N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
10/10/2022	E.C	87	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Non- Hispanic	Retired	Married	Celecoxib, Citalopram
Code Status	**Height**	**Weight**	
Full	5’6” (167 cm)	136 lbs.	

Medical History (5 Points)

Past Medical History: Adenocarcinoma, Coronary Artery Disease (CAD), Hypothyroidism, Atrial Fibrillation, Dilated cardiomyopathy, angina pectoris, anxiety, high cholesterol, lung cancer, premature ventricular contractions, neoplasm of breast, sleep apnea.

Past Surgical History: Mastectomy, knee surgery and total hip arthroplasty

Family History: Family history is unknown to patient

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): patient quit smoking 10 years ago. Patient never used smokeless tobacco and does not drink alcohol.

Assistive Devices: Patient uses a walker at home for mobility

Living Situation: Patient lives with husband

Education Level: N/A

Admission Assessment

Chief Complaint (2 points): Acute Confusion

History of Present Illness – OLD CARTS (10 points): The patient is an 87 year old female who came to the emergency room with her husband on 10/10/2022 with complains of acute confusion which started on 10/10 2022 morning. The husband mentioned that for the past day’s patient had been very week and sleepy than usual but did not complain of any other symptoms at

the time. Before husband brought patient to the hospital, he notices that patient was more confused and showed signs of distress and pain. Husband also states that patient did not take any of her home medications for the day. No nausea or vomiting was noted upon arrival, and was unresponsive on arrival and moaning due to pain on palpation.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Sepsis

Secondary Diagnosis (if applicable): UTI, Uncontrolled hypertension, A fib, dilated Cardiomyopathy

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

Sepsis is a systemic response to infections that may occur after surgery, a burn, a severe illness, or an untreated infection (Capriotti, 2020). Pathogens enter the bloodstream causing septicemia. The body's immune system becomes overactive to the circulation of infection (Hinkle & Cheever., 2018). A load of pathogens invading the bloodstream makes the immune system react extremely by releasing chemicals to fight the infection, eventually leading to a multisystem inflammatory response called sepsis (Hinkle & Cheever., 2018). The presence of infection cause endotoxins and exotoxins to continuously produce an inflammatory surge that results in cytokines release into the bloodstream to restore homeostasis during a systemic inflammatory response (Capriotti., 2020). A prolonged inflammatory response will cause the body to get out of balance initiating cellular changes. Inflammation causes small blood clots to form throughout the system and can block blood and oxygen supply circulations to vital organs

and body parts, leading to tissue death (Capriotti., 2020). Severe cases of sepsis may progress to septic shock, a medical emergency that causes multiple organ dysfunction (Capriotti., 2020).

Signs and symptoms of sepsis include chills, cold, clammy skin, high fever or low temperature, tachycardia, rapid breathing, low blood pressure, warm skin, light-headedness due to low blood pressure, confusion, or delirium, and warm skin (Capriotti., 2020). The patient was brought into the emergency department with complaints of acute confusion, whose heart rate was 120 bpm, respiratory rate was greater than 24, and body temperature was more than 100.1 F. These are consistent with symptoms of sepsis. Also, the patient white blood cells and lymphocytes are elevated, indicating the presence of an infection. Moreso, the patient's Neutrophils were elevated; an Increase in Neutrophils indicates an ongoing bacterial infection. The patient was diagnosed with a Urinary tract infection that may be the underlying cause for sepsis.

Diagnostic tests were performed to identify this disease, including blood tests from different sites to check the presence of an infection. A complete blood count was done to check liver and kidney function, electrolyte balance, clotting problems, and serum lactate levels. Also, a chest x-ray was carried out to rule out suspected lung infection, and a head CT scan was also performed to roll out acute hemorrhage or acute infarction. Moreso, an EKG 12 lead revealed tachycardia and marked ST abnormalities.

Intravenous broad-spectrum antibiotics are the initial treatment choice for sepsis because they kill many bacteria (Hinkle & Cheever., 2018). When the cause of the infection is identified, the healthcare provider shifts to the right type of antibiotics to treat the underlying infection (Hinkle & Cheever, 2018). Oxygen therapy is also used to treat sepsis, as in most patients this

infection causes low oxygen saturation levels and requires oxygen administration (Hinkle & Cheever, 2018). Moreso intravenous fluids and vasopressors are used in patients with low blood pressure levels. Patients may require intravenous fluid and vasopressors to increase blood pressure and stabilize blood circulation (Hinkle & Cheever., 2018). My patient was on a broad-spectrum antibiotic (vancomycin) and continuous intravenous fluid.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). Davis advantage for pathophysiology (2nd ed.). F. A. Davis.

