N321 Care Plan #1

Lakeview College of Nursing

Jamal Drea

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
5/15/22	J.M.	84	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White or Caucasian	Not employed	Widowed	Morphine
Code Status	**Height**	**Weight**	
FULL	5' 11.5"	170	

Medical History (5 Points)

Past Medical History: Atrial fibrillation, acute renal failure (2009), rectal cancer, stenosis of rectum and anus, colostomy (2013), HTN, hearing loss (2013), hyperlipidemia, thrombocytopenia, cataract

Past Surgical History: polypectomy, retinal detachment surgery (right), cataract removal with implant, colonoscopy stoma, capsulotomy laser (right - 2019)

Family History: N/A

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Former tobacco smoker of 35 years (stopped 30 years ago), used to drink 6 cans of beer a week, no history of drug use

Assistive Devices: Hearing aid, walker, reading glasses

Living Situation: Lives alone

Education Level: Adult

Admission Assessment

Chief Complaint (2 points): Confusion

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

Onset: Confusion occurred 1 week ago, but patient was found negative for stroke

Location: Brain

Duration: Intermittent

Characteristic Symptoms: N/A during time of assessment

Aggravating Factors: N/A

Associated Manifestations: Impaired memory, weakness and unequal strength in extremities

Relieving Factors: N/A

Treatments: No previous treatment for confusion

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute metabolic encephalopathy

Secondary Diagnosis (if applicable):

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

An encephalopathy is a condition of the brain in which function is impaired as a result of several possible factors that can cause a patient to be confused, experience muscle weakness, lose memory, or have other symptoms that are neuropathic in origin. These factors include and could also be a combination of abnormal blood flow, abnormal energy metabolism, abnormal neurotransmission, and cellular maintenance processes that may contribute to cerebral metabolic insufficiency (Williams, 2013). Since metabolism has a significant influence on energy and cellular processes, problems with liver function could be the cause of the disorder that leads patients to be in an altered mental state. Hepatic encephalopathy happens due to liver failure and is commonly linked to cirrhosis that is associated with alcohol abuse and inflammation. Ammonia is a nitrogenous waste and toxin that can build up if the liver is unable to remove it from the body, which could affect the

health of the brain and lead to symptoms like confusion, disorientation, and even coma (Capriotti & Frizzell, 2020). Another example would be pulmonary encephalopathy in which the lungs function insufficiently as a result of infection or congestive heart failure. In this case, carbon dioxide is not exchanged and arterial pressure rises to levels of hypercapnia that exerts onto cerebrospinal fluid and changes level of consciousness with impaired neuronal metabolism (Angel & Young, 2011). An imbalance in electrolyte levels is an additional instance that could cause metabolic encephalopathy. In a situation where a patient has a significantly low level of sodium, or hyponatremia, it could alter the osmotic pressure that is responsible for the movement of water through the intracellular space and this may bring about cerebral edema that impairs brain function with symptoms like headaches, respiratory failure, and seizures (Angel & Young, 2011). There are multiple ways that can make a patient suffer this condition but they are similarly rooted in metabolism and homeostasis. It is important to be mindful of the vitals and lab diagnostics that could indicate an issue that would help prevent damage by this condition.

Pathophysiology References (2) (APA):

Angel, M. J., & Young, G. B. (2011). Metabolic encephalopathies. *Neurologic clinics*, *29*(4), 837–882. https://doi.org/10.1016/j.ncl.2011.08.002

Capriotti, T. & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed.). F.A. Davis Company.

