N321 Care Plan #

Lakeview College of Nursing

Name

Carsen White

Demographics (3 points)

Date of Admission 4/5/22	Client Initials J.M.	Age 65	Gender Female
Race/Ethnicity Caucasian	Occupation Not employed	Marital Status Widow	Allergies • Aspirin • Depakote [Divalprolex] • Hydrocodone-acetaminophen • Sulfa (sulfonamide antibiotics) • Tramadol
Code Status Full	Height 5'6"	Weight 129lbs	

Medical History (5 Points)

Past Medical History: Adhesive capsulitis of shoulder, arthritis, asthma, fibromyalgia, low back pain. Post Traumatic Stress Disorder, skin cancer, and dysphasia.

Past Surgical History: Cervical spine, colonoscopy, EGD, left knee surgery, shoulder surgery, upper gastrointestinal endoscopy, PR laryngoscopy, and vulva surgery.

Family History: Hypertension (Mother, Father, and Brother.) Breast cancer (Mother.)

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): 1 pack for 40 years.

Assistive Devices: Cane, walker, and gait belt.

Living Situation: At home.

Education Level: High-school

Admission Assessment

Chief Complaint (2 points): Confusion

History of Present Illness – OLD CARTS (10 points): Onset? 4/5/22. Location? In her house, fell on her the back of her head. Duration? 4/5/22-4/6/22/ (roughly two days.) Characteristics? Can not state current month or year. Aggravating factors? Lithium. Relieving factors? None. Treatment? Ativan. Symptoms? Confused and disoriented.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Lithium Toxicity

Secondary Diagnosis (if applicable): Acute confusion

Pathophysiology of the Disease, APA format (20 points): Lithium is a type of metal that can be consumed in the diet or by pills/medications. Lithium is known for helping some mental disorders by increasing the activity of chemical messengers in the brain (Lithium toxicity, 2017.) Some individuals may also use this drug for an alcohol disorder or even depression (Lithium, 2017.) The FDA has even approved this medication for bipolar disorder. If the medication is not prescribed and is just a supplement, then the dose is usually smaller. However, lithium toxicity is a very serious condition that could lead to serious confusion. Lithium toxicity can occur when an individual is taking lithium on a daily basis. When an individual is taking lithium on a daily basis this can cause the blood serum level to rise into a toxic range resulting in vision changes, nausea, vomiting, and confusion (Lithium Overview, 2020.) The patient showed signs of confusion which lead the provider to it was due to lithium toxicity once they saw her medications. Once lithium reaches a level of 1.5 mEq/L or higher, that is when it can really due damage to the body. Certain blood tests can

be drawn to determine the level and how serious the treatment needs to be. The best treatment for lithium toxicity is a cut in the dosage and airway protection due to emesis and aspiration.

Pathophysiology References (2) (APA):

Lithium: Overview, uses, side effects, precautions, interactions, dosing and reviews. (2020.). WebMD - Better information. Better health. https://www.webmd.com/vitamins/ai/ingredientmono-1065/lithium

Lithium toxicity: Types, symptoms, diagnosis, and treatment. (2017.). Verywell Mind. https://www.verywellmind.com/lithium-toxicity-types-causes-and-treatment-380283

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	**4.35-5.65**	**4.91**	**3.75**	**The reason behind the patients low red blood cell count can be from poor oxygen supply due to deranged morphology of the red blood cells causing a decrease in supply (Mayo Clinic, 2021.)**
Hgb	**13.2-16.6**	**14.7**	**11**	**The patients hemoglobin may be low due to the wounds and lacerations from blood loss caused by the fall (Mayo Clinic, 2021.)**
Hct	**38.3-48.6**	**43.0**	**32.6**	**The patients hematocrit was low due to a poor supply of red blood cells (Mayo Clinic, 2017.) This could be a result of the patients pressure ulcer on her back causing a loss of blood. Also, when the patient fell they could have loss a significant amount of blood**
Platelets	**135-317**	**488**	**324**	**The patients high platelet count could be from the patient injury from falling. The patients body could be suffering inflammation from their injuries (Mayo Clinic,**
WBC	**3.4-9.6**	**19.41**	**12.89**	**The high white blood cell count could be from the patients body fighting an infection. The patient is a very heavy smoker causing the bodies immunity system to be weak resulting in the patient being more prone to infections (Mayo Clinic, 2021.)**
Neutrophils	**2.5-7**	**None**	**None**	

