

N431 Care Plan # 1
Lakeview College of Nursing
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Demographics (3 points)

Date of Admission 9/13/2022	Client Initials LJ	Age 60	Gender Female
Race/Ethnicity White	Occupation Unemployed/disability	Marital Status Married	Allergies No known Allergies
Code Status Full	Height 5'7"	Weight 69.3 kg	

Medical History (5 Points)

Past Medical History: Anxiety, Depression, Diabetes Mellitus, High Cholesterol, Hypertension, Neuropathy

Past Surgical History: Below right knee amputation, carpal tunnel release, removal of fallopian tube

Family History: Father has a history of cancer and mother has a history of Diabetes Mellitus

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

Current everyday cigarette smoker ½ pack/day, Denies alcohol and drug use.

Assistive Devices: Wheelchair, walker, shower chair

Living Situation: Lives at home with her husband and 18-year-old son.

Education Level: Undergraduate education

Admission Assessment

Chief Complaint (2 points): Altered mental status

History of Present Illness – OLD CARTS (10 points): Unable to assess patients OLD CARTS.

Per patients' mother, she went to help the patient run errands on 9/13/22 like they had agreed to the day before. When she arrived, the patient was lying in her bed, confused, and covered in feces. The patient's mother called emergency medical services (EMS). They arrived on scene 20

minutes after the call. After assessing the scene EMS brought the patient into the OSF Danville emergency room to be treated.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): UTI

Secondary Diagnosis (if applicable):

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

A urinary tract infection (UTI) is an infection to any part of the urinary system ("Urinary tract infection (UTI) - Symptoms and causes," 2021). This includes the kidneys, ureters, bladder, and urethra. There are two different types of urinary tract infections, lower and upper. Women are at a higher risk for contracting UTIs over men ("Urinary tract infection (UTI) - Symptoms and causes," 2021). This is because women have a shorter urethra than men and the female urethra is closer to the rectal mucosa. 40% of women in the United States between the ages of 20-40 have had a lower UTI (Capriotti, 2020). UTIs are caused when bacteria enter the urethra and spread to the bladder. The type of bacteria that is commonly found in UTIs is *Escherichia coli* (*E. coli*). Some of the symptoms from a UTI are, a burning sensation when urinating, urine that appears cloudy, foul-smelling urine, and pelvic ("Urinary tract infection (UTI) - Symptoms and causes," 2021). To diagnose a UTI an analysis is done of a urinary sample. To be confirmed for a UTI this sample should show bacteria or white blood cells which is a sign of infection. In addition to the changes in urine a patient may also have an increased WBC. The treatment for a UTI is antibiotics (Capriotti, 2020).

The patient came into the emergency room on 9/11/22 complaining of a burning sensation when urinating, and frequent urination. Due to the symptoms the patient complained of

the healthcare provider ordered a urinary analysis. The results of this analysis identified that the patient likely has a UTI. The patient was then sent home with antibiotics. When the patient was brought back to the hospital on 9/13/22 a complete blood count (CBC) was done which identified an elevated white blood cell (WBC) count and an increase in neutrophils. Both lab results correlate with a diagnosis of a UTI.

Pathophysiology References (2) (APA):

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

Urinary tract infection (UTI) - Symptoms and causes. (2021, April 23). Mayo

Clinic. <https://www.mayoclinic.org/diseases-conditions/urinary-tract-infection/symptoms-causes/syc-20353447>

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	3.8-5.3	4.88	4.58	N/A
Hgb	12.0-15.8	13.4	12.9	N/A
Hct	36-47	39.8	37.0	N/A
Platelets	140-440	279	278	N/A
WBC	4.0-12.0	12.6	11.00	WBC are likely elevated in this patient due to her urinary tract infection (Pagana, 2019).
Neutrophils	47.0-75.0	83.7	82.3	Neutrophils are likely elevated in this patient due to her urinary tract infection (Pagana, 2019).
Lymphocytes	18.0-42.0	10.9	10.9	I am unable to determine why the

