N431 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 4-3-22	**Client Initials** V.C.	**Age** 83	**Gender** Female
Race/Ethnicity African American	**Occupation** Retired	**Marital Status** Divorced	**Allergies** Lisinopril, Ambien, Amitriptyline, Sinemet, and Losartan.
Code Status DNR	**Height** 167.6 cm	**Weight** 60.5 kg	

Medical History (5 Points)

Past Medical History: The patient's (pt) past medical history includes: arthritis, atrial fibrillation (A-fib), arteriovenous malformation (AVM) of the colon with hemorrhage, chronic pain, benign neoplasm of the colon, bradycardia, cardiomegaly, cataracts bilaterally, unspecified chronic heart failure (CHF), lumbar denigrative disc disease (DDD), depression, unspecified disease of the tricuspid valve, hypertension (HTN), two previous falls (2014), hypothyroid, impingement syndrome of the left shoulder, infarction of the kidney, insomnia, iron deficiency anemia, mechanical heart valve present, peripheral neuropathy, perivalvular leak of the prosthetic heart valve (sequela), plantar fascial fibromatosis, polyp of the colon, sciatica, single kidney, sick sinus syndrome (SSS), sinus pause, and unspecified constipation.

Past Surgical History: The pt's past surgical history includes hysterectomy, PR replacement of the mitral valve, three colonoscopies, shoulder arthroplasty, PR lap, radical nephrectomy, excisional biopsy, two cataract removal, chalazion excision, Yag capsulotomy laser, four EDG colonoscopy, four upper gastrointestinal endoscopies two video capsule, unspecified cath lab, and left heart cath.

Family History: The patient's family history includes the father passing due to lung cancer, the mother dying due to diabetes (DM) and unspecified heart issues, the brother who has hypertension (HTN), DM, unknown heart issues, and psychiatry problems, the patient's sister who has breast cancer and unknown psychiatry problems, the patient's son has DM, and her daughter has HTN.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): Pt smoked a pack of cigarettes for 22 years and quit in 1976. It has been 46.2 years since pt quit smoking tobacco. The pt denies any alcohol or drug use.

Assistive Devices: Pt has glasses and a walker.

Living Situation: Pt lives alone with the help of a home caregiver.

Education Level: Pt only has a high school diploma.

Admission Assessment

Chief Complaint (2 points): Altered mental status

History of Present Illness – OLD CARTS (10 points): The patient is an 83-year-old old female with a past medical history of recurrent GIB, SSS S/P pacemaker, chronic A-fib not on anticoagulation, CHF, CKD, chronic anemia who was brought to the hospital by the family for altered mental status. The patient lives alone, with the help of a home caregiver. The family went to see the patient on 4-3-22 and found her standing in the house naked, not responding to the family, and with black tarry stool all over the house. The patient did not respond to questions asked in the emergency department and did not follow simple commands. On exam, the patient showed JVD and abdomen distention. A rectal exam revealed a positive hemoccult, and the stool was red. The patient brain CT

without contrast showed no evidence of acute intracranial abnormality. Mild parenchymal volume loss and findings consistent with mild chronic microangiopathic ischemic change have not progressed.

Primary Diagnosis

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

Secondary Diagnosis (if applicable):

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

Urinary tract infection (UTI) is an infection that occurs in any part of the urinary system, including the kidneys, bladder, or urethra (Capriotti, 2020). A UTI is also referred to as cystitis. Generally, a healthy urinary tract is sterile in a patient, and bacterial flora is usually confined to the urethral opening. Women are more susceptible to UTIs because our anatomical proximity of the rectum and the urinary tract enables the bacteria to quickly colonize in the urethra (Sorenson et al., 2019). A patient can also obstruct the urinary outflow decreasing the bladder's resistance to any bacteria (Capriotti, 2020). Uropathogenic bacteria can adhere, proliferate, and resist host defenses when in the bladder (Capriotti, 2020). Proteus mirabilis, another bacterium from the bowel, secretes urease, which decreases the acidity of the urine and enhances its ability to invade the bladder (Sorenson et al., 2019). The bacteria change the pH of the urine, which can improve the formation of struvite calculi in the kidneys. Struvite calculi are calcium deposits that stay in the kidney and do not move. Interference with the urinary outflow occurs in conditions such as chronic voluntary suppression of urination, sexual intercourse, urinary tract obstruction, urinary tract instrumentation use of catheters not drained to gravity, and

vesicoureteral reflux (CaprioUTIs2020). UTIs are most common in women and rarely in males. Hospital-acquired UTI is often associated with urinary catheterization and multidrug-resistant pathogens (Capriotti, 2020).

Risk factors may include women who wear tight, restrictive clothing, improper perineal hygiene, irritating bath products, dehydration, diabetes, urinary catheterization, bladder cancer, sexual intercourse, and oral contraceptives (Capriotti, 2020). Most of the time, the patients' history reveals the classic UTI symptoms of frequency, pain or burning on urination (dysuria), urgency, and occasionally hematuria (Capriotti, 2020). Hematuria means that there is blood in the urine. The naked eye can see gross hematuria, or microhematuria, which means it cannot be seen by the naked eye and must be seen by the microscope or a dipstick at the doctor's office to determine if blood is present in the urine. UTIs do not cause fever; if a fever is present, the physician should assess something else that is the cause of the fever. To diagnose a patient with a UTI, the patient must provide the nurse and doctor with a urinalysis and urine culture. A urinalysis using a dipstick usually shows some red blood cells (RBCs); positive leukocyte esterase indicates WBCs; and nitrates, which indicate bacteria (Sorenson et al., 2019). On microscopic urinalysis, neutrophils, RBCs, and bacteria are present in a clean-catch midstream urine specimen (Sorenson et al., 2019). On a urine culture, infection is indicated by a colony count of bacteria greater than 10^5/mL (Capriotti, 2020).

