N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
8/11/2022	WM	83 years	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	No employment history found	Divorced	No Known Allergies
Code Status	**Height**	**Weight**	
Full	6’ (182.9 cm)	196 lbs (89 kg)	

Medical History (5 Points)

Past Medical History:

Hypertension, hyperlipidemia, dementia, atrial fibrillation on apixaban

Past Surgical History:

Cardioversion 8/19/22, EDG with PEG 8/24/22

Family History:

No family history was reported on file. The patient is divorced and has a son B.M. on file for advanced directives.

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

The patient was never a smoker, never used alcohol, never used drugs, and was not sexually active.

Assistive Devices:

The patient has a G tube placement in LUQ due to not eating/drinking and uses an ambulatory walker with a 1 assist gait belt due to difficulty with ADLs and mobility.

Living Situation:

The patient is currently living alone and is divorced. If discharged in the near future doctor noted to go to skilled care.

Education Level:

No education level was found on file and the student was unable to get an accurate answer due to a patient being diagnosed with dementia.

Admission Assessment

Chief Complaint (2 points): Palpitations

History of Present Illness – OLD CARTS (10 points): The patient could not participate, information was found on the chart.

Onset- 8/4/22 Seven days before admission

Location- Chest

Duration- Non-stop prior to treatment

Characteristics- Tachycardia in 150s, Hypotensive 82/53, Respiration rate 22/min, A. Fib**.**

Associated/Aggravating factors- low back pain, overall weakness, confusion,

Relief- beta-blockers

Treatment- IV diltiazem

Severity- The patient had rapid atrial fibrillation

This patient was admitted to the ED on 8/11/2022 with a chief complaint of palpitations. The patient stated that these palpitations started seven days before he was admitted (8/4/22). The patient stated that these were nonstop prior to the treatment. Upon assessment, the patient was found to have rapid atrial fibrillation, tachypnea in the 150s, hypotensive at 82/53, and respirations at 22 breaths per min. This patient also mentioned having lower back pain and overall weakness and presented to be disoriented. The providers gave beta-blockers to help relieve some factors and treated them with IV diltiazem.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Sepsis with weakness, confusion, and back pain due to severe sepsis from acute cystitis and pyelonephritis.

Secondary Diagnosis (if applicable): No secondary diagnosis.

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

This patient was diagnosed with sepsis with associated factors of weakness, confusion, and back pain. His symptoms were due to severe sepsis from acute cystitis and pyelonephritis. Sepsis results from the body fighting an infection that is too strong for the patient's body. Sepsis can be life-threatening, especially to older adults. Most sepsis cases spread through the body, starting in the urinary or respiratory tract (Centers for Disease Control and Prevention, 2022). Symptoms associated with sepsis include weak pulses, confusion, extreme pain, fever, shortness of breath, and sweaty skin (Centers for Disease Control and Prevention, 2022). When sepsis gets terrible enough, the body will go into shock, leading to multiple organ failures (Capriotti, 2020). Immunosuppressed persons, older adults, and infants are most susceptible to sepsis due to their weaker immune systems (Capriotti, 2020).

Urinary tract infections are also a common cause of sepsis in susceptible groups of people. Cystitis is defined as an infection of the lower urinary tract and bladder (Li R et al., 2022). Pyelonephritis is an infection of the upper urinary tract and kidneys. This patient suffers from both, which could lead him to experience shock in the future. This patient also mentioned having lower back pain which his cystitis and pyelonephritis would cause. This patient has an indwelling urinary catheter, which is a risk factor for UTIs in males for prolonged use (Capriotti, 2020). In order to diagnose cystitis or pyelonephritis, one would have to have a urinalysis with verified abnormal results. Men's most common cause of UTIs results in urolithiasis and benign

prostatic hyperplasia (BPH) (Capriotti, 2020). Treatment for this client would be to encourage fluids and administer antibiotics for the specific bacteria in their urinary tract.

References:

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [FADavis]. Retrieved from https://fadavisreader.vitalsource.com/#/books/9781719641470/

Centers for Disease Control and Prevention. (2022). *Sepsis*. https://www.cdc.gov/sepsis/what-is-sepsis.html

Li R, Leslie SW. (2022). Cystitis. *National Library of Medicine*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK482435/

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	**4.2-5.4**	**4.57**	**2.49**	**The patient's red blood cell count was low due to the previous atrial fibrillation causing the heart to weaken, slowing the amount of blood being pumped out of it.**
Hgb	**12-16**	**13.6**	**7.7**	**The patient hemoglobin levels were lower than normal due to his sepsis which can indicate his body is going into shock due to the inflammatory response (Sung et al., 2019).**
Hct	**37-47**	**26.5**	**21.9**	**This patient's hematocrit levels were low due to his Atrial fibrillation episodes.**
Platelets	**150-400**	**137**	**217**	**This value was not abnormal.**
WBC	**4.5-11.0**	**18.3**	**13.0**	**The patient's WBC were high due to**

				him having sepsis and his immune system fighting infections though out his body.
Neutrophils	**55-70**	**87.6**	**67.8**	**The patient's neutrophils were high due to his body fighting multiple infection.**
Lymphocytes	**20-40**	**5.0**	**9.9**	**He patient's lymphocytes were lower than usual due to his lack in nutrition, evidence by G Tube 70ml/ hr.**
Monocytes	**2-8**	**5.4**	**18.9**	**The patient's monocytes were high due to his bod fighting multiple infection.**
Eosinophils	**1-4**	**1.0**	**2.3**	**This value was not abnormal.**
Bands	**0-5**	**There was no value for this lab.**	**There was no value for this lab.**	**There were no Bands value present on the client's chart.**

(Capriotti, 2020).

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**135-145**	**144**	**138**	**This value was not abnormal.**
K+	**3.5-5**	**4.3**	**4.6**	**This value was not abnormal.**
Cl-	**98-106**	**104**	**106**	**This value was not abnormal.**
CO2	**26-35**	**34**	**24**	**The patient's CO2 was low due to the impaired gas exchange he was experiencing with the high respirations.**
Glucose	**60-120**	**136**	**107**	**The patient's glucose was high which could indicate why they developed a kidney infection due to the GFR not filtering out the waste correctly.**
BUN	**10-20**	**39**	**31**	**The patient's BUN levels where elevated due to the kidneys not working properly.**
Creatinine	**0.5-0.8**	**3.56**	**1.72**	**The patient's creatinine levels**

				were increased related to their kidney infection and their body not filtering out waste properly.
Albumin	**3.5-5**	**2.8**	**2.8**	**The patient's albumin levels were low due to the kidneys not working well.**
Calcium	**9-11**	**8.7**	**8.2**	**The patient's calcium was slightly low related to the kidneys not processing the waste properly.**
Mag	**1.3-2.1**	**2.1**	**2.1**	**This value was not abnormal.**
Phosphate	**3.0-4.5**	**3.5**	**3.5**	**This value was not abnormal.**
Bilirubin	**0.3-1**	**1.4**	**0.5**	**The patient's bilirubin was slightly high possibly due to his diagnosis of sepsis and the multiple system infections it has on the body.**
Alk Phos	**30-120**	**108**	**98**	**This value was not abnormal.**
AST	**10-30**	**18**	**15**	**This value was not abnormal.**
ALT	**10-40**	**20**	**17**	**This value was not abnormal.**
Amylase	**23-85**	**There was no value for this lab.**	**There was no value for this lab.**	**There was no value for this lab.**
Lipase	**0-160**	**7.7**	**There was no value for this lab.**	**This value was not abnormal.**
Lactic Acid	**0.5-2.2**	**2.2**	**There was no value for this lab.**	**This value was not abnormal.**
Troponin	**0-0.04**	**Elevated 0.268**	**There was no value for this lab.**	**This value was elevated which indicated the patient has a MI early and the heart muscles injured.**
CK-MB	**3-5%**	**There was**	**There**	**There was no value for this lab.**

		no value for this lab.	**was no value for this lab.**	
Total CK	**22-198**	**There was no value for this lab.**	**There was no value for this lab.**	**There was no value for this lab.**

(Capriotti, 2020).