				patients' lymphocytes are decrease however, one reason is that the patient may be malnourished (Pagana, 2019).
Monocytes	4.0-12.0	4.2	6.6	N/A
Eosinophils	0.0-5.0	0.5	0.0	N/A
Bands	0.0-1.0	0.7	0.2	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-	133-144	134	142	N/A
K+	3.5-5.1	3.5	2.9	Unable to assess the cause of the decreased potassium however, long term use of pantoprazole can decrease potassium levels ("Q-pantoprazole," 2020).
Cl-	98-107	98	103	N/A
CO2	21-31	31	29	N/A
Glucose	70-99	372	287	The patient's glucose levels are likely elevated due to the patient's diagnosis of diabetes. Her body is unable to produce its own insulin (Pagana, 2019).
BUN	7-25	25	22	N/A
Creatinine	0.50-1.0	0.87	0.84	N/A
Albumin	3.5-5.7	3.8	3.5	N/A
Calcium	8.5-10.2	9.0	8.6	N/A
Mag	1.6-2.6	1.6	1.8	N/A
Phosphate	2.8-4.5	N/A	N/A	N/A

Bilirubin	0.2-0.8	0.6	0.7	N/A
Alk Phos	34-104	103	90	N/A
AST	13-39	14	16	N/A
ALT	7-52	9	8	N/A
Amylase	10-140	N/A	N/A	N/A
Lipase	0-160	N/A	N/A	N/A
Lactic Acid	0.5-2.0	1.4	N/A	N/A
Troponin	0-0.04	<0.030	N/A	N/A
CK-MB	3-5%	N/A	N/A	N/A
Total CK	5-25	54	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	1.1	N/A	N/A
PT	10.1-13.1	12.8	N/A	N/A
PTT	25-36	29	N/A	N/A
D-Dimer	<0.5	N/A	N/A	N/A
BNP	<100	N/A	N/A	N/A
HDL	>40	41	N/A	N/A
LDL	<130	148	N/A	N/A
Cholesterol	<200	197	N/A	N/A
Triglycerides	<150	104	N/A	N/A

Hgb A1c	4-6	9.1	N/A	The patients A1c is high likely due to poor management of the patient's diabetes (Pagana, 2019).
TSH	0.27-4.2	0.451	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	Yellow/clear	Yellow/clear	N/A	N/A
pH	5-9	7.0	N/A	N/A
Specific Gravity	1.003-1.030	1.020	N/A	N/A
Glucose	Negative	3+	N/A	This can be caused due to the patient's high blood glucose levels (Pagana, 2019).
Protein	Negative	3+	N/A	Protein in the urine can identify damage in the kidneys, this damage could be due to the patient's diabetes (Pagana, 2019).
Ketones	Negative	1+	N/A	Ketones in the urine can be caused by too much acidity in the blood, or ketoacidosis (Pagana, 2019).
WBC	0-5	0-5	N/A	N/A
RBC	0-2	3-5	N/A	The red blood cells identified in the urine can be due to an infection in the bladder or kidney (Pagana, 2019).
Leukoesterase	Negative	Negative	N/A	N/A

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	N/A	N/A	N/A
PaO2	80-100	N/A	N/A	N/A
PaCO2	35-45	N/A	N/A	N/A
HCO3	22-26	N/A	N/A	N/A
SaO2	95-100	N/A	N/A	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	N/A	N/A	N/A
Blood Culture	No growth	Cultures drawn	No growth in 1 day	This result identifies that after one day the blood culture have no bacterial growth in them (Pagana, 2019).
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

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

Reference (14th ed.). Elsevier.

Q-pantoprazole. (2020, June 4). Canadian Health, Disease, & Medication Information -

MedBroadcast.com. <https://www.medbroadcast.com/drug/getdrug/q-pantoprazole>

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Diagnostic Test Correlation (5 points):

CT head/brain without contrast

The purpose of this test was to detect an acute hemorrhage in the brain (“Mayo foundation for medical education and Research”, 2020). This test was done to identify the reason for the patients AMS. The CT showed no significant findings.

MRI brain without contrast

The purpose of the MRI of the brain without contrast was to identify if the patient has had a stroke (“Mayo foundation for medical education and Research”, 2020). This was done to identify a reason for the patients AMS as well as the weakness identified in the patients’ right arm. The MRI found mild mucosal thickening of the ethmoid sinus cells. This does not explain the patients AMS or weakness on the right side.