Williams S. T. (2013). Pathophysiology of encephalopathy and delirium. *Journal of clinical neurophysiology : official publication of the American Electroencephalographic Society*, *30*(5), 435–437. https://doi.org/10.1097/WNP.0b013e3182a73e04

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	4.7-6.1	3.65	3.68	Hemolytic medications that the patient takes could lower RBC. The low value for red blood count could also be attributed to overhydration as the patient was put on a liquid intake restriction of 1 L by the provider (Pagana, 2018). A urinalysis shows hematuria so blood loss could be a factor.
Hgb	14-18	10.8	11.4	A lower than expected HgB is related to a reduced RBC count (Pagana, 2018).
Hct	42-52%	30.9	32.6	Hematocrit reflects the HgB and RBC count which could explain a less than normal range (Pagana, 2018).
Platelets	150-400	109	131	A urinalysis of the patient shows an infection, which could be the reason for a reduced platelet count. The patient may have a thrombocytopenia disorder since this is shown in their medical history (Pagana, 2018).
WBC	5-10	4.9	4.58	WBC count is slightly reduced and could be caused by impaired bone marrow function since RBC is also lower than the expected value (Pagana, 2018).
Neutrophils	55-70%	52	51	Slightly reduced neutrophil count could be due to anemia shown by RBC (Pagana, 2018).
Lymphocytes	20-40%	26.9	31	
Monocytes	2-8%	16.5	13.1	Monocytosis could be caused by inflammation (Pagana, 2018).
Eosinophils	1-4%	3.1	0.7	
Bands	0.5-1%	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	125	129	Hyponatremia could be caused by renal insufficiency. The patient has a history of renal complications that could be the reason for this low level of sodium (Pagana, 2018). Patient is currently treated with sodium tablets.
K+	3.5-5.0	4.1	4.7	
Cl-	98-106	90	94	Hypochloremia could be caused by diuretic therapy and the patient has been prescribed furosemide (Pagana, 2018).
CO2	23-30	22	25	Slightly low CO2 levels could be due to the patient's renal insufficiency (Pagana, 2018).
Glucose	82-115	100	90	
BUN	10-20	12	28	
Creatinine	0.6-1.2	0.94	1.18	
Albumin	3.5-5.0	3.5	N/A	
Calcium	9.0-10.5	8.3	8.5	Low calcium could be the result of renal insufficiency but the patient is also of elderly age and may suffer from malabsorption of vitamin C. It is not likely that it is by dietary causes since the patient enjoys milk and ice cream during meals (Pagana, 2018).
Mag	1.3-2.1	1.3	1.8	
Phosphate	3.0-4.5	3.5	N/A	
Bilirubin	0.3-1.0	1.2	N/A	Bilirubin is elevated and this could be caused by salicylate

				medications. The patient takes aspirin as a home medication (Pagana, 2018).
Alk Phos	**30-120**	**78**	**N/A**	
AST	**0-35**	**16**	**N/A**	
ALT	**4-36**	**11**	**N/A**	
Amylase	**6.6-35.2**	**N/A**	**N/A**	
Lipase	**0-160**	**N/A**	**N/A**	
Lactic Acid	**5-20**	**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	**0.8-1.1**	**N/A**	**1.0**	
PT	**11-12.5**	**N/A**	**12.3**	
PTT	**30-40**	**N/A**	**27.3**	**PTT is slightly low which can be supported by overactive blood clotting proteins (Pagana, 2018).**
D-Dimer	**< 250**	**N/A**	**865**	**Anemia shown by RBC could have increased the value of D-Dimer (Pagana, 2018).**
BNP	**< 100**	**N/A**	**147**	**BNP levels are usually higher in older adults (Pagana, 2018).**
HDL	**> 45**	**N/A**	**50**	
LDL	**<130**	**N/A**	**87**	
Cholesterol	**< 200**	**N/A**	**149**	
Triglycerides	**40-160**	**N/A**	**61**	