Treatment for a UTI is an antibiotic. To determine the appropriate antibiotic by culture and sensitivity testing (Capriotti, 2020). Hydration is critical to help the clearance of the bacteriuria. Some studies have shown that cranberry juice can decrease the risk of UTI because it lessens the adherence of bacteria to the bladder wall (Sorenson et al., 2019). There is a significant complication to be aware of, which is urosepsis. Urosepsis is a condition because of bacteremia, which means if the patient's UTI is not under control, the

infection can travel from the bladder to the bloodstream and cause sepsis. Patients who present with urosepsis can have signs and symptoms of fever, chills, disorientation, confusion, and hypotension (Sorenson et al., 2019).

With the older population, UTIs can confuse patients. My patient is an 83-year-old female who presented with altered mental status. She has no previous history of any conditions that alter her mental status. She has been receiving intravenously (IV) antibiotics since 4-3-22, and since then, her mental status has improved tremendously.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives* (2nd ed.). F. A. Davis Company.

Sorenson, M., Quinn, L., & Klein, D. (2019). *Pathophysiology: Concepts of human disease*. Pearson Education.

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**4.2-6.1**	2.36	***Unable to obtain***	Pt could have low RBC due to being anemic, prosthetic valves, and possibly chronic illness and only having one kidney (Pagana et al., 2021).
Hgb	**12-18 g/dL**	8.3	7.9	Pt could have low Hgb due to being anemic and having kidney problems (Pagana et al., 2021).

Hct	**Female: 36-47%**	27.0	26.1	Pt could have low Hct due to being anemic, prosthetic valves, and possibly chronic illness and only having one kidney (Pagana et al., 2021).
Platelets	**150-400 x 10^9/L**	150	*	*
WBC	**5-10 x 10^9/ L**	5.30	*	*
Neutrophils	**55-70**	*	*	*
Lymphocytes	**20-40**	21.2	*	*
Monocytes	**2-8**	7.4	6.8	*
Eosinophils	**1-4**	2.3	3.1	*
Bands	**0.5-1**	0.5	0.5	*

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**136-145 mEq/L**	142	144	*
K+	**3.5-5 mEq/L**	4.6	3.9	*
Cl-	**98-106 mEq/L**	109	113	Pt could have high chloride due to anemia and kidney dysfunction (Pagana et al., 2021).
CO2	**23-30 mEq/L**	21.0	19.0	Pt could have low carbon dioxide due to possibly renal failure and

				possible shock (Pagana et al., 2021).
Glucose	**74-106 mg/dL**	109	111	Pt could have high glucose due to possible chronic renal failure and acute stress response (Pagana et al., 2021).
BUN	**10-20 mg/dL**	39	39	Pt could have high BUN due to CHF and could be from renal disease, GI bleeding, or renal failure (Pagana et al., 2021).
Creatinine	**0.5-1.1 mg/dL**	2.16	2.26	Pt could have high creatinine due to reduced renal blood flow from CHF (Pagana et al., 2021).
Albumin	**3.5-5 g/dL**	4.4	*	*
Calcium	**9-10.5 mg/dL**	10.2	8.8	Pt could have low calcium due to possible renal failure (Pagana et al., 2021).
Mag	**1.3-2.1 mEq/L**	*	2.1	*
Phosphate	**3-4.5 mg/dL**	*	*	*
Bilirubin	**0.3-1 mg/dL**	0.7	*	*
Alk Phos	**30-120 U/L**	112	*	*
AST	**0-35 U/L**	29	*	*
ALT	**4-36 U/L**	12	*	*
Amylase	**60-120 U/L**	142	*	Pt could have high amylase, possibly due to necrotic or

				perforated bowel and possible duodenal obstruction from pt unspecified constipation (Pagana et al., 2021).
Lipase	**0-160 U/L**	13	*	*
Lactic Acid	**0.3-2.2 mmol/L**	2.84	3.17	Pt could have high lactic acid due to possible shock and sepsis from UTI (Pagana et al., 2021).
Troponin	**Less than 0.1 ng/mL**	0.03	0.04	Pt could have high troponin due to possible MI injury or infarction (Pagana et al., 2021).
CK-MB	**5-25 IU/L**	*	*	*
Total CK	**22-198 U/L**	*	*	*

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	**0.9-1.1**	1.1	*	*
PT	**11.7-13.8**	16.6	*	Pt could have high PT due to receiving a blood transfusion due to being anemic (Pagana et al., 2021).
PTT	**22.4-35.9**	31.9	*	*
D-Dimer	**Less than 0.50**	*	*	*
BNP	**Less than**	*	*	*

	100 pg/mL			
HDL	**Less than 45 mg/dL**	*	*	*
LDL	**313-618**	*	*	*
Cholesterol	**More than 200 mg/dL**	*	*	*
Triglycerides	**40-180 mg/dL**	*	*	*
Hgb A1c	**Less than 5.7%**	*	*	*
TSH	**0.35-4.94**	*	*	*

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	**Clear, Amber/ Yellow**	Clear and yellow	*	*
pH	**4.6-8 Average: 6**	5.0	*	*
Specific Gravity	**1.005-1.03**	1.016	*	*
Glucose	**Negative**	Negative	*	*
Protein	**0-8 mg/dL**	30	*	Pt could have protein in her urine due to a possible indicator of renal disease and possibly UTI (Pagana et al., 2021).