Echocardiography

The purpose of this test is to identify how the heart chambers and valves are pumping blood through the heart (“Mayo foundation for medical education and Research”, 2020). This test was likely done to identify if there is any problem with the patient’s heart due to the low potassium level. This is likely not directly related to the UTI diagnosis.

Diagnostic Test Reference (1) (APA):

Mayo Foundation for Medical Education and Research. (2020, June 13). *Ards*. Mayo Clinic.

Retrieved May 27, 2022, from <https://www.mayoclinic.org/diseases-conditions/ards/diagnosis-treatment/drc-20355581>

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

Home Medications (5 required)

Brand/ Generic	Metoprolol/ Lopressor	Metformin/ Glucophage	Pantoprazol e/ Protonix	Sertraline/ Zoloft	Lorazepam/ Ativan
Dose	25mg	500mg	40mg	50mg	0.5mg
Frequency	BID	BID	Daily	Daily	PRN every 8 hours
Route	PO	PO	PO	PO	PO
Classification	Pharmacologi cal: Beta1- adrenergic Therapeutic: Antianginal, antihypertensi ve	Pharmacolo gical: Biguanide Therapeutic : Antidiabeti c	Pharmacolo gical: Proton pump inhibitor Therapeutic : Antiulcer	Pharmacolo gical: Selective serotonin reuptake inhibitor (SSRI) Therapeutic : Antidepress ant and antianxiety	Pharmacolo gical: Benzodiazep ine Therapeutic : Anxiolytic
Mechanism of Action	Inhibits stimulation of beta1- receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and	May promote storage of excess glucose as glycogen in the liver, which reduces glucose production. Metformin also may	Interferes with gastric acid secretion by inhibiting the hydrogen- potassium- adenosine triphospat e enzyme system, or proton	Inhibits reuptake of the neurotrans mitter serotonin by CNS neurons, thereby increasing the amount of serotonin available in	May potentiate the effects of Gramm aminobutyri c acid (GABA) and other inhibitory neurotrans mitters by binding to specific

	myocardial oxygen demand.	improve glucose used by adipose tissue and skeletal muscle to increase glucose transport across cell membrane.	pump, in gastric parietal cells.	nerve synapses. An elevated serotonin level may result in elevated mood and reduce depression.	benzodiazepine receptors in cortical and limbic areas of CNS.
Reason Client Taking	Patient is taking this due to a history or hypertension.	To reduce blood glucose in type 2 diabetes.	Patient is taking medications for gastroesophageal reflux disease (GERD).	Patient is taking this medication to treat anxiety.	Patient is taking this medication to treat anxiety.
Contraindications (2)	Overt cardiac failure and sinus bradycardia.	Renal dysfunction and impaired hepatic function.	Nephritis and systemic lupus erythematosus.	Suicidal thoughts and manic behavior	Acute narrow-angle glaucoma and hypersensitivity to benzodiazepines.
Side Effects/Adverse Reactions (2)	CVA and Heart failure	Metallic taste and nausea.	Blurred vision and fruit-like breath odor.	Hyperthermia and fluctuating vital signs	Drowsiness and dizziness
Nursing Considerations (2)	Use caution for patients with Asthma and COPD because it can cause bronchoconstriction. It also can mask symptoms of hypoglycemia in diabetics.	Monitor urine and serum glucose levels	Monitor for a history of liver disease or lupus and ask for if there is a known allergy to pantoprazole.	Monitor for signs of serotonin syndrome and delirium.	Use caution with COPD patients and assess for sleep apnea.

Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Monitor the patients' blood pressure and heart rate before administering .	Monitor fasting blood glucose and A1C every 3 to 6 months.	Assess for GI symptoms and drowsiness before administrations.	Monitor sodium and changes in mental status.	Respiratory depression and sedation.
Client Teaching Needs (2)	Instruct the client to take it the same time every day and the pill should be swallowed whole and not crushed or chewed	Should be taken on an empty stomach and do not crush, break, or chew pill.	Patient should avoid alcohol and report any rashes or itching.	Take the medication at the same time every day and take as prescribed.	Take medication as prescribed and avoid alcohol (Jones & Bartlett, 2022).