Hgb A1c	**4-5.9 in nondiabetic**	**N/A**	**5.1**	
TSH	**2-10**	**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	**Amber-Light Yellow and clear**	**Light yellow and clear**	**N/A**	
pH	**4.6-8.0**	**6**	**N/A**	
Specific Gravity	**1.005-1.030**	**1.011**	**N/A**	
Glucose	**Negative**	**Negative**	**N/A**	
Protein	**0-8**	**Negative**	**N/A**	
Ketones	**Negative**	**15**	**N/A**	**The patient has no record of diabetes in their health history so a diet that lacked carbohydrates before admission could have resulted in ketones in the urine sample (Pagana, 2018).**
WBC	**0-4**	**Negative**	**N/A**	
RBC	**<2**	**Moderate**	**N/A**	**Overaggressive anticoagulant therapy or bleeding disorders may have caused RBCs in the urine (Pagana, 2018).**
Leukoesterase	**Negative**	**Negative**	**N/A**	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**Negative < 100,000**	**>100,000 gram**	**N/A**	**Klebsiella oxytoca was found in the urine culture.**

		negative bacilli		
Blood Culture	**Negative**	**Negative**	**N/A**	
Sputum Culture	**Negative**	**Negative**	**N/A**	
Stool Culture	**Negative**	**Negative**	**N/A**	

Lab Correlations Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). ***Mosby's Diagnostic and Laboratory Test Reference*** **(14th ed.). Mosby.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT Chest w/o contrast shows pleural thickening, stomach lining thickening, coronary artery disease, trace pericardial effusion, mild mediastinal lymphadenopathy, subpleural nodularity in right upper lobe.

Diagnostic Test Correlation (5 points): CT of chest is a noninvasive x-ray procedure for diagnosing and evaluating pathologic conditions such as tumors, nodules, hematomas, parenchymal lesions, cysts, abscesses, pleural effusion, and enlarged lymph nodes (Pagana, 2018).

Diagnostic Test Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). ***Mosby's Diagnostic and Laboratory Test Reference*** **(14th ed.). Mosby.**

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

Home Medications (5 required)

Brand/Generic	Lipitor (Atorvastatin)	Flomax (Tamsulosin)	Lopressor (Metoprolol tartrate)	Prilosec (Omeprazole magnesium)	Spiriva respimat (Tiotropium bromide)
Dose	20 mg	0.4 mg	75 mg	40 mg	2.5 mcg
Frequency	Daily with evening meal	Daily	BID	Daily	Daily
Route	oral	oral	oral	oral	inhalation
Classification	Pharmacologic class: HMG-CoA reductase inhibitor Therapeutic class: Antihyperlipidemic	Pharmacologic class: Alpha adrenergic antagonist Therapeutic class: Benign prostatic hyperplasia (BPH) agent	Pharmacologic class: Beta1 -adrenergic blocker Therapeutic class: Antianginal, antihypertensive	Pharmacologic class: Proton pump inhibitor Therapeutic class: Antiulcer	Pharmacologic class: Anticholinergic Therapeutic class: Bronchodilator
Mechanism of Action	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.	Blocks alpha1 -adrenergic receptors in the prostate. This action inhibits smooth muscle contraction in the bladder neck and prostate, prostatic capsule, and prostatic urethra, which improves the rate of urine flow and reduces symptoms of BPH.	Inhibits stimulation of beta1 -receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand. These effects help relieve angina, minimize cardiac tissue damage from a myocardial infarction, and help relieve symptoms of heart failure. Metoprolol	Omeprazole interferes with gastric acid secretion by inhibiting the hydrogen potassium adenosine triphosphatase (H+ K+ -ATPase) enzyme system, or proton pump, in gastric parietal cells. Normally, the proton pump uses energy from hydrolysis of adenosine triphosphate to drive hydrogen (H+) and chloride	Prevents acetylcholine from attaching to muscarinic receptors on membranes of smooth-muscle cells. By blocking acetylcholine's effects in the bronchi and bronchioles, tiotropium relaxes smooth muscles and causes bronchodilation.

