N321 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 3/14/2022	**Client Initials** B.M.	**Age** 38 years old	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Nurse	**Marital Status** Married	**Allergies** Morphine Sulfate-unknown reaction Ragweed-unknown reaction
Code Status Full	**Height** Five feet one inch	**Weight** 123 pounds	

Medical History (5 Points)

Past Medical History: Hypertension, urinary tract infections, kidney stones, iron-deficiency anemia

Past Surgical History: Cesarean section (unknown date), Cholecystectomy (2012)

Family History:

Mother: diabetes

Brother: diabetes

Father: myocardial infarction

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use):

The client is a current smoker and reports using one pack per day for the past ten years. The client states, “casual drinker one to two times per month.” The client denies a history of drug use.

Assistive Devices: N/A

Living Situation: Lives at home with husband and eight children.

Education Level: Bachelor’s degree in nursing.

Admission Assessment

Chief Complaint (2 points): Redness, swelling, and pain to the right lower extremity.

History of Present Illness – OLD CARTS (10 points): The client is a 38-year-old female that reports “she was playing with her children outside and tripped over a rock, fell, and skinned her knee on the pavement.” The client reports no alleviating factors or precipitating factors.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): The client’s primary diagnosis is cellulitis of the right lower extremity.

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points): Cellulitis is a bacterial skin infection that can occur anywhere in the body. The most common area for cellulitis to appear is in the lower extremities. Cellulitis occurs when there is a break in the skin, such as a cut or abrasion, and bacteria can enter the body and cause infection. Group A ß - hemolytic streptococcus (Strep), Streptococcus pneumoniae (Strep), Staphylococcus aureus (Staph) can enter a wound or break in the skin and can cause cellulitis (Johns Hopkins Medicine, n.d.). Other causes of cellulitis may include human/animal bites or injuries that occur in water that can cause bacteria to enter the body (Johns Hopkins Medicine, n.d.). Risk factors for cellulitis can include an injury to the skin, a weakened immune system, eczema, fungal infections of the skin, shingles, lymphedema, history of cellulitis, and obesity (Mayo Foundation for Medical Education and Research, 2020). Redness, swelling, tenderness, pain, warmth, fever, red spot, blisters, and skin dimpling can be signs and symptoms of cellulitis (Mayo Foundation for Medical Education and Research, 2020). Severe symptoms that require immediate medical attention include a very large area of red, inflamed skin, a high fever, the area affected is causing numbness, tingling, or other changes in a hand, arm, leg, or foot, the skin appears black, the area that is red and swollen is around eyes or behind the ears, a history of diabetes or have a weakened immune system and

develop cellulitis (Johns Hopkins Medicine, n.d.). A physical exam, health history, blood tests, and skin/wound cultures may help diagnose cellulitis (Johns Hopkins Medicine, n.d.). Blood and skin cultures detect what bacteria is causing the cellulitis (Mayo Foundation for Medical Education and Research, 2020). There are many treatment options for cellulitis that may include: oral, intramuscular injection, or intravenous antibiotics, cool, wet dressings on the infection site, keeping the area dry and clean, surgery, if the arm or leg is affected, elevating the arm or leg may help, topical antibiotics, pain medicine as needed (Johns Hopkins Medicine, n.d.). The client's provider will decide what treatment options are the best based on the severity of the cellulitis infection. The client is at risk for cellulitis due to falling and causing an abrasion on the right knee. The client reports the symptoms of redness, swelling, and pain in the right lower extremity. The client was diagnosed with cellulitis based on a physical exam, health history, and blood tests for elevated white blood cells. The client's treatment is intravenous antibiotics and pain medication to control pain associated with cellulitis.