Ketones	**negative**	Negative	*	*
WBC	**0-25**	8	*	*
RBC	**0-20**	17	*	*
Leukoesterase	**negative**	Negative	*	*

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.310-7.410**	*	*	***Per the chart, pt did not have the test done. ***
PaO2	**75-120 mm Hg**	*	*	*
PaCO2	**41.0-51.0 mm Hg**	*	*	*
HCO3	**22-28 mEq/ L**	*	*	*
SaO2	**94%-100%**	94%	99%	*

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: less than 10,000 per mm of U** **Positive: greater than 100,000 per mm of U**	Positive: Greater than 100,000	*	Pt has positive urine culture because that is an indicator of a UTI (Pagana et al., 2021).
Blood Culture	**Negative**	*	*	*
Sputum Culture	**Normal Upper RT**	*	*	*
Stool Culture	**Normal intestinal flora**	*	*	*

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference*. St. Louis, MO: Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points) & Diagnostic Test Correlation (5 points):

Pt received a Computed tomography (CT) of the head and brain without contrast. CT of the head uses special x-ray equipment to help assess head injuries, severe headaches, dizziness, and other symptoms of an aneurysm, bleeding, stroke, and brain tumors (ACR, 2020). Like x-rays, it produces multiple images or pictures of the inside of the body (ACR, 2020). The cross-sectional images generated during a CT scan can be reformatted in multiple planes (ACR, 2020). They can even generate three-dimensional images. CT scanning provides more detailed information on head injuries, stroke, brain tumors, and other brain diseases than regular radiographs (x-rays) (ACR, 2020). The patient's impression was that there was no evidence of an acute intracranial abnormality. Mild parenchymal volume loss and findings consistent with mild chronic microangiopathic ischemic change have not progressed. This test was done in the emergency department when she was brought to the hospital.

Diagnostic Test Reference (1) (APA):

ACR, R. S. N. A. and. (2020, January 17). *Computed Tomography (CT) - head*. Radiologyinfo.org. Retrieved April 8, 2022, from https://www.radiologyinfo.org/en/info/headct

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

Home Medications (5 required)

Brand **Generic**	Tylenol acetaminophen	Protonix pantoprazole sodium	Compazine prochlorperazine	The patient only had three home medications per chart.	
Dose	500mg	40mg	10mg		

Frequency	Q4hr PRN	BID with before meals.	PRN		
Route	PO	PO	PO		
Classification	Nonsalicylate, paraminophenol derivative, antipyretic, nonopioid analgesic.	Proton pump inhibitor, antiulcer.	Piperaze phenothiazine, antiemetic.		
Mechanism of Action	It inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system (Jones & Bartlett Learning, 2020).	Interferes with gastric acid secretions by inhibiting the hydrogen-potassium-adenosine triphosphatase enzyme system, or proton pump, in gastric parietal cells. It inhibits gastric acid production (Jones & Bartlett Learning, 2020).	Alleviates psychotic symptoms by blocking dopamine receptors, the depressing release of selected hormones, and producing an alpha-adrenergic blocking effect in the brain (Jones & Bartlett Learning, 2020).		
Reason Client Taking	Pt is taking this medication to help relieve mild to	Pt is taking this medication to help maintain the healing of	Pt is taking this medication to help relieve nausea.		

	moderate pain.	erosive esophagitis and reduce signs and symptoms of GERD.			
Contraindications (2)	Hypersensitivity to acetaminophen or its components, severe hepatic impairment, and active liver disease.	Hypersensitivity and concurrent therapy with rilpivirine-containing products.	Hypersensitivity to this medication or its components does not pertain to this patient other than pediatric patients.		
Side Effects/Adverse Reactions (2)	Hypertension, fatigue, and anxiety.	Hyperglycemia, hyperlipidemia, and generalized pain.	Tachycardia, dry mouth, and possible constipation.		
Nursing Considerations (2)	Monitor renal function in patients on long-term therapy and use cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe	Flush IV line with D5W, normal solution, or lactated ringers' injection before and after administering the medication. Know that this medication is not long-term and should only be used as prescribed	Avoid contact with the skin because it could cause dermatitis. Protect this medication from light (Jones & Bartlett Learning, 2020).		

	hypovolemia, or severe renal impairment (Jones & Bartlett Learning, 2020).	(Jones & Bartlett Learning, 2020).			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor patient's liver functions.	The book did not state key nursing assessments or labs to look at before administration.	Do not mix in the same syringe with other medications. The precipitate may form when prochlorperazine edisylate is mixed in the same syringe with morphine sulfate (Jones & Bartlett Learning, 2020).		
Client Teaching Needs (2)	Tell the patient that tablets may be crushed or swallowed whole. Advise the patient to contact their prescriber about OTC products because they may contain acetaminophen	Instruct pt to swallow the whole pill and not chew or break the tablet. Tell pt it takes up to 2 weeks before they notice the medication working (Jones & Bartlett	Tell the patient to take with food or a full glass of milk or water to minimize GI distress. Advise the patient to swallow whole and not crush or chew them (Jones &		

	(Jones & Bartlett Learning, 2020).	Learning, 2020).	Bartlett Learning, 2020).		

