N311 Care Plan #3

Lakeview College of Nursing

Dakota Clayton

Demographics (5 points)

Date of Admission 9/29/2022	**Client Initials** A.D.	**Age** 46	**Gender** M
Race/Ethnicity White	**Occupation** Retired Military	**Marital Status** Divorced	**Allergies** Penicillin – hives Aspirin – hives Metformin – stomach issues
Code Status DNR	**Height** 71 in.	**Weight** 90.9 Kg (200 lbs.)	

Medical History (5 Points)

Past Medical History: Type 2 Diabetes Mellitus (2006)

Fractured T12 vertebrae (January 2022)

- Associated chronic back pain since incident

Gastroparesis (2022)

Addison's Disease (August 2022)

Past Surgical History: Right foot infection intervention (2019)

- Patient did not state what type of infection

Carpal tunnel surgery – right wrist (2020)

Family History: Emphysema **(**Maternal grandfather)

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

- Patient has used chewing tobacco for 34 years. Patient reports using approx. 4 cans a week and chewing multiple times throughout the day. Patient did not report wanting to quit.
- Patient reported a recent uptake in marijuana use for pain management. Patient uses marijuana occasionally, with small amounts each time. Patient prefers smoking marijuana

as opposed to other methods of use. Patient has been using marijuana for less than a month.

- Patient reported he used to drink 5-6 beers a week, but has stopped alcohol use. Patient did not state how long since he ceased alcohol use.

Admission Assessment

Chief Complaint (2 points): Leg disfunction related to orthostatic hypotension

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

Patient was admitted two weeks ago for dysfunction related to bilateral lower extremities, with more dysfunction reported in the left leg. Patient states that leg dysfunction has been occurring for approximately 1 month and is related to his recent Addison's Disease diagnosis. Patient also reports recent bouts of orthostatic hypotension and related loss of consciousness, causing numerous falls in the last month. Patient reports that leg dysfunction is continuous, and the orthostatic hypotension occurring mainly when moving from sitting or lying to standing. Patient reports pain associated with leg dysfunction is localized to the kidney area, and characterizes pain as a dull, continuous pain. Patient reports that walking makes the leg dysfunction and associated pain worse, and rest makes the pain better. Patient has been receiving treatment for the condition for 1 month.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Addison's Disease with orthostatic hypotension

Secondary Diagnosis (if applicable): Gastroparesis

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

According to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), Addison's disease is a primary adrenal insufficiency, characterized by the adrenal glands being unable to synthesize enough cortisol and aldosterone for the body's needs (2018, para. 1-3). Munir et al. (2022) further explains that Addison's disease is a potentially life-threatening condition that is commonly autoimmune in nature, with the body attacking its own adrenal cortex. Munir et al. (2022) explains that Addison's disease can present non-specifically, but can also present acutely, which happens commonly with simultaneous disease processes. According to Munir et al. (2022), Addison's disease is extremely rare, affecting approximately 4-11 per 100,000 individuals. Munir et al. (2022) also describes other risk factors such as female gender, ages between 30-50, and other present autoimmune diseases.

With Addison's disease, the lack of the hormones cortisol and aldosterone from the adrenal cortex can be very detrimental to the body (National Institute of Diabetes and Digestive and Kidney Diseases [NIDDK], 2018). The NIDDK (2018) explains that in emergent and stressful situations the body needs cortisol, and without it individuals can experience potentially fatal low blood pressure and low blood glucose. Additionally, the lack of aldosterone due to Addison's disease can cause low blood sodium, or hyponatremia (NIDDK, 2018). The NIDDK (2018) explains that when sodium levels drop, individuals can experience symptoms including fatigue, confusion, and seizures. Low aldosterone can also lead to high levels of potassium, or hyperkalemia, which if uncontrolled can cause potentially fatal changes to heart rhythm (NIDDK, 2018).

According to Munir et al. (2022), signs and symptoms of Addison's disease can present non-specifically, with signs and symptoms including fatigue, weakness, nausea, vomiting, and

abdominal pain. The NIDDK (2018), also states that low blood pressure upon standing causing dizziness and fainting, also known as orthostatic hypotension, is a common symptom. My patient has been experiencing recurrent bouts of orthostatic hypotension, leading to multiple falls and difficulty completing ADLs. According to Capriotti and Frizzell (2020), orthostatic hypotension is due to a delay in arterial vasoconstriction, leading to a delay in in adequate cerebral perfusion (p. 66). Common symptoms of orthostatic hypotension are the individual feeling weak, dizzy, and loss of consciousness (Capriotti & Frizzell, 2020). Capriotti and Frizzell (2020), explain that providers need to be cognizant of individuals with orthostatic hypotension, and along with the patient, play a role in preventing falls.