Pathophysiology References (2) (APA):

Johns Hopkins Medicine. (n.d.). *Cellulitis*. Johns Hopkins Medicine. Retrieved March 17, 2022, from https://www.hopkinsmedicine.org/health/conditions-and-diseases/cellulitis

Mayo Foundation for Medical Education and Research. (2020, February 6). *Cellulitis*. Mayo Clinic. Retrieved March 17, 2022, from https://www.mayoclinic.org/diseases-conditions/cellulitis/symptoms-causes/syc-20370762

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.0-5.8 x10^6/mcL	N/A	N/A	
Hgb	12.0-15.8g/dL	8.8 g/dL	N/A	A low hemoglobin may be from the client's history of iron-deficiency anemia which causes a low amount of hemoglobin in the blood (Writers, 2021).
Hct	36.0-47.0%	N/A	N/A	
Platelets	140-440 K/mcL	N/A	N/A	
WBC	4.0-12.0 K/mcL	17.4 K/mcL	N/A	An increased white blood cell count can be caused by the client's diagnosis of cellulitis. White blood cell levels increase when infection or inflammation is present in the body (Writers, 2021).
Neutrophils	40-60%	N/A	N/A	
Lymphocytes	19-49%	N/A	N/A	
Monocytes	3.0-13.0%	N/A	N/A	
Eosinophils	0.0-8.0%	N/A	N/A	
Bands	0.0-10.0%	N/A	N/A	

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145 mmol/L	138 mmol/ L	N/A	
K+	3.5-5 mmol/ L	3.6 mmol/L	N/A	
Cl-	98-107 mmol/L	N/A	N/A	

CO2	21-31 mmol/L	N/A	N/A	
Glucose	70-99 mg/dL	86 mg/dL	N/A	
BUN	7-25 mg/dL	10 mg/dL	N/A	
Creatinine	0.50-1.20 mg/dL	1.67 mg/dL	N/A	Elevated creatinine levels can be caused by kidney stones or high blood pressure, which can cause damage to the kidneys (Writers, 2021). Lisinopril can cause changes in kidney function (Jones & Bartlett, 2020).
Albumin	3.5-5.7 g/dL	N/A	N/A	
Calcium	8.6-10.3 mg/dL	N/A	N/A	
Mag	1.6-2.6 mg/dL	N/A	N/A	
Phosphate	2.4-4.5 units/L	N/A	N/A	
Bilirubin	0.3-1.0 mg/dL	N/A	N/A	
Alk Phos	34-104 units/L	N/A	N/A	
AST	5-30 U/L	N/A	N/A	
ALT	5-30 U/L	N/A	N/A	
Amylase	30-125 U/L	N/A	N/A	
Lipase	10-150 U/L	N/A	N/A	
Lactic Acid	4.5-19.8 mg/dL	N/A	N/A	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal

INR	0.9-1.2	N/A	N/A	
PT	11-14 sec	N/A	N/A	
PTT	20-40 sec	N/A	N/A	
D-Dimer	< 500 ng/mL	N/A	N/A	
BNP	< 100 pg/mL	N/A	N/A	
HDL	40-80 mg/dL	N/A	N/A	
LDL	85-125 mg/dL	N/A	N/A	
Cholesterol	3-5.5 mmol/ L	N/A	N/A	
Triglycerides	50-150 mg/dL	N/A	N/A	
Hgb A1c	4%-6%	N/A	N/A	
TSH	0.5-5 mIU/L	N/A	N/A	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	yellow, clear	N/A	N/A	
pH	5.0-9.0	N/A	N/A	
Specific Gravity	1.003-1.013	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0.0-0.5	N/A	N/A	
RBC	0.0-3.0	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	N/A	N/A	
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):

Writers, R. N. S. (2021, July 28). *Laboratory values: NCLEX-RN*. RegisteredNursing.org. Retrieved October 18, 2021, from https://www.registerednursing.org/nclex/laboratory-values/.