			also helps reduce blood pressure by decreasing renal release of renin.	**(Cl −) out of parietal cells and into the stomach lumen in exchange for potassium (K+), which leaves the stomach lumen and enters parietal cells. After this exchange, H+ and Cl − combine in the stomach to form hydrochloric acid (HCl), as shown below left. Omeprazole irreversibly blocks the exchange of intracellular H+ and extracellular K+ , as shown below right. By preventing H+ from entering the stomach lumen, omeprazole keeps additional HCl from forming.**	
Reason Client Taking	**To control lipid levels and disorders such as hypercholesterolemia and dyslipidemia. The client has a past medical history with hyperlipidemia.**	**To treat benign prostatic hyperplasia**	**To treat acute MI early and treat hypertension**	**To provide active treatment of active benign gastric ulcer or maintain GERD**	**To provide maintenance treatment of asthma**
Contraindications (2)	**Active hepatic disease and persistent rise in serum**	**Sensitivity to tamsulosin and quinazolines**	**Hypersensitivity to beta blockers and heart blocks**	**Concurrent therapy with rilpivirine-containing products;**	**Hypersensitivity to atropine and its derivatives**

	transaminase level		**greater than 1sr degree**	**hypersensitivity to omeprazole or substituted benzimidazoles**	**such as ipratropium and tiotropium**
Side Effects/Adverse Reactions (2)	**Arrhythmias and hypoglycemia**	**Arrhythmia and respiratory impairment**	**Cardiac arrest and leukopenia**	**Hypoglycemia and hepatic dysfunction or failure**	**Atrial fibrillation and intestinal obstruction**
Nursing Considerations (2)	**Use with caution for patients who have liver disease because atorvastatin could increase liver dysfunction. Monitor diabetic patient's blood glucose level.**	**Flomax should be given 30 minutes after the same meal every day. If the patient takes the medication on an empty stomach then their blood pressure should be monitored due to risk for orthostatic hypotension.**	**Use cautiously in patients with angina or hypertension who have congestive heart failure because beta blockers such as metoprolol can further depress myocardial contractility, worsening heart failure. Before starting therapy for heart failure, expect to give an ACE inhibitor, digoxin, and a diuretic to stabilize the patient.**	**Give omeprazole before meals, preferably in the morning for once-daily dosing. If needed, also give an antacid, as prescribed. Monitor the patient for macrocytic anemia because the drug can interfere with the absorption of vitamin K.**	**This drug should not be used for acute bronchospasms, it is strictly for maintenance. You should monitor the patient's pulmonary function to evaluate effectiveness of treatment.**

Hospital Medications (5 required)

Brand/Generic	**Plavix (Clopidogrel bisulfate)**	**Lovenox (Enoxaparin)**	**Lasix (Furosemide)**	**Seroquel (Quetiapine fumarate)**	**Zofran (Ondansetron)**
Dose	**75 mg**	**40 mg**	**20 mg**	**12.5 mg**	**4 mg**
Frequency	**Daily**	**Daily**	**BID**	**Daily at bedtime**	**Daily PRN**
Route	**Oral**	**Subcutaneous**	**Oral**	**Oral**	**IV**
Classification	**Pharmacologic class: P2Y12 platelet inhibitor** **Therapeutic class: Platelet aggregation inhibitor**	**Pharmacologic class: Low-molecular-weight heparin** **Therapeutic class: Anticoagulant**	**Pharmacologic class: Loop diuretic** **Therapeutic class: Antihypertensive, diuretic**	**Pharmacologic class: Dibenzothiazepine derivative** **Therapeutic class: Antipsychotic**	**Pharmacologic class: Selective serotonin (5-HT3) receptor antagonist** **Therapeutic class: Antiemetic**
Mechanism of Action	**Binds to adenosine diphosphate (ADP) receptors on the surface of activated platelets. This action blocks ADP, which deactivates nearby glycoprotein IIb/IIIa receptors and prevents fibrinogen from attaching to receptors. Without fibrinogen, platelets can't aggregate and form thrombi.**	**Potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors (primarily factor Xa and thrombin). Without thrombin, fibrinogen can't convert to fibrin and clots can't form.**	**Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation. As the body's plasma volume decreases, aldosterone production increases, which promotes sodium reabsorption and the loss of potassium and hydrogen ions. Furosemide also increases the excretion of calcium, magnesium, bicarbonate, ammonium, and phosphate. By**	**May produce antipsychotic effects by interfering with dopamine binding to dopamine type 2 (D2)-receptor sites in the brain and by antagonizing serotonin 5-HT2 , dopamine type 1 (D1), histamine H1 , and adrenergic alpha1 and alpha2 receptors.**	**Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting by preventing serotonin release in the small intestine and by blocking signals to the CNS.**

