in her level of dizziness. Upon discharge, the patient is expected to follow up with his primary provider on 2/11/22. The patient's chart also mentions the need to discuss with a cardiologist the next treatment step. The patient is encouraged to switch positions slowly to prevent dizziness. The patient will also be discharged on the same medications before taking them home to control his blood pressure. The patient is not expended to be discharged on any new medications at the time of the assessment.

Discharge Planning

Discharge location:

Upon discharge, the patient will be returning home to her apartment where he resides at the assisted living facility.

Home health needs (if applicable):

The patient will not require home health needs upon discharge.

Equipment needs (if applicable):

The patient will not require any form of equipment needs upon discharge. The patient can continue to be independent with his activity of daily living with the assistance of a walker and cane. She does not require respiratory support, agency support or assistance with transportation.

Follow up plan:

Post discharge, the patient is expected to follow up with dis primary healthcare provider on 2/11/22 at 1:20pm for evaluation. In this chart, it also mentioned probably discussing an appointment with cardiologic for his next step regarding his PVC.

Education needs:

The patient will require education on medication, follow-up medications, seeking medical attention for new symptoms, deep breathing exercises to manage pain, taking new medications or home medications, and side effects and prevention from infection from her wound. She will also need education on a diet to help with his blood pressure. This patient will also require education on the importance of changing position slowly to prevent orthostatic hypotension.

Nursing Diagnosis

Nursing Diagnosis	Rationale	Interventions	Outcome Goal	Evaluation
1. infection **related to** inadequate primary defense, IV devices, age, poor nutritional intake, compromised host deference, chronic diseases,	This nursing diagnoses was chosen for this particular patient due to her being at high risk for developing an infection. She has a stage 2	**1.** Maintain free of infection as evidenced by normal vital signs, absence of purulent drainage from wound site from 0700 to	**1.** Client will remain free of infection, as evidenced by normal vital signs and absence of signs and symptoms of infection	1. Goal met. Patient maintained free of infection during shift on 1/25/22 from 0700 to 1300. Patient's vital signs were slightly elevated due to her not taking metoprolol at the

compromised circulation **as evidenced by** break in skin due to stage 2 pressure ulcer, history of hypertension and neuropathy, elevated glucose levels on 129 on 1/25/22	pressure ulcer currently that is healing nicely according to the patient's chart with progressive photos. He also has an IV in place which creates a break in the skin which allows bacteria to enter the skin. This patient also has a history of neuropathy which impair his circulatory system. With her extensive history of hypertension, it has resulted in peripheral nerve damaged and reduced blood flow to her extremities which increases her changes of contracting an infection. With high glucose levels in the blood and tissue, it allows bacteria to grow and allows infection to then develop more quickly (University of Michigan, 2018).	1300 on 1/25/22. **2.** Explain the importance of wash hands with patients and between procedures with the patient by 1300 on 1/25/22.	throughout shift on 1/25/22.	time of this assessment. However there were no elevation of pulse or temperature. Patient's wound abnormal drainage. Patient's wound on her sacrum was covered with a dressing that is dry, closed and intact. 2. Goal met. Patient was educated on proper handwashing techniques. The patient explained it is important to perform proper handwashing to reduce the risk of infection and transmitting pathogens during shift on 1/25/22 by 1300. Patient stated it will help her not any infections. When dealing with the patient throughout my shift, hand hygiene was done, and gloves were worn in order to help decrease the chances of infection.
2. fall **related to**	This nursing	**1.** With each	1. Patient and	1. Goal Met. Patient

age greater than 64, impaired physical mobility, use of medications, improper use of aids, mobility deficit/ weakness, **as evidence by** patient is 94 years old, uses a cane and walker, verbalized weakness and dizziness when changing position, fall risk of 6, need assistance with care, bedrest, bed alarm, use of antihypertensive medication (metoprolol)	diagnosis is important for this patient due to her high risk of falling. This patient does not have a history of falls or an event where she has fell, however due to her increased weakness and her verbally expressing increased levels of dizziness since being hospitalized, it is likely she could fall. Prior to admission, this patient is independent with her ADLs without any supervision assistance, so it is possible she may want to resume activity sooner than it is safe in doing so, so education regarding safety measures is very prevalent for this patient. This patient also has an extensive medical history that compromises her immune system like hypertension, so	encounter with the patient, explain the importance of using the call light and remind patient to call and wait on nurse before getting out of bed throughout shift from 0700 to 1300 on 1/25/22. **2** Guarantee appropriate room lighting, especially during the night and environment is free of cluster from 0700 to 1300 on 1/25/22.	caregivers will implement strategies to increase safety and prevent falls in the home throughout shift on 1/25/22 from 0700 to 1300.	was free from injuries and falls during shift on 1/25/22 from 0700 to 1300. With each encounter with the patient, I explained the important of using the call light. I rounded on the patient frequently. When coming in contact with patient, I was sure to ask her if she needed to use the bedpan or if I could assist her with anything while I was in there to decrease her chances of falling. Patient verbalize that she understood the important or calling for help and demonstrated the use of using her call light if needing help. 2. Goal Met. I was sure to declutter the patient's room and keep patient's phone, tv remote and call light within reach and the windows open to provide adequate lighting throughout my shift from 0700 to 1300 on 1/25/22.

	a fall could be detrimental to her health and her ability to full heal. The patient did have a low fall risk score, but she is still a high fall risk due to her change in position and increased ability to fall. Patient's bed alarm is activated, and she has yellow socks on a fall risk yellow sign on her door as well as a fall risk arm band. This patient also is on antihypertensive medications which increases her risk for falling due to a common side effect dizziness or lightheadedness and drowsy. The patient also wears glasses which can impair her ability to see. She also used an assistive device like a walker and cane to ambulate.			
3. decreased cardiac output	This nursing diagnosis is	**1.** Monitor and record blood	1. Patient demonstrates	1. Goal met. I was able to obtain the

related to alteration in heart rhythm and conduction, impaired contractility, increased peripheral vascular resistance secondary to hypertension **as evidenced by** elevation in blood pressure at 0858 of 148/74 and again at 1100 of 155/75, presence of chronic elevation of the right hemidiaphragm remains indistinct seen on a chest x-ray, first degree AV block with occasional PVC and a bifascicular block seen on an EKG	prevalent is this patient due to his extensive history of hypertension. This patient manages her hypertension with Metoprolol 50 mg daily. Upon admission to the ED on 1/25/22, it was founded when conducting an EKG that the patient has a first-degree AV block with an occasional PVC. This can result in the patient experiencing periods of dizziness due to her heart not being able to slow down the extra heartbeat long enough for the heart to fully pump.	pressure every four hours throughout shift on 1/25/22 from 0700 to 1300. **2.** Auscultate heart tones and breath sounds during shift on 1/25/22 by 1300 such it is common for S4 heart sound to be heard in hypertensive patients because of atrial hypertrophy (Vena, 2018).	adequate cardiac output as evidenced by blood pressure and pulse rate and rhythm within normal parameters for the patient by 1300 on 1/25/22.	patient's blood pressure throughout my shift on 1/25/22 by 1300. The patient verbalized a understanding of frequent monitoring her blood pressure due to his history of hypertension. The patient state at the assisted living facility, they take her vitals daily. 2. Goal met. I was able to auscultate the patient's heart sounds during my shift on 1/25/22. The patient's heart sounds were Clear S1 and S2 sounds heard without the presence of murmurs, gallops or rubs. PMI at 5th intercostal space at MCL.