Lymphocytes	**4.5-11.0**	**24.1**	**34.5**	**The patients high lymphocytes could be from the patients weak immune system from smoking or from their body being inflamed from falling and suffering injuries (Mayo Clinic, 2021.)**
Monocytes	**3-13**	**5.7**	**7.3**	
Eosinophils	**0.0-0.6**	**0.5**	**2.2**	**The high eosinophils could be a result of the patient fighting off an allergic reaction, considering they have asthma (Mayo Clinic, 2021.)**
Bands	**None**	**None**	**None**	

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-	**134-143**	**138**	**143**	
K+	**3.5-4.5**	**3.5**	**3.6**	
Cl-	**95-108**	**108**	**115**	**The high chlorine could be from dehydration from the patient not properly drinking enough water as she should, which could further lead to kidney disease and an even higher blood chlorine level (Mayo Clinic, 2021.)**
CO2	**20-30**	**16**	**19**	**The patient has low carbon dioxide levels, which could be a result of the patient dehydrating and kidney disease (Mayo Clinic, 2021.)**
Glucose	**90-120**	**84**	**80**	
BUN	**6-24**	**9**	**5**	**The patients low BUN level could be a result of the patient having a very low protein in their diet by malnutrition (Mayo Clinic, 2021.)**
Creatinine	**0.7-1.4**	**0.75**	**0.7**	
Albumin	**3.5-5.5**	**None**	**None**	
Calcium	**8.5-10.5**	**9.0**	**7.9**	**The patient has low calcium due to possible malnutrition. If the patient is taking too much medication and getting sedated a lot, this could result in poor nutrition and decreased calcium (Mayo Clinic, 2021.)**
Mag	**1.5-2.5**	**2.4**	**1.5**	
Phosphate	**None**	**None**	**None**	

Bilirubin	**1.2**	**None**	**None**	
Alk Phos	**44-147**	**None**	**None**	
AST	**10-40**	**None**	**None**	
ALT	**10-30**	**None**	**None**	
Amylase	**None**	**None**	**None**	
Lipase	**None**	**None**	**None**	
Lactic Acid	**None**	**None**	**None**	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**1.1-3.0**	**1.1**	**None**	
PT	**9.6-11.8**	**13.4**	**None**	**The patient could have a high PT time due to a possible Vitamin K deficiency resulting from taking sedative medications not allowing her to intake a proper diet and not receiving then nutrients needed (Mayo Clinic, 2021.)**
PTT	**30-40**	**36.3**	**None**	
D-Dimer	**>0.50**	**None**	**None**	
BNP	**>450**	**None**	**None**	
HDL	**>60**	**None**	**None**	
LDL	**<130**	**None**	**None**	

Cholesterol	**>200**	**None**	**None**	
Triglycerides	**>150**	**None**	**None**	
Hgb A1c	**4%-5.6%**	**None**	**None**	
TSH	**0.5-5.0**	**None**	**None**	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Pale/light yellow**	**Amber**	**None**	
pH	**4.6-8.0**	**5.0**	**None**	
Specific Gravity	**1.005-1.030**	**1.028**	**None**	
Glucose	**90-120**	**Negative**	**None**	
Protein	**0-14mg/dL**	**30**	**None**	**A high protein count in this patient could be possible kidney damage from an extensive family history of high blood pressure (Mayo Clinic, 2021.)**
Ketones	**>0.6**	**15**	**None**	**The patients high ketones could be from chronic vomiting from the overuse of medications mixing in the body (Mayo Clinic,**
WBC	**4,500-11,000**	**111**	**None**	**The patients high white blood cell count in the urine could be from the body fighting off an infection (UTI) from not properly voiding enough or not hydrating enough (Mayo Clinic, 2021.)**
RBC	**>4**	**54**	**None**	**The patients high red blood cells in the urine could also be from an infection, or other kidney problems relating to not properly hydrating (Mayo Clinic, 2021.)**
Leukoesterase	**0-5**	**Negative**	**None**	

