Medications

Allopurinol(zyloprim) oral dosage of 600mg once daily (Jones and Bartlett 2022).

Pharmacological classification: Xanthine oxidase inhibitor Therapeutic Class: Antigout agents

Reason: treats gout and hyperuricemia

Key nursing assessments: obtain CBC, uric acid level and review renal and liver function tests before and during treatment.

Atorvastatin (Lipitor) 10mg PO once daily (Jones and Bartlett 2022).

Pharmacological classification: HMG-CoA reductase inhibitor Therapeutic Class: Antihyperlipidemic

Reason: to control lipid levels

Key nursing assessments: measure lipid levels 2-4 weeks after therapy starts, & monitor patients' glucose as it may affect glucose control

Ceftriaxone (Rocephin) 2 g IV or IM every 12 (Jones and Bartlett 2022).

Pharmacological classification: Third-generation cephalosporin Therapeutic Class: Antibiotic

Reason: Treats infections such as bacterial septicemia

Key nursing assessments: obtain culture and sensitivity results before giving drug, assess urine

Enoxaparin(lovenox) 1mg sub-q q12H (Jones and Bartlett 2022).

Pharmacological classification: Low-molecular-weight heparin Therapeutic Class: Anticoagulant

Reason: Prevents DVT after hip or knee replacement, also to prevent thromboembolic risk factors

Key nursing assessments: neurological evaluation, and check platelet count to prevent any bleeding disorders

Gabapentin (Neurontin) 300 mg PO 3 times per day (Jones and Bartlett 2022).

Pharmacological classifications: 1-amino-methyl cyclohexane acetic acid Therapeutic Class: Anticonvulsant

Reason: prevents exaggerated response to painful stimuli

Key nursing assessments: monitor patient closely for suicidal thinking or behavior

Levothyroxine (Synthroid) 25 mcg/day PO (Jones and Bartlett 2022).

Pharmacological classification: Synthetic thyroxine (T4) Therapeutic Class: Thyroid hormone replacement

Reason: Treats hypothyroidism

Key nursing assessments: Monitor vitals and glucose levels

Lurasidone HCI tabs 40 mg PO once daily with food (Jones and Bartlett 2022).

Pharmacological classifications: atypical antipsychotic Therapeutic Class: Antipsychotic

Reason: Treats schizophrenia

Key nursing assessments: monitor lung sounds and mental status

Miconazole 2% powder topical application twice daily (Jones and Bartlett 2022).

Pharmacological classifications: azole antifungals Therapeutic Class: imidazole

Reason: Treat fungal or yeast infections of the skin

Key nursing assessments: assess the skin for swelling, bumps & tenderness

Pantoprazole (Protonix) 40 mg PO once daily (Jones and Bartlett 2022).

Pharmacological classifications: Proton pump inhibitor Therapeutic Class: Antiulcer

Reason: Treats short term GERD

Key nursing assessments: Monitor patient urine output

Quetiapine (Seroquel) 50 mg PO once daily in the evening (Jones and Bartlett 2022).

Pharmacological classifications: Dibenzothiazepine derivative Therapeutic Class: Antipsychotic

Reason: Treats schizophrenia

Key nursing assessments: monitor patients' mood as depression may occur

Vitamin D3 tablet 2 tablets twice daily with food (Jones and Bartlett 2022).

Pharmacological classifications: vitamin D analogs. Therapeutic Class: fat-soluble secosteroids

Reason: Strengthens bones and muscles

Key nursing assessments: Monitor bone conditions take vitamin D test

Pathophysiology

Disease process: Weakness is a decrease in the strength in one or more muscles. Weakness may be generalized and affect one muscle or muscle group exclusively. Diseases of the neuromuscular system, injuries, & metabolic diseases can all cause of measurable muscle weakness. According to Lenvin et al. (2019), Voluntary movement is initiated in the cerebral motor cortex, at the posterior aspect of the frontal lobe. The neurons involved (upper motor or corticospinal tract neurons) synapse with neurons in the spinal cord (lower motor neurons). Lower motor neurons transmit impulses to the neuromuscular junction to initiate muscle contraction. Due to my patient not being able to move her right leg is due to the weakness of the muscle, causing the patient to experience pain

S/S of disease: body fatigue, tiredness, unable to move extremities, issues with gait, and unable to complete daily tasks. (Lenvin. M, 2019)

Method of Diagnosis: CT scan or MRI to examine structure of the body, EMG to test nerve activity, and blood tests for signs of infection. (Lenvin. M, 2019)

Treatment of disease: ventilatory support, occupational therapy, physical therapy, & completing ROMs daily. These are all good to restore strength and bone density. (Lenvin. M, 2019)

Date of Admission: 9-10-22
Admission Diagnosis/Chief Complaint: Generalized weakness and chronic rt hip
Age: 66
Gender: Female
Race/Ethnicity: Caucasian/Non-Hispanic
Allergies: Codeine (chest pain radiates to shoulder and down the back)
Code Status: Patient is a Full Code
Height in cm: 147.3cm
Weight in kg: 91kg
Psychosocial Developmental Stage: (integrity vs despair) existential identity; a sense of integrity strong enough to withstand physical disintegration.
Cognitive Developmental Stage: Formal operational Becomes concerned with the hypothetical, the future, and ideological
Problems.
Braden Score: 19
Morse Fall Score: 10
Infection Control Precautions: N/A