Hospital Medications (5 required)

Brand **Generic**	Lipitor atorvastatin calcium	Rocephin ceftriaxone sodium	Feosol ferrous sulfate	Vitamin D3 cholecalciferol	Eltroxin (CAN) levothyroxine sodium
Dose	20mg	1g	324mg	2,000 units	150mcg
Frequency	Daily with evening meals.	Daily	BID	Daily	Daily at 0700
Route	PO	IV push	PO	PO	PO
Classification	HMG-CoA reductase inhibitor, antihyperlipidemic.	Third-generation cephalosporin, antibiotic.	Hematinic, antianemia, nutritional supplement.	Hormone and synthetic substitute, vitamin D analog.	Synthetic thyroxine, thyroid hormone replacement.

Mechanism of Action	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown (Jones & Bartlett Learning, 2020).	Interferes with bacterial cell wall synthesis by inhibiting cross-linking of peptidoglycan strands. It makes the cell membranes rigid and protective (Jones & Bartlett Learning, 2020).	Acts as a normalized RBC production by binding with hemoglobin or oxidizing and stored as hemosiderin or aggregated ferritin in reticuloendothelial cells of bone marrow, liver, and spleen (Jones & Bartlett Learning, 2020).	The activated form of cholecalciferol binds to vitamin D receptors and modulates gene expression. This increases serum calcium concentrations by increasing intestinal absorption of phosphorus and calcium, promoting distal renal tubular reabsorption of calcium and osteoclastic resorption (Jones & Bartlett Learning, 2020).	Replaces endogenous thyroid hormone, which may exert physiologic effects by controlling DNA transcription and protein synthesis (Jones & Bartlett Learning, 2020).
Reason Client Taking	The patient is taking this medication to help with CHF.	The patient is taking this medication to help with her UTI.	The patient is taking this medication to help with her anemia due to iron deficiency.	The patient is taking this medication to help with her renal functions and vitamin D3 deficiency.	The patient is taking this medication for hypothyroidism.
Contraindications (2)	Active hepatic disease and hypersensitivity to this medication or its components (Jones & Bartlett	Hypersensitivity to the medication or its components and intravenous administration	Hemolytic anemia and hemochromatosis (Jones & Bartlett Learning, 2020).	Hypersensitivity to vitamin D and hypercalcemia. (Jones & Bartlett Learning, 2020).	Hypersensitivity to the medication or components and uncorrected adrenal

	Learning, 2020).	of this medication while it contains lidocaine (Jones & Bartlett Learning, 2020).			insufficiency (Jones & Bartlett Learning, 2020).
Side Effects/Adverse Reactions (2)	Anemia, infection, and weakness.	Elevated liver enzymes, hemolytic anemia, and chills.	Dizziness, HTN, and metallic taste.	Difficulty swallowing, dizziness, and tachycardia.	Increased blood pressure and pulse, nausea, and vomiting.
Nursing Considerations (2)	This medication should not be taken with cyclosporine, gemfibrozil, tipranavir plus ritonavir, or telaprevir because of the high risk of rhabdomyolysis with acute renal failure. Do not use it in patients without apparent CAD (Jones & Bartlett Learning, 2020).	Never give this medication with calcium via IV at the same time. Protect this medication from light (Jones & Bartlett Learning, 2020).	Give iron and capsules with a full glass of juice or water. Do not crush enteric-coated tablets or open capsules (Jones & Bartlett Learning, 2020).	Monitor for manifestations of hypercalcemia. Monitor serum calcium whenever there is a dosage adjustment (Jones & Bartlett Learning, 2020).	This medication is not to be used to treat weight loss or obesity. Use cautiously in patients with underlying cardiovascular disease because this medication can increase cardiac contractility (Jones & Bartlett Learning, 2020).
Key Nursing Assessment(s)/Lab(s) Prior to	Monitor liver functions.	Obtain culture and sensitivity results before	Monitor the patient's blood pressure after each	Determine baseline and periodic serum calcium,	Monitor the patient's vitals and thyroid

Administration		administration. Monitor BUN, creatinine, ALT, AST, CBC, LD, bilirubin, hematocrit, and serum alkaline phosphatase levels (Jones & Bartlett Learning, 2020).	dose (Jones & Bartlett Learning, 2020).	phosphorus, magnesium, and alkaline phosphatase (Jones & Bartlett Learning, 2020).	levels (Jones & Bartlett Learning, 2020).
Client Teaching Needs (2)	Tell the patient to take the drug simultaneously every day to maintain its effects and tell the patient to take a missed dose as soon as possible (Jones & Bartlett Learning, 2020).	Urge the patient to report watery, bloody stools to the provider and report any adverse reactions such as rash, itching, or hives (Jones & Bartlett Learning, 2020).	Inform the patient that the stool may become dark green or black from this medication. Encourage the patient to eat more protein and vitamin C to improve iron absorption (Jones & Bartlett Learning, 2020).	Do not take this drug if experiencing S&S of hypercalcemia and report immediately to the physician. Consult the physician before taking an OTC medication. Calcium, phosphate, or magnesium-containing laxatives and antacids, mineral oil, and vitamin D preparations may increase adverse effects of calcifediol and, therefore,	Tell the patient that this medication is a lifelong drug. Advise the patient not to stop drugs or change dosage unless instructed by the provider (Jones & Bartlett Learning, 2020).

				should be avoided (Jones & Bartlett Learning, 2020).	

Medications Reference (1) (APA):

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:**	Pt appears alert and oriented to person, place, time, and situation (A & Ox4). Pt was well-groomed and in no acute distress.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:**. **Braden Score: 17** **Drains present: Y☐ N ☒** **Type:**	All extremities are brown (pt is African American), warm, dry, and symmetrical. Pulses 2+ throughout bilaterally. Capillary refill less than 3 seconds in fingers and toes bilaterally normal skin turgor. No edema is present in the upper and lower extremities bilaterally. Epitrochlear lymph nodes are nonpalpable bilaterally. Pt had a negative Homan's sign. Pt had no rashes, lesions, bruises, or wounds. Pt also scored a Braden Score of 17, which means the pt is at a mild risk for skin breakdown.
HEENT: **Head/Neck:**	The head and neck are symmetrical; the trachea is midline without deviation; the thyroid is not

Ears: **Eyes:** **Nose:** **Teeth:**	palpable, no noted nodules. Bilateral carotid pulses are palpable, and 2+—no lymphadenopathy in the head or neck. No scars were noted. —bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage from eyes. Bilateral lids are moist and pink without lesions or discharge noted. PERRLA bilaterally, red light reflex, and Rosenberg 20/20 were unable to obtain due to not having the proper equipment. EOMs are intact bilaterally. Bilateral auricles are moist and pink without lesions. I did not have the appropriate equipment to look in pt ear canals in the septum. The septum is midline with no deviation, no bleeding noted, and I could not see polyps due to not being able to see inside the septum. Bilateral sinuses are nontender to palpation. Overall, the oral mucosa is moist and pink without lesions, and the uvula is midline; the soft palate rises and falls symmetrically. Pt has white teeth.
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 & S2 without murmurs, gallops, or rubs. PMI palpable at 5th intercostal space at MCL. Normal rate and rhythm. Pulses are 2+ throughout bilaterally. Capillary refill is less than 3 seconds in fingers and toes bilaterally. Pt had no edema in the lower and upper extremities. No neck vein distention as well.
RESPIRATORY:	Normal rate and pattern of respirations,

Accessory muscle use: Y☐ N ☒ **Breath Sounds: Location, character**	symmetrical and non-labored, lungs sounded clear throughout anterior/posterior bilaterally, and no wheezes, crackles, or rhonchi were noted.
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:**	Pt has a regular diet at home, and pt was on a clear liquid diet in the hospital. Pt's height is 167.6 cm, and her weight is 60.5 kg. The abdomen is soft and non-tender upon light palpation of all four quadrants. No organomegaly or masses were noted in all four quadrants—no CVA tenderness. Bowel sounds are normoactive in all four quadrants; pt's last bowel movement was the night before. Pt had no scars, wounds, rashes, lesions, or drains noted.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Pt's urine is clear and yellow. Pt had no pain upon urination. Pt voided once during the shift.

MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 60 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☒ **She needs support to stand and walk**☒	.All extremities have a full range of motion (ROM). Hand grips and pedal pushes and pulls demonstrated normal and equal strength. Pt's balance was unsteady. Pt did need assistance walking and moving around with a gait belt and two assistive personnel; she does have glasses but not with her. PERRLA is intact bilaterally. Pt had a fall score of 60 on the Morse Fall Scale, which means she is at risk for falls. She has a fall score due to IV; she walks with a walker and forgets her limitations.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	All extremities have a full range of motion (ROM). Hand grips and pedal pushes and pulls demonstrated normal and equal strength. Pt's balance was unsteady. Pt is A & Ox4. PERRLA intact bilaterally. Pt was able to talk with me and others. Pt did not have sensory abnormalities, and pt never 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):**	Pt lives alone with a caregiver there during the day. Her daughter lives close by. Pt is ready to go home. She copes by reading. Pt has high school education. Pt did not talk about a preference for religion. Pt has two children, but the grandchildren check on her most often.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0755	105	162/78	18	97.6 F (oral)	92% Room air.
0955	98	137/79	20	98.4 F (oral)	95% Room air.

Vital Sign Trends: Pt's vitals are in the normal range for her due to having HTN. Her pulse was slightly elevated due to wanting to get out of the vail bed. Respiration was within normal limits but still at the end of elevation due to transferring pt from bed to chair.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0755	0-10	n/a	0, pt denies any pain. Verbally and nonverbally.	n/a	n/a
0955	0-10	n/a	0, pt denies any pain. Verbally and nonverbally.	n/a	n/a

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** **The date on IV:** 04-05-2022 **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Pt's IV is in the anterior left lower forearm. Pt's IV size is 20 gauge. Pt's IV access is intact and clean, with no redness or drainage noted at the site. Flushes without difficulty, the date on the IV is 4-5-22.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
800 mL	Pt voided once during the shift. It was a small amount.

Nursing Care

Summary of Care (2 points)

Overview of care: Made sure pt's call light was in reach. Monitored pt with fluids intake. Helped the pt use the bathroom and assisted her to the chair with a gait belt and second assistive personnel.

Procedures/testing done I helped administer the pt's medications via PO and gave her an IV antibiotic. Pt had a vail bed, but it was discontinued due to pt's status improvement.

Complaints/Issues: n/a

Vital signs (stable/unstable): Pt's vitals were normal besides an elevated blood pressure due to hypertension and other cardiac problems. Her respirations were elevated due to her transferring to the chair.

Tolerating diet, activity, etc.: Pt was on a clear liquid diet in case of going into surgery.

Physician notifications: The physician's idea was to discontinue the vail bed and keep her on clear liquids in case of surgery.

Future plans for the client: Plans were not discussed with the pt. She needed to be in the hospital for a few more days for observation and possible surgery.

Discharge Planning (2 points)

Discharge location: The physician discussed with nursing staff about possible long-term care but was not concerned with family at this time. Pt wants to go home.

Home health needs (if applicable): Pt needs assistance with ambulation and possibly someone to help maintain her health and care.

Equipment needs (if applicable): Pt will need a walker for home.

Follow-up plan: Follow-up plans were not discussed due to pt not being discharged and needing more observation.

Education needs: Pt needs education on proper perineal care and signs and symptoms of a UTI.

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • 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. Risk for falls related to Morse Fall Score of 60 as evidenced by the patient needing assistance walking and is weak.	This nursing diagnosis was chosen due to the patient's high fall score. She walks with a walker, is weak, has an IV, and still does not know her limitations.	**1.** Design an individualized plan of care for preventing falls. Provide a plan of care that is individualized to the patient's unique needs. **2.**. Place beds at the lowest possible position. Set the patient's sleeping surface near the floor as needed.	Planning an individualized fall prevention program is essential for nursing care in any healthcare environment and needs a multifaceted approach. Avoid relying too much on universal fall precautions as different individuals have different needs. Universal fall precautions are established for all patients to reduce their risk of falling. These standard strategies, in general, help	The patient will not sustain a fall. The patient will relate the intent to use safety measures to prevent falls. The patient will demonstrate selective prevention measures. Patients and caregivers will implement strategies to increase safety and prevent falls in the home.

			develop a safe environment that reduces accidental falls and delineates core preventive measures for all patients. Keeping the beds closer to the floor reduces the risk of falls and serious injury. Placing the mattress on the floor reduces fall risk in some healthcare settings. Low beds are designed to lessen the distance a patient falls after moving out of bed. Although these beds don't prevent a fall, they reduce the distance of a fall, reducing trauma and injury.	
2. Risk for impaired skin integrity related to Braden Score of 17 as evidenced by chairfast, poor	This nursing diagnosis was chosen due to the patient's Braden Score of 17.	**1.** Encourage the patient to change position every 15 minutes and change chair-bound positions every hour.	During sitting, the pressure over the sacrum may exceed 100 mm Hg. The force needed to close capillaries is	The patient reports any altered sensation or pain at the site of tissue impairment. The patient demonstrates an understanding of the plan to heal tissue and prevent

nutrition, and limited mobility.		**2.**Educate patients and caregivers about proper skincare.	around 32 mm Hg; any pressure above 32 mm Hg leads to ischemia. Educating patients and caregivers on methods to maintain skin integrity enhances their sense of self-efficacy and prevents skin breakdown.	injury. The patient describes measures to protect and heal the tissue, including wound care.
3. Fatigue related to iron deficiency anemia as evidenced by the patient's decreased RBC, Hgb, and Hct.	This nursing diagnosis was chosen due to the patient suffering from chronic iron deficiency anemia. Her RBCs, Hgb, and Hct, were all low, and her chart stated that she needed a blood transfusion upon arriving in the emergency department, and the patient is taking iron supplements.	**1.** Educate energy-conservation techniques. **2.**Assist the patient in developing a schedule for daily activity and rest.	Energy reserves may be depleted unless the client respects the body's need for increased rest. A plan that balances periods of activity with rest periods can help the client complete desired activities without adding fatigue levels. Clients and caregivers may need to learn skills for delegating tasks to others, setting	The client verbalized an understanding of the use of energy conservation principles. The client verbalized hopes of reducing fatigue, as evidenced by reporting increased energy and ability to perform desired activities.

			priorities, and clustering care to use the available energy to complete desired activities. Organization and time management can help the client conserve energy and reduce fatigue.	
4. Deficient knowledge related to unfamiliarity with nature and treatment of UTI as evidenced by patient's first UTI.	This diagnosis was chosen due to the patient not knowing the signs and symptoms of UTI and her first time having a UTI.	**1.**Explain to the patient about UTI risk factors, prevention, and treatment. **2.** Teach the patient about measures to prevent UTIs.	Frequent recurrences of UTI may indicate that the client has difficulty understanding the disease and complying with prescribed therapeutic management. Client teaching aims to resolve the current infection and prevent a recurrence.	The patient verbalized knowledge of the causes and treatment of UTIs, controls risk factors and completed medical therapy for UTIs.

