N321 Care Plan # 1

Lakeview College of Nursing

Name Brianna Lilly

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
02/20/22	CP	75	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Not employees	Married	NKA
Code Status	**Height**	**Weight**	
Full	5'7"	144lbs 9.6oz	

Medical History (5 Points)

Past Medical History: Parkinson's (no date provided), BPH (no date provided), HTN (no date provided), GERD (no date provided).

Past Surgical History: No surgical history recorded in chart or reported by patient

Family History: father died of prostate cancer, mother died of stroke

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): no reported tobacco, alcohol or recreational drug use.

Assistive Devices: patient uses glasses

Living Situation: patient was living at home with wife at time of admission

Education Level: patient attended a business college, has a certification.

Admission Assessment

Chief Complaint (2 points): acute syncope, with alteration of mental status

History of Present Illness – OLD CARTS (10 points): Patient was at his home with his wife. He went the bathroom and his wife checked on him shortly after finding him slumped over on the toilet (02/20/22). He was minimally responsive to stimuli, and nonverbal. Wife reported that she tried to get him to stand up and couldn't. She called 911 and patient was

taken to Carle hospital ED (2/20/22). Patient vomited in the ED and was intubated to prevent aspiration at this time (2/20/22). A CT scan of the brain without contrast, CT scan of the cervical spine without contrast, and a chest X-ray were ordered in the ED (2/20/22). The CT of the brain was negative for visible acute intracranial processes. The CT of the cervical spine showed degenerative change visible throughout the spine. The chest X-Ray showed mild vascular congestion and prominence of the interstitial suggesting pulmonary edema. Patient was admitted to the hospital that day (2/20/20). Patient has been diagnosed with Parkinson's but wife reports that the patient has never had an episode like he did. Patient had a UTI 3 days prior to (2/20/20). Patient is currently responsive to stimuli, as well as verbally responsive, although confused (3/10/22).

Primary Diagnosis

Primary Diagnosis on Admission (2 points): obstructive uropathy

Secondary Diagnosis (if applicable): aspiration pneumonia

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

Obstructive Uropathy is when the urinary tract is blocked in some way. Most commonly, in males over sixty obstructive uropathy is "secondary to benign prostatic hyperplasia" (Capriotti, pp. 548). In women obstructive uropathy is secondary to "kidney stones, gynecological surgery, pregnancy, and cancers of the pelvic organs" (Capriotti, pp. 548).

Obstructive uropathy is normally discovered when people struggle to urinate (dysuria). Obstructive uropathy can also cause urgency, hesitancy, and frequency (Capriotti, pp. 549).

When obstructive uropathy is suspected typically abdominal x-ray and a urine culture will be ordered. An abdominal x-ray will show any object that may be obstructing the urinary tract. Vital signs may be normal. Pain may be noted in the abdomen. Mostly intake and output as well as the qualities of the output will be assessed (Capriotti, pp. 549).

Taking a X-ray of the abdomen can diagnose obstructive uropathy if the obstruction is visible. Other imaging studies taken to diagnose obstructive uropathy are CT scans, MRI, ultrasound or cystoscopy. A CT and an MRI will show masses or stones in the urinary tract. While a cystoscopy is used as a biopsy for bladder cancers or tumors that may be obstructing the urinary tract (Capriotti, pp. 550).

A Urinary dipstick or a urinary analysis may be ordered for patients reporting similar symptoms of obstructive uropathy. Both of these urinary tests may show an UTI which will show bacterial growth in the urinary tract. A UTI is treated differently than obstructive uropathy even though similar symptoms may show up with both issues. Urinary analysis may confirm an UTI which will be treated with antibiotics rather than surgery to remove an obstruction (Capriotti, pp. 550).

Treatment for obstructive uropathy will depend on the exact cause of the obstruction. If there is presence of a tumor, the tumor must be removed. If the problem is BPH surgery is done to remove the prostate from obstructing the urinary tract. In other

cases it may be kidney stones which in severe cases may need lithotripsy to sever into smaller stones (Capriotti, pp. 550).