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	**1-3**	**4.0**	**There was no value for this lab.**	**This patient had high INR levels which put them at a higher risk for bleeding. This as due to their A.FIB.**
PT	**12-16**	**18.5**	**There was no value for this lab.**	**This patient had high PT levels which puts him at a higher risk for bleeding. This was due to their A. FIB.**
PTT	**30-55**	**36**	**There was no value for this lab.**	**This value was not abnormal.**
D-Dimer	**<0.50**	**There was no value for this lab.**	**There was no value for this lab.**	**There was no value for this lab.**
BNP	**<100**	**456**	**617**	**An increased BNP level means that the heart was over working and is associated with cardiovascular problems. This patient has this due to his precious atrial fibrillation.**
HDL	**>60**	**There was no value for this lab.**	**There was no value for this lab.**	**There was no value for this lab.**
LDL	**<130**	**There was no value for this lab.**	**There was no value for this lab.**	**There was no value for this lab.**

Cholesterol	**<170**	**There was no value for this lab.**	**There was no value for this lab.**	**There was no value for this lab.**
Triglycerides	**<150**	**There was no value for this lab.**	**There was no value for this lab.**	**There was no value for this lab.**
Hgb A1c	**4-6**	**There was no value for this lab.**	**There was no value for this lab.**	**There was no value for this lab.**
TSH	**0.5-5.0**	**1.695**	**There was no value for this lab.**	**This value was not abnormal.**

(Capriotti, 2020).

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 Yellow**	**Yellow cloudy**	**There were no urinalysis values for this date.**	**This patient was diagnosed with cystitis and pyelonephritis which is upper and lower urinary tract infections which indicated these abnormalities.**
pH	**4.6-8**	**5.0**	**There were no urinalysis values for this date.**	**This value was not abnormal.**
Specific Gravity	**1.005-1.030**	**1.017**	**There were no urinalysis values for this date.**	**This value was not abnormal.**
Glucose	**negative**	**Positive**	**There were no urinalysis values for this date.**	**This patient was diagnosed with cystitis and pyelonephritis which is upper and lower urinary tract infections which indicated these abnormalities.**
Protein	**0-8**	**4+**	**There were no urinalysis**	**This value was not abnormal.**

			values for this date.	
Ketones	**negative**	**Positive**	**There were no urinalysis values for this date.**	**This patient was diagnosed with cystitis and pyelonephritis which is upper and lower urinary tract infections which indicated these abnormalities.**
WBC	**negative**	**11-20**	**There were no urinalysis values for this date.**	**This patient was diagnosed with cystitis and pyelonephritis which is upper and lower urinary tract infections which indicated these abnormalities.**
RBC	**negative**	**11-20**	**There were no urinalysis values for this date.**	**This patient was diagnosed with cystitis and pyelonephritis which is upper and lower urinary tract infections which indicated these abnormalities.**
Leukoesterase	**negative**	**3+**	**There were no urinalysis values for this date.**	**This patient was diagnosed with cystitis and pyelonephritis which is upper and lower urinary tract infections which indicated these abnormalities.**

(Capriotti, 2020).

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	**7.35-7.45**	**7.36**	**7.42**	**This value was not abnormal.**
PaO2	**80-100**	**50**	**61**	**The patient's partial pressure of O2 was low due to the back flow in the pulmonary system from the cardiovascular problems.**
PaCO2	**35-45**	**48**	**34**	**The patient's CO2 levels were fluctuating probably due to the body trying to compensate for**

				the abnormalities.
HCO3	**22-26**	**27.0**	**21.7**	**The patient's bicarb was also fluctuating due to the body trying to compensate for the abnormalities.**
SaO2	**92%-100%**	**81%**	**90%**	**The patient's oxygen saturation was low due to the cardiovascular system trying to work harder to keep up with the palpitations.**

(Capriotti, 2020).

