N321 Care Plan # 2

Lakeview College of Nursing

Noredia Asia

Demographics (3 points)

Date of Admission 4/12/22	**Client Initials** J.S.	**Age** 75	**Gender** Male
Race/Ethnicity White	**Occupation** Unemployed	**Marital Status** Married	**Allergies** Ativan – Delusions Vicodin – Severe anxiety Tramadol – Insomnia; Anxiety
Code Status FULL	**Height** 5'8	**Weight** 243lbs	

Medical History (5 Points)

Past Medical History:

BPH; CAD; Kidney stones; Iron deficiency anemia; multiple myeloma; Parkinson's; Pulmonary embolism; PVD; Sleep apnea; RLS

Past Surgical History:

Multiple angioplasty's; pacemaker insertion; cholecystectomy; cervical spinal surgery; upper GI endoscopy

Family History:

Sister: Blood disease; Maternal aunt: Breast cancer; Mother: cancer

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

Quit smoking 6 years ago; Smoking included cigarettes; started 50 years ago; 20 pack a year; never used smokeless tobacco, No alcohol or other drugs

Assistive Devices: Walker

Living Situation: Lives with wife

Education Level: High School Diploma

Admission Assessment

Chief Complaint (2 points): Altered Mental Status

History of Present Illness – OLD CARTS (10 points):

75-year-old male presents to the ED with a chief complaint of an altered mental status. The patient was confused and couldn't provide history of present illness. The patient's wife was at the bedside and provided his information and history. The patient has a history of Parkinson's and upper extremity tremors that got worse the night before the patient's admission. This occurred all night to the point where the patient's CPAP had to be removed for safety. The patient's wife observed some aphasia and difficulty expressing himself from the client along with the vigorous tremors. The wife says the patient had "no fever, chills or pain". Nothing has worked to relieve or make his symptoms worse and the ED is the first line of treatment for this patient.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Encephalopathy

Secondary Diagnosis (if applicable): Hyperkalemia

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

Encephalopathy means damage or disease that affects the brain. It happens when there has been a change or alteration in the way the brain works or a change in the body that affects the brain. Those changes lead to an altered mental state, leaving you confused and not acting like you usually do. Encephalopathy is not a single disease but a group of disorders with several causes. It is a serious health problem and without treatment, can cause temporary or permanent brain damage.

There are 2 types of encephalopathy which include reversible and irreversible. Reversible includes an attack on the brain. With Hashimoto's encephalopathy, the immune system attacks the brain, while Metabolic encephalopathy includes other health. Conditions like diabetes, kidney failure and heart failure make it hard for the brain to work. Infections of the brain like meningitis or a UTI, brain tumors and exposure to toxins. The type of irreversible encephalopathy is chronic traumatic encephalopathy which is caused by repeated head injuries that damage the brain like football. Another type is hypoxic-ischemic encephalopathy that occurs when you don't enough oxygen like carbon dioxide.

Signs and symptoms of encephalopathy include confusion, memory loss, personality changes, trouble thinking clearly or focusing. Symptoms also include trouble speaking, muscle weakness, involuntary eye movements, tremors, trouble swallowing, sleepiness, and seizures. To diagnose the disorder, the doctor will give a physical exam and may do tests of concentration, blood and urine tests, spinal fluid tests, a CT and MRI, and possible EEG test. The patient had a CT scan completed. Treatment of the disorder can include medications that stop seizures or ammonia levels, changing the foods you eat, dialysis or organ transplant. The patient was given medications to suppress the symptoms.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for Pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

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	3.5-5.2	2.37	2.37	Anemia
Hgb	11-16	8.4	8.0	Anemia
Hct	34-47	25.4	25.3	Anemia
Platelets	140-400	367	333	N/A
WBC	4-11	6.08	5.36	N/A
Neutrophils	1.6-7.70	4.86	4.32	N/A
Lymphocytes	1.0-4.9	0.48	0.44	Anemia
Monocytes	0.0-1.110	0.52	0.39	N/A
Eosinophils	0.0-0.510	0.10	0.10	N/A
Bands	0.0-10	N/A	N/A	N/A

