N431 Care Plan # 2

Lakeview College of Nursing

Samantha Christison

Demographics (3 points)

Date of Admission 10-11-2022	**Client Initials** S.B.	**Age** 37 years old	**Gender** female
Race/Ethnicity white	**Occupation** none	**Marital Status** single	**Allergies** No Known allergies
Code Status Full	**Height** 177.8 cm	**Weight** 60.4 kg	

Medical History (5 Points)

Past Medical History: endocarditis x's 2, mitral valve replacement, hepatitis C

Past Surgical History: C-Section, Foot Surgery, Mitral valve replacement

Family History: patient states "all my family is healthy." Would not answer regarding each person

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

Alcohol: none

Tobacco: smokes a ½ a pack a day

Drugs: heroin "I use $50 worth every 2-3 hours. I snort and shoot it."

Assistive Devices: top set of dentures

Living Situation: lives with girlfriend

Education Level: patient states "I went to school." Would not specify highest level of education.

Admission Assessment

Chief Complaint (2 points): fever, headache, nausea, and vomiting

History of Present Illness – OLD CARTS (10 points):

Patient present to DMH with the complaint of headache and fever for two days and nausea and vomiting for a day. Patient states her headache was all over and it was a constant throbbing pain.

patient states she had a fever and the pain caused her to have nausea and vomiting. Patient stated she took Tylenol for the pain with no relief.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): sepsis

Secondary Diagnosis (if applicable): NA

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

Sepsis is an infection that has spread throughout the body and cause the body to have extreme signs and symptoms. Sepsis usually begins as a small infection but if not treat spreads throughout the body resulting in sepsis. The infection spreads throughout the body and organs causing the cells to become inflamed. The cells also can experience energy failure and even death if not treated. When the cells become inflamed, they prevent blood flow to vital organs which then causes organ failure and eventually death if not treated.

Patient can experience fever, shortness of breath, change in mental status, cold clammy skin, and pain. patient vitals will be a high heart rate, high respiratory rate, and a low blood pressure. Patient will also have an elevated PCT level and lactic levels (Fan et al., 2016). Patients may also experience electrolyte imbalances and abnormal kidney and liver function test. Sepsis is typically diagnosed through blood cultures, x-rays, ct scans and MRI.Treatment usually includes the patient receiving antibiotics.

For my patient she was experiencing a fever, chills, nausea and vomiting along with pain. my patient was diagnosed through blood cultures and an abnormal chest x-ray. My patient has abnormal electrolyte levels as well as gram negative bacteria in her blood. The patient is currently being treated via IV antibiotics.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for Pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis.

Fan, S. L., Miller, N. S., Lee, J., & Remick, D. G. (2016). Diagnosing sepsis - The role of laboratory medicine. *Clinica chimica acta; international journal of clinical chemistry*, *460*, 203–210. https://doi.org/10.1016/j.cca.2016.07.002

Sepsis - Diagnosis and treatment - Mayo Clinic. (2021, January 19). Retrieved October 15, 2022, from https://www.mayoclinic.org/diseases-conditions/sepsis/diagnosis-treatment/drc-20351219

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	4.3	Na	Within normal range
Hgb	12-16	10.5	Na	Pt Hgb may be decreased due to nutritional deficiency.
Hct	37-47	31.6	Na	Pt Hct may be decreased due to blood loss as dr. is currently trying to determine where pt is losing blood.
Platelets	150-400	27	Na	Pt platelets may be decreased due to blood loss as dr. is currently trying to determine where pt is losing blood.
WBC	4.5-11	4.83	Na	Within normal range
Neutrophils	55-70%	Na	Na	Not completed on this admission
Lymphocytes	20-40%	30	Na	Within normal range
Monocytes	2-8%	2	Na	Within normal range

Eosinophils	0-4%	0	Na	Within normal range
Bands	0.5-1%	0.6	Na	Within normal range