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	**10,000-1,000 ,000**	**>100,000**	**None**	**The patients high urine culture could indicate that the patients does in fact have a urinary tract infection (Mayo Clinic, 2021.)**
Blood Culture	**4.32-5.72**	**Negative**	**None**	
Sputum Culture	**>25 <10**	**None**	**None**	
Stool Culture	**7.0-7.5**	**None**	**None**	

Lab Correlations Reference (1) (APA):

Hematocrit test. (2019, February 12). Mayo Clinic - Mayo Clinic. https://www.mayoclinic.org/tests-procedures/hematocrit/about/pac-20384728

(2021, April 29). Mayo Clinic - Mayo Clinic. https://www.mayoclinic.org

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-Ray, Cat Scan of the head, and Electrocardiogram.

Diagnostic Test Correlation (5 points): The chest x-ray was done to help rule out any serious condition with the patients lungs since they smoked a pack for 40 years. The cat scan was done to get a better visual on the clients head because they fell on it. The ECG was done to check heart rhythm to see if the confusion and fall was related to any heart abnormalities like heart failure.

Diagnostic Test Reference (1) (APA):

U.S. National Library of Medicine. (2020, November 9). ***Diagnostic tests*****. MedlinePlus. Retrieved February 27, 2022, from https://medlineplus.gov/diagnostictests.html**

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

Home Medications (5 required)

Brand/Generic	**Aceta-minophen**	**Melatonin**	**Alum-mag Hydroxide-simeth**	**guaiFENesin**	**None**
Dose	**500 mg**	**3 mg**	**30 mL**	**200 mg (10 mL)**	**None**
Frequency	**Q4**	**At Bedtime**	**6 Hours PRN**	**4 Hours PRN**	**None**
Route	**Oral**	**Oral**	**Oral**	**Oral Liquid**	**None**
Classification	**Nonsalicylate, paraaminophenol**	**Hormone dopamine antagonist**	**Aluminum Salt**	**Expectorants**	**None**
Mechanism of Action	**Inhibits the enzyme cyclooxyrgenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin.**	**Promote sleep by regulating the patients sleep/wake cycle by binding melatonin receptors in the plasma membrane.**	**Neutralizes or reduces gastric acidity, increasing stomach and duodenal alkalinity. Protects stomach and duodenum lining by inhibiting pepsin's proteolytic activity. Binds with phosphate ions in the intestine to form insoluble aluminum-phosphate compounds, which lower blood**	**Guaifenesin is thought to act as an expectorant by increasing the volume and reducing the viscosity of secretions in the trachea and bronchi.**	**None**

Reason Client Taking	**To reduce fever, and mild to moderate pain.**	**To help the patient create a better sleep cycle.**	**To treat hypersensitivity associated with gastric**	**To loosen secretions in the patients throat.**	**None**
Contraindications (2)	**1. Hypersensitivity to this medication. 2. Severe hepatic impairme**	**1. Pregnancy 2. Autoimmune conditions**	**1. Hypersensitivity to this medication 2. Hypersensitivity to this**	**1. Diabetes 2. High Blood Pressure**	**None**
Side Effects/ Adverse Reactions (2)	**1. Agitation 2. Hypertension**	**1. Headache 2. Nausea**	**1. Encephalopathy 2. Constipation**	**1. Dizzy 2. Nausea**	**None**
Nursing Considerations (2)	**1. Use medication cautiously in patients with hepatic impairment. 2. Monitor renal function in patient on long**	**1. Caution patient to avoid driving due to making the patient tired. 2. Avoid the use of alcohol with the medication.**	**1. Don't give aluminum hydroxide within 1 to 2 hours of other oral drugs. 2. Monitor patients serum levels of sodium.**	**1. Take an adequate amount go fluids when taking this medication. 2. Avoid irritants that could make the patient cough.**	**None**

Hospital Medications (5 required)