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145	132	139	Adrenal insufficiency
K+	3.5-5.1	5.2	4.7	Renal issues
Cl-	98-107	93	104	Renal issues
CO2	22-29	28	26	N/A
Glucose	60-99	122	126	Diabetic
BUN	10-20	35	14	Possible urinary tract obstruction
Creatinine	0.55-1.02	2.37	0.81	Urinary obstruction
Albumin	3.4-4.8	3.2	2.8	Liver failing

Calcium	**8.9-10.6**	**11**	**8.3**	**Renal failing**
Mag	**1.6-2.6**	**1.6**	**1.7**	**N/A**
Phosphate	**2.8-4.5**	**N/A**	**2.9**	**N/A**
Bilirubin	**0.2-1.2**	**0.4**	**0.4**	**N/A**
Alk Phos	**40-150**	**72**	**69**	**N/A**
AST	**4-34**	**9**	**9**	**N/A**
ALT	**0-55**	**<5**	**<5**	**N/A**
Amylase	**25-115**	**N/A**	**N/A**	**N/A**
Lipase	**73-393**	**N/A**	**N/A**	**N/A**
Lactic Acid	**0.5-2.20**	**N/A**	**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	**0.9-1.1**	**1.4**	**1.0**	**Anemia**
PT	**11.7-13.8**	**16.7**	**12.3**	**Anemia**
PTT	**22.4-35.9**	**29.6**	**29.4**	**N/A**
D-Dimer	**<500**	**N/A**	**N/A**	**N/A**
BNP	**0-100**	**63**	**65**	**N/A**
HDL	**40-60**	**N/A**	**N/A**	**N/A**
LDL	**<100**	**N/A**	**N/A**	**N/A**
Cholesterol	**0-200**	**N/A**	**N/A**	**N/A**

Triglycerides	**<150**	**N/A**	**N/A**	**N/A**
Hgb A1c	**4-6**	**N/A**	**N/A**	**N/A**
TSH	**0.350-4.940**	**N/A**	**N/A**	**N/A**

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Colorless yellow; Clear**	**Straw; Clear**	**Colorless; Clear**	**N/A**
pH	**5.0-7.0**	**6.0**	**6.2**	**N/A**
Specific Gravity	**1.003-1.035**	**1.008**	**1.008**	**N/A**
Glucose	**Neg**	**Neg**	**Neg**	**N/A**
Protein	**Neg**	**Neg**	**Neg**	**N/A**
Ketones	**Neg**	**Neg**	**Neg**	**N/A**
WBC	**0-25**	**1**	**Neg**	**N/A**
RBC	**0-20**	**2**	**Neg**	**N/A**
Leukoesterase	**Neg**	**Neg**	**Neg**	**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	**Neg**	**N/A**	**N/A**	**N/A**
Blood Culture	**Neg**	**No growth**	**No growth**	**No blood affliction to cause encephalopathy**
Sputum Culture	**Neg**	**N/A**	**N/A**	**N/A**
Stool Culture	**Neg**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (1) (APA):

Kee, J. L. F. (2017). *Pearson Handbook of Laboratory & Diagnostic Tests with Nursing implications* (8th ed.). Pearson.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

CT Brain w/ Contrast: No intra- or extra- axial hemorrhages or fluid collections. No mass effect or midline shift. Ventricles are mildly prominent with associated cortical volume loss with patient stated age. Mild chronic ischemic changes in periventricular deep white matter.

X-RAY Chest AP: Possible mild increased vascular congestion. No acute airspace consolidation or pleural effusion.

X-RAY Foot Right Complete: Normal alignment. No fractures. Soft tissue defect along the plantar aspect of heel. No visible bone destruction.

Diagnostic Test Correlation (5 points):

CT Brain w/ Contrast: This test was done in order to analyze for any brain or neurological damages/problems that could cause the patient to be disoriented.

X-RAY Chest AP: Assessing the chest for possible lung fluid buildup due to the removal of the CPAP.

X-RAY Foot Right Complete: To assess if there were any other damages to the patient's foot that could add onto the pain that is currently affecting the patient.

Diagnostic Test Reference (1) (APA):

Kee, J. L. F. (2017). *Pearson Handbook of Laboratory & Diagnostic Tests with Nursing implications* (8th ed.). Pearson.