Hospital Medications (5 required)

Brand/Generic	Acetylsalicylic acid/ Aspirin	Carvedilol/ Coreg	Citalopram/ Celxa	Spiroinolactone/ Aldactone	Potassium Chloride
Dose	300mg	6.25 mg	10mg	25mg	20mEq
Frequency	Daily	BID with meals	Daily	Daily	Every 2 hours
Route	Rectal	Oral	Oral	Oral	IV
Classification	Pharmacologic class: Salicylate Therapeutic class: NSAID	Pharmacologic class: Nonselective beta blocker and alpha-1 blocker Therapeutic class: antihypertensive	Pharmacologic class: selective serotonin reuptake inhibitors Therapeutic class: antidepressant	Pharmacologic class: potassium-sparing diuretic Therapeutic class: diuretic	Pharmacologic class: Electrolyte cation Therapeutic class: Electrolyte replacement

		nsor, heart failure treatment adjusts			
Mechanism of Action	Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis. Prostaglandins, important mediators in the inflammatory response, cause local vasodilation with swelling and pain.	Reduces cardiac output and tachycardia. Causes vasodilation, and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload, when given for at least 4 weeks, carvedilol reduces plasma renin activity.	Blocks serotonin reuptake by adrenergic nerves, which normally release this neurotransmitter from their storage sites when activated by a nerve impulse. This blocked reuptake increases serotonin levels at nerve synapses, which may elevate mood and reduce depression	Normally, aldosterone attaches to receptors on the walls of distal convoluted tubule cells causing sodium and water reabsorption in the blood, as shown at left.	Acts as the major cation in intracellular fluid, activating many enzymatic reactions essential for physiologic processes, including nerve impulse transmission and cardiac and skeletal muscle contractions.
Reason Client Taking	To reduce complications such as a stroke.	To control hypertension	To treat depression	To treat hypertension	To treat hypokalemia
Contraindications (2)	Impaired renal or liver function	Severe bradycardia and second- or third-degree AV block	Pimozide therapy, and hypersensitivity to citalopram or its components	Addison's disease, and hyperkalemia	High levels of potassium and high amount of chloride in the blood.

Side Effects/Adverse Reactions (2)	Stomach pain and confusion	Asthenia and abdominal pain	Angina and acute renal failure	Ataxia and irregular menses.	Bleeding and rash
Nursing Considerations (2)	Should be taken on a full stomach and take with a full glass of water.	Tell patient to notify prescriber of all medications taken, including OTC preparation, before using them.	Monitor for hypotension and orthostatic hypotension.	Evaluate spironolactone's effectiveness by assessing blood pressure and presence and degree of edema and caution patient that he may experience dizziness during spironolactone therapy if fluid imbalance is altered.	Monitor the infusion site for redness and inflammation and cardiac monitoring should be done.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Signs of bleeding and petechiae.	Monitor BP and pulse before administrations.	Assess for suicidal thoughts and ideology and confusion.	Monitor blood pressure and for headache.	Monitor potassium levels and ECG.
Client Teaching Needs (2)	Do not crush pill and avoid taking it with alcohol.	Do not crush pill and avoid taking it with alcohol.	Take medication at the same time each day and take exactly as directed.	Take as direct and shake oral suspension before each use.	Notify RN is you feel heart palpitations or have shortness of breath. (Jones & Bartlett, 2022).

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2022). *2021 Nurse's Drug Handbook* (21st ed.).

Assessment

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

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>Alert and oriented x0, patient does not appear in distress and is well groomed.</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: 12 Drains present: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Type:</p>	<p>Skin is pink, warm, and dry upon palpation. No rashes, lesions, or bruising. Normal quantity, distribution, and texture of hair. Nails without clubbing or cyanosis. Skin turgor normal mobility. Capillary refill less than 3 seconds fingers and toes bilaterally.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck are symmetrical, trachea is midline without deviation. Bilateral carotid pulses are palpable and 2+. No lymphadenopathy in the head or neck is noted. Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage from eyes. Bilateral lids are moist and pink without lesions or discharge noted. PERRLA bilaterally, EOMs intact bilaterally. Septum is midline, turbinates are</p>