Patient had a history of UTI. It was reported that he had a UTI three days prior to 2/20/22. UTI commonly causes similar symptoms to obstructive uropathy, if he was not fully recovered from this infection the patient would have had two compounding issues to sufficient urinary clearance as the patient is also diagnosed with BPH. The patient slumped over on the toilet and had an alteration in mental status, this is why he was brought into the hospital. Straining to urinate due to his obstructive uropathy may have caused his syncope episode.

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). *Davis advantage for pathophysiology: introductory concepts and clinical perspectives (2nd ed.). F. A. Davis Company.* https://fadavisreader.vitalsource.com/books/9781719641470

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 (2/20/22)	Today's Value (3/10/22)	Reason for Abnormal Value
RBC (x10^6/UL)	4.10-5.70	4.42	4.28	Within defined normal limits
Hgb (g/dL)	12-18	13.8	13.1	Within defined normal limits
Hct (%)	37.0-51.0	41.3	40.3	Within defined normal limits

Platelets (K/uL	**140-400**	**179**	**316**	
WBC (K/uL)	**4-11**	**15.9**	**16.28**	**Increased WBC due to trauma and inflammation response (Van Leeuwen & Bladh)**
Neutrophils (x100/mm3)	**1.60-4.90**	**13.76**	**13.87**	**Increased neutrophils due to previous UTI (Van Leeuwen & Bladh)**
Lymphocytes (%)	**1.00-4.90**	**4.7**	**0.9**	**Decreased lymphocytes due to poor nutrition related to tube feedings and altered mental status (Van Leeuwen & Bladh)**
Monocytes (%)	**0-10**	**7.5**	**1.19**	
Eosinophils (%)	**0.00-0.50**	**0.2**	**0.07**	
Bands (%)	**0.0-10**	**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 (2/20/22)	Today's Value (3/10/22)	Reason For Abnormal
Na- (mmol/l)	**136-145**	**144**	**145**	**Within defined normal limits**
K+ (mmol/l)	**3.5-5.1**	**6.9**	**4.3**	**Elevated potassium levels due to kidney damage related to to obstructive uropathy (Van Leeuwen & Bladh)**
Cl- (mmol/l)	**98-107**	**108**	**113**	**Elevated chloride levels due to kidney damage related to obstructive uropathy (Van Leeuwen & Bladh)**
CO2 (mmol/l)	**22.0-29.0**	**19.0**	**22.0**	**Decreased CO2 levels due to kidney damage related to obstructive uropathy (Van Leeuwen & Bladh)**

Glucose (mg/dL)	**74-100**	**99**	**100**	**Within defined normal limits**
BUN (mg/dL)	**8-26**	**76**	**51**	**Elevated BUN levels due to kidney damage and dehydration related to obstructive uropathy and vomiting/poor intake (Van Leeuwen & Bladh)**
Creatinine (mg/dL)	**0.55-1.50**	**9.61**	**1.22**	**Elevated creatinine due to kidney damage related to obstructive uropathy (Van Leeuwen & Bladh)**
Albumin (g/dL)	**3.4-4.8**	**3.3**	**2.8**	**Decreased albumin levels due to malnutrition (Van Leeuwen & Bladh)**
Calcium (mg/dL)	**8.9-10.6**	**8.7**	**9.1**	**Decreased calcium levels due to diminished kidney function related to damage caused by obstructive uropathy (Van Leeuwen & Bladh)**
Mag (mg/dL)	**1.6-2.6**	**N/A**	**2.4**	**Within defined normal limits**
Phosphate (units/L)	**2.4-4.5**	**N/A**	**N/A**	**N/A**
Bilirubin (mg/dL)	**0.2-1.2**	**0.9**	**0.4**	**Within defined normal limits**
Alk Phos (units/L)	**34-104**	**170**	**143**	**Elevated alk. Phos. due to recent UTI (Van Leeuwen & Bladh)**
AST (u/L)	**5-34**	**22**	**40**	**Within defined normal limits**
ALT (u/L)	**0-55**	**N/A**	**N/A**	**N/A**
Amylase (u/L)	**250-4200**	**N/A**	**N/A**	**N/A**
Lipase (U/L)	**114-7352**	**N/A**	**N/A**	**N/A**
Lactic Acid (mmol/L)	**0.5-2.0**	**1.7**	**N/A**	**Within defined normal limits**