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

Home Medications (5 required)

Brand/Generic	**Acyclovir/ Zovirax**	**Alprazolam/ Xanax**	**Atorvastatin/ Lipitor**	**Cephalexin/ Keflex**	**Duloxetine / Cymbalta**
Dose	400mg	0.5mg	20mg	250mg	60mg
Frequency	Bid	Daily	Daily	Daily	Daily
Route	PO	PO	PO	PO	PO
Classification	Pharm: Nucleoside analogue Therapeutic: Antiretroviral	Pharm: Benzodiazepine Therapeutic: Anxiolytic	Pharm: HMG-CoA reuctase inhibitor Therapeutic: Antihyperlipidemic	Pharm: First-generation cephalosporin Therapeutic: Antibiotic	Pharm: SNRI Therapeutic: Antidepressant
Mechanism of Action	Several actions combine to inhibit herpes virus replication	May increase effects of GABA by binding to specific benzodiazepine receptors in cortical and limbic areas of the CNS	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductive and cholesterol synthesis in the liver	Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross-linking of peptidoglycan strands	Inhibits dopamine, serotonin, norepinephrine reputable in CNS
Reason Client Taking	Preventing herpes zoster in immunocompromised patients	Anxiety	Atherosclerotic cardiovascular disease	Treat bone infection	Neuropathic pain
Contraindications (2)	Hypersensitivity to acyclovir or	Acute angle-closure glaucoma;	Active hepatic disease; Hypersensitivity	Hypersensitivity (ONLY)	Chronic liver disease;

	valacyclovir (ONLY)	Hypersensitivity			hypersensitivity
Side Effects/Adverse Reactions (2)	Encephalopathy; Hepatitis	Hepatitis; Angioedema	Hypoglycemia; Pancreatitis	Hepatic failure; Nephrotoxicity	Pancreatitis; Hepatitis
Nursing Considerations (2)	Ensure the patient is well hydrated; Know that hemolytic uremic syndrome and thrombotic thrombocytopenic purpura	Warn patient not to consume alcohol or take an opioid during treatment; Inform patient of fatal additive effects	Notify provider immediately if patient develops myopathy; Monitor diabetic patient's blood glucose levels	Assess live labs; Monitor patient BUN and creatinine levels to detect early signs of nephrotoxicity	Monitor patient for serotonin syndrome; Know that treatment with linezolid or IV methylene blue is not recommended

Hospital Medications (5 required)

Brand/Generic	**Cilostazol/ Pletal**	**Morphine/ MS Contin**	**Pantoprazole/ Protonix**	**Prednisone/ Rayos**	**Rivaroxaban/ Xarelto**
Dose	100mg	60mg	40mg	10mg	10mg
Frequency	Bid ac	Every 12 hrs	Daily	Daily	Daily
Route	PO	PO	PO	PO	PO
Classification	Pharm: Phosphodiesterase Therapeutic: Antiplatelet	Pharm: Opioid Therapeutic: Opioid analgesic	Pharm: Proton pump inhibitor Therapeutic: Antiulcer	Pharm: Glucocorticoid Therapeutic: Immunosuppressant	Pharm: Factor Xa Inhibitor Therapeutic: Anticoagulant
Mechanism of Action	May inhibit phosphodiestrase; increases cAMP in	Binds with and activates opioid	Interferes with gastric acid secretion by inhibiting the	Binds to intracellular glucocorticoid receptors	Selectively blocks the active site of factor Xa;

	platelets and blood vessels	receptors in brain and spinal cord	hydrogen-potassium-adenosine triphosphate enzyme system	and suppresses inflammatory and immune responses	blood clotting is impaired
Reason Client Taking	Reduce symptoms of intermittent claudication	Severe pain	Gastroesophageal reflux disease	Adrenal insufficiency	Reduce the risk of DVT and stroke
Contraindications (2)	Heart failure; Hypersensitivity	Asthma; Respiratory depression	Rilpivirine-containing products; Hypersensitivity	Hypersensitivity; Systemic fungal infection	Bleeding; Hypersensitivity
Side Effects/Adverse Reactions (2)	GI hemorrhage; Leukopenia	Coma; Cardiac arrest	C-Diff; Hepatotoxicity	Seizures; Heart failure	GI bleeding; Cerebral hemorrhage
Nursing Considerations (2)	Take 1 hour before or 2 hours after a meal; Monitor patient's vitals signs and cardiovascular status closely	Extreme caution with patients with hypercapnia, hypoxia, or decreased respiratory reserve; Extreme caution with patients at risk for carbon dioxide retention	Monitor patient for C. Diff; Monitor patient for bone fracture	Do not stop abruptly; Monitor fluid intake and output and daily weight	Monitor patient closely for bleeding; Monitor patient hepatic and renal function

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *Nurse's Drug Handbook* (12th ed.).