	<p>moist and pink bilaterally and no visible bleeding or polyps. Posterior pharynx and tonsils are moist and pink without exudate noted. Hard palate intact. Dentition is good, oral mucosa overall is moist and pink without lesions noted.</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Clear S1 and S2 without murmurs gallops or rubs. PMI palpable at 5th intercostal space at MCL. Normal rate and rhythm. Pulses 2+ throughout bilaterally. Capillary refill less than 3 seconds fingers and toes bilaterally. No edema inspected or palpated in all extremities.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Normal rate and pattern of respirations, respirations symmetrical and non-labored, lung sounds clear throughout anterior/posterior bilaterally, no wheezes, crackles, or rhonchi noted.</p>
<p>GASTROINTESTINAL: Diet at home: Regular Current Diet: Diabetic/cardiac Height: 5'7" Weight: 69.3 kg Auscultation Bowel sounds: Last BM: 9/12/22 Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Abdomen is flat, soft, non-tender, no organomegaly or masses or pain notes upon palpation of all four quadrants. No scars, incision, drains, or wounds noted. Bowel sounds are normoactive in all four quadrants.</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: 375 Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Urine is yellow/clear</p>

<p>Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 12 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input checked="" type="checkbox"/> Needs support to stand and walk <input checked="" type="checkbox"/></p>	<p>Patient's right leg amputated below the knee. Has full range of motion in left arm and leg, general weakness in the right arm and hand. Patient uses a wheelchair, shower chair, and walker.</p>
<p>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Patient is alert and oriented x 0, Speech is slurred, PERRLA, patient is arousable.</p>
<p>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):</p>	<p>Unable to assess patients coping methods and developmental level. Patients mother states that patient does not believe strongly in one religion. Patient lives at home with her son and husband. Her mother comes over daily to help the patient run errands or with anything she may need. Overall, the patient has an excellent support system and appears to have good home environment.</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1200	118	203/94	18	97.7	95
1600	114	203/94	18	98.5	94

Vital Sign Trends: Vitals remained constant over the clinical, blood pressure and pulse remain elevated throughout clinical.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1200	Denies Pain	N/A	N/A	N/A	N/A
1600	Denies Pain	N/A	N/A	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock	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:	20G Right hand 9/13/22 Patient, flushes well No signs of erythema or drainage IV dressing is clean, dry, and intact Saline Lock	22G Left A/C 9/14/22 Patient, flushes well No signs of erythema or drainage IV dressing is clean, dry, and intact Saline Lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 ml of water	375 ml of urine

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was sleeping most of the day, her speech was slurred. Blood pressure and pulse were closely monitored as well as the patient's temperature.

Procedures/testing done: Patient had an echocardiogram completed during the shift. The results are not yet available.

Complaints/Issues: The patient did not have any complaint during the shift.

Vital signs (stable/unstable): Pulse and blood pressure were monitored throughout the day due to both of them being elevated.

Tolerating diet, activity, etc.: Patient is tolerating their diet, unable to assess the patient's activity.

Physician notifications: Physician was notified about the patients elevated blood pressure.

Future plans for client: Client will continually be monitored for sepsis, monitor client's temperature closely.

Discharge Planning (2 points)

Discharge location: Patient will likely discharge to her home with her husband and son.

Home health needs (if applicable): No addition care needs will be needed

Equipment needs (if applicable): No addition equipment will be needed

Follow up plan: Patient will need follow ups with physical therapy to work on the range of motion in her right arm.

Education needs: Client should be educated on how to identify signs of low potassium and learn how to better manage her diabetes.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rationale	Interventions	Outcome	Evaluation
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<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>(2 per dx)</p>	<p>Goal (1 per dx)</p>	<ul style="list-style-type: none"> • How did the client/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for decreased cardiac output related to hypertension as evidence by a blood pressure of 203/94.</p>	<p>After assessing the patients’ vital signs and noticing the elevate blood pressure the nurse noted that this could impart the patients cardiac output making this a concern.</p>	<p>1. Monitor the patients’ blood pressure every 4 hours.</p> <p>2. Monitor the patients potassium level at least twice daily.</p>	<p>1. The outcome goal is that the patients’ blood pressure and potassium fall with in normal range.</p>	<p>The patient’s family encouraged the nurse to monitoring the patients’ blood pressure and potassium. The patient was unable to assess on this matter. During the shift the patients’ blood pressure remained elevated, and the provider was notified. The potassium levels were not checked during the shift. No modifications were made to the plan during the shift.</p>
<p>2. Infection related to neutrophilia as evidence by elevated neutrophil count.</p>	<p>After checking the patients CBC, the student become concerned about the increased level of</p>	<p>1. Monitor the patient’s temperature for signs of a fever.</p> <p>2. Monitor the patients CBC to identify if the neutrophil</p>	<p>1. The outcome goal is that the patient does not get a fever and that the neutrophil count decreases.</p>	<p>The family encouraged the nurse to monitor the patients’ temperatures and CBC. Unable to assess the patient’s response to the nurses’ actions. The</p>