Jones & Bartlett. (2020). *Nurse's Drug Handbook* (12th ed.). Jones & Bartlett Learning.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

The client received a chest x-radiation related to ruling out other conditions that could cause swelling, redness, and pain of the right lower extremity. A chest x-radiation uses radiation to produce an image of the heart, lungs, blood vessels, airways, and bones of the chest and spine for any abnormalities (Mayo Foundation for Medical Education and Research, 2022). The chest X-radiation shows negative for any acute abnormalities. An electrocardiogram was performed to rule out any heart-related conditions that could cause swelling, redness, and pain to the right lower extremity. An electrocardiogram records the electrical signals of the heart through electrodes to detect any abnormal heart rhythms. The electrocardiogram reveals a normal sinus

rhythm with no noted abnormalities. A right foot x-radiation was performed because the client fell and wanted to rule out any broken bones or fractures. A foot x-radiation uses radiation to produce an image of the bones of the foot. The right foot X-radiation shows negative for any acute abnormalities. A venous doppler ultrasound is used to detect blood flow in the lower extremities because the client reported pain, swelling, and redness of the right lower extremity. The use of the venous doppler ultrasound was used to rule out a blood clot in the right lower extremity. A venous doppler ultrasound uses sound waves from the probe to the gel on the skin to produce an image of the blood flow. The venous doppler of the right lower extremity reveals negative for a deep vein thrombosis.

Diagnostic Test Reference (1) (APA):

Mayo Foundation for Medical Education and Research. (2022, March 5). *Chest X-rays*. Mayo Clinic. Retrieved March 17, 2022, from https://www.mayoclinic.org/tests-procedures/chest-x-rays/about/pac-20393494

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

Home Medications (5 required)

Brand/ Generic	Claritin/ loratadine	Vitafusion/ prenatal vitamin	Zestril/ lisinopril	Flomax/ tamsulosin	Feosol/ ferrous sulfate
Dose	10 mg	2 gummies	20mg	0.4mg	325 mg
Frequency	Daily	Daily	Once daily	Daily	Three times a day
Route	By mouth	By mouth	By mouth	By mouth	By mouth
Classification	Second generation antihistamine (Jones & Bartlett, 2020).	Vitamin	Pharmacologic: angiotensin-converting enzyme inhibitor Therapeutic: Antihypertensive (Jones & Bartlett, 2020).	Pharmacologic: Alpha-adrenergic antagonist (Jones & Bartlett, 2020).	Pharmacologic: hematinic Therapeutic: Antianemic (Jones & Bartlett, 2020).
Mechanism of Action	Blocking the action of histamine by binding to histamine receptors (Jones & Bartlett, 2020).	Vitamin and mineral supplement (Jones & Bartlett, 2020).	Inhibits the conversion of angiotensin I to angiotensin II resulting in a reduced blood pressure (Jones & Bartlett, 2020).	Blocks alpha one adrenergic receptors to relax urinary tract smooth muscle (Jones & Bartlett, 2020).	Normalize red blood cell production by binding with hemoglobin (Jones & Bartlett, 2020).
Reason Client Taking	Allergic rhinitis	Trying to get pregnant, breastfeeding, or to treat iron deficiency anemia	Hypertension	Off-label use for lower urinary tract symptoms (Jones & Bartlett, 2020).	Iron deficiency anemia
Contraindications (2)	Kidney disease or liver disease (Jones & Bartlett, 2020).	Stomach ulcer or diverticular disease (Jones & Bartlett, 2020).	Concurrent aliskiren use in patients with diabetes and angioedema related to previous treatment with	Hypersensitivity to quinazolines and pregnancy or breastfeeding	Hemochromatosis and hemolytic anemia (Jones & Bartlett, 2020).