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert Well groomed Non-cooperative No acute distress Confused, disoriented, follows commands
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** N/A **Bruises:** N/A **Wounds:** Yes **Braden Score: 14** **Drains present: Y☐ N ☒** **Type:**	Skin is dry and intact, no drains noted. Normal distribution, quantity, and texture of hair across all regions. Skin warm upon palpitation. Skin turgor normal mobility. No rashes. Chronic wound to right heel from PVD; history of infection but no current discharge or redness – necrotic in prior admission – possible amputation
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is midline with no deviations. Hair is blonde. Ears show no abnormal drainage, tympanic membrane visible, pearly grey. PEERLA is noted. Patient uses glasses regularly. Nose shows no deviated septum, turbinates equal bilaterally. Oral mucosa is pink and moist with no notable abnormalities. Dentures noted.
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:**	Normal Sinus Rhythm noted. Bradycardia. S1 and S2 heard, radial pulses palpable, pedal pulses palpable. Capillary refill less than 3 seconds.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breathing normal, breath sounds clear. Not using accessory muscles. The chest moves equally with respiration and there is no use of accessory muscles with intercostal, subcostal and suprasternal retraction. There are no chest wall deformities. On palpation,

	chest expansion is equal on both sides. Tactile fremitus is equal on both sides.
GASTROINTESTINAL: **Diet at home:** Regular **Current Diet:** Cardiac; low K+; diabetic **Height:** 5'8 **Weight:** 243lbs **Auscultation Bowel sounds:** **Last BM:** 4/13/22 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Bulged abdomen – normal for client from wife Obese Bowel sounds normal and active in all 4 quadrants, no masses, no organomegaly. The liver and spleen were not palpable. No drains noted. Upon inspection, no distention, incisions, scars, drains, or wounds.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** External **Size:** Large	Urinary incontinence Large male external catheter noted Urine appears clear yellow without any difficulty or pain with urination. Genitals are without redness, bruises, or sores.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 15** **Activity/Mobility Status:** **Independent (up ad lib) ☐**	Nystagmus noted Unsteady gait Tested cranial nerves intact. Active range of all extremities. Strength is equal in all extremities. Patient placed on bed rest. High risk for falls.

Needs assistance with equipment ☐ **Needs support to stand and walk X**	
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Awake, disoriented to person, place, time, and able to state reason for visit. He does not speaks but comprehends English well and follows basic commands. Pupils are equal and reactive. Equal grips bilaterally in upper extremities and equal in lower extremities. Hand grips demonstrate equal strength and pedal push 5 out of 5 on all extremities. Normal sensation upon assessment. Speech is confused.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient does not handle emotions well and frequently gets frustrated. Wife assists in calming patient down Appropriate developmental level for age Christianity is important to patient and life Patient is physically unable to articulate support by family, friends, and environment

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	61	137/60	20	97.7F	99% - 2L nasal cannula
.1110	65	128/63	20	98F	97% - 2L nasal cannula

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

0730	0-10	Bilateral; lower extremities	8	Constant; aching	Around-the-clock dosing; quiet environment; care-clustered
0919	0-10	Bilateral foot	9	"It just hurts"	Around-the-clock dosing; quit environment; care-clustered

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: 20G **Location of IV:** Anterior; left; lower; proximal arm **Date on IV:** 4/13/22 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:**None **IV dressing assessment:** Intact, dry, clean, and dressing in place	IV infusing pump – 0.9% NaCl 125 mL/hr

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
360 mL – water 900 mL – IV fluid 100% - breakfast	600 mL – urine

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was agitated for majority of shift and wanted to be left alone. Vital signs and medications passing was successful. The patient refused a bath and decided to sleep.