Brand/Generic	**Aspirin**	**Atorvastatin (LIPITOR)**	**Enoxaparin (LOVENOX)**	**Folic acid Tablet**	**Prami-Pexole (MIRAPEX)**
Dose	**81 mg**	**20 mg**	**40 mg**	**1 mg**	**0.5 mg**
Frequency	**Daily @0900**	**Daily @0900**	**Daily @1300**	**Daily @0900**	**Daily x2**
Route	**Oral**	**Oral**	**Sub Q**	**Oral**	**Oral**
Classification	**nonsteroidal anti-inflammatory drugs**	**HMG-CoA reductase inhibitor**	**Low-molecular weight heparin**	**Folic Acid**	**Nonergoline dopamine agonist**

Mechanism of Action	**Blocks the activity of cyclooxyrgenase, the enzyme needed for prostaglandin synthesis. Prostaglandins, important mediators in the inflammatory response, cause local vasodilation with swelling and pain. With blocking of cyclooxyrgenase and inhibition of prostaglandins, inflammatory symptoms subside**	**Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG- CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL. Uptake and breakdown.**	**Potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors. Without thrombin, fibrinogen can't convert to fibrin and clots can't form.**	**Stimulates the production of red blood cells, white blood cells, and platelets in persons suffering from certain megaloblastic anemias.**	**May stimulate dopamine receptors in the brain, thereby easing symptoms of Parkinson's disease, which is thought to be caused by a dopamine deficiency.**
Reason Client Taking	**To relieve mild pain or fever**	**To control lipid levels as adjunct to diet in primary.**	**To prevent deep vein thrombosis after hip or knee placement.**	**To treat low blood levels of folate.**	**To treat Parkinson's disease**

Contraindications (2)	**1. Active bleeding 2. Chicken pox**	**1. Active hepatic disease 2. Hypersensitivity to atorvastatin**	**1. Active major bleeding 2. Pork products**	**1. Renal disease 2. Pernicious anemia.**	**1. Hypersensitivity to pramipexole 2. Hypersensitivity to this medication components.**
Side Effects/ Adverse Reactions (2)	**1. Confusion 2. Hearing loss**	**1. Hypoglycemia 2. Loss of taste**	**1. Confusion 2. Alopecia**	**1. Nausea 2. Sleep problems**	**1. Cardiac failure 2. Pneumonia**
Nursing Considerations (2)	**1. Don't crush these medications. 2. Ask about tinnitus.**	**1. Monitor diabetic patients blood glucose levels 2. Expect to measure lipid levels 2 to 4 weeks after therapy starts, to adjust dosage as directed.**	**1. Use enoxaparin with extreme caution in patients with a history of heparin-induced thrombocytopenia. 2. Use cautiously in those with bleeding diathesis.**	**1. Doses higher than 1 mg may be unsafe 2. You can take folic acid with or without food.**	**1. Use cautiously in patients with penal impairment 2. Monitor patient for postural deformity.**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *Nurse's Drug Handbook* (20th ed.).

Assessment

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

GENERAL: **Alertness: x3** **Orientation: x2 (confused with not remembering certain faces.)** **Distress: No distress.** **Overall appearance: At stated age**	**Here the nurse should be looking for any confusion or disoriented behavior. The patient was brought in for confusion and a recent fall to the head, it is best to shake to make sure you check for alert and orientated.**
INTEGUMENTARY: **Skin color: Pale** **Character: Dry** **Temperature: Warm** **Turgor: Normal recoil** **Rashes: None** **Bruises: From elbows down on left and right arm** **Wounds: Head laceration and pressure ulcer .** **Braden Score: 8** **Drains present: None** **Type: None**	**The nurse should check the patients skin here thoroughly. The patent suffered from a recent fall and needs to have their skin checked to make sure no cuts or wounds get worse and that they are all recorded to show the hospital did not cause these problems.** **Checking for any wounds from the fall also helps the nurse check for pressure ulcers which were present and helps the hospital care for the wound.**
HEENT: **Head/Neck: Normocephalic** **Ears: Temporal Membrane pearly gray** **Eyes: Conjuctiva clear** **Nose: Oral mucosa clear** **Teeth: Dentures**	**Due to the patients recent fall it is also important to check for any abnormalities in the HEENT that could negatively effect the patient in any way.**
CARDIOVASCULAR: **Heart sounds: S1 and S2 heard no murmur** **Cardiac rhythm (if applicable): Normal sinus rhythm.** **Peripheral Pulses: +2 normal** **Capillary refill: >3 seconds** **Neck Vein Distention: None** **Edema None** **Location of Edema: None**	**The patient had an ECG done when they first arrived so it is important to check over the heart again to make sure nothing has happened over the course of the patients stay.**