Hinkle, J. L., & Cheever, K. H. (2018). Brunner & Suddarth's textbook of medical-surgical nursing (14th ed). Wolters Kluwer.

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	**3.80-5.30**	4.87	4.48	N/A
Hgb	**12.0-15.8**	14.1	12.9	N/A
Hct	**36.0-47%**	41.8%	40%	N/A
Platelets	**140-440**	280	282	N/A
WBC	**4.00-12.00**	**8.40**	**19.20**	Increase in WBC is indication of infection. Thus, patient diagnosed with Sepsis (Pagana., 2019)
Neutrophils	**47.0-73.0%**	**79.2**	**87.1**	Increase in Neutrophils is an indication of an ongoing bacteria infection. Patient was diagnosed with a Urinary tract infection (Pagana., 2019)

Lymphocytes	**18.0-42.0%**	**13.5**	**5.6**	Increase in lymphocyte is indicative that the body is fighting an infection (Pagana., 2019)
Monocytes	**4.0-12.0 %**	**6.0**	**7.1**	**N/A**
Eosinophils	**0.0-5.0**	**0.0**	**0.2**	**N/A**
Bands				

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145	131	134	Low sodium levels may be due to patient being hydrated (Pagana., 2019)
K+	3.5-5.1 Mmol/dl	3.5	3.1	Low potassium levels may be due Patient being on Digoxin. Low potassium is associated to increased cardiac sensitivity to Digoxin ((Pagana., 2019)
Cl-	98-107 Mmol/L	98	106	
CO2	22-30 Mmol/L	19	20	CO2 may be low because patient is progressing into shock (Pagana., 2019)
Glucose	70-99 Mg/dl	111	138	Patient high blood glucose levels may be due to patient being on beta blockers. Beta-adrenergic blockers may cause increase in glucose levels (Pagana., 2019)
BUN	10-20 Mg/dl	15	13	N/A
Creatinine	0.60-1.00 Mg/dl	0.96	1.231	An increase in creatinine may be sign of an impaired renal function ((Pagana., 2019)
Albumin	3.5-5.0 g/dl	4.1	3.6	
Calcium	8.7-10.5 Mg/dl	10.0	9.0	
Mag	1.6-2.6 Mg/dl	1.7	1.8	

Phosphate	0.7-2.0	2.5	1.6	
Bilirubin	0.3-1.0	N/A	N/A	
Alk Phos	40-150	119	92	
AST	5-34 U/l	17	28	
ALT	0-55 u/l	12	14	
Amylase	30-110	N/a	N/a	
Lipase	11-82	N/a	N/a	
Lactic Acid	0.7-2.0	7.9	1.6	Increase in lactic acid may be due patient going into septic shock (Pagana., 2019)
Troponin	0.00-0.04 Mg/ml	0.057	1.737	May be elevated due to muscle injury. Patient has a history of angina pectoris (Pagana., 2019)
CK-MB	3-5%	n/a	n/a	
Total CK	22-198	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	
PT	10.1-13.1 secs	12.3	n/a	
PTT	25-36 secs	32	n/a	
D-Dimer	< 200	N/a	n/a	
BNP	0-100	n/a	n/a	
HDL	23-92	n/a	n/a	
LDL	<100	n/a	n/a	

Cholesterol	<199	n/a	n/a	
Triglycerides	0-149	n/a	n/a	
Hgb A1c	<6.4	n/a	n/a	
TSH	0.45-5.33	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	**Clear**	**clear**	**clear**	
pH	5.0-9.0	6.5	n/a	
Specific Gravity	1.003-1.030	1.011	n/a	
Glucose	Negative	negative	n/a	
Protein	Negative	2+	n/a	Presence of protein in urine may be a sign of tubular disease. Which means patient kidney are not functioning properly (Pagana., 2019)
Ketones	Negative	2+	n/a	
WBC	Negative	2+	n/a	Presence of WBC is that indication that patient has a urinary track infection (Pagana., 2019)
RBC	Negative	0-2	n/a	Presence of RBC is indication that patient has a urinary track infection
Leukoesterase	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	
PaO2	80-100	n/a	n/a	
PaCO2	35-45	n/a	n/a	
HCO3	22-26	n/a	n/a	
SaO2	92-100	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	
Blood Culture	Negative	n/a	n/a	
Sputum Culture	Negative	n/a	n/a	
Stool Culture	Negative	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. St. Louis, MO: Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

CT of Head or Brain without intravenous contrast: A CT image provides a view of the head as if one was looking down from the top. The CT scan is used in different diagnosis of cerebral

infarction, ventricular displacement or enlargement, cerebral aneurysms, intracranial hemorrhage, and hematoma AV malfunction.

ECG 12 Lead: ECG is a graphic representation of the electrical impulses that the heart generates during cardiac cycle (Pagana et al., 2019). A 12 lead ECG provides a comprehensive view of the flow of the hearts' electrical currents into two different planes (Pagana et al., 2019).

Chest X Ray: Chest X Ray is used in the complete evaluation of the pulmonary and cardiac systems (Pagana et al., 2019).

Diagnostic Test Correlation (5 points):

A CT of the head was performed on my patient because husband stated that patient was experiencing confusion. The results revealed no acute hemorrhage, no acute infarction and no mass infiltrates identified**.**

An ECG was carried on the patient to have a graphical representation of electrical impulses. Upon arrival at the Emergency department patient pulse rate was 120 and patient was unresponsive. ECG 12 lead revealed Sinus tachycardia marked by ST segment abnormality.

A Chest x ray was performed to roll out any abnormalities with lungs. Patient has a history of lung cancer and upon arrival respiration rate was 24. The results revealed lungs and surrounding structures.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference. St. Louis, MO: Elsevier.

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

Home Medications (5 required)

Brand/Generic	**Lorazepam (Ativan)**	**Apixaban (Eliquis)**	**Losartan (Cozaar)**	**Metoprolol (Toprol XL)**	**Nitroglycerin (Nitrostat)**
Dose	2mg	5mg	50mg	200mg	0.4mg
Frequency	2 x daily	2x daily	daily	daily	Every 5 minutes as needed
Route	oral	oral	oral	oral	sublingual
Classification	Benzodiazepine	Factor Xa Inhibitors	Angiotensin II receptor antagonist	Antihypertensive	Vasodilators / Nitrates
Mechanism of Action	May potentiate the effects of GABA, depress the Central nervous system, and suppress the spread of seizure activity	Inhibits factors Xa, decreasing thrombin generation And thrombus development	It is a vasoconstrictor; it stimulates aldosterone secretion by adrenal cortex. Angiotensinogen is converted to angiotensin I by an enzyme renin that is released form the glomerular apparatus of the kidney.	A beta blocker that selectively blocks beta receptors, decreases cardiac output, peripheral resistance, and cardiac oxygen consumption.	Decreases cardiac oxygen demands by reducing preload and to a lesser extent afterload. It also increases blood flow through collateral coronary vessels.

Reason Client Taking	Anxiety	Reduces risk for stroke and systemic embolism in patient with atrial fibrillation	Hypertension	Hypertension	For Acute chest pain
Contraindications (2)	Contraindicated for patients with hypersensitivity to this medication. Use cautiously in patients with pulmonary, renal, or hepatic impairment**.**	Contraindicated for patients with hypersensitivity to this medication. Use cautiously in patient with risk for severe bleeding	Use cautiously in patient with impaired renal or hepatic function. Contraindicated for patients with hypersensitivity to this medication	Contraindicated in patient with sinus bradycardia. Use cautiously in patients with heart failure, diabetes, respiratory or hepatic disease.	Contraindicated in patients with early MI Use cautiously in patients with hypotension
Side Effects/Adverse Reactions (2)	Drowsiness Sedation Weakness and dizziness	Anemia, bruising nausea	Headache Fatigue Edema Chest pain	Mental confusion Dizziness Fatigue	Headaches Syncope weakness
Nursing Considerations (2)	Monitor renal, hepatic functions regularly when patient is on this medication Do not stop this medication abruptly after long term use.	Monitor patient for bleeding. Monitor patient for neurologic impairment like motor deficits, weakness in lower extremities**.**	Monitor patient blood pressure close to determine effective of the medication. Regularly assess patient renal function.	Always check patient apical pulse rate for a full minute before administering this medication. Monitor BP frequently because drug mask common signs and symptoms of	Closely monitor vital signs especially blood pressure. Medication may cause headache especially at the beginning of the therapy.