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 < 10,000 Postive > 100,000**	**There were no values taken upon admission.**	**8/31/22 No Growth**	**This value was not abnormal.**
Blood Culture	**negative**	**There were no values taken upon admission.**	**8/29/22 No growth**	**This value was not abnormal.**
Sputum Culture	**Normal URT**	**There were no values taken upon admission.**	**8/26/22 Candida albicans and scant mixed flora**	**Scant mixed flora is a normal finding for a sputum culture. Candida albicans is found in most immune comprised patients (Moss, 2021).**
Stool Culture	**Normal**	**There**	**Normal**	**This value was not abnormal.**

	Intestinal Flora	**were no values taken upon admission.**		

(Capriotti, 2020).

Lab Correlations Reference (1) (APA):

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

Moss, B.J., Musher, D.M. *Candida* species in community-acquired pneumonia in patients with chronic aspiration. *Pneumonia* (2021). https://doi.org/10.1186/s41479-021-00090-x

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Elsevier.

Sung Min, Jung. Youn-Jung, Kim. Seung, Mok Ryoo. Won Young, Kim. (2019). Relationship Between Low Hemoglobin Levels and Mortality in Patient's with Septic Shock. *PubMed Central.*

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

On 8/15/22 the patient had an EKG done that showed atrial flutter. On 8/24/22 the patient had a chest x-ray that showed mild pulmonary vascular congestion, and also a MRI taken of the entire back which was negative for osteomyelitis.

Diagnostic Test Correlation (5 points):

The patient’s chief complaint on admission was sever palpitation which resulted in the EKG on 8/15/22 finding atrial flutter and sever atrial fibrillation. The patient also had a chest x-ray that

showed mild pulmonary vascular congestion which results in the buildup of fluids in the lungs. This could be cause due to heart failure of the abnormal heart rates with the atrial fibrillation.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Elsevier.

Phelps, L. L. (2021). *Sparks & Taylor's nursing diagnosis pocket guide*. Wolters Kluwer.

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

Home Medications (5 required)

Brand/Generic	**Apixaban (Eliquis)**	**Bisacodyl (Dulcolax)**	**Lisinopril (Zestril) (Prinivil)**	**Meclizine (Antivert)**	**Pravastatin (Pravachol)**
Dose	**5mg**	**5mg**	**2.5mg**	**25mg**	**20mg**
Frequency	**1 tablet taken twice daily**	**2 tablets taken three times daily**	**1 tablet taken once daily**	**1 tablet taken twice daily as needed**	**20mg taken daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Pharmacological class-Factor Xa inhibitor Therapeutic-anticoagulant.**	**Therapeutic class-stimulant laxatives**	**Pharmacological class-angiotension-converting enzyme (ACE) inhibitor Therapeutic class-antihypertension**	**Pharmacologic class-antihistamine, antiemetic**	**Pharmacological class-HMG-CoA reductase inhibitor (statin) Therapeutic class-antilipemic**
Mechanism of Action	**Inhibits free and clot-bound factor Xa and**	**This medication is used to help**	**May reduce blood pressure by inhibiting**	**This drug is a H1 antagonist which**	**Inhibits cholesterol synthesis in liver by**

	prothromina se activity.	**increase the frequency of bowel movements .**	**conversion of angiotension I to angiotension II. This decreases the water and sodium reabsorption and increases their excretion there by reducing blood pressure.**	**blocks receptors that give it it's antiemetic properties.**	**blocking the enzyme HMG-CoA. This increases the LDL in the patient.**
Reason Client Taking	**Atrial fibrillation**	**Help with bowel movement s**	**This patient is taking this drug for his cardiovascul ar problems and to control the bp and heart rate.**	**Nausea and dizziness**	**Helps prevent cardiovascul ar and coronary events. Also helps increase the LDL.**
Contraindicatio ns (2)	**Active pathological bleeding, severe hypersensitivi ty to apixaban or its components.**	**This drug may cause severe abdominal pain, and electrolyte imbalances if over used.**	**The patient should not sue this drug if they have previous reactions to ACE inhibitors or hypersensitiv ity to lisinopril. Patient should also be monitored for hypoglycemi a.**	**Patient's who have hypersensit ivity to this drug should not use it. Patients should not take this drug and drive due to the effects of drowsiness it has on people.**	**Elevated liver enzymes and active hepatic diseases and major contraindicat ions.**
Side Effects/Adverse Reactions (2)	**Hypotension, thrombocytop enia.**	**Adverse side effects**	**High-potassium diet and**	**Common side effects of this drug**	**Hepatic failure and hyperglycemi**