			an ACE inhibitor (Jones & Bartlett, 2020).		
Side Effects/Adverse Reactions (2)	Trouble breathing and swelling (Jones & Bartlett, 2020).	Upset stomach and black stools (Jones & Bartlett, 2020).	Arrhythmias and bronchospasms (Jones & Bartlett, 2020).	Angioedema and dyspnea (Jones & Bartlett, 2020).	Hypotension and hemolysis (Jones & Bartlett, 2020).
Nursing Considerations (2)	Avoid alcohol and report dizziness or trouble breathing (Jones & Bartlett, 2020).	Avoid taking antacids within two hours of taking medication (Jones & Bartlett, 2020). Take medication with food to prevent stomach upset (Jones & Bartlett, 2020).	Monitor blood pressure and monitor serum creatinine levels (Jones & Bartlett, 2020).	Give medication thirty minutes after a meal (Jones & Bartlett, 2020). If a patient does take medication on an empty stomach, monitor blood pressure (Jones & Bartlett, 2020).	Give with a full glass of water or juice and monitor for abdominal pain (Jones & Bartlett, 2020).

Hospital Medications (5 required)

Brand/	Colace/	Cleocin/	Tylenol/	Hydrocodone/	Dilaudid/

Generic	docusate	clindamycin	acetaminophen	acetaminophen	hydromorphone
Dose	100 mg	200 mg	650 mg	5/325 tablet	0.5 mg
Frequency	Twice a day	Every 6 hours	Every 6 hours PRN	Every 4 hours	Every 4 hours
Route	By mouth	Intravenous	By mouth	By mouth	Intravenous
Classification	Pharmacologic: Surfactant Therapeutic: laxative or stool softener (Jones & Bartlett, 2020).	Pharmacologic: lincosamide Therapeutic: Antibiotic (Jones & Bartlett, 2020).	Pharmacological: nonsalicylate, para-aminophenol derivative Therapeutic: antipyretic, nonopioid analgesic (Jones & Bartlett, 2020).	Pharmacologic: Opioid and nonsalicylate, para-aminophenol derivative Therapeutic: opioid analgesic and antipyretic nonopioid analgesic (Jones & Bartlett, 2020).	Pharmacologic: opioid Therapeutic: opioid analgesic (Jones & Bartlett, 2020).
Mechanism of Action	Acts on surfactant that softens stool by decreasing surface tension between oil and water in feces (Jones & Bartlett, 2020).	Inhibits protein synthesis in bacteria (Jones & Bartlett, 2020).	Blocks prostaglandin production and interferes with pain impulse (Jones & Bartlett, 2020).	Binds and activates opioid receptors to produce pain relief and Blocks prostaglandin production and interfering with pain impulse (Jones & Bartlett, 2020).	Binds with opioid receptors in the spinal cord (Jones & Bartlett, 2020).
Reason Client Taking	Constipation	Cellulitis	Mild pain and fever	Moderate pain	Severe pain
Contraindications (2)	Concurrent use of mineral oil and fecal impaction (Jones & Bartlett, 2020).	Hypersensitivity for clindamycin and neuromuscular blockers (Jones & Bartlett, 2020).	Severe hepatic impairment and severe active liver disease (Jones & Bartlett, 2020).	Acute or severe bronchial asthma and significant respiratory depression (Jones & Bartlett, 2020).	Acute asthma and gastrointestinal obstruction (Jones & Bartlett, 2020).
Side Effects/Adverse	Dizziness and diarrhea (Jones & Bartlett,	Toxic epidermal necrolysis	Hepatotoxicity and hypokalemia	Seizures and respiratory depression (Jones	Respiratory depression and adrenal insufficiency

Reactions (2)	2020).	and neutropenia (Jones & Bartlett, 2020).	(Jones & Bartlett, 2020).	& Bartlett, 2020).	(Jones & Bartlett, 2020).
Nursing Considerations (2)	Long term use can cause dependence of laxatives and take with a full glass of milk or water (Jones & Bartlett, 2020).	Expect to obtain wound specimen for culture testing before giving first does (Jones & Bartlett, 2020). Give intravenous dose by infusion only (Jones & Bartlett, 2020).	Monitor renal function and monitor liver function tests (Jones & Bartlett, 2020).	Monitor patient for respiratory depression and monitor patient for seizure history or activity (Jones & Bartlett, 2020).	Monitor patient for respiratory depression and hydromorphone therapy increases the risk for abuse, addiction, and misuse (Jones & Bartlett, 2020).