				shock.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor patients' creatinine, AST, and ALT prior to the administration of this medication	Monitor PT, INR, and aPTT.	Monitor liver enzymes (AST, ALT), and Bilirubin levels.	Monitor alkaline phosphate, transaminase, LDH and Uric acid levels.	Nitroglycerin may interfere with anticoagulant effect of heparin. Monitor PTT
Client Teaching needs (2)	Avoid alcohol while taking this medication Educate patient that smoking may reduce drug effectiveness	Educate patient that bruising may occur more easily. Educate patient to report unusual bleeding.	Teach patient to avoid salt substitutes because these products contain potassium which can lead to high potassium levels in patient Advice patient to report swelling face, eyes, lips, tongue, or any breathing difficulty	Take medication as prescribed with meals. Avoid driving until response to therapy is established	Educate patient to this medication as prescribed and have always it accessible. Teach patient how to give the prescribed form of nitroglycerin

Hospital Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol)	Potassium Chloride	Vancomycin (vancocin)	Atorvastatin (Lipitor)	Digoxin (Lanoxin)

Dose	650mg	200meq in 100ml	1000mg in 250ml of 0.9 NaCl	40mg	125mg
Frequency	Q 4 hrs	Q 2 hrs		Nightly	daily
Route	oral	Intravenous	Intravenous	oral	oral
Classification	Analgesics	Potassium Supplement	Antibiotics	Antilipemic	Inotropes
Mechanism of Action	Inhibits the enzyme cyclooxygenase, Blocking prostaglandin production and inferring with pain impulse generation in peripheral Nervous system (Jones, 2021).	Replaces potassium and maintains potassium levels (Jones, 2021).	Hinders bacteria cell wall cell wall synthesis, damaging the plasma membrane and making the cell wall more vulnerable to osmotic pressure. This medication also interferes with RNA synthesis (Jones, 2021).	Atorvastatin inhibits the enzyme 3-hydroxy-3-methylglutary A reductase. This inhibition reduces lipid levels by increasing the number of hepatic low-density lipoproteins	Inhibits sodium potassium activated adenosine triphosphate there by promoting movement of calcium from extra cellular to intracellular cytoplasm and strengthening myocardial contractions (Jones, 2021).
Reason Client Taking	Mild or severe Pain	Hypokalemia	To treat infection	For CAD	Atrial fibrillation
Contraindications (2)	Hypersensitivity To acetaminophen with any other medication. Diazepam and chlorpromazine, severe hepatic impairment,	Contraindicated in patient with severe renal impairment. (Jones, 2021). Use cautiously in patients with cardiac disease	Contraindicated for patients with hypersensitive reaction to its components (Jones, 2021). Use cautiously in patients	Use cautiously in patient with hepatic and renal failure (Jones, 2021). Contraindicated for patient with hypersensitivity to this	Use with caution in elderly patients and those with MI (Jones, 2021). Do not use in patients with Wolff – Parkinson's white

	severe active liver Jones, 2021).	(Jones, 2021).	with hepatic and renal impairment (Jones, 2021).	medication (Jones, 2021).	syndrome (Jones, 2021).
Side Effects/Adverse Reactions (2)	Hypotension, angioedema (Jones, 2021).	Paresthesia of limbs, Confusion (Jones, 2021).	Ototoxicity, hypotension Abdominal pain.	Insomnia Abdominal pain**.**	Agitation fatigue
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment. Monitor renal impairment (Jones, 2021	Monitor continuous ECG and electrolyte levels during therapy (Jones, 2021). Monitor renal function (Jones, 2021).	Obtain hearing evaluation before and during prolong therapy (Jones, 2021). Monitor patient for fluid balance (Jones, 2021).	Patient should follow standard cholesterol lowering diet (Jones, 2021) Watch for signs of myositis (Jones, 2021)	Patients with hypothyroidism are sensitive cardiac glycoside and may need lower doses (Jones, 2021). Monitor potassium levels carefully (Jones, 2021).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor liver enzymes	Monitor potassium levels (Jones, 2021).	Monitor kidney and liver enzymes	Monitor ALT, AST and CK levels (Jones, 2021).	May prolong PR or depress ST segments (Jones, 2021).
Client Teaching needs (2)	Teach patient not to exceed recommended dosage. Teach patient that this medication may reduce	Educate patient to take this medication with meals or after meals with a full glass of water (Jones,	Teach patient to take the entire drug as prescribed even after feeling better (Jones,	Teach patient about dietary management weight control and exercise (Jones, 2021).	Teach patient to report pulse rate of less than 60. Advice patient to avoid the use of herbal

	fertility in both females and males.	2021). Teach patient not to use salt substitutes concurrently with this medication (Jones, 2021).	2021). Instruct patient receiving to report discomfort at IV site (Jones, 2021).	Explain the importance of controlling high fat levels (Jones, 2021).	drugs (Jones, 2021).