			reducing intracellular and extracellular fluid volume, the drug reduces blood pressure and decreases cardiac output. Over time, cardiac output returns to normal.		
Reason Client Taking	**To reduce thrombotic events, such as MI and stroke, in patients with atherosclerosis documented (in this case by arterial disease as evidenced by CT of chest)**	**To prevent DVT**	**To reduce edema and hypertension**	**To treat disorders with behavior**	**To prevent nausea and vomiting**
Contraindications (2)	**Active pathological bleeding and hypersensitivity to clopidogrel**	**Active major bleeding and history of immune-mediated heparin-induced thrombocytopenia**	**Anuria and hypersensitivity to furosemide**	**Hypersensitivity to quetiapine or components of quetiapine**	**Use of apomorphine or hypersensitivity to ondansetron**
Side Effects/Adverse Reactions (2)	**Hypotension and bronchospasm**	**CHF and Hematemesis**	**Arrhythmia and thromboembolism**	**Cardiomyopathy or thrombocytopenia**	**Hypotension and arrhythmias or chest pain**
Nursing Considerations (2)	**Use with caution for patients with hepatic or renal disease and those at risk for bleeding from trauma or surgery. Obtain blood cell count, as ordered, whenever**	**Use with caution for patients with increased risk of hemorrhage. This medication should not be used in patients with prosthetic heart valves.**	**Use furosemide cautiously in patients with advanced hepatic cirrhosis, especially those who also have a history of electrolyte imbalance or hepatic encephalopath**	**Know that quetiapine shouldn't be used for elderly patients with dementia-related psychosis because the drug increases the risk of death in these patients. Know that this drug**	**Electrolyte imbalances should be corrected before administration of ondansetron. Monitor the patient for arrhythmia or CHF.**

	signs and symptoms suggest a hematologic problem.		**y. Obtain the patient's weight before and during administration to evaluate fluid loss.**	**should not be administered to patients who have a history of cardiac arrhythmias. Monitor for dehydration.**	

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). 2021 Nurse's Drug Handbook (19 th ed.). Jones & Bartlett Learning

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 **Alert x 3** **Oriented x 3** **No acute distress** **Calm and normal appearance**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	 **Normal** **Normal, dry** **Cold on palpation** **Normal, no tenting** **None** **None** **Wound present on left elbow** **Braden Score: 20** **No observable drainage present**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 **Normocephalic, atraumatic/no deviation** **External ears normal** **Sclera and conjunctiva normal, PERRL, EOMs intact** **Nose appears normal with no congestion or rhinorrhea** **Has upper dentures in good condition**

	Mucosa of the mouth and oropharynx is pink and moist
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 S1 and S2 heart sounds** **Normal heart rate and rhythm** **Peripheral pulses 2+** **Capillary refill <3 seconds** **No neck vein distention** **No edema present**
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**Pulmonary effort is normal, no accessory muscle use** **No respiratory distress** **Breathing sounds normal bilaterally, no wheezing or rales**
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:**	**Normal diet, no restrictions** **Current diet is soft bite and thin liquid** **5'11.5"** **170 lbs (23.1 BMI)** **Last BM: 1115** **Bowel sounds are normoactive in all quadrants** **No distension or reported pain in abdomen** **No tenderness or guarding** **No incisions around abdominal region** **No scars around abdominal region** **No drainage around abdominal region** **No wounds around abdominal region** **Patient has a colostomy** **No nasogastric or feeding tubes**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐**	**Light yellow, clear urine** **450 mL output** **No reported pain with urination** **No dysuria, urgency, frequency; hematuria present according to urinalysis** **No dialysis** **No catheter**