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	136	140	Within normal range
K+	3.5-5	3.4	3.3	Pt potassium may be decreased due to deficient dietary intake
Cl-	98-106	102	106	Within normal range
CO2	23-30	21.0	24	CO2 may be decreased due to not eating.
Glucose	74-106	104	88	Within normal range
BUN	10-20	37	24	Pt BUN may be increased due to dehydration
Creatinine	0.5-1.1	1.1	Na	Within normal range
Albumin	3.5-5	2.5	1.9	Albumin may be decreased due to acute infection
Calcium	8-10.5	8.9	8.4	Within normal range
Mag	1.3-2.1	2.1	1.7	Within normal range
Phosphate	3.0-4.5	Na	Na	Not completed on this admission
Bilirubin	Total 0.3-1	Na	1	Within normal range
Alk Phos	30-120	120	111	Within normal range
AST	10-30	16	11	Within normal range
ALT	4-36	14	10	Within normal range
Amylase	60-120	Na	Na	Not completed on this admission

Lipase	0-160	Na	Na	Not completed on this admission
Lactic Acid	0.5-2.2	1.46	Na	Within normal range
Troponin	0.03	Na	Na	Not completed on this admission
CK-MB	0%	Na	Na	Not completed on this admission
Total CK	30-135	Na	Na	Not completed on this admission

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	1.2	Na	INR may be increased due to hepatitis C
PT	9.5-11.3	14.6	Na	Pt may be increased due to hepatitis C.
PTT	30-40	30.7	Na	Within normal range
D-Dimer	<250	Na	Na	Not completed on this admission
BNP	<100	Na	Na	Not completed on this admission
HDL	>60	Na	Na	Not completed on this admission
LDL	<130	Na	Na	Not completed on this admission
Cholesterol	<200	Na	Na	Not completed on this admission
Triglycerides	<150	Na	Na	Not completed on this admission
Hgb A1c	4%-5.9%	Na	Na	Not completed on this admission
TSH	2-10	Na	Na	Not completed on this admission

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	Clear; yellow	Na	Within normal range
pH	4.6-8	5.5	Na	Within normal range
Specific Gravity	1.005-1.030	1.010	Na	Within normal range
Glucose	Negative	Negative	Na	Within normal range
Protein	0-8	Negative	Na	Within normal range
Ketones	Negative	Negative	Na	Within normal range
WBC	Negative	Negative	Na	Within normal range
RBC	Negative	Negative	Na	Within normal range
Leukoesterase	Negative	Negative	Na	Within normal range

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	Na	Na	Not completed on this admission
PaO2	80-100	Na	Na	Not completed on this admission
PaCO2	35-45	Na	Na	Not completed on this admission
HCO3	21-28	Na	Na	Not completed on this admission
SaO2	95-100	Na	Na	Not completed on this admission

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 Positive>100,000	Na	Na	Not completed on this admission
Blood Culture	Negative	Positive	Na	Gram negative bacteremia, presence of infection in blood
Sputum Culture	Normal URT	Na	Na	Not completed on this admission
Stool Culture	Normal internal flora	Na	Na	Not completed on this admission

Lab Correlations Reference (1) (APA): Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory desk reference* (14th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): chest x ray

Diagnostic Test Correlation (5 points): A chest x-ray was completed to rule out infection in the lungs and heart.

Unable to view results from imaging due to the imaging being done at a different hospital.

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for Pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis.