Medications Reference (1) (APA):

Jones, D. W. (2021). *Nurse's drug handbook.* (A. Barlett, Ed.) (20th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	I was not able to assess patient alertness and orientation because patient is unresponsive. Overall, the patient appeared to be well groomed.
INTEGUMENTARY: **Skin color:** **Character:**	**Patients skin is pink and** The Patient skin is warm, pink, and dry. Skin turgor is expected limits. Patient does not have

Temperature: **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	rashes, bruises, wounds, and no drains noted. Braden scale: 20
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head and neck are symmetrical, trachea is midline, no deviation. Patients' ears were free of discharge, slightly visible cerumen. Pupils equal and reactive Teeth look well maintained
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:**	Regular heart rate and rhythm**,** S1 and S2 present No murmurs noted upon auscultation Pulses are 2+ throughout bilaterally Capillary refill less 3 seconds in all extremities No visible edema or Neck vein distention.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	Lungs sound clear on auscultation, no wheezes, or rales, unlabored breathing. Patient had no ET tube placement
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:**	 Patient is on regular diet at home Patient currently NPO 167cm 136lbs Hypoactive bowel sounds No bowel movement during my shift

Palpation: Pain, Mass etc.: **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Abdomen is flat and patient moans when abdomen is palpated precisely around supra public area. No organomegaly and no signs of fluid retention. No incisions No scars No drains
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:16** **CAUTI prevention measures:**	Urine is yellow and clear Patient urine output is 90ml. Patient is unresponsive, I was not able to determine if patient experience pain with urination. Urethral catheter with temperature probe Size 16 Perform hand hygiene before and after emptying the catheter bag. Wear gloves
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 50** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	Patient is unresponsive. This student was not able to perform any musculoskeletal assessment. I was asked by the nurse not to perform any ROM on her at the moment. Was not able to determine if patient used any assistive devices.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:**	Difficult to perform full neuro assessment as patient is unresponsive and does not follow command.

Speech: **Sensory:** **LOC:**	
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):**	Patient's husband was at her bed side and daughter also came to visit. Patient seem to have a strong support system. I was unable to determine patient developmental level because patient was unresponsive.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	**73**	**163/65** (Supine Left arm)	**22**	**101.3 F (Core)**	**97% (room air)**
1100	**74**	**158/70** (Supine Left arm)	**21**	**100.2 F (Core)**	**96 % (room air)**

Vital Sign Trends/Correlation: Vital signs are unstable. Patient blood pressure is significant high despite taking medications, this may be due to patient history of hypertension. Also, patient temperature high and fluctuates for 101.3 F to 100.2. Increase in temperature is usually a sign that body is fighting an infection**.**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	0-10	n/a	n/a	n/a	Patient is currently unresponsive**.**
1100	0-10	n/a	n/a	n/a	Patient is currently unresponsive

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:**	The patient has an 18-gauge IV in the left forearm. The IV was placed on 10/2/2022. IV site is dry, and intact. IV is patent. No Drainage, erythema, swelling, inflammation, or warmth. IV dressing was clear and intact**.**
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☒** **CLABSI prevention measures:**	The patient has an 20-gauge midline in the right forearm. The IV was placed on 10/10/2022. The site is dry, and intact. IV is patent. No Drainage, erythema, swelling, inflammation, or warmth. IV dressing is clear and intact.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
100ml of Sodium chloride **Vancomycin 1000mg in 250ml of NaCl**	**90ml**

Nursing Care

Summary of Care (2 points):

Overview of care: Patient admitted on 10/10/2022 with acute confusion. Patient is on room air. Intravenous medication was administered and Head to Assessment performed by the Nurse and I. Vitals signs were taken two times during my shift.

Procedures/testing done: No procedures performed during my shift

Complaints/Issues: N/A

Vital signs (stable/unstable): Vital signs were unstable with consistent increase in blood pressure 163/65 and 158/70. Temperature was high 101 F and 103 F. Pulse rate, and oxygen saturation was stable.