Procedures/testing done: None

Complaints/Issues: There were no complaint or issues

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Cardiac, low K+, and diabetic diet; ROM as much as possible; SCD; Up with 2 people with a walker and gait belt

Physician notifications: None

Future plans for client: Go home with wife

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): non-slip rug, well-lit areas, removal of clutter, walker, hand-rails to stairs, grab bars for bathroom

Equipment needs (if applicable): Walker, grab bars, and rails

Follow up plan: Follow up with surgeons concerning possible amputation

Education needs: Safety education, chronic pain and opioid information, medication education, mobility impairment

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

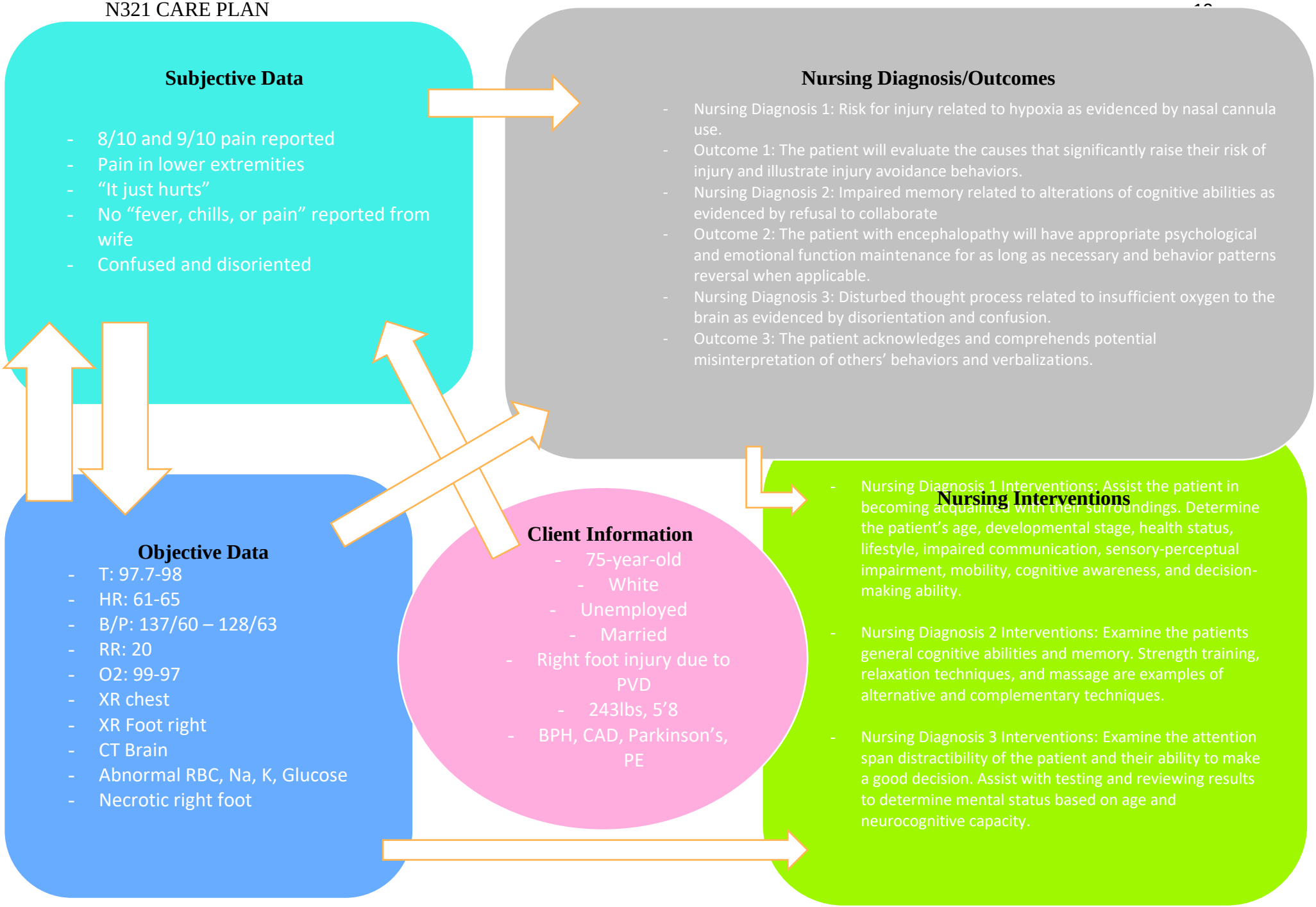
Nursing Diagnosis	**Rationale**	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation**
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions?

• Listed in order by priority – highest priority to lowest priority pertinent to this client				• Client response, status of goals and outcomes, modifications to plan.
1. Risk for injury related to hypoxia as evidenced by nasal cannula use.	The patient is a high fall risk and the usage of oxygen can impair the patients thoughts and cause falls.	1.Assist the patient in becoming acquainted with their surroundings. 2.Determine the patient's age, developmental stage, health status, lifestyle, impaired communication, sensory-perceptual impairment, mobility, cognitive awareness, and decision-making ability.	1. The patient will evaluate the causes that significantly raise their risk of injury and illustrate injury avoidance behaviors.	The patients wife was happy about the nurses actions and the patient was still uncooperative. The goal for the patient is to be free of injuries after adequate nursing actions and teaching.
1. Impaired memory related to alterations of cognitive abilities as evidenced by refusal to collaborate.	The patient has been disoriented and unaware of his surrounding and refused to collaborate which may rapidly decline.	1. Examine the patients general cognitive abilities and memory. 2.Strength training, relaxation techniques, and massage are examples of alternative and complementary techniques.	1. The patient with encephalopathy will have appropriate psychological and emotional function maintenance for as long as necessary and behavior patterns reversal when applicable.	The patient enjoyed this because it helped calm his nerves and suppressed. The goal is for family members will demonstrate knowledge of required care, appropriate coping skills, and the use of community resources.

2. Disturbed thought process related to insufficient oxygen to the brain as evidenced by disorientation and confusion.	The patient had been experiencing a lot of disorientation and agitation that may lead to mental breakdowns.	1.Examine the attention span distractibility of the patient and their ability to make a good decision. 2.Assist with testing and reviewing results to determine mental status based on age and neurocognitive capacity.	1. The patient acknowledges and comprehends potential misinterpretation of others' behaviors and verbalizations.	The patients family responded well to these actions by the nurse. The client was originally agitated by the nurses advances but started to cooperate. The goal is for the patient to recognize situations that occur prior to the disturbed thought process.

Other References (APA):

Concept Map (20 Points):


Subjective Data
- 8/10 and 9/10 pain reported
- Pain in lower extremities
- "It just hurts"
- No "fever, chills, or pain" reported from wife
- Confused and disoriented
Nursing Diagnosis/Outcomes
- Nursing Diagnosis 1: Risk for injury related to hypoxia as evidenced by nasal cannula use.
- Outcome 1: The patient will evaluate the causes that significantly raise their risk of injury and illustrate injury avoidance behaviors.
- Nursing Diagnosis 2: Impaired memory related to alterations of cognitive abilities as evidenced by refusal to collaborate
- Outcome 2: The patient with encephalopathy will have appropriate psychological and emotional function maintenance for as long as necessary and behavior patterns reversal when applicable.
- Nursing Diagnosis 3: Disturbed thought process related to insufficient oxygen to the brain as evidenced by disorientation and confusion.
- Outcome 3: The patient acknowledges and comprehends potential misinterpretation of others' behaviors and verbalizations.
Objective Data
- T: 97.7-98
- HR: 61-65
- B/P: 137/60 – 128/63
- RR: 20
- O2: 99-97
- XR chest
- XR Foot right
- CT Brain
- Abnormal RBC, Na, K, Glucose
- Necrotic right foot
Client Information
- 75-year-old
- White
- Unemployed
- Married
- Right foot injury due to PVD
- 243lbs, 5'8
- BPH, CAD, Parkinson's, PE
Nursing Interventions
- Nursing Diagnosis 1 Interventions: Assist the patient in becoming acquainted with their surroundings. Determine the patient's age, developmental stage, health status, lifestyle, impaired communication, sensory-perceptual impairment, mobility, cognitive awareness, and decision-making ability.
- Nursing Diagnosis 2 Interventions: Examine the patients general cognitive abilities and memory. Strength training, relaxation techniques, and massage are examples of alternative and complementary techniques.
- Nursing Diagnosis 3 Interventions: Examine the attention span distractibility of the patient and their ability to make a good decision. Assist with testing and reviewing results to determine mental status based on age and neurocognitive capacity.