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

Home Medications (5 required)

Brand/Generic	Acetaminophen Tylenol extra strength	Ondansetron Zofran ODT			
Dose	650 mg	4 mg			
Frequency	PRN	PRN			
Route	PO	ODT			
Classification	Pharmacologic	Pharmacologic class: selective			

	class: nonsalicylate, para-aminophenol derivative Therapeutic class: antipyretic, nonopioid analgesic	serotonin receptor antagonist Therapeutic class: antiemetic			
Mechanism of Action	"Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin e2." (Jones and Bartlett, 2021)	"Blocks serotonin receptors centrally in the chemoreceptors trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting by preventing serotonin release in the small intestine and by blocking signals to the CNS. Ondansetron may also bind to other serotonin receptors and to mu- opioid receptors." (Jones and Bartlett, 2021)			
Reason Client Taking	For pain	for nausea			
Contraindications (2)	Severe hepatic impairment, severe active liver disease	Concomitant use of apomorphine, hypersensitivity to ondansetron or its components			
Side Effects/Adverse Reactions (2)	Hypotension hepatotoxicity	Hypotension Arrhythmias			
Nursing Considerations (2)	"Use cautiously with patients with hepatic impairments." "Monitor liver function when giving medication." (Jones and bartlett, 2021)	"Monitor patient electrocardiogram." "Monitor closely for anaphylaxis or bronchospasms." (Jones and bartlett, 2021)			
Key Nursing	Assess renal	Assess electrolytes			

Assessment(s)/Lab(s) Prior to Administration	function	before administration			
Client Teaching Needs (2)	"Teach signs of hepatoxicity." "Inform patient it may cause reduced fertility." (Jones and Bartlett, 2021)	"Let dissolve under tongue before swallowing." "Immediately report rash." (Jones and Bartlett, 2021)			

Hospital Medications (5 required)

Brand/Generic	Ibuprofen Actiprofen	Levofloxacin Levaquin	Meropenem Merrem I.V.	Nicotine transdermal system Habitrol	Na
Dose	600 mg	750 mg	500 mg	21 mg	na
Frequency	Q6	daily	Q6	Daily	na
Route	PO	IV	IV push	Transdermal patch	na
Classification	Pharm: NSAID Therapeutic: analgesic, anti-inflammatory, antipyretic	Pharm: fluoroquinolone Therapeutic: antibiotic	Pharm: carbapenem Therapeutic: antibiotic	Pharm: nicotine agonist Therapeutic: smoking cessation adjunct	na
Mechanism of Action	"Blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling and vasodilation." (Jones and Bartlett, 2021)	"Interferes with bacterial cell replication by inhibiting the bacterial enzyme DNA Gyrase." (Jones and Bartlett, 2021)	"Penetrates cell walls of most gram negative and gram-positive bacteria, inactivating penicillin-binding protein." (Jones and bartlett, 2021)	"Binds selectively to nicotine-cholinergic receptors at autonomic ganglia, at neuromuscular junctions and in the brain." (Jones and Bartlett, 2021)	na

Reason Client Taking	To relive pain	To treat bacterial infection	To treat gram negative bacteria	Relief nicotine withdrawal	na
Contraindications (2)	Bleeding, coagulation defects	Myasthenia gravis: hypersensitivity to fluoroquinolones.	Hypersensitivity to beta- lactams or carbapenem drugs	Hypersensitivity to soy or menthol	na
Side Effects/Adverse Reactions (2)	Seizures, GI bleed	Seizures, arrhythmias	Seizures, renal failure	Dizziness, arrhythmias	na
Nursing Considerations (2)	"Know that the risk of heart disease increases with the use of NSAIDS." "NSAIDS can cause serious GI bleeds." (Jones and Bartlett, 2021)	"Monitor blood glucose level," "avoid giving drug within 2 hours of antacids." (Jones and bartlett, 2021)	"Monitor patient closely for diarrhea." "Take seizure precautions per facility protocol." (Jones and bartlett, 2021)	"Remove before procedure to reduce risk for burns." "Use with caution in patients with hyperthyroidism." (Jones and Bartlett, 2021)	na
Key Nursing Assessment(s)/Lab(s) Prior to Administration	"Monitor CBC for decreased hemoglobin and hematocrit." (Jones and Bartlett, 2021)	"Assess renal function before administration." (Jones and bartlett, 2021)	"Obtain culture and sensitivity before administration." (Jones and Bartlett, 2021)	None	na
Client Teaching Needs (2)	"Take with a full glass of water." "Advise to take with meals to avoid GI distress." (Jones and Bartlett, 2021)	"Increase fluid intake during therapy." "Notify provider if experiencing. Pain or tenderness in right upper quadrant." (Jones and Bartlett, 2021)	"Report immediately if trouble breathing." "Report diarrhea that last longer than 3 days." (Jones and Bartlett, 2021)	"Report shortness of breath immediately." "Report irregular heartbeat immediately." (Jones and Bartlett, 2021)	na