4. activity intolerance **related to** muscle weakness, physical impairment, insufficient sleep, difficulty engaging in activity **as evidenced by** patient verbalizing, she has felt an increase in weakness and dizziness since the previous day of admission, the patient stated she was unable to walk or stand at the time of admission due to her level of dizziness, expressed dizziness when changing positions, elevated blood pressure of 155/75 @ 1100 on 1/25/22	This nursing diagnosis for chosen for this particular patient due to her present state of health. The patient verbalized that prior to the onset of dizziness, the patient already ate dinner and was now doing her laundry. The was unable to finish her laundry and had to try to sleep or lay down. The patient stated she was not able to sleep due to the dizziness. The patient stated she felt dizzy when she was changing position from a lying to sitting position when she was getting ready to eat lunch.	**1.** Coordinate rest periods before straining activities such as eating, bathing, and ambulating throughout shift on 1/25/22 from 0700 to 1300. 2. Provide enough time for the patient to perform task throughout shift on 1/25/22 by 1300.	**1.** The patient will report an increased tolerance to perform activities by 1300 on 1/25/22.	1. Goal met. The patient was provided a rest period when she was preparing to use the restroom on 1/25/22. The patient was encouraged to sit on the side of the bed for 5 minutes prior to ambulating to the bathroom. 2. Goal met. The patient was provided enough time to perform ADLs as independently as possible with a standby assist by 1/25/22.
5. Impaired tissue integrity **related to** trauma, impaired circulation, nutritional deficits, impaired physical mobility, obesity	This nursing diagnoses was chosen for this patient due her having multiple risk factors that increase her risk for maintain an intact tissue	1. Monitor the patient's WBCs, prealbumin, albumin, and total protein levels by 1300 on 1/25/22.	1. Patient will maintain intact skin integrity throug hout shift on 1/25/22 from 0700 to 1300.	1. Goal met. The patient's labs were within normal values throughout shift with the exception of her glucose on 1/25/22. The patient's WBC was 6.70. Her

as evidenced by stage 2 pressure ulcer, expresses feeling of not likely the food served at the nursing home, feelings of dizziness is affecting her ability to be as mobilize as she usually is, history of hypertension	integrity. The patient already has a stage 2 pressure ulcer that is healing so it is important to prevent her chances of obtaining another one. It is important to follow up with the patient's labs because her WBCs and albumin level can indicate signs of malnutrition which can cause tissue breakdown as well as cause complications from her healing from the wound she already has.	2. Assess skin turgor, sensation, and circulation throughout shift on 1/25/22 by 1300.		albumin levels were 4.4. 2. Goal met. The patient's skin was assessment by 1300 on 1/25/22. When assessing the patient's skin, it was founded that her skin is warm, pink and dry, not pale or ashy, nails are without clubbing and cyanosis. Her skin turgor normal mobility, quick to return to original state. The patient does have a stage 2 pressure ulcer on her sacrum. The stage states that the wound is healing. According to the patient chart and progression pictures, it appears that it wound is healing nicely. The wound is cover with a dressing. The dressing is dry and intact without redness surrounding the dressing.

Other References (APA):

Vena, M. (2018, August 12). *6 Hypertension Nursing Care Plans*. Nurseslabs. https://nurseslabs.com/hypertension-nursing-care-plans/

University of Michigan. (2018). *Diabetes and Infections | Michigan Medicine*. Uofmhealth.org. https://www.uofmhealth.org/health-library/uq1148abc

Concept Map (20 Points):

Subjective Data

- "couldn't stand or walk"
- "Dizziness and weak"
- History of hypertension, coronary artery disease
- Rated pain 0/10 twice on the numeric scale
- Poor diet intake
- Stated she does not like the food served at the assisted living facility
- Stated she doesn't drink enough liquids/ fluids

Objective Data

- Low magnesium upon admission (1.5)
- Orthostatic hypotension vital signs positive
- When she was at a lying position, it blood pressure read 160/82. When she is changing into a sitting up position at the side of the bed, she insistently complained of dizziness. When we took her blood pressure, there was much of a change in her diastolic pressure, however her systolic pressure dropped to 136. Lastly, when this patient was standing at the side of the bed, it blood pressure read 110/62.
- On an EKG it was shown that this patient had a first-degree AV heart block with occasional PVC
- Elevated glucose of 126
- Stage 2 pressure ulcer
- 0858 blood pressure was 148/74
- 1100 blood pressure was 155/75

Client Information

M.B. is a 94-year-old with a history of hypertension, neuropathy, coronary artery disease (since her early 50s), hypothyroidism. This patient has a past surgical history of coronary artery bypass graft surgery in 2008. The patient has known allergies to Metronidazole and Nitrofurantoin. The patient is a DNR. The patient weights 178 pounds and is 5'3". The patient is admitted for reports of dizziness. Upon admission, it was determined that the patient has orthostatic hypotension, first degree AV heart block with occasional PVC when doing an EKG. The patient stated her symptoms started the previous night at 7pm after dinner and got progressively worse. The patient stated she was unable to walk or stand up due to the dizziness.

Nursing Diagnosis/Outcomes

1. infection **related to** inadequate primary defense, IV devices, age, poor nutritional intake, compromised host deference, chronic diseases, compromised circulation **as evidenced by** break in skin due to stage 2 pressure ulcer, history of hypertension and neuropathy, elevated glucose levels on 129 on 1/25/22
DESIRED OUTCOME: Client will remain free of infection, as evidenced by normal vital signs and absence of signs and symptoms of infection throughout shift on 1/25/22.
2. fall **related to** age greater than 64, impaired physical mobility, use of medications, improper use of aids, mobility deficit/ weakness, **as evidence by** patient is 94 years old, uses a cane and walker, verbalized weakness and dizziness when changing position, fall risk of 6, need assistance with care, bedrest, bed alarm, use of antihypertensive medication (metoprolol)
DESIRED OUTCOME: Patient and caregivers will implement strategies to increase safety and prevent falls in the home throughout shift on 1/25/22 from 0700 to 1300.
3. decreased cardiac output **related to** alteration in heart rhythm and conduction, impaired contractility, increased peripheral vascular resistance secondary to hypertension **as evidenced by** elevation in blood pressure at 0858 of 148/74 and again at 1100 of 155/75, presence of chronic elevation of the right hemidiaphragm remains indistinct seen on a chest x-ray, first degree AV block with occasional PVC and a bifascicular block seen on an EKG
DESIRED OUTCOME: Patient demonstrates adequate cardiac output as evidenced by blood pressure and pulse rate and rhythm within normal parameters for the patient by 1300 on 1/25/22.
4. activity intolerance **related to** muscle weakness, physical impairment, insufficient sleep, difficulty engaging in activity **as evidenced by** patient verbalizing, she has felt an increase in weakness and dizziness since the previous day of admission, the patient stated she was unable to walk or stand at the time of admission due to her level of dizziness, expressed dizziness when changing positions, elevated blood pressure of 155/75 @ 1100 on 1/25/22
DESIRED OUTCOME: The patient will report an increased tolerance to perform activities by 1300 on 1/25/22.
5. Impaired tissue integrity **related to** trauma, impaired circulation, nutritional deficits, impaired physical mobility, obesity **as evidenced by** stage 2 pressure ulcer, expresses feeling of not likely the food served at the nursing home, feelings of dizziness is affecting her ability to be as mobilize as she usually is, history of hypertension
DESIRED OUTCOME: Patient will maintain intact skin integrity throughout shift on 1/25/22 from 0700 to 1300.

Nursing Interventions

1a. Maintain free of infection as evidenced by normal vital signs, absence of purulent drainage from wound site from 0700 to 1300 on 1/25/22.
1b. Explain the importance of wash hands with patients and between procedures with the patient by 1300 on 1/25/22.

2a. With each encounter with the patient, explain the importance of using the call light and remind patient to call and wait on nurse before getting out of bed throughout shift from 0700 to 1300 on 1/25/22.
2b. Guarantee appropriate room lighting, especially during the night and environment is free of cluster from 0700 to 1300 on 1/25/22.

3a. Monitor and record blood pressure every four hours throughout shift on 1/25/22 from 0700 to 1300.
3b. Auscultate heart tones and breath sounds during shift on 1/25/22 by 1300 such it is common for S4 heart sound to be heard in hypertensive patients because of atrial hypertrophy (Vena, 2018).

4a. Coordinate rest periods before straining activities such as eating, bathing, and ambulating throughout shift on 1/25/22 from 0700 to 1300.
4b. Provide enough time for the patient to perform task throughout shift on 1/25/22 by 1300.

5a. Monitor the patient's WBCs, prealbumin, albumin, and total protein levels by 1300 on 1/25/22.
5b. Assess skin turgor, sensation, and circulation throughout shift on 1/25/22 by 1300.