	<p>neutrophils. This identifies an infection, and the patient should be monitored to ensure it does not escalate.</p>	<p>count is decrease or increasing.</p>		<p>patient did not have a fever during the shift, and the patients' blood was not drawn during the shift. There were no modifications made to the plan during the shift.</p>
<p>3. Impaired physical mobility related to decrease in muscle strength as evidence by weak grip strength in the right hand.</p>	<p>After assessing the patient's strength, the student noticed weakness in the right hand and arm. The weakness is a concern to the patient's mobility.</p>	<p>1. Monitor the patient's strength every 2 hours to identify any changes. 2. Have the physical therapy assess the patient.</p>	<p>1. The outcome goal is that the patient's weakness does not get worse, and that physical therapy is able to help the patient have full function of her hand.</p>	<p>Once again, the patient's family was very supportive of the interventions. The patient's weakness was assessed every 2 hours and there were no changes. A physical therapy assessment was not done. Unable to assess the client's response. There were no changes made to the plan.</p>
<p>4. Impaired verbal communication related to aphasia, as evidence by slurred speech and difficulty expressing thoughts.</p>	<p>After assessing the patient, the student noticed that the patient was slurring her words and had difficulty expressing her thoughts. This led to concern about the patient's ability to</p>	<p>1. Monitor the patient's speech throughout the shift and document any changes. 2. Have speech therapy meet with the patient to assess them.</p>	<p>1. The outcome goal is that the patient's speech improves with the help of speech therapy.</p>	<p>Once again, the family is very supportive of the nursing interventions. The patient's speech remains the same. Unable to assess the patient's response to the interventions. An order for speech therapy consult was made however, it has not been completed. There</p>

	verbally communicate.			were no changes made to the plan during the shift (Phelps, 2021).
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Other References (APA):

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

Concept Map (20 Points):

Subjective Data

Current everyday smoker (0.5 packs/day)
Denies Alcohol and Drug use
Denies pain

Risk for decreased cardiac output related to hypertension as evidence by a blood pressure of 203/94.

Outcome goal is that the patient's potassium level fall within normal range.

Infection related to neutrophilia as evidence by elevated neutrophil count.

The outcome goal is that the patient does not get a fever and that the neutrophil count decreases.

Impaired physical mobility related to decrease in muscle strength as evidence by weak grip strength in the right hand.

The outcome goal is that the patient's weakness does not get worse, and that physical therapy is able to help the patient have full function of her hand.

Impaired verbal communication related to aphasia, as evidence by slurred speech and difficulty expressing thoughts.

The outcome goal is that the patient's speech improves with the help of speech therapy.

Nursing Diagnosis/Outcomes

Objective Data

WBC of 12.6
BP of 203/94
Pulse of 118
Weakness in the right arm and hand
RBC in urinalysis is 3-5

Client Information

White 60-year-old female brought into the ER by EMS. Patient was found confused and lying-in bed covered in feces. Patient was diagnosed with a UTI two days ago.

Nursing Interventions

- 1. Monitor the patients' blood pressure every 4 hours.
- 2. Monitor the patients potassium level at least twice daily.
- 1. Monitor the patient's temperature for signs of a fever.
- 2. Monitor the patients CBC to identify if the neutrophil count is decrease or increasing.
- 1. Monitor the patient's strength every 2 hours to identify any changes.
- 2. Have the physical therapy assess the patient.
- 1. Monitor the patient's speech throughout the shift and document any changes.
- 2. Have speech therapy meet with the patient to assess them.