		include blood in the stool and abdominal pain.	**bronchospasms could be some adverse interaction with this drug.**	**are drowsiness and dry mouth.**	**a are side effects of this medication.**
Nursing Considerations (2)	**This drug should not be given to patients with severe hepatic dysfunction. This drug should be discontinued 48hrs before an invasive procedure.**	**The nurse should not give this drug to patients who are already experiencing diarrhea. This drug should not be used for longer than 3 days in a row.**	**The nurse should be aware of patients who are hemodynamically unstable after an acute MI. This can also cause fluid volume deficit in patients with impaired renal function.**	**Patient's should not use this drug if they are also taking CNS depressants. This drug can also cause prostate enlargement in men.**	**This drug should be used cautiously in patients who have hepatic failure. The nurse should also know that if the patient starts getting muscle aches they should stop the drug immediately.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**The nurse should know the patient's PTT and PT times prior to administering this medication.**	**The nurse should monitor the patient's electrolyte level prior to administering this medication, especially sodium ad potassium.**	**The nurse should understand the patients GFR and blood pressure vitals prior to administration.**	**The nurse should monitor blood pressure due to the effects this drug has on causing patient's to become hypotensive. Also the nurse needs to monitor hepatic function with this drug.**	**The nurse should monitor the patients BUN and serum creatine levels. The blood lipoprotein levels also need to be monitored.**
Client Teaching Needs (2)	**Ensure the patient takes the**	**The nurse should educate**	**Educate the patient on the use of the**	**The patient should understand**	**The patient should be consistent**

	medication as prescribed. If patient is unable to swallow tablets, they can crush it and put in apple juice or water and be taken immediately.	**the patient on the side effects of electrolyte imbalances. The patient should report any blood in the stool to their provider immediately.**	**drug helps manage symptoms of hypertension but not cure it. Also educate the patient on using salt substitutes without potassium.**	**to not drink while taking this medication. The patient should take this medication with food to avoid increased stomach aches.**	**with this medication. Educate the patient to contact their provider if any muscle aches start to happen.**

(Jones et al., 2021).

Hospital Medications (5 required)

Brand/Generic	**Ceftaroline fosamil (teflaro)**	**Diltiazem (Cardizem)**	**Miconazole 2% powder**	**Fluconazole (Diflucan)**	**Famotidine (Pepcid)**
Dose	**300mg in sodium chloride 0.9% 100ml/hr**	**30mg**	**Apply as needed on groin and buttocks**	**200mg**	**20mg**
Frequency	**Every 8hrs**	**4 times a day**	**Twice daily**	**daily**	**daily**
Route	**IV**	**Per G-tube**	**Topical**	**PO**	**Per G-Tube**
Classification	**Pharmacologic class-fifth-generation cephalospori**	**Pharmacological class-calcium channel blocker Therapeutic**	**Therapeutic class-Antifungal**	**Pharmacological class-azole antifungal Therapeutic**	**Pharmacological class-histamine-2 blocker Therapeutic**