RESPIRATORY: **Accessory muscle use: None** **Breath Sounds: Location, character** **Vesicular breath sounds no abnormalities.**	The patient is a very heavy smoker of 1 pack a day for forty years and has asthma, so the nurse should do a thorough exam of the lungs to make sure they are working properly.
GASTROINTESTINAL: **Diet at home: Regular** **Current Diet: Regular** **Height: 5'6"** **Weight: 129 lbs** **Auscultation Bowel sounds: Normative** **Last BM: Today 4/7/2022** **Palpation: Pain, Mass etc.: None** **Inspection: No abnormalities** **Distention: None** **Incisions: None** **Scars: Small scar on LLQ** **Drains: None** **Wounds: None** **Ostomy: None** **Nasogastric: None** **Size: None** **Feeding tubes/PEG tube None** **Type: None**	The nurse should check the patients diet history to make sure it does not interfere with the nursing care. The nurse should have to check the patients bowels sounds to check to see if there is any abnormal bowel sounds so they can take medications and not throw it back up and digest it properly.
GENITOURINARY: **Color: Amber** **Character: Foul smell** **Quantity of urine: 600 mL** **Pain with urination: None** **Dialysis: None** **Inspection of genitals: Normal** **Catheter: None** **Type: None** **Size: None**	**The nurse should check the patients urine to make sure the patient is voiding properly. The patient was confused which could have lead to improper urine output and UTI. The nurse should check to make sure the patient is voiding because if they are not this could lead to a UTI and confusion.**

MUSCULOSKELETAL: **Neurovascular status: Normal** **ROM: Normal** **Supportive devices: Gait belt, cane, and walker** **Strength: Equal bilaterally** **ADL Assistance: Yes** **Fall Risk: Yes** **Fall Score: 8** **Activity/Mobility Status: Up x1 with gait belt** **Independent (up ad lib) Needs a x1 assistance** **Needs assistance with equipment? Yes.** **Needs support to stand and walk? Yes.**	**It is crucial to exam the musculoskeletal of the patient after experiencing confusion to make sure the patient can do activities of daily living that do not harm put them at harm. The nurse should also make sure the patients range of motion is in tact so they can do some activities by themselves to build total strength.**
NEUROLOGICAL: **MAEW: Yes** **PERLA: Yes** **Strength Equal: Yes** **Orientation: x2** **Mental Status: Alert x3 Oriented x2** **Speech: Normal for stated age** **Sensory:Aware of current surroundings** **LOC: None**	**Checking the neurological status is crucial due to the patient being admitted for lithium toxicity and confusion. Checking the neurological status helps the nurse decide if the patient needs a sitter for safety to make sure the patient does not accidentally hurt themselves.**
PSYCHOSOCIAL/CULTURAL: **Coping method(s): Praying and "helping others."** **Developmental level: High school** **Religion & what it means to pt.: Did not state any forms of religion** **Personal/Family Data (Think about home environment, family structure, and available family support): The patient states her husband is her support but she is a widow.**	The nurse checking the patients cultural history could help make the patient feel for comfortable in their care. If the patient is super religious it could increase their health mentally and potentially make them healthier if they pray. The nurse respecting and asking their religious view is very important in their care.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1100	**91**	**134/66**	**18**	**97.7 degrees F**	**98%**
1627	**92**	**161/74**	**18**	**97.9 degrees F**	**99%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1100	**0-10 Stated "0."**	**None**	**None**	**None**	**None**
1245	**0-10 Stated "0."**	**None**	**None**	**None**	**None**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: None **Location of IV: No where** **Date on IV: Removed for discharge** **Patency of IV: None** **Signs of erythema, drainage, etc.: None** **IV dressing assessment: None**	None

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
740 mL	600 mL

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was very stable when I first met her. The patient was very open and allowed for the whole assessment to happen. However, the second time I went to check on her she was hesitant and stated, "I did not invite anyone else in my room I don't know who that is." After I told her who I was and that we previously talked she was comfortable and apologized. Overall, my patient was comfortable and professional when it came for me caring for her.