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 2/20/20	Today's Value 3/10/22	Reason for Abnormal
INR (secs)	0.9-1.1	1.1	N/A	Within defined normal limits
PT (secs)	11.7-13.8	14.1	N/A	Elevated PT due to patient receiving heparin injections (Van Leeuwen & Bladh)
PTT (secs)	22.4-35.9	28.0	N/A	Within defined normal limits
D-Dimer (ng/mL)	0-0.50	N/A	N/A	N/A
BNP (pg/mL)	100-400	N/A	N/A	N/A
HDL (mg/dL)	40-60	N/A	N/A	N/A
LDL (mg/dL)	60-130	N/A	N/A	N/A
Cholesterol (mg/dL)	150-200	N/A	N/A	N/A
Triglycerides (mg/dL)	30-150	N/A	N/A	N/A
Hgb A1c	4.7-6.8	N/A	N/A	N/A
TSH	0.4-5.5	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 2/20/22	Today's Value 3/10/22	Reason for Abnormal
Color & Clarity	Yellow, clear	NA	Yellow	Within defined normal limits
pH	5.0-7.0	NA	5.0	Within defined normal limits
Specific Gravity	1.003-1.035	NA	1.018	Within defined normal limits
Glucose	Negative	NA	Negative	Within defined normal limits
Protein	Negative	NA	Negative	Within defined normal limits
Ketones	Negative	NA	Negative	Within defined normal limits
WBC	0-25	NA	5	Within defined normal limits
RBC	0-20	NA	67	Elevated RBC due to catheter related trauma of the urinary tract (van Leeuwen & Bladh)
Leukoesterase	Negative	NA	Negative	Within defined normal limits

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 2/20/22	Today's Value 3/10/22	Explanation of Findings
Urine Culture	**No growth**	**NA**	**No growth**	**Within defined normal limits**
Blood Culture	**No growth**	**No growth**	**NA**	**Within defined normal limits**
Sputum Culture	**No growth**	**NA**	**NA**	**Within defined normal limits**
Stool Culture	**No growth**	**NA**	**NA**	**Within defined normal limits**

Lab Correlations Reference (1) (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2019). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implication (8th ed.)*. F. A. Davis Company

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT scan of brain without contrast 2/20/22, Ct of cervical spine without contrast 2/20/22, Chest X-ray 2/20/22.

Diagnostic Test Correlation (5 points):

CT scan of the brain without contrast 2/20/22: Patient had experienced acute syncope with alteration of mental status. With any alteration of mental status it is crucial to visualize the brain for any signs of clots, stoke, or damage. The scan was negative for visual acute intracranial processes.

CT of Cervical spine without contrast 2/20/22: Patient had an acute alteration of mental status it is important to check the status of the spinal cord for neurological damage. The scan came back with no acute process evident. Degenerative changes were visible throughout the spine. Patient is diagnosed with Parkinson's degenerative changes throughout the body are somewhat expected.

Chest X-Ray 2/20/22: Patient experienced syncope, the status of the heart is important to visualize to rule out heart issues as the underlying cause. Mild vascular congestion and prominence of the interstitial suggesting pulmonary edema.