	n Therapeutic class- antibiotic	**class- antianginal, antiarrhythmic, antihypertension**		**class- antifungal**	**class- antiulcer agent.**
Mechanism of Action	**Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross-linking of peptidoglycan strands.**	**Inhibits calcium movement into coronary and vascular smooth muscle cells by blocking slow calcium channels in cell membranes.**	**This drug inhibits the synthesis of ergosterol which is part of the fungal cell membranes.**	**Damages fungal cells by interfering with cytochrome P-450 enzyme needed to convert lanosterol to ergosterol which is a part of the cell membrane.**	**Reduces HCl formation that is associated with GERD and peptic ulcers.**
Reason Client Taking	**Antibiotic for Escherichia coli.**	**Treat atrial fibrillation**	**This is used to treat antifungal and yeast infection in the groin area.**	**Treats oral candidiasis that was found in his sputum culture.**	**This is taken into the PEG tube to help reduce the risk of GERD or peptic ulcers.**
Contraindications (2)	**Hypersensitivity to cefazoline or its components. There are no noted drug interaction.**	**Acute MI and cardiogenic shock are major contraindications for this drug.**	**Burning, irritation, and allergic reactions are common for tis powder.**	**This drug is known to prolong the QT interval. The patient should not use this if they have a hypersensitivity to this drug.**	**Hypersensitivity to famotidine or other H2-receptor antagonists.**
Side Effects/Adverse Reactions (2)	**Some common side effects are clostridium difficile associated**	**This may cause atrial flutter and ECG abnormalities.**	**This may cause itching and dryness.**	**Amitriptyline and cyclosporin should not be used with this drug.**	**AV blocks and arrythmias are possible with this drug.**

	diarrhea and renal failure.			**Side effects of this drug are prolonged QT interval, and thrombocytopenia.**	
Nursing Considerations (2)	**Patients with hypersensitivities to penicillin should not use this drug. Nurses should also monitor patients closely for adverse reactions.**	**The nurses should monitor any beta-blockers and this drug due to their increase risk of adverse cardiovascular effects. Nurses should not give this drug to patient's with hepatic failure.**	**This drug should not be used more than 3 times per day due to irritation.**	**The nurse should monitor liver and renal functions. The nurse should also monitor coagulation test results as needed.**	**The nurse should monitor the temperature of the oral suspension of this drug.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**The nurse should have a culture sensitivity test prior to administering this drug.**	**The nurse should monitor the patient's blood pressure prior and after the administration.**	**The nurse should monitor the area of placement of the powder to ensure there is no infection or irritation.**	**The nurse should have a BUN and serum creatine levels as well as a culture sensitivity test prior to giving this treatment.**	**Monitor the patient's gastric PH before administering the medication per GTube.**
Client Teaching Needs (2)	**Patients should be educated to report any hypersensitivity**	**Ensure the patient knows to take the tablet whole. The patient**	**The nurse should educate the client on the**	**Advise patient's to take this whole course of medication. Urge the**	**Caution elderly patient's about the risk of renal impairment.**

	reactions such as a rash or difficulty breathing immediately. Ensure the patient understand to report any bloody or water stool to their provider.	**should be educated to report any chest pain or swollen ankles immediately.**	**dosage amount to use and also how often to use it. The nurse should tell the patient if any irritation occurs to stop the powerd and notify the provider.**	**patient to monitor their blood glucose levels.**	**Ensure the patient understand to notify their provider if any bloody or dark stools accrue.**

(Jones et al., 2022).

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2022). *2022 Nurse's Drug Handbook* (20th ed.).

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:**	**The patient is alert and oriented x2 to person and place. Not to time or situation. The patient seems to be disorganized and is in no distress.**

Overall appearance:	
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**The patient's skin color was warm and normal with no rashes notes. The patient does have a bruise on the upper left arm from previous IV sticks. The patient has a Braden score of 15. The patient has a pressure ulcer on the right heel seen on 8/25/22. This wound is clean and dry with no drainage noted upon assessment. The patient has a posterior gluteal pressure injury that is being treated. This was noted on 8/29/22 and is clean but red and looks irritated.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**The head is symmetrical with the neck. The trachea is midline with no deviation. The thyroid is non-palpable and no nodules were noted upon assessment. No lymph nodes are palpable bilaterally. Carotid pulses + 2 bilaterally. Oral mucosa was pale and teeth were missing.**
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:**	**The patient has clear S1 and S2 heart sounds with no murmurs or S3,S4 noted. Rate and rhythm appears normal. The patient had all peripheral pulse at a +2 with capillary refill being less than 2 seconds. There was no noted edema or neck vein distention upon assessment.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**The patient has slight bilateral wheezes in the upper respiratory track with overall bilateral diminished lung sounds.**
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:**	**At home, the patient stopped eating and drinking. The patient was admitted and had a PEG tube placed for nutritional needs. Patients height is 6' and weight is 196lbs . Appon assessment, the patient has normoactive bowel sounds in all four quadrants. The patient is fecal incontint with his last bowel movement being 9/7/22. Upon palpation, there were not noted masses or pain in all four quadrants. The patient has no distention, scars, or drains noted. The patient**