Active Orders

tient does not have diet restrictions)

phrology for (AKI & hypotension)

um (checks health of kidneys)

itiates the quality of blood cells).

provides important information about your body's chemical balance and metabolism

for (AKI)

uate & treat (assisted daily living to help patient walk again)

uate & treats (to elevate pain in hip)

e ox spot (to ensure blood is producing enough O2 in throughout the body)

esidual is greater than 300 (indicates patient is retaining urine, pt. will be catharized to urine)

to help with breathing and comfort level)

manage urinary retention and obstruction)

nd output (patient is at risk of fluid imbalance, ensures patient isn't getting rid of too ids)

ent is at risk of dehydration, this will help maintain healthy fluid intake)

ls (to view s/infiltration/phlebitis and assist with morning labs, this will ensure patients ren't being affected)

to help patient get adequate blood flow so walking can be restored, & to decrease the y)

sure patients bp, heart rate and pulse are still within normal limits. It is useful to make condition isn't getting worse, or medications aren't creating adverse affects)

or has slight tenting and goes down
are not any drains present. Braden

tient has good vision, and placement. Patients' ears appear to be normal tympanic membrane is seen throughout. Patients nose is structured with no sneezing, drainage, bleeding, polyps, or edema. Patients' mucosa membranes are pink, uvula is midline, patient does not have any teeth, (needs dentures). Mouth has normal formation.

Cardiovascular: Patient does not have any heart problems S1 and S2 are heard throughout w/o murmurs. Pulses are at a 2+ bilaterally. Cap refill time is normal patients finger blanches within 3 seconds. There are no signs of edema or neck vein distention.

Respiratory: Patients respirations are a bit shallow, sitting the patient up right helped with breathing patterns. Patients' breath sounds sound like she may be experiencing rhonchi, lung sounds were heard in all four quadrants.

Genitourinary: Patients urine is yellow and clear, the patient does not experience any pain while urinating, patient is not on dialysis, genitals appear normal, patient has a foley catheter due to urinary retention.

Gastrointestinal: Patients bowel sounds are active, last BM was Monday 9/13/22. Patient eats home cooked meals & states that she only eats out 1-2x a month. Patient weighs 200lb with a height of 147.3cm. upon palpation there aren't any lumps or feelings of tumors, abdomen soft and nontender. Upon auscultation I didn't hear excess fluid in the abdomen, bowel sounds were normal. Patient does have scarring due to picking the scab from her gallbladder as it was healing. Patient does not have an ostomy, NG tube, or any feeding tubes.

Musculoskeletal: Patient's nail beds are normal without clubbing or cyanosis. Patient can move all upper extremities. Temperature Is warm to touch. Able to perform active ROM but only the upper body, patient was unable to move legs bilaterally due to right hip pain. Patient has a walker at home but does not use it, strength is equal bilaterally

Neurological: Patient is alert and orientedx4, with normal cognition, patient speech is clear and answers questions appropriately. Patient only moved upper extremities well, lower extremities can't be moved w/o experiencing pain. Patellar reflexes normal and symmetrical, no CN deficits noted.

Most recent VS (include date/time and highlight if abnormal):

1530 BP 123/53, Pulse 75, O2 100, Respirations 20, Temp 97.5F

Pain and pain scale used: 9, on pain scale 0 to 10.

Nursing Diagnosis 1	**Nursing Diagnosis 2**	**Nursing Diagnosis 3**
Risk for deficient fluid volume Related to low albumin level	Risk for pressure ulcers Related to immobility	Risk for Activity intolerance Related to neuromuscular skeletal impairment
Rationale due to dehydration as evidence by tenting of skin turgor upon assessment.	**Rationale** due to hip pain as evidence by inability to ambulate.	**Rationale** secondary to hip pain as evidence by pain upon movement.
Interventions Intervention 1: Encourage or remind patient to drink fluids & monitor output of voided urine to aid estimate of patient fluid balance. Intervention 2: Educate patient and family on how important it is to stay hydrated to help prevent dehydration and abnormal lab values.	**Interventions** **Intervention 1:** Recommend physical therapy to increase motivation for physical activity. **Intervention 2:** Turn and position patient every two hours to help keep blood flowing and prevent unhealthy skin tissue from developing.	**Interventions** **Intervention 1:** Have the patient perform activities at a slower pace initiating rest or pauses, to increase the tolerance for activity **Intervention 2:** Provide emotional support and positive attitude regarding abilities. Patient may be nervous or doubtful, appropriate support can enhance confidence
Evaluation of Interventions Patients' electrolyte values are normal Patient demonstrates understanding of importance of maintaining fluid balance	**Evaluation of Interventions** Patient does not have any bed sores or signs of skin breakdown Patient understands the importance of being repositioned every two hours	**Evaluation of Interventions** Patient can complete ROM with little help Patient Patient can perform daily activities without feeling excessive fatigue or pain.

References (3) (APA):

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