Medications

Penicillin G Potassium 18 Million in Sodium Chloride (Pfizerpen) - (Pencillin) (Antibiotic)

0.75 mil units/hr (23.3 mL/hr) IV - Continuous

The patient take the medication to treat for Serious infections due to susceptible strains of staphylococci that causes pneumonia or endocarditis.

Nursing Assessments: Obtain Body Tissue/fluid samples for culture and sensitivity before giving dose. Assess the patient for signs of secondary infection such as diarrhea, Monitor sodium level and assess for early signs of heart failure when patient receives high doses. The patient is at risk for fluid overload or hypertension (Jones & Bartlett Learning, 2020).

Iron Sucrose (Venofer) - (Iron Mineral) (Hematinic)

200 mg IV ONCE

The Patient takes this medication to treat iron deficiency anemia.

Nursing Assessments: Given IV injection slow. Monitor patient for anaphylaxis signs and symptoms such as collapsing, dyspnea, loss of consciousness, seizures, or severe hypotension. Hypotension is the most common adverse reaction. Test iron levels after 48 hours after last dose and notify doctor to prevent iron toxicity. Monitor signs for iron overload such as GI bleeding or in the lungs, decreased activity, and pale eyes with sedation (Jones & Bartlett Learning, 2020).

Lovenox (Enoxaparin) - (Low-Molecular Weight Heparin) (Anticoagulant)

40 mg Subcutaneously every 24 hours

The patient take the medication to help prevent blood clots from forming.

Nursing Assessments: Prior to administration a nurse should assess for signs of bleeding or unusual bruising and a drop in hematocrit or blood pressure levels (Jones & Bartlett Learning, 2020).

Demographic Data

Date of Admission: 09-26-2022

Admission Diagnosis (Principle Problem): Bacteremia

Secondary Dx: Pneumonia in Left Lower Lung

Chief Complaint: Altered Mental Status

Age: 75 years old

Gender: Female

Race/Ethnicity: Caucasian

Allergies: Iodine (Reaction - Rash-like Hive)

Code Status: Full Code

Height in cm: 159 cm

Weight in kg: 61.1 kg

Psychosocial Developmental Stage: Integrity vs. Despair

Cognitive Developmental Stage: Patient is able to read/write fully formed sentence structure with minimal difficulty. Patient is cognitively sound to make informed decisions based on information given. (Formally operational)

Active Orders

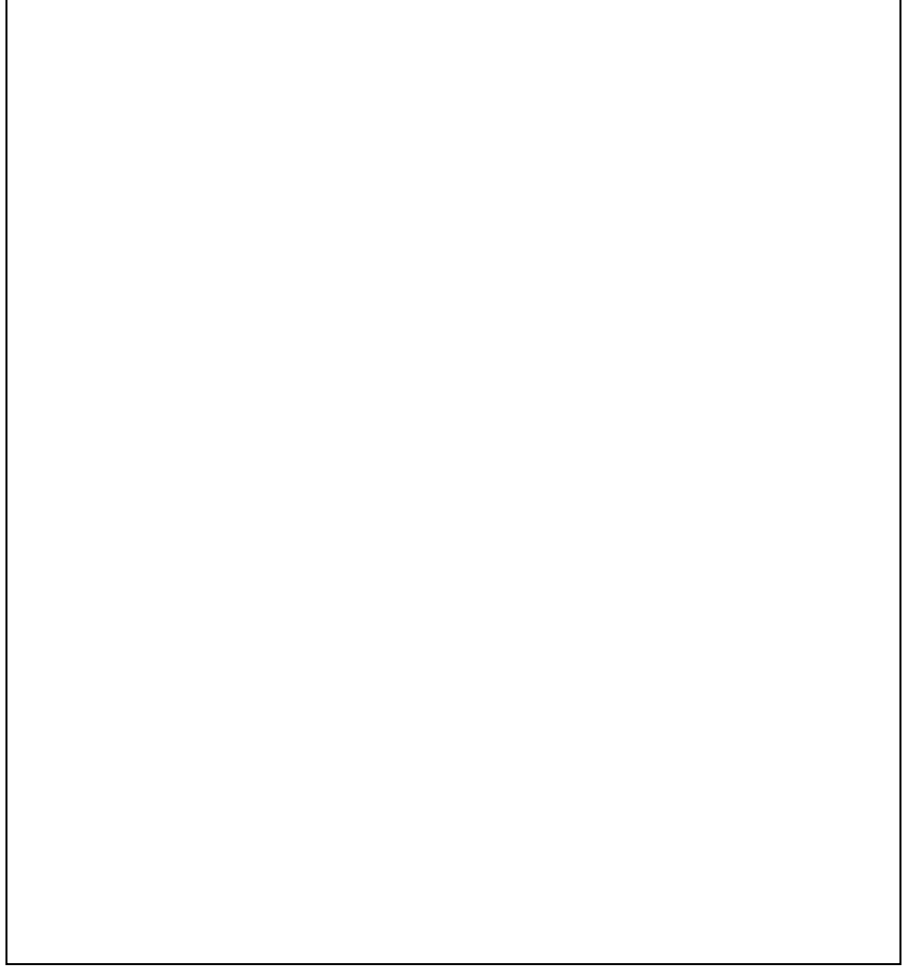
Diet: Soft to chew - Soft until dinner time (09-26-2022)
IP Consult to Cardiology - Bacteremia, Patient needs TEE (09-29-22)
IP Consult to Pharmacy - Vancomycin Therapy.
Urine Culture - Collect Specimen (09-27-2022) (Pending Results)
X-Ray Chest Single View: Altered Mental Status AMS (STAT)
I/O Tracking: Every 8 hours to help assess - for AMS
Up as Tolerated: Regain mobility
Vital Signs: Post-procedural Routine, VS should be taken q 15 mins for 1 hour, then q 30 mins for 2 hours, then every hour if stable