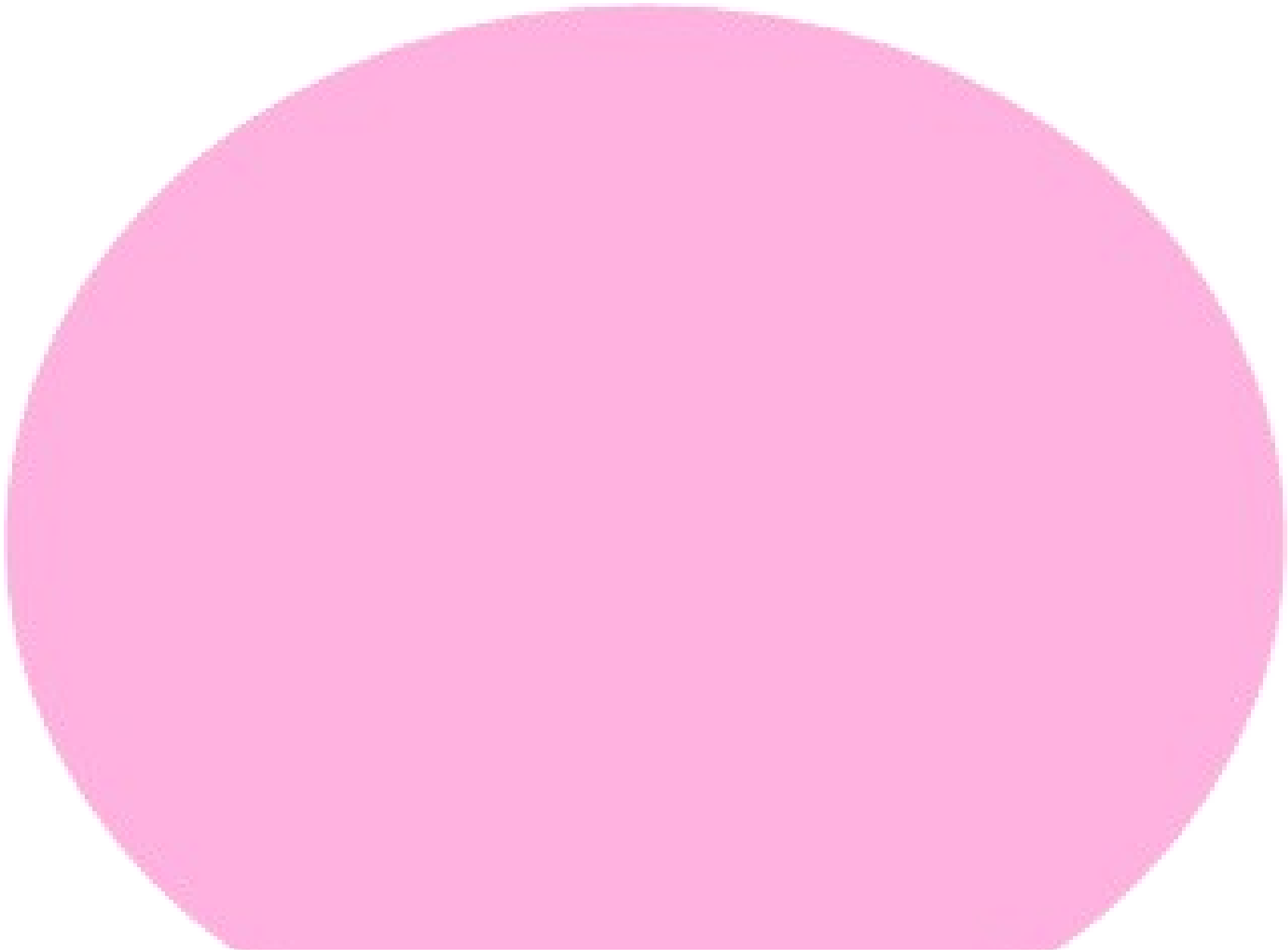
Other References (APA):