Diagnostic Test Reference (1) (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2019). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implication (8th ed.).* F. A. Davis Company

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

Home Medications (5 required)

Brand/Generic	**Brimonidine tartrate/ Alphagan P 0.15% ophthalmic solution**	**Cholecalciferol/vitamin D3**	**Mirabegron/ Myrbetriq**	**Omeprazole/ Prilosec**	**Zocor/ simvastatin**
Dose	**1 drop in each eye**	**1,000U**	**50mg**	**20mg**	**20mg**
Frequency	**BID**	**Daily**	**Daily**	**Daily**	**Daily**
Route	**Ocular**	**PO**	**PO**	**PO**	**PO**
Classification	**Alpha adrenergic agonists (Drugbank)**	**Vitamin D analogs (Jones)**	**Beta 3 adrenergic agonists (Jones)**	**Proton pump inhibitor (Jones)**	**Statins (Jones)**
Mechanism of Action	**Agonist against alpha-1,-2 adrenoceptors which contribute to increased ocular pressure (Drugbank)**	**Supplements naturally diet acquired vitamin D when levels are inadequate (Jones)**	**Relaxes urinary tract muscles by activating beta-3 adrenoceptors (Jones)**	**Inhibits stomach acid secretion by the proton pump in the gastric parietal cells (Jones)**	**Reduces the amount of cholesterol produced in the liver to reduce the amount of arterial build up (Jones).**
Reason Client Taking	**Eye irritation**	**Vitamin D deficiency**	**Overactive bladder**	**GERD**	**High cholesterol**
Contraindications (2)	**Hypersensitivity, depression**	**High amounts of vitamin D, kidney stones**	**High blood pressure, liver problems**	**Lupus, liver problems**	**Hypersensitivity, liver problems**

Side Effects/ Adverse Reactions (2)	**Blurred vision, headache**	**Chest pain, shortness of breath**	**High blood pressure, headaches**	**Headache, nausea**	**Confusion, muscle pain**
Nursing Considerations (2)	**May lower blood pressure, assess for eye irritation**	**Assess for weakness, too much vitamin D3 can harm an unborn baby**	**Monitor blood pressure, reassess for urinary urgency**	**Assess for dizziness, patient should take 30-60 mins prior to eating**	**Reassess cholesterol levels, assess liver function**

Hospital Medications (5 required)

Brand/Generic	**Dextrose 50% injection/ glucose**	**Haloperidol/ haldol**	**Heparin injection/ hep lock**	**Labetalol/ no brand name**	**Acetaminophen/ tylenol**
Dose	**12.5 g**	**1mg**	**5,000u**	**10mg**	**650mg**
Frequency	**PRN**	**X 4hrs PRN**	**X 8 hours PRN**	**X 4 hours PRN**	**X 4 hours PRN**
Route	**IV push**	**IV push**	**Sub Q**	**IV Push**	**Rectally**
Classification	**Glucose elevating agents (Jones)**	**Antipsychotics (Jones)**	**Glycosaminoglycan (Jones)**	**Beta blocker (Jones)**	**Analgesics (Jones)**
Mechanism of Action	**Dextrose oxidizes into sugar and calories in the body (Jones)**	**Blocks dopamine effects and increases turnover (Jones)**	**Slows thrombin and fibrin from clotting the blood (Jones)**	**Blocks beta adrenergic receptors to reduce blood vessel pressure (Jones).**	**Inhibits prostaglandins from inflammation and pain reaction (Jones).**
Reason Client Taking	**Hypoglycemia**	**Agitation**	**To prevent blood clots**	**Hypertension**	**For mild 1-3/10 pain**
Contraindications (2)	**Severally dehydrated, hepatic coma**	**Low WBC, low magnesium**	**Active bleeding, hypersensitivity**	**Complete heart block, low blood pressure**	**Liver failure, hepatitis C**
Side Effects/ Adverse Reactions (2)	**Edema, fever**	**Dry mouth, heartburn**	**Brusing, ingestion site irritation**	**Headache, dizziness**	**Nausea, stomach pain**

Nursing Considerations (2)	**Assess heart rate, assess blood glucose levels**	**Monitor for hypersensitivity, assess blood pressure**	**Monitor for hypersensitivity, monitor clotting factors**	**Assess heart rate, assess blood pressure**	**Assess for nausea, assess for signs of hepatotoxicity**