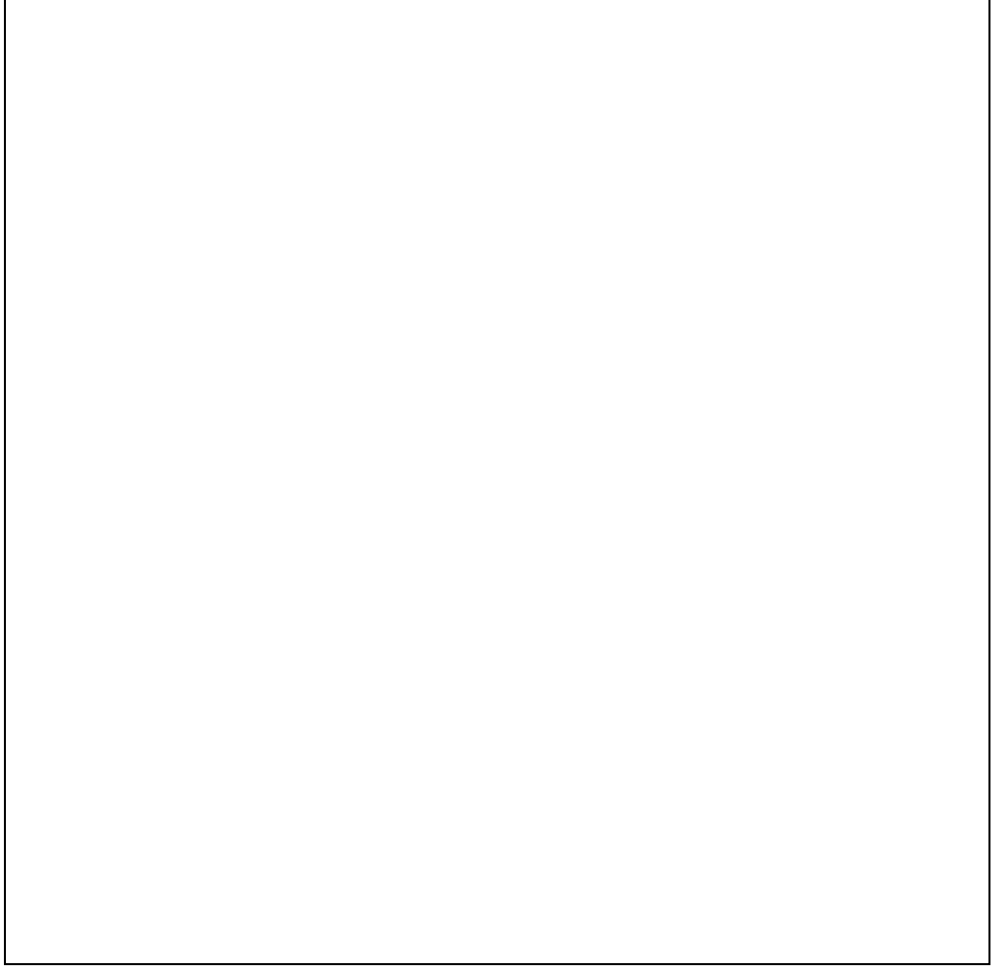
Admission History

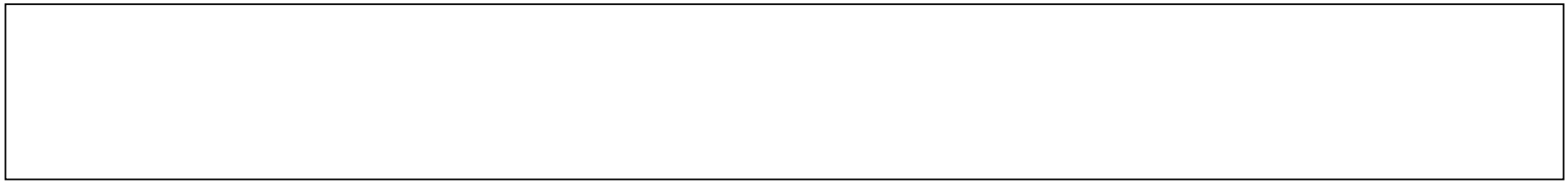
The patient was admitted with a chief complaint of altered mental status that started a day prior to admission. Location is generalized throughout the entire body. The duration of symptoms lasted for 4 days (now going on the 5th day - Sunday to Thursday). The patient stated that the they felt a lot of shakiness, unbalanced, and feverish that progressively gotten worse from the onset of symptoms. They also stated they felt confused to their surroundings and to what the husband trying to communicate to them. The patient stated that the pain level during the time of admission was a 0/10. The husband stated that nothing helped relieve the onset of symptoms due to it progressively getting worse. The patient had the husband give tylenol for the fever that the patient was feeling.

Lab Values

Diagnostic Imaging







Physical Exam/Assessment

General:
Patient is alert and oriented X3 to person, place, and time. No distress appearance at the moment and was resting/laying in bed with HOB elevated at 30 degrees. Patient is alert and responsive to verbal and painful stimuli.

Integument:
Skin color was a tan with age-related wrinkling. Skin was also dry and warm upon palpation. Skin turgor was retractable almost immediate. No signs of contusions or rashes in the cervical/trunk areas and upper/lower extremities. The patient had a IV saline (20 gauge) in the right antecubital area with patent IV (Rate was 23.3 mL/hr). Braden score is 19 (low risk)

HEENT:
Skull and face are symmetrical. Trachea is midline with no deviations. Upon palpation trachea movement is present when patient swallows. Carotid artery is palpable and is +2 bilaterally. All cervical lymph nodes are nonpalpable bilaterally. Eyelids have no visible discoloration, lesions, or swelling bilaterally. Sclera is white and clear bilaterally. Conjunctiva is pink and moist bilaterally. Pupils (PERRLA) are round and equal, reactive to light, and are able to accommodate bilaterally. 6 Extraocular movements are present in both eyes with no deviations bilaterally. No present ear tenderness upon palpation with no visible drainage or discoloration bilaterally. No visible impaction in ears bilaterally. Nose septum is midline. Turbinates are moist and pink in nose bilaterally with no visible signs of bleeding. Frontal sinuses are nontender to palpation bilaterally. Uvula is midline. Soft palate and hard palate are present. Swallow reflex is present with a soft palate able to move upward. Buccal mucosa is moist. Teeth are present and are a yellow/white color and is consistent in the top section and bottom section of the mouth. A cavity is apparent in the left/right/upper/lower back section of the molar teeth.

Cardiovascular:
Sinus Rhythm is present along with S1 and S2 sound present. No signs of S3, S4, or murmurs. Heart rhythm is regular. Upper left arm pulse is +1 and upper right arm pulse is +2. lower peripheral pulses were +2 bilaterally. Apical pulse palpable and auscultated at the midclavicular line at the 5th intercostal space (pulse is a +2 and the rhythm/rate is regular). No signs of neck vein distention or edema in the upper/lower extremities. Cap refill is less than 3 seconds.

Respiratory:
Normal rate and regular pattern of respirations. Respirations are symmetrical and non-labored. Lung sounds clear throughout anterior/posterior bilaterally. No wheezes or rhonchi noted. No use of accessory muscle or signs of breathing distress. Lung aeration is equal bilaterally.