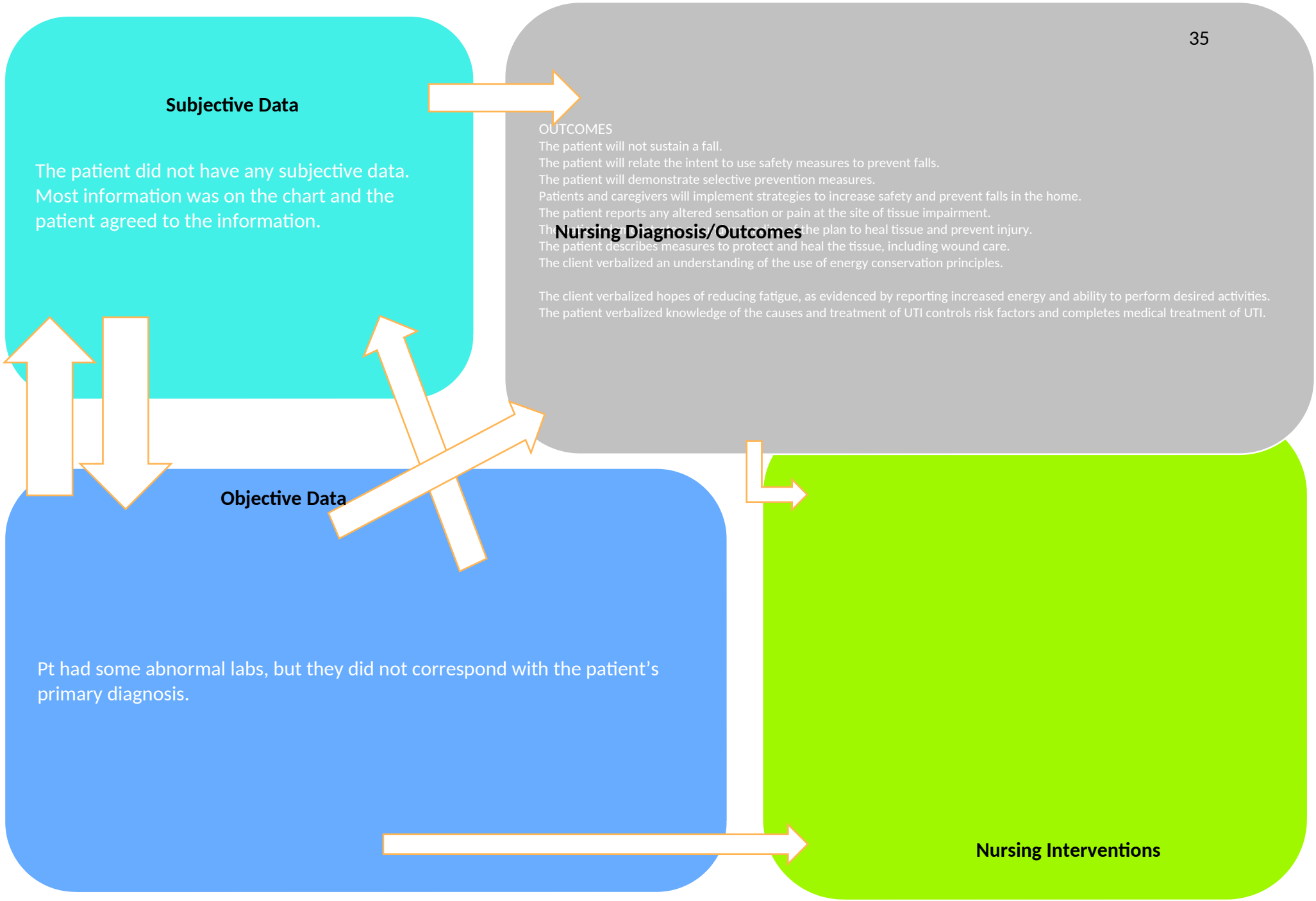
Concept Map (20 Points):

Client Information.

Date of Admission	Client Initials	Age	Gender
4-3-22	V.C.	83	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	Retired	Divorced	Lisinopril, Ambien, Amitriptyline, Sinemet, and Losartan.
Code Status	**Height**	**Weight**	
DNR	167.6 cm	60.5 kg	

Past Medical History: The patient's (pt) past medical history includes: arthritis, atrial fibrillation (A-fib), arteriovenous malformation (AVM) of the colon with hemorrhage, chronic pain, benign neoplasm of the colon, bradycardia, cardiomegaly, cataracts bilaterally, unspecified chronic heart failure (CHF), lumbar denigrative disc disease (DDD), depression, unspecified disease of the tricuspid valve, hypertension (HTN), two previous falls (2014), hypothyroid, impingement syndrome of the left shoulder, infarction of the kidney, insomnia, iron deficiency anemia, mechanical heart valve present, peripheral neuropathy, perivalvular leak of the prosthetic heart valve (sequela), plantar fascial fibromatosis, polyp of the colon, sciatica, single kidney, sick sinus syndrome (SSS), sinus pause, and unspecified constipation.
Past Surgical History: The pt's past surgical history includes hysterectomy, PR replacement of the mitral valve, three colonoscopies, shoulder arthroplasty, PR lap, radical nephrectomy, excisional biopsy, two cataract removal, chalazion excision, Yag capsulotomy laser, four EDG colonoscopy, four upper gastrointestinal endoscopies two video capsule, unspecified cath lab, and left heart cath.
Family History: The patient's family history includes the father passing due to lung cancer, the mother passing due to diabetes (DM) and unspecified heart issues, the brother who has hypertension (HTN), DM, unspecified heart issues, and psychiatry problems, the patient's sister who has breast cancer and unspecified psychiatry problems, the patient's son has DM, and her daughter has HTN.
Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): Pt smoked a pack of cigarettes for 22 years and quit in the year 1976. It has been 46.2 years since pt quit smoking tobacco. The pt denies any alcohol or drug use.
Assistive Devices: Pt has glasses and a walker.
Living Situation: Pt lives alone with help of a home caregiver.
Education Level: Pt only has a high school diploma.




Subjective Data
The patient did not have any subjective data. Most information was on the chart and the patient agreed to the information.
OUTCOMES
The patient will not sustain a fall.
The patient will relate the intent to use safety measures to prevent falls.
The patient will demonstrate selective prevention measures.
Patients and caregivers will implement strategies to increase safety and prevent falls in the home.
The patient reports any altered sensation or pain at the site of tissue impairment.
The patient describes the plan to heal tissue and prevent injury.
The patient describes measures to protect and heal the tissue, including wound care.
The client verbalized an understanding of the use of energy conservation principles.
The client verbalized hopes of reducing fatigue, as evidenced by reporting increased energy and ability to perform desired activities.
The patient verbalized knowledge of the causes and treatment of UTI controls risk factors and completes medical treatment of UTI.
Nursing Diagnosis/Outcomes
Objective Data
Pt had some abnormal labs, but they did not correspond with the patient's primary diagnosis.
Nursing Interventions