Type: **Size:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y ☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Alert and responsive** **Normal ROM** **Walker** **Strength unequal in legs during neuro assessment, plantar flexion and dorsiflexion especially weak in left leg** **ADL assistance required for mobility and food preparation** **Fall Risk: 15** **Requires support with standing and walking**
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**MAEW ✓** **PERLA ✓** **Strength unequal in legs (left noticeably weaker)** **Oriented x 3** **Normal during assessment** **Normal** **Normal** **Alert and responsive**
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):**	**Watches TV and sleeps throughout the day** **Developmental level: Adult** **N/A** **Is widowed but has daughter that calls in to receive updates on condition of the patient**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0810	**76**	**112/50**	**12**	**98.3**	**95**
1100	**72**	**110/52**	**12**	**97.7**	**92**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0810	**0**	**N/A**	**N/A**	**N/A**	**N/A**
1100	**0**	**N/A**	**N/A**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 G
Location of IV:	Left antecubital
Date on IV:	5/15/22
Patency of IV:	Open and functional, no swelling
Signs of erythema, drainage, etc.:	No signs of erythema or drainage
IV dressing assessment:	IV is secure

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
980	**450**

Nursing Care

Summary of Care (2 points)

Overview of care: Plan is for long term care

Procedures/testing done: CBC, CMP, CT of chest

Complaints/Issues: CC is confusion, needs assistance with mobility

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Patient tolerates diet, activity is limited

Physician notifications: N/A

Future plans for client: Physical therapy in long term care facility

Discharge Planning (2 points)

Discharge location: Extended care facility

Home health needs (if applicable): Arrangements for reduced fall risk

Equipment needs (if applicable): Walker for assistance with mobility

Follow up plan: Follow up on diagnostic tests of chest due to presence of nodule in lungs

Education needs: Mobility, fall risk, medications, diagnosis

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 of fall related to acute	**The patient is at risk for fall as a result of their condition,**	**1. Remove anything from the environment that will increase the**	**1. The patient will assist in identifying and applying physical changes in the**	**The patient will optimize activities of daily living**

	metabolic encephalopathy as evidenced by need for assisted mobility and unequal strength in extremities.	which has left them with weakness and limited energy for physical activity. The high fall risk score indicates that it is important that safety measures are put in place to protect the client from injury.	risk of falls. Patient's immediate environment must be reviewed frequently to prevent unnecessary falls. 2. Identify and educate on the factors that may cause or contribute to injury from a fall in order to enhance the patient, family, and caregiver awareness of the risks.	environment to ensure increased safety.	within limitations. The patient and their family will understand the factors that could contribute to fall risk.
2.	Risk of acute confusion related to acute metabolic encephalopathy as evidenced by intermittent disorientation and memory loss.	The patient is at risk for acute confusion, which has been shown by intermittent instances of confusion and disorientation that affect the patient's cognitive ability and puts them at risk of injury.	1. Monitor neurological status every 4 hours to determine if the client is alert and oriented or experiencing a decline in brain function. 2. Use appropriate safety measures to protect the patient from injury.	1. Patient's neurological status will remain stable and they will participate in ADLs.	The patient will understand safety measures that need to be put in place to protect them and family will know when to report change in behavior.
3.	Risk for electrolyte imbalance related to acute metabolic encephalopathy as evidenced by hyponatremia and hypocalcemia.	Metabolic encephalopathies can be caused by electrolyte imbalances so it is important to educate the patient about how it relates to their condition so that they could avoid further effects.	1. Assess the patient's fluid status and monitor for physical signs of electrolyte imbalance (cardiac, neuro, musculoskeletal). 2. Educate the patient and their family members on the risk of electrolyte imbalances along with their medical condition and	1. The patient will maintain normal values for their electrolyte levels.	The patient will be able to verbalize risks and symptoms that require interventions. The patient and family will understand the goal of the teachings.

		symptoms to watch for in the future.		

Other References (APA):

Phelps, L.L. (2020). ***Sparks and Taylor's Nursing Diagnosis Reference Manual*** **(11 th ed.).**

Wolters Kluwer.

N321 CARE PLAN

Concept Map (20 Points):