Procedures/testing done: A chest x-ray, ECG, and cat scan were done on my patient.

Complaints/Issues: There was no complaints or issues, the patient was just frequently asking about when she was getting discharged.

Vital signs (stable/unstable): The patients vital signs were stable.

Tolerating diet, activity, etc.: The patient was eating 75% of her regular diet and was up with assistance to the bathroom.

Physician notifications: The physician was notified for the patients discharge and has to sign off.

Future plans for client: The future plans for this client are to be discharged home and provided education on safety from fall risks and medication toxicity.

Discharge Planning (2 points)

Discharge location: Patients home.

Home health needs (if applicable): The patient should get rid of throw rugs around the home and install ninth lights to see for bathroom breaks during the middle of the night.

Equipment needs (if applicable): A cane, walker and gait belt.

Follow up plan: The patient should follow up with her provider regarding her current medications to reduce toxicity.

Education needs: The patient needs education on the lithium drug toxicity, pressure ulcer education, and fall risk for medications she is taking that can be sedative.

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

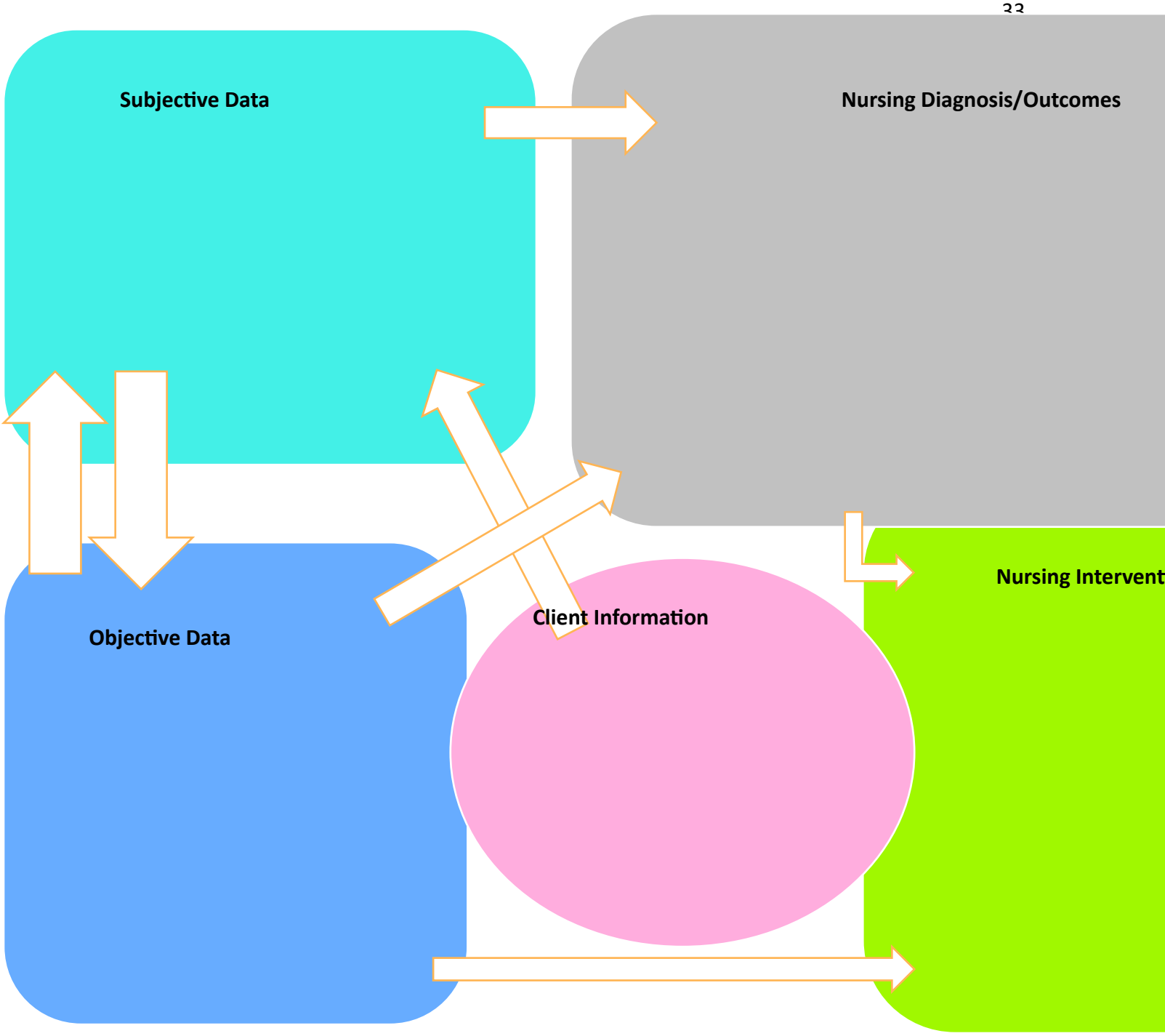
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 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 acute confusion related to medication toxicity.	**This was chosen due to the patient being admitted for lithium toxicity.**	**1. The patient was educated on the importance on using assistive devices to eliminate risk for falls.** **2. A gait belt was used whenever the patient went to the bathroom so she did not fall.**	**1. The outcome goal here was to make sure the patient maintained safety as well as being able to be mobile at the same time to gain strength again.**	**The client was very eager to get up and be active, however she was not use to requiring safety when she would walk before, however she was comfortable with using all assistive devices and understand why they were needed.**
2. Risk for activity intolerance related to imbalanced gait.	**The patient is at risk for falling and causing bodily harm to themselves resulting in immobility caused by their imbalanced gait.**	**1. The patient was given a 1 to 1 sitter to help ambulate around the room if needed.** **2. The patient was also provided information on how to wait for help whenever they needed to stand up.**	**1. The outcome goal here was for the patient to use help whenever they needed to ambulate to reduce causing harm and putting themselves in harm resulting in activity intolerance.**	**The client was a little hesitant on using help and needed to be reminded every now and then on why it is important to call for help.**