Medications Reference (1) (APA):

DrugBank online: Database for Drug and Drug Target Info. DrugBank Online | Database for Drug and Drug Target Info. (n.d.). Retrieved March 14, 2022, from https://go.drugbank.com/

Jones & Bartlett Learning. (2020). *2021 nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient was alert oriented to person and place, but not to time or situation.** **Patient did not appear to be in any acute distress. Patient appeared frail, pale, hair disheveled.**

INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score:** **Drains present: Y□ N □** **Type:**	**Skin was clammy, and pale. Patient had two wounds one on his left wrist from a skin tear and one on his sacrum from moisture. Skin turgor was sluggish. Patient had no rashes. A few bruises were present on wrists likely due to the heparin. Braden score: 12, high risk for pressure ulcers. No drains present.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head was normocephalic. Neck symmetrical. trachea midline. Ears symmetrical with no visible bleeding or drainage. Patient is somewhat hearing impaired but does not use hearing aides and can respond to heightened verbal cues. Patient wears glasses, pupils 3mm, and exhibited PERRLA. Eyes were symmetrical and had no drainage. Conjunctiva was pink and moist. Nose was midline, septum undeviated, nares symmetrical and unobstructed. Patient has intact natural teeth. Tongue midline, tonsils 2+ no sores or lesions visible.**
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:**	**S1, S2 heart sounds audible. No S3/4 or murmurs auscultated. Regular heart rate and rhythm. Peripheral pulses somewhat diminished 2+, capillary refill greater than 2 secs, no neck vein distention, no edema present.**
RESPIRATORY: **Accessory muscle use: Y□ N □** **Breath Sounds: Location, character**	Crackles were auscultated. Respiratory rate was regular and rhythmic. Patient did not use accessory muscles when breathing. Patient did have a productive cough sputum was not able to be assessed. No chest deformities visible.

GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y □ N □** **Nasogastric: Y □ N □** **Size:** **Feeding tubes/PEG tube Y □ N □** **Type:**	Patient was on a regular diet at home. However, patient had been on tube feedings while in the hospital and diet has been increased as tolerated. Patient is currently on pureed diet as he failed his swallow study. Patient is currently 5'7" 144lbs and 9.6oz. bowel sounds present in all four quadrants. Last BM 3/9/22. Patient is not currently experiencing any vomiting or diarrhea. Patient denies pain upon palpation of the abdomen. Abdomen is soft, non tender, non distended. No incisions, scars, drains or wounds present on the abdomen. No ostomy present. No ng, feeding, or PEG tubes present.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y □ N □** **Dialysis: Y □ N □** **Inspection of genitals:** **Catheter: Y □ N □** **Type:** **Size:**	Urine is yellow and clear. Patient has an indwelling catheter and had 703 mL of void throughout clinical time. Patient did not report pain upon urination. Patient is not on dialysis. Genital inspection deferred. Indwelling Catheter 16.

MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y□ N □** **Fall Risk: Y □ N□** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	Neurovascular status intact, Patient has full ROM although somewhat weakened. Patient uses a gait belt to ambulate. 4/5 upper and lower extremities. ADL assistance needed. Patient is a fall risk fall score 45. Increase activity as tolerated, needs nurse assistance with gait belt to ambulate.
NEUROLOGICAL: **MAEW: Y □ N□** **PERLA: Y □ N□** **Strength Equal: Y □ N □ if no - Legs □ Arms □ Both □** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	MAEW and PERRLA present. Strength equal. Alert and Oriented x 2, patient pleasant although somewhat confused. Speech is garbled. Patient senses touch and is conscious.
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 has been in room watching television with his wife. His wife is present most of the time. He also has a son that comes and visits. He is Christian. Developmental level is diminished due to Parkinson's. Patient went to a business college and received a certification.