Genitourinary
Urine is yellow and clear (Patient stated). No urine voiding was witnessed within the interaction time (patient voided the night before). Patient denies pain when voiding. Genitals are clean (By patient statement). Patient is not on dialysis and has not catheter in place for voiding.

Gastrointestinal:
No signs of distention, incisions, drains, or wounds upon inspection. Scar is apparent in the right lower quadrant (about 3 inches long - smooth and flat with not redness). Bowel sounds were audible within normal limits in all 4 quadrants. No signs pain or tenderness upon palpation in all 4 quadrants. No ostomy or nasogastric tube present. Last bowel movement was the day before at 1300 (afternoon). Diet at home is regular but during hospitalization a soft to chew diet was ordered. Height is 5'2''(159 cm) and current weight is 134 lbs (61.1 kg).

Musculoskeletal
Neurovascular is intact with no impaired blood flow or damage to the peripheral nerves in the extremities bilaterally. Patient is able to perform all ROM actively in upper and lower extremities bilaterally (During time of hospitalization, the patient is ordered to be supervised when doing ADLs). Muscle strength is 5/5 in upper and lower bilaterally. Client is independent but with assistance and no use of supportive devices. Fall Risk score is 45 (low fall risk = standard fall prevention interventions).

Neurological
MAEW is intact and PERRLA is equal, round and reactive. Muscle Strength in both upper and lower extremity is equal. Orientation x3 to person,place, time, and situation. Mental status is normal with behavior appropriate to their responses. speech and sensory is normal. LOC is 15 with patient alert and awake to question and answers appropriately.

Vital Signs (include date/time and highlight if abnormal): 09/29/22

0824			1011			1050		
B/P: 119/62	**Temp**: 97.5F	**HR**: 60	**B/P:** 125/67	**Temp**: 97.3F	**HR**: 58	**B/P:** 126/66	**Temp**: 97.4F	**HR**: 54
Respiratory Rate: 16		**O2**: 97%	**Respiratory Rate:** 16		**O2**: 97%	**Respiratory Rate:** 14		**O2**: 94%

Pain and pain scale used:
@ 0824: 0/10 - verbalized/number scale (Denied presence of pain)
@ 1011: 0/10 - verbalized/number scale (Denied presence of pain)
@ 1050: 0/10 - verbalized/number scale (Denied presence of pain)

Acute … as ev… the … patie…		…fusion …ance …only …e of …blood …in the
I be… patient due to recent confusion, patient was only oriented to name but not place, time and situation, and leukoestarse present in urinalysis.	patients current situation because a UTI is present that has progressed in the bloodstream (evident by blood culture). The patient is taking Penicillin G K intravenously for the initial treatment of broad-spectrum antibiotic. The patient was admitted with altered mental status as a result of the current UTI.	…patient …situation because of the recent symptoms of loss of balance with shakiness presented in the time of admission, patient is a low fall risk score of 45 at the present time but during admission was scored higher (stated by nurse), and patient needs supervision and assistance when moving.
Interventions 1.) Assess the patient current LOC to obtain a baseline to compare later in ongoing assessment findings (Phelps, 2020).	**Interventions** 1.) Minimize the patient risk of infection by washing hands before and after care. (Phelps, 2020).	**Interventions** 1.) Improve environmental safety factors as needed. (Phelps, 2020). 2.) Assess the patient's ability to use the call light

2.) reassure the family members that the confusion is temporary to ease high levels of anxiety. (Phelps, 2020)	2.) Monitor WBC count as ordered and report elevations that can indicate infection. (Phelps, 2020).	or other safety systems and remove anything form the environment that increases the chance of falls like cords, shoe, or throw rugs. (Phelps, 2020)
Evaluation of Interventions The patient will present improvement of LOC and will be oriented to person, place, time, and situation. The Family will express an understanding of the temporary situation and report feelings of being calm (Phelps, 2020).	**Evaluation of Interventions** The patient's WBC count with differentials will remain normal range and no evident of infection. Patient will not experience signs and symptoms of infection (Phelps, 2020).	**Evaluation of Interventions** The patient will show understanding of factors that increases the chance of falling and assist in making changes to promote fall prevention. (Phelps, 2020).

References (3) (APA):

Capriotti, T. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives*. F. A. Davis Company.

Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (20th ed.).

Pagana, K., Pagana, T., & Pagana, T. (2018, November 29). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

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