Scars: **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☒ N ☐** **Type: Left upper quad PEG tube**	**does has a left upper quadrant wound/incision related to his insertion of a PEG tube.**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: Indwelling Urinary Catheter** **Size: Unknown**	**The patient had 625cc of yellow cloudy urine at 1310. The patient has an indwelling urinary catheder due to incontence. Catheter appears to be appropriate and clean. The patient has a posterior gluteal pressure sore that was red and seemed irritated. Patient was receiving powder and pain medications for this.**
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☒**	**Patients neros were intact. ROM was limited on own, needed +1 assistance. Patient uses a walker for support when standing. Patient's hand grips were strong. Patient needs assistance with movements. Fall score was 27 on a Johns Hopkins fall risk assessment tool. https://www.hopkinsmedicine.org/institute_nursing/models_tools/JHFRAT_acute%20care%20original_6_22_17.pdf**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**PERLA was intact. Strength was limited, but present in all extremities. The patient was alert and oriented to person and place, but was confused due to dementia. Speech was gargled and hard to understand. Patient was aware of surroundings and awoke spontaneously when spoke to.**
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:**	**The patient had no cultural preferences for his care. Developmental level was unclear and unable to ask patient. There was no personal or family data notes on chart. This patient had**

Personal/Family Data (Think about home environment, family structure, and available family support):	**no family contact information on chart but did have son down on advanced directives.**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1500	**75**	**113/62**	**18**	**98.1**	**97%**
The student only got to take one set of vitals while at clinical.	**-**	**-**	**-**	**-**	**-**

Vital Sign Trends:

All of the patient's vital signs were normal except blood pressure was a little bit low due to medications. His vital signs upon admission were very different then they are now indicating an improvement. The patient also indicated that he was in no pain when asked.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1500	**Number**	**Patient denies pain**	**0**	**Denies pain or discomfort**	**Pain medication was given prior to assessment.**
1630	**Number**	**Patient denies pain**	**0**	**Denies pain or discomfort**	**Pain was assessed when passing**

					medication. PRN pain medication was held due to no pain.

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Size: 20g Location: Left anterior wrist Date: 9/6/22 Patency: IV appears to be clean and dry with no signs of drainage or erythema. IV dressing is in place and clean.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
440cc	**625cc @1310**

Nursing Care

Summary of Care (2 points)

Overview of care:

This patient was a one assist and incontinent. This patient had a PEG tube for feeding and tolerated the 70ml/hr well. Upon assessment the patient appeared to not be in any distress and report a 0 on the numerical pain scale. The patient was cooperative but did not listen to commands well. This patient had to be redirected often when being spoke to. The patient tolerated the medication well, but was trying to pull out IV, G tube, and ID bands. The patient needed to be redirected often on where he was and to not touch certain cords.

Procedures/testing done:

There were no procedures done on patient while student was there.

Complaints/Issues:

The patient did not complain of any issues or problems during this shift.

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.:

Patient has difficulty following instructions. Patient also has difficulty with ADLs and mobility.

Physician notifications:

There were no new physician notification, only to continue with planned care.

Future plans for client:

The future plans for this client is to assess swallowing and ADL difficulties and eventually discharge to a skilled care facility.

Discharge Planning (2 points)

Discharge location: No discharge planning notes at this time.

Home health needs (if applicable):

Equipment needs (if applicable):

Follow up plan: The patient will be discharged to a skilled care facility for daily assistance in care.

Education needs: The patient and care givers will need education on the patient's difficulty to communicate needs and help with swallowing liquids and food.

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	• Explain why the nursing diagnosis			• How did the client/family respond

with “related to” and “as evidenced by” components • Listed in order by priority – highest priority to lowest priority pertinent to this client	was chosen			to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for falls related to alterations in cognitive function.	**This nursing diagnosis was chosen for since this patient is diagnosed with dementia and if very disorganized in LOC.**	**1. Improve environmental safety factors.** **2.Teach patient with unstable gait the proper use of assistive devices.**	**1. Patient is able to call for help when needing assistance on repositioning.**	**The patient should be able to identify the call light and be able to press it within reach.**
2. Risk for infection related to pressure sores	**This nursing diagnosis was chose due to the patient's diagnosis with sepsis and him having open pressure sores in two spots on his body.**	**1.** Assess the client for a possible source of infection. **2.** Maintain sterile technique when changing dressings, suctioning, and providing site care, such as an invasive line or a urinary catheter.	**1. The patient will remain free from signs of infection and vital signs will be in the normal range.**	**The patient will establish normal cultures that are free of growth and bacteria.**
3. Risk for acute confusion related to ANO’s x2 as evidence	**This diagnosis was chosen due to the altered cognitive state this patient is in.**	**1. The nurse should use simple commands for the client to respond and act out.**	**1. The patient is able to help with small tasks of daily living with partial help.**	**The patient should be able to follow small commands and respond well to them.**

by Dementia		**2 The nurse should eliminate any loud noises or distractions as needed for this patient.**		
4. Risk for shock related to septic diagnosis.	**This diagnosis was chosen due to the patient having sepsis and already having acute cystitis and pyelonephritis.**	**1. The nurse should explain the need for communication and always keep open wounds and sites as sterile as possible.** **2. The nurse will check for signs of increased infection and malnutrition in the patient.**	**1. The patient should maintain stable vital signs. Including LOC.**	**1. The patient should inform the nurse of any new symptoms of pain or weakness.**

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

The patient is divorced, no employment history The patient stated he was never a smoker, never used alcohol, and is not sexually active. The patient currently lives at home by himself. The patient stated he has had the palpitations nonstop for seven days prior to admission. The patient stated he was in no pain upon assessment and stated to have no cultural prefrences.

Nursing Diagnosis/Outcomes

Risk for falls related to alteration in cognitive function – The patient outcome is that he is able to call out for help when needing assistance on repositioning.
Risk for infection related to pressure sores- The patient outcome is that he will remain free from signs of infection and vital signs will be in the normal ranges.
Risk for acute confusion related to ANO's x2 as evidence by dementia. – The patient outcomes is that he will be able to help with small tasks of daily living with partial help.
Risk for shock related to septic diagnosis.- The patient outcome is that he should maintain stable vital signs including LOCs, while also understanding any changes in pain or in his body systems.

Objective Data

The patient is diagnosed with sepsis and acute cystitis and pyelonephritis. He is positive for a UTI. His vital signs were all within normal ranges beside his blood pressure being slightly hypotensive at 113/62. This patient is alert and oriented x2 and has a PEG tube for feedings that was placed on 8/24/22.

Client Information

The patient is a 83 year old male who was admitted for palpitations and was found to be in rapid atrial fibrillation. This patient has a history of hypertension, hyperlipidemia, dementia, and atrial fibrillation.

Nursing Interventions

The nurse should improve safety for this patient and teach him to use proper stable devices with his unstable gait.
The nurse should assess the client for possible sources of infection nd maintain a sterile field when dealing with any open wounds o ressings.
he nurse should use simple commands that the patient can respond nd react to. The nurse should also eliminate any loud noises or istractions for the patient.
The nurse should explain the need for communication and always keep open wound sites as sterile as possible. The nurse should also monitor the patient for signs of infection and monitor malnutrition to keep vitamins and protein up.