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
900	**85 RA**	**154/81 RA**	**18 R per Min**	**97.8 F**	**93% RA**
1100	**87 RA**	**149/80 RA**	**18 R per min**	**97.8 F**	**93% RA**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
900	**0/10**	**NA**	**0/10**	**NA**	**NA**
1100	**0/10**	**NA**	**0/10**	**NA**	**NA**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	20g right upper arm 2/27/22 patent with no signs of erythema, drainage or swelling. Dressing intact. No fluids running at this time.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL of thickened lemonade **200 mL pureed pancakes**	**703 mL urine in catheter bag**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was turned x2hours. Comfort was assessed. Patient did not receive any medications. Patient ate breakfast and visited with wife. Wife and nursing student spoke about patient's condition, and discharge plans.

Procedures/testing done: none today

Complaints/Issues: finding placement has taken along time

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: tolerating diet and activity

Physician notifications: did not notify physician during clinical

Future plans for client: patient plans on being discharged to a rehabilitation facility, consults for hospice and feeding tube.

Discharge Planning (2 points)

Discharge location: not yet found, rehab facility

Home health needs (if applicable): will not be returning home

Equipment needs (if applicable): gait belt

Follow up plan: patient may be placed on hospice and can find placement easier after qualifying for hospice care versus rehabilitation care.

Education needs: hospice/comfort care education

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

N321 CARE PLAN

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • **Explain why the nursing diagnosis was chosen**	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • **How did the client/family respond to the nurse's actions?** • **Client response, status of goals and outcomes, modifications to plan.**

1. Imbalanced nutrition: less than body requirements related to difficulty swallowing as evidenced by 30lb weight loss over hospitalization	**1. Patient has lost a considerable amount of weight throughout his hospitalization, feeding tube may need to be replaced**	**1. Patient will tolerate eating six small meals a day** **2. Patient will consult for a possible need for parenteral nutritional support**	**1. Patient will experience no further weight loss**	**Family and patient were accepting and motivated to meet goal for plan of care. Further assessment is needed due to feeding tube consult not yet completed.**
2. Risk for aspiration related to difficulty swallowing as evidenced by failed swallow study	**Patient struggles to eat and it causes him to cough, pulmonary edema is present.**	**1. Suction available at bedside** **2. Patient should eat sitting in high fowlers**	**1. Patient will not experience aspiration**	**Family and patient were willing to meet plan of care. They were agreeable and patient's wife helped feed patient in high fowlers. Goal met patient did not aspirate during clinical.**

3. Impaired skin integrity related to pressure and moisture over boney prominence as evidenced by pressure ulcer on sacrum.	**Patient already has a pressure ulcer, it is important to include interventions in nursing plan of care to prevent it from getting worse, or new wounds arising.**	**1. Reposition patient x 2 hours** **2**. Clean and change pressure sore's dressing as ordered	**1. Patient does not experience further skin breakdown**	**Family and patient were willing to comply with plan of care. Patient agreed to be turned and repositioned every 2 hours. Patient did no experience further skin break down throughout clinical goal was met.**

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

No pain present
No nausea or vomiting present
"Can't get rid of this cough"

Nursing Diagnosis/Outcomes

Imbalanced nutrition: less than body requirements related to difficulty swallowing as evidenced by weight loss of 30lbs over hospitalization
Risk for aspiration related to difficulty swallowing as evidenced by failed swallow study
Impaired skin integrity related to pressure and moisture over boney prominence as evidenced by pressure ulcer on sacrum

Objective Data

Patient has lost 30lbs throughout hospitalization
Patient has a productive cough and lung crackles
Patient has a bed sore at sacrum.

Client Information

75 year old white male with a history of HTN, GERD, BPH, and Parkinson's
Admitted due to syncope

Nursing Interventions

Patient will tolerate 6 small meals a day. Patient will consult for possible feeding tube.
Suction available at bedside.
Patient should eat in high fowler's
Patient will be repositioned x2hours
Patient will have dressing cleaned and changed as ordered.