Medications Reference (1) (APA):

Jones & Bartlett. (2020). *Nurse's Drug Handbook* (12th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** Alert **Orientation:** Oriented times four **Distress:** Not distressed **Overall appearance:** Well groomed	The client is alert and oriented times four and does not show any signs of distressed. The client is well groomed.
INTEGUMENTARY: **Skin color:** Red in the right lower extremity **Character:** dry, intact **Temperature:** warm **Turgor:** elastic **Rashes**: N/A **Bruises:** N/A **Wounds:** Abrasion on the knee **Braden Score:** 23 **Drains present: Y☐ N ☒** **Type:** N/A	The client's skin is red, swollen, and warm in the right lower extremity. The clients skin turgor is elastic with no rashes, bruises noted. The client has an abrasion on the right knee. No bleeding is noted, and the dressing is clean, dry, and intact. The Braden score is twenty-three. No drains are present.
HEENT: **Head/Neck:** normocephalic, neck supple, no masses noted **Ears:** symmetrical, no signs of drainage **Eyes**: pupils are equal and reactive to light, PERLA, and EOM intact **Nose:** nares patent with no signs of deviated septum **Teeth:** gums are pink and moist, teeth show no signs of carries, no masses or lesions noted.	The client's head is normocephalic, the neck is supple, and no masses noted. The ears are symmetrical with no signs of drainage present. The pupils are equal and reactive to light. PERLA and EOM intact. The nares are patent with no signs of deviated septum. The gums are pink, moist, and intact. The teeth show no signs of dental carries. No masses or lesions noted.
CARDIOVASCULAR: **Heart sounds:** auscultated, no murmurs present **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** S1 and S2 **Peripheral Pulses:** radial +2 **Capillary refill:** less than 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:** N/A	The heart sounds auscultated with no murmurs present. S1 and S2 with normal sinus rhythm. +2 radial pulses noted bilaterally. The capillary refill less than three seconds noted in all extremities. No signs of neck vein distention or edema.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** Anterior and posterior auscultated clear and equal bilaterally	The client showed no signs of accessory muscle being used. Anterior and posterior breath sounds auscultated clear and equal bilaterally.

GASTROINTESTINAL: **Diet at home:** regular **Current Diet:** regular **Height:** five-foot one inch **Weight:** 123 pounds **Auscultation Bowel sounds:** active in all four quadrants **Last BM:** N/A **Palpation: Pain, Mass etc.:** Soft, nontender, no masses noted **Inspection:** **Distention:** N/A **Incisions:** N/A **Scars:** on abdomen **Drains:** N/A **Wounds:** N/A **Ostomy: Y** ☐ **N** ☒ **Nasogastric: Y** ☐ **N** ☒ **Size:** N/A **Feeding tubes/PEG tube Y** ☐ **N** ☒ **Type:** N/A	The client's diet at home and the current diet is regular. The client is five-foot one inch and weighs 123 pounds. The client has active bowel sounds in all four quadrants and the last bowel movement has not been noted. The client's abdomen is soft and nontender with no masses noted. There are no signs of distention, incisions, or wounds in the abdominal area. A scar on the lower abdomen is noted. No ostomy is present. Nasogastric tube is not present. No feeding or PEG tubes are present.
GENITOURINARY: **Color:** pale yellow **Character:** clear **Quantity of urine:** N/A **Pain with urination: Y** ☐ **N** ☒ **Dialysis: Y** ☐ **N** ☒ **Inspection of genitals:** clean, dry, intact **Catheter: Y** ☐ **N** ☒ **Type:** N/A **Size:** N/A	The client's urine is pale yellow and clear. The quantity of urine is not noted. The client reports no pain with urination. The client is not receiving dialysis. The genitalia are clean, dry, and intact. No catheter is present.
MUSCULOSKELETAL: **Neurovascular status:** intact **ROM:** Active and passive intact **Supportive devices:** N/A **Strength:** 5/5 in all extremities **ADL Assistance: Y**☐ **N** ☒ **Fall Risk: Y** ☐ **N**☒ **Fall Score:** 45 **Activity/Mobility Status:** **Independent (up ad lib)** ☒ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	The neurovascular status is intact. The range of motion is intact active and passively. The client does not use supportive devices and has strength 5/5 in all extremities. The client does not need activities of daily living assistance and is not a fall risk. The fall score is forty-five and the client is independent.

NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** times four **Mental Status:** Alert **Speech:** Clear **Sensory:** N/A **LOC:** N/A	The client can move all extremities well and PERLA is intact. The strength is equal in arms and legs. The client is alert and oriented times four. The client's speech is clear with no sensory or LOC.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** N/A **Developmental level:** Bachelor's degree in nursing **Religion & what it means to pt.:** N/A **Personal/Family Data (Think about home environment, family structure, and available family support):** client lives at home with husband and eight children	The client did not express any coping methods. The client has a bachelor's degree in nursing. The client does not partake in any religion. The client lives at home with husband and eight children

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	76 beats per minute	126/68 mmHg	16 breaths per minute	36.5 ℃	98% room air
1100	68 beats per minute	118/62 mmHg	16 breaths per minute	36.8 ℃	97% room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	All over	6/10	Generalized	Tylenol administered
1100	Numeric	All over	2/10	Generalized	No interventions at this time

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gage **Location of IV:** left antecubital **Date on IV:** 3/14/22 **Patency of IV:** patent with no complications **Signs of erythema, drainage, etc.:** no signs of complication **IV dressing assessment:** The clients dressing is clean, dry, and intact	Normal saline at 100 mL/ hour

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Normal saline at 100 mL/hr x4 hours Tea by mouth 240 mL with breakfast Apple juice 120 mL with breakfast 760 mL total	Urine 1750 mL total voided in 4 hours Stool x2 1750 mL total

Nursing Care

Summary of Care (2 points)

Overview of care: No noted discharge needs or case management concerns. Patient plans to discharge back home with her husband and children. Will follow up with primary care provider in one week following discharge.

Procedures/testing done: The patient received a chest x-radiation, right foot x-radiation, electrocardiogram, and a venous doppler ultrasound of the right lower extremity on 3/14/22.

Complaints/Issues: The patient complains of redness, swelling, and pain to the right lower extremity.

Vital signs (stable/unstable): The vital signs are stable at this time and will continue to monitor.

Tolerating diet, activity, etc.: The client is tolerating food well, the client is up as tolerated. The client's output exceeds the intake of fluid during the nursing shift. Client should be monitored closely for fluid imbalances.

Physician notifications: N/A

Future plans for client: Monitor vital signs and intake and output. The client should be educated on smoking cessation and reducing the risk of falls.

Discharge Planning (2 points)

Discharge location: The client will be discharged at home with husband and eight children.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: The patient will follow up with primary care provider in one week following discharge.

Education needs: The client should be educated on smoking cessation and how to reduce the risk of falls.