3. Risk for falls related to confusion and medication toxicity.	**The patient could fall again due to lithium toxicity or any other medication toxicity.**	**1. The patient was provided information on certain medications that could be sedative causing her to feel more tired than usual.** **2**. The patient was also educated on when to take certain sedating medications. For example, how some of her medications may be taken at night to reduce staying awake while taking sedating medications.	**1. The outcome goal here was for the patient to understand how some medications can alter her cognition and could put her at risk for falling.**	**The patient was confused on what medications could make her "sleepy" but was able to repeat back the education given and was under stable of the outcomes that could happen.**

Other References (APA):

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Objective Data
Client Information
Nursing Intervent

Subjective Data: The patient states that they “are ready to go home” and also said “who are you again” after I reentered the room twice. The patient also said “get out of my room I invited no guests!” Forgetting where she was and who was taking care of her.

Nursing Diagnosis: 1. Risk for acute confusion related to medication toxicity. 2. Risk for activity intolerance related to imbalanced gait. 3. Risk for falls related to confusion and medication toxicity.

Objective Data: The patients gait was unbalanced. The patients vital signs were stable but her walking, was not. The patient also had noticeable bruises on each arm and head from her recent fall at home.

Client Information: The patient is a 65 year old caucasian female who was brought from home into the hospital with signs of confusion and suffered minor injuries from a recent fall at home due to lithium toxicity.

Nursing Interventions: Some interventions introduced to the patient were education on medications and their reactions. The patient was also provided a 1 to 1 sitter due to an imbalanced gait. A walker, cane, and gait belt were also given to the patient to prevent falls.