Tolerating diet, activity, etc.: Patient was NPO and unresponsive

Physician notifications: Perform Lumbar puncture to roll out meningitis

Future for client: Stabilize patient

Discharge Planning (2 points)

Discharge location: No discharge planning yet until patient is stable

Home health needs (if applicable): N/a

Equipment needs (if applicable): n/a

Follow up plan: n/a

Education needs: Education patients' family on Atrial Fibrillation and prevention of UTI.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Hyperthermia related to dehydration and inflammatory process as evidence by patient experiencing increase body temperatures of 103 degrees F, and weak	Nursing diagnosis was chosen because patient vital signs showed patient temperature above 100 F.	1.Administer prescribed antipyretic medication 2.Assess patient vital signs every hour	1. Patient will maintain body temperature within normal limits	Patient temperature was 100.1 at the end of my shift.

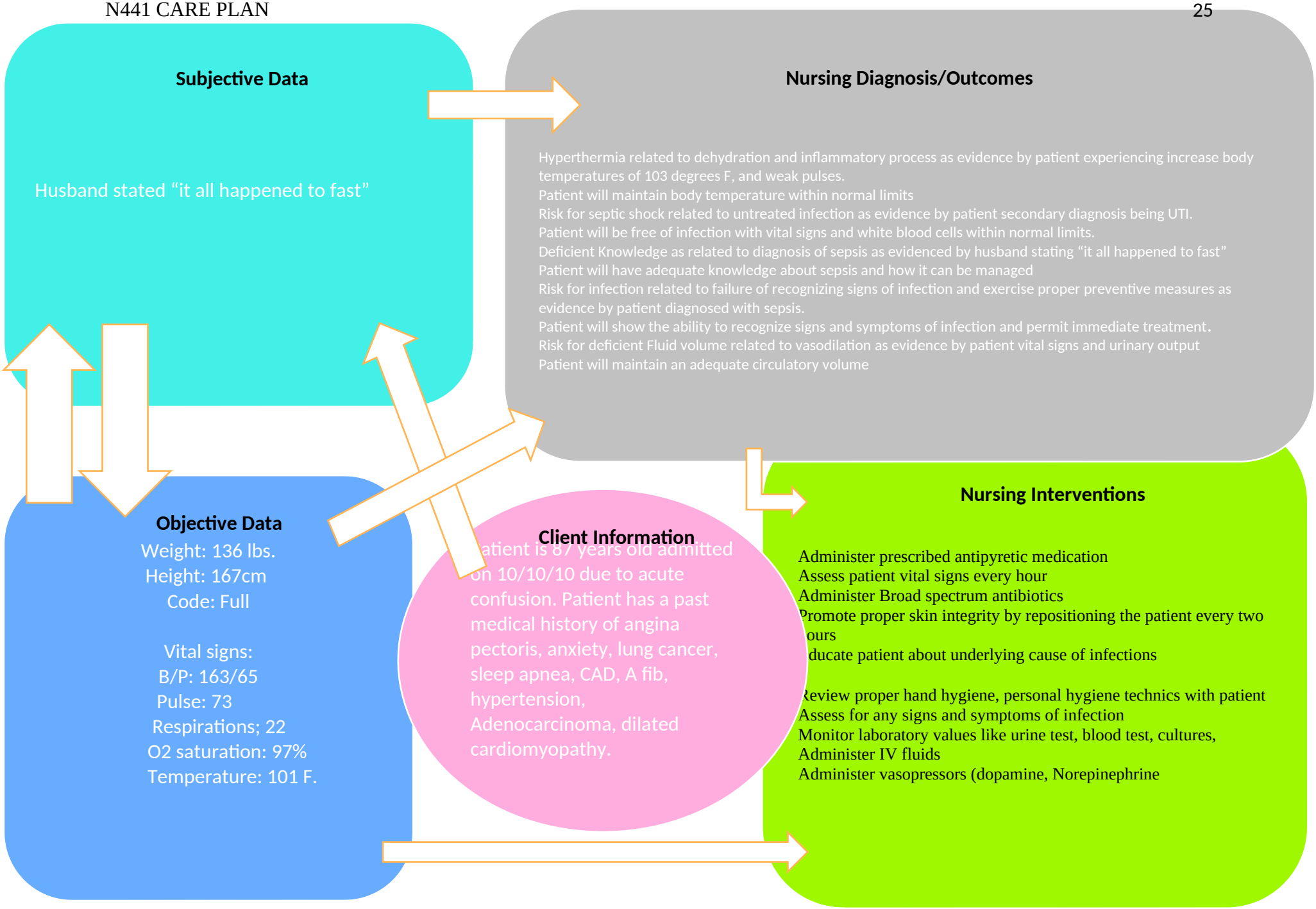
pulses.				
2. Risk for septic shock related to untreated infection as evidence by patient secondary diagnosis being UTI.	This nursing diagnostic was chosen because patient white blood cells and creatinine is high, and patient has a high risk of septic shock if not treated.	**1.** Administer Broad spectrum antibiotics 2.Promote proper skin integrity by repositioning the patient every two hours.	**1.** Patient will be free of infection with vital signs and white blood cells within normal limits.	Patient was still unresponsive at the end of shift
3. Deficient Knowledge as related to diagnosis of sepsis as evidenced by husband stating "it all happened to fast"	This diagnosis was chosen because patient and family need to understand the disease process and methods of prevention	1. Educate patient about underlying cause of infections 2.Review proper hand hygiene, personal hygiene technics with patient	1. Patient will have adequate knowledge about sepsis and how it can be managed	Patient was unresponsive but patient husband was appreciative of the information provided
4. Risk for infection related to failure of recognizing signs of infection and exercise proper preventive measures as evidence by patient diagnosed with sepsis.	This nursing diagnosis is chosen because sepsis is a systemic infection and requires close monitoring**.**	**1.**Assess for any signs and symptoms of infection 2. Monitor laboratory values like urine test, blood test, cultures,	**1.** Patient will show the ability to recognize signs and symptoms of infection and permit immediate treatment**.**	Patient is unresponsive. No evaluation carried out**.**
5. Risk for deficient Fluid volume	Sepsis can worsen into septic shock	1.Administer IV fluids	1. Patient will maintain an adequate	Patient is on continuous IV fluids and

related to vasodilation as evidence by patient vital signs and urinary output.	causing a shift of fluids out of the intravascular space leading to hypotension and needing fluid resuscitation (Phelps et al., 2018)	2. Administer vasopressors (dopamine, Norepinephrine).	circulatory volume	urinary out put is 90ml.

Other References (APA):

Phelps, L. L., & Ralph, S. S. (2018). *Sparks & Taylor's nursing diagnosis pocket guide*. Wolters Kluwer.

Concept Map (20 Points):


Subjective Data
Husband stated “it all happened to fast”
Nursing Diagnosis/Outcomes
Hyperthermia related to dehydration and inflammatory process as evidence by patient experiencing increase body temperatures of 103 degrees F, and weak pulses.
Patient will maintain body temperature within normal limits
Risk for septic shock related to untreated infection as evidence by patient secondary diagnosis being UTI.
Patient will be free of infection with vital signs and white blood cells within normal limits.
Deficient Knowledge as related to diagnosis of sepsis as evidenced by husband stating “it all happened to fast”
Patient will have adequate knowledge about sepsis and how it can be managed
Risk for infection related to failure of recognizing signs of infection and exercise proper preventive measures as evidence by patient diagnosed with sepsis.
Patient will show the ability to recognize signs and symptoms of infection and permit immediate treatment.
Risk for deficient Fluid volume related to vasodilation as evidence by patient vital signs and urinary output
Patient will maintain an adequate circulatory volume
Objective Data
Weight: 136 lbs.
Height: 167cm
Code: Full
Vital signs:
B/P: 163/65
Pulse: 73
Respirations; 22
O2 saturation: 97%
Temperature: 101 F.
Client Information
atient is 87 years old admitted on 10/10/10 due to acute confusion. Patient has a past medical history of angina pectoris, anxiety, lung cancer, sleep apnea, CAD, A fib, hypertension, Adenocarcinoma, dilated cardiomyopathy.
Nursing Interventions
Administer prescribed antipyretic medication
Assess patient vital signs every hour
Administer Broad spectrum antibiotics
Promote proper skin integrity by repositioning the patient every two ours
ducate patient about underlying cause of infections
eview proper hand hygiene, personal hygiene technics with patient
Assess for any signs and symptoms of infection
Monitor laboratory values like urine test, blood test, cultures,
Administer IV fluids
Administer vasopressors (dopamine, Norepinephrine