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

Nursing Diagnosis • Include full	**Rationale** • Explain why the	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family

nursing diagnosis with “related to” and “as evidenced by” components • Listed in order by priority – highest priority to lowest priority pertinent to this client	nursing diagnosis was chosen			respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to cellulitis as evidenced by a self-report of intensity using the numeric pain scale (Phelps, 2020).	The client rated pain as six out of ten on the numeric pain scale at 0700.	1. Client requested acetaminophen and the acetaminophen was administered. 2. Help client move into a comfortable position using pillows and blankets (Phelps, 2020).	1. To reduce pain so the client is more comfortable.	Goal met. The client reported a pain of two out of ten after the acetaminophen was administered. Goal met. The client reported less pain after moving the client into a more comfortable position.
2. Impaired skin integrity related to an infection of the skin secondary to cellulitis as evidenced by redness,	The client reports “redness, swelling, pain, and warmth of the right lower extremity.”	1. Inspect the client’s skin at least every eight hours (Phelps, 2020). 2. Administer antibiotics as prescribed (Phelps, 2020).	1. The patient will follow treatment plan to rebuild skin integrity.	Goal met. The client’s skin was assessed during nursing shift. Goal met. The client received intravenous antibiotics as prescribed.

swelling, warmth, and pain to the affected leg (Phelps, 2020).				
3. Risk for disturbed body image related to skin injury as evidenced by swelling and redness of the right lower extremity (Phelps, 2020).	The client reports redness and swelling of the right lower extremity.	1. Encourage patient to actively participate in self-care (Phelps, 2020). 2. Encourage patient to express feelings about physical changes (Phelps, 2020).	1. The client will express feelings related to body image and participate in self-care activities.	Goal met. The patient responded well to helping perform self-care tasks. Goal met. Client was able to express feelings related to changes in the body.

Other References (APA):

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

Concept Map (20 Points):

Client complains of redness, swelling, warmth, and pain of the right lower extremity. Client reports they are a current smoker and reports the use of one pack per day for the past ten years. Client states “casual drinker one to two times per month”. Client denies history of drug use. Client reports pain of six out of ten on the numeric pain scale at 0700. Client reports pain as generalized and all over. At 1100 client reports pain of two out of ten on the numeric pain scale and pain is generalized and all over.

Subjective Data

Objective Data

Hemoglobin: 8.8 g/dL, White blood cells: 17.4 K/mcL, Creatinine: 1.67 mg/dL. A chest X-radiation revealed negative for any acute abnormalities. An electrocardiogram shows normal sinus rhythm with no noted abnormalities. An x-radiation of the right foot reveals negative for any acute abnormalities. A venous doppler of the right lower extremity shows negative for a deep vein thrombosis.

A 38-year-old female complains of redness, swelling, and pain of the right lower extremity. The client has a past medical history of hypertension, urinary tract infections, kidney stones, and iron deficiency anemia. The client’s past surgical history includes cesarean section with unknow dates and a cholecystectomy in 2012. Family history includes mother and brother: diabetes and father myocardial infarction. The client is a current smoker with one pack a day use for the past ten years. The client is a causal drinker with one to two times of use a month. Client denies drug use. Client lives at home with husband and 8 children. Clients educational leave is a bachelor’s degree in nursing.

Client Information

Nursing Diagnosis/Outcomes

Acute pain related to cellulitis as evidenced by a self-report of intensity using the numeric pain scale (Phelps, 2020).
Outcome: To reduce pain so the client is more comfortable.
Impaired skin integrity related to an infection of the skin secondary to cellulitis as evidenced by redness, swelling, warmth, and pain to the affected leg (Phelps, 2020).
Outcome: The patient will follow treatment plan to rebuild skin integrity.
Risk for disturbed body image related to skin injury as evidenced by swelling and redness of the right lower extremity (Phelps, 2020).
Outcome: The client will express feelings related to body image and participate in self-care activities.

Nursing Interventions

1. Client requested acetaminophen and the acetaminophen was administered.
2. Help client move into a comfortable position using pillows and blankets (Phelps, 2020).

1. Inspect the client’s skin at least every eight hours (Phelps, 2020).

2. Administer antibiotics as prescribed (Phelps, 2020).

1. Encourage patient to actively participate in self-care (Phelps, 2020).

2. Encourage patient to express feelings about physical changes (Phelps, 2020).