Medications Reference (1) (APA):

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

Assessment

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

GENERAL: **Alertness:** A&O x's 4 **Orientation: :** oriented to person, place, time and event. **Distress:** patient noted to be in no distress at this time **Overall appearance:** patient is well groomed laying supine in bed with the head of the bed elevated. Irritable but answers most questions.	*Patient is alert and oriented times 4. Patient appears to be in no apparent distress at this time. Patient is well groomed and is laying supine in bed with head of bed elevated. Patient is irritable but answers most questions.*
INTEGUMENTARY: **Skin color:** pale **Character:** dry **Temperature:** warm **Turgor:** rapid recoil **Rashes:** no rashes noted **Bruises:** no bruising noted **Wounds:** patient noted to have tract marks along both arm from frequent heroin use. **Braden Score:** 20 **Drains present: Y☐ N ☒** **Type:**	*Patients skin is pale, dry and warm. Patient has rapid recoil when completing the turgor test. When completing a skin assessment patient noted to have no rashes or bruises but has bilateral tract marks on arms from frequent shooting up of heroin. Patient has a Braden score of 20 and has no drains present.*
HEENT: **Head/Neck:** normal cephalic, head and neck are symmetrical, trachea is midline without deviation. Thyroid is not palpable. Carotid pulses +2 bilaterally. **Ears:** auricle is moist, and pink noted to have no cerebrum build up. Patient dose not wear hearing aids. **Eyes:** PERRLA, pupils' size 2 does not wear glasses **Nose:** sinuses are nontender upon palpitation, patient noted to have no drainage from both nostrils**.** **Teeth:** uvula is midline soft palate rises and falls symmetrical. Patient noted to have no teeth on top and only 8 teeth on bottom, oral mucosa is moist, pink and no lesions were seen or noted**.** Patient does wear top dentures.	Patient head is normal shape and size, head and neck are symmetrical, trachea is midline with no deviation's thyroid is not palpable. Carotid pulses are =2 bilaterally. Ears are symmetrical, auricle is moist and pink, no cerebrum build up noted along with no drainage. Eyes are PERRLA, pupils are a size 2 and patient does not wear glasses. Sclera is white, conjunctiva is clear no drainage from eyes noted. Patients' sinuses are nontender upon palpation, patient noted to have no drainage from both nostrils. Patient mouth is moist and pink. Patient noted to have no teeth on top and wears dentures on the top. Patient has only 8 teeth on bottom. Patient noted to have no lesions or wound in mouth.
CARDIOVASCULAR: **Heart sounds:** heart sounds heard in all fields S1 and S2 audible **S1, S2, S3, S4, murmur etc.**	*Patient heart sounds are clear upon auscultation, S1 and S2 are heard. No murmurs were heard peripheral pulse are present, strong and regular +2. Capillary refill is less than three*

Cardiac rhythm (if applicable):NA **Peripheral Pulses:** peripheral pulses present in all areas +2 **Capillary refill:** less than 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:** none	*seconds in fingers and toes. Patient noted to have no neck vein distention. Patient has no edema*
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** Clear in all fields	Patient has no accessory muscle use. Lung sounds are clear upon auscultation in all fields anteriorly and posteriorly.
GASTROINTESTINAL: **Diet at home:** regular **Current Diet** regular **Height:** 177.8 cm **Weight:** 60.4 kg **Auscultation Bowel sounds:** hypoactive **Last BM:** 10-8-2022 **Palpation: Pain, Mass etc.:** none **Inspection:** **Distention**: no distention noted **Incisions:** no incisions noted **Scars:** no scars noted **Drains:** not drains noted **Wounds:** no wounds noted **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Patient is on a regular diet at home and is on a regular diet while admitted. Patient is 177.9 cm tall and weighs 60.4 kg. upon auscultation patient bowel sounds were hypoactive due to being NPO overnight. Patients last bowel movement was 10-8-2022 states its normal to have only 1 every few days. Upon inspection patient noted to have not distention, incisions, scars, drains, or wounds. Upon palpation patient noted to have no masses or pain. patient does not have an ostomy, nasogastric tube of feeding tube.
GENITOURINARY: **Color:** yellow **Character:** clear **Quantity of urine**: 1 void **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: NA** **Catheter: Y ☐ N ☒** **Type:** **Size:**	*Patient voided 1 time while on shift patient flushed before allowing it to be measured. Patient urine is clear and yellow. Patient denies pain with urination. Patient is not a dialysis patient. Patient does not have a catheter and no need for inspection on genitals.*
MUSCULOSKELETAL: **Neurovascular status**: normal **ROM:** full range of motion in upper and lower extremities	Patient has full range of motion in upper and lower extremities. Patient does not use any assistive devices. Patient has equal strength in upper and lower extremities. patient does all

Supportive devices: none **Strength:** patient has equal strength in upper and lower extremities **ADL Assistance:** **Y☐ N ☒** **Fall Risk:** **Y ☐ N☒** **Fall Score: 3** **Activity/Mobility Status:** **Independent (up ad lib)** ☒ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	ADL's by herself. Patient is not a fall risk and has a fall score of 3 and is independent.
NEUROLOGICAL: **MAEW:** **Y ☒ N☐** **PERLA:** **Y ☒ N☐** **Strength Equal:** **Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** person, place, time and event **Mental Status:** alert and oriented **Speech:** clear **Sensory:** no deficits **LOC:** alert	Patient moves all extremities well and eyes are PERLA. Patient has equal strength in both upper and lower extremities. Patient is alert and oriented to person, place, time, and event. Patient speech is clear, no sensory deficits and alert with no LOC.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** Unable to assess **Developmental level:** average level appropriate for age **Religion & what it means to pt.:** Unable to assess **Personal/Family Data (Think about home environment, family structure, and available family support):** Unable to assess	Patient is average developmental level, Unable to assess any further, patient states "I have answered enough of your questions I'm not answering anymore."

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1400	72	97/56	14	98.1˚F	96% ra
1700	70	108/64	14	98.3˚F	97% ra

Vital Sign Trends: stable for patient baseline

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1306	1-10	General	7	Achy	Px medication administered
1340	1-10	General	5	Achy	Repositioned in bed

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** left ac **Date on IV:** 10-11-2022 **Patency of IV:** good **Signs of erythema, drainage, etc.:** none **IV dressing assessment:** clean dry and well intact	The patient has a 20-gauge IV placed in her left AC on 10-11-2022. The IV is good and flushes well. There are no signs of erythema or drainage. The dressing is clean, dry and well dressed. The patient has 0.9% normal saline running at 150 ml/hr.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600 ml of 0.9% normal saline 10ml IV push of meropenem 480 ml of water 80% of meal	1 urine void throughout shift unable to measure

Nursing Care

Summary of Care (2 points)

Overview of care: Patient asleep at the start of shift. Patient was woken up to administer medication and be taken down for a TEE procedure. Patients' TEE was canceled due to low platelet count. Physician requesting a GI consult to determine why platelet count is so low.

Patient started becoming agitated due to not being able to eat and not getting the medication she wanted. Patient refused blood work and refused a reassessment after returning from the cardiology department.

Procedures/testing done: none patient was scheduled for a scope procedure but procedure was canceled due to low platelet count. Patient was due to have blood drawn but refused twice.

Complaints/Issues: Patient stated the pain medicine we were administering is not helping with the pain. states she does to much heroin and needs something stronger. Patient complained of body aches all over.

Vital signs (stable/unstable): Patient vitals were stable with a low blood pressure but that is normal per patient.

Tolerating diet, activity, etc.: The patient is tolerating the diet well but becomes agitated when asked to reposition or have testing or medication given.

Physician notifications: physician notified after procedure was canceled, physician also notified after patient refused blood work 2 times.

Future plans for client: the plan for this patient is to have GI consult to try to find why her platelet count is so low and then have the procedure done once platelet count is higher.

Discharge Planning (2 points)

Discharge location: home

Home health needs (if applicable): none

Equipment needs (if applicable): none

Follow up plan: follow up with PCP in one week.

Education needs: patient needs education on the risk of using heroin and proper care of her body due to heart surgeries and heart problems.

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. Risk for infection related to the blood as evidence by positive blood culture	Patient is at an increased risk for infection due to having a positive blood culture**.**	**1.** Educate the patient about the importance of good hand hygiene. **2.**Ensure adequate nutritional intake.	**1. T**he antibiotics will treat the infection and the patient will remain free from infection.	Patient verbalized understanding of adequate nutrition to aid in the getting rid of the infection.
2. Decreased cardiac output related to blood loss as evidence by low platelet count	Patient has decreased cardiac output due to low platelet count.	**1.** monitor heart rate rhythm and blood pressure every 2 hours **2.**measure intake and output	**1.** patients vitals will remain stable, and her platelet count will go up.	Patient understood the need for monitoring vitals but refused to let us monitor her output.
3. Acute pain related to infection as evidence by	Patient is at risk for pain related to infection in	1.Monitor patient pain every hour and administer pain	**1.** patients' pain will be controlled and tolerable	Patient understood pain monitoring but refused to learn about relaxation

rating pain a 7.	her blood**.**	medication as prescribed. **2** preform comfort measures and teach relaxation techniques	for the patient.	techniques.
1. Deficient knowledge related to insufficient interest in learning and evidence by relapse of heroin use.	Patient has deficient knowledge of heroin use as evidence by relapse of heroin use.	**1.** Limit lengths of teaching **2.** Provide patient with the resources to seek help after hospitalization	**1.** patient will be accepting of the teaching and take the resources given to seek help.	Patient refused to talk about her drug use and states to the RN at bedside “I stopped once and it didn’t work why would I do it again.”

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

Time	Scale	Location	Severity
1306	1-10	General	7
1340	1-10	General	5

Headache, fever upon admission with nausea and vomiting

Nursing Diagnosis/Outcomes

1. Risk for infection related to the blood as evidence by positive blood culture
   - The antibiotics will treat the infection and the patient will remain free from infection.
2. Decreased cardiac output related to blood loss as evidence by low platelet count
   - patients' vitals will remain stable, and her platelet count will go up.
3. Acute pain related to infection as evidence by rating pain a 7.
   - patients' pain will be controlled and tolerable for the patient.
4. Deficient knowledge related to insufficient interest in learning and evidence by relapse of heroin use.
   - patient will be accepting of the teaching and take the resources given to seek help.

Objective Data

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1400	72	97/56	14	98.1˚F	96% ra
1700	70	108/64	14	98.3˚F	97% ra

Client Information

s.b
37-year-old female
Single
No occupation
No known allergies

Nursing Interventions

1. Educate the patient about the importance of good hand hygiene.
2. Ensure adequate nutritional intake.

1. monitor heart rate rhythm and blood pressure every 2 hours
2. measure intake and output

1. Monitor patient pain every hour and administer pain medication as prescribed.
2. preform comfort measures and teach relaxation techniques

1. Limit lengths of teaching
2. Provide patient with the resources to seek help after hospitalization