There are multiple diagnostics used to determine an Addison's disease diagnosis. The NIDDK (2018) explains that in the early stages, Addison's disease is difficult to diagnose, and often is suspected after an individual experiences various disease-related symptoms. The most common test used to diagnose Addison's disease is the ACTH stimulation test (NIDDK, 2018). According to the NIDDK (2018), the ACTH stimulation test will test the adrenal glands response to ACTH, and determine if there has been a subsequent release of cortisol from ACTH stimulation. Individuals with Addison's disease will show a small or no increase in cortisol levels when stimulated by ACTH (NIDDK, 2018). In addition to the ACTH stimulation test, individuals can be tested for antibodies related to Addison's disease, but not all people with Addison's disease will have these antibodies (NIDDK, 2018). My patient's diagnosis of Addison's disease had been made within the last month, and these labs had not been made available for review yet.

According to the NIDDK (2018), Addison's disease is commonly treated by hormone medications to replace the hormones being insufficiently synthesized by the adrenal glands.

Common cortisol replacements are corticosteroids, and common aldosterone replacements are fludrocortisone (NIDDK, 2018). The NIDDK (2018) also states it is important for individuals with Addison's disease to keep a corticosteroid injection with them at all times to use in an emergent situation. While my patient's treatment for Addison's disease is still in the early phases, he has been taking fludrocortisone daily to replace the insufficient aldosterone production.

Pathophysiology References (2) (APA):

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

Munir, S., Rodriguez, B. S., Waseem, M., & Haddad, L. M. (2022, August 7). *Addison disease (nursing)*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK568775/

National Institute of Diabetes and Digestive and Kidney Diseases (2018, September). *Adrenal insufficiency & Addison's disease*. National Institute of Diabetes and Digestive and Kidney Diseases. https://www.niddk.nih.gov/health-information/endocrine-diseases/adrenal-insufficiency-addisons-disease/all-content

Laboratory Data (20 points)
If laboratory data is unavailable, values will be assigned by the clinical instructor

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	4.5 – 5.5 $x10^6$/ mcL (Males)	N/A	3.84 $x10^6$/ mcL	The patient has been diagnosed with gastroparesis, and during the assessment stated he experiences bouts of diarrhea and vomiting related to the disease. According to the National Institute for Diabetes and Digestion and Kidney Diseases (NIDDK) (2018), these are common symptoms of gastroparesis. The NIDDK (2018) states one complication of gastroparesis (and the condition's related symptoms) is malnutrition due to poor absorption of nutrients. Nutritional deficits are a cause of decreased RBC count in individuals, which the patient is experiencing (Van Luuewen & Bladh, 2021, p. 1062).
Hgb	13 – 18 g/dL (Males)	N/A	10.9 g/dL	The lowered RBC count the patient is experiencing due to the effects of gastroparesis is also impacting the patient's amount of hemoglobin, which is also decreased in response to a nutritional deficit (Van Luuewen & Bladh, 2021, p. 699).
Hct	45 – 52% (Males)	N/A	31.3%	The lowered RBC count the patient is experiencing due to the effects of gastroparesis is also effecting the patient's hematocrit, which is also decreased in response to the malabsorption of nutrients (Van Luuewen & Bladh, 2021, p. 699).
Platelets	150 - 400 K/ mcL	N/A	193 K/mcL	

WBC	4 – 10 KmcL	N/A	8.3 KmcL	
Neutrophils	40 – 80%	N/A	56.1%	
Lymphocytes	20 – 40%	N/A	35.3%	
Monocytes	2 – 10%	N/A	6.0%	
Eosinophils	1 – 7%	N/A	2.1%	
Bands	0 -10%	N/A	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+	135 – 145 mmol/L	N/A	137 mmol/L	
K+	3.5 – 5.2 mmol/L	N/A	3.4 mmol/L	Hypokalemia (low potassium) is a side effect of one of the medications the patient takes daily for diabetes mellitus management – Lantus (insulin glargine). This noted side effect indicates that the Lantus is contributing to the patient's lowered potassium levels (Vallerand & Sanoski, 2023, p. 719).
Cl-	95 – 105 mmol/L	N/A	102 mmol/L	
CO2	21-31 mmol/L	N/A	29 mmol/L	
Glucose	74-109 mg/dL	N/A	268 mg/dL	During the assessment, the patient stated his diabetes was "controlled OK" but stated he, "could be better." The elevated blood glucose lab finding is indicative of poorly controlled diabetes mellitus. Elevated blood glucose is the most indicative finding used to diagnose diabetes mellitus (Van Luuewen & Bladh, 2021).
BUN	8 – 25 mg/dL	N/A	13 mg/dL	

Creatinine	0.6 – 1.3 mg/dL	N/A	0.77 mg/dL	
Albumin	3.4 – 5.0 g/dL	N/A	3.5 g/dL	
Calcium	8.7 – 10 mg/ dL	N/A	8.2 mg/dL	According to the NIDDK (2018), a common symptom of gastroparesis is malnutrition related to poor nutrient absorption. Van Luuewen and Bladh (2021) list malabsorption as a common cause of decreased calcium levels (p. 265)
Mag	1.5 – 2.5 mg/dL	N/A	1.9 mg/dL	
Phosphate	2.5 – 4.5 mg/dL	N/A	3.7 mg/dL	
Bilirubin	0.3 – 1.0 mg/dL	N/A	0.6 mg/dL	
Alk Phos	35 – 150 units/mL	N/A	112 units/ mL	

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	Pale yellow and clear	N/A	N/A	*Urinalysis was not completed
pH	4.5- 7.8	N/A	N/A	*Urinalysis was not completed
Specific Gravity	1.005 – 1.03	N/A	N/A	*Urinalysis was not completed
Glucose	Normal	N/A	N/A	*Urinalysis was not completed
Protein	Negative	N/A	N/A	*Urinalysis was not completed
Ketones	Negative	N/A	N/A	*Urinalysis was not completed
WBC	< 5	N/A	N/A	*Urinalysis was not completed
RBC	< 5	N/A	N/A	*Urinalysis was not completed
Leukoesterase	Negative	N/A	N/A	*Urinalysis was not completed

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	*Urine culture was not assessed
Blood Culture	Negative	N/A	Negative	
Sputum Culture	Negative	N/A	N/A	*Sputum culture was not assessed
Stool Culture	Negative	N/A	N/A	*Stool culture was not assessed

Lab Correlations Reference (1) (APA):

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

National Institute of Diabetes and Digestive and Kidney Diseases (2018, January). *Gastroparesis.* National Institute of Diabetes and Digestive and Kidney Diseases. https://www.niddk.nih.gov/health-information/digestive-diseases/gastroparesis

Sarah Bush Lincoln Hospital (2022). Lab values. Sarah Bush Lincoln Hospital.

Vallerand, A. H., & Sanoski, C. A. (2023). *Davis's Drug Guide for Nurses* (18th ed.). F.A. Davis Company.

Van Leeuwen, A. M., & Bladh, M. L. (2021). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implication* (9th ed.). F. A. Davis Company

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

On 9/22, my patient had Magnetic Resonance Imaging (MRI) completed on his thoracic and lumbar vertebrae. This MRI was in reference to the fractured T12 vertebrae he experienced in January of 2022. The MRI impression was that the T12 fracture had stabilized, but there was also suggestion of osteomyelitis. According to Graeber and Cecava (2022), vertebral osteomyelitis is an infection of the vertebral body, and commonly develops after injury to the spine. Graeber and Cecava (2022) also explain that MRI is the gold standard for assessing and evaluating vertebral osteomyelitis, and are used commonly. The information from Graeber and Cecava explains why my patient had an MRI completed, and what the providers hoped to find with the exam.

Diagnostic Imaging Reference (1) (APA):

Graeber, A. & Cecava, N. D. (2022, October 3). *Vertebral osteomyelitis*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK532256/

Current Medications (10 points, 2 points per completed med)
5 <u>different</u> medications must be completed

Medications (5 required)

Brand/ Generic	Oxycontin/ Oxycodone	Florinef/ Fludrocortisone	Protonix/ Pantoprazole	Lyrica/ Pregabalin	Lantus / Insulin glargine
Dose	325 mg	0.1 mg	40 mg	300 mg	64 units (100 units/mL)
Frequency	TID	Daily	BID	BID	Daily
Route	PO	PO	PO	PO	Sub-cut
Classification (Thera. / Pharma.)	T: Opioid analgesic P: Opioid agonist (Vallerand & Sanoski, 2023).	T: Hormones P: Corticosteroid (Vallerand & Sanoski, 2023).	T: Antiulcer agent P: Proton-pump inhibitor (Vallerand & Sanoski, 2023).	T: Analgesic P: Gamma Aminobutyric Acid Analogue (Vallerand & Sanoski, 2023).	T: Antidiabetic P: Pancreatic
Mechanism of Action	Medication binds to opioid receptors in the CNS, causing a decrease in the perception of painful stimuli (Vallerand & Sanoski, 2023, p. 986).	Medication acts on distal renal tubes causing sodium retention and water retention, and hydrogen and potassium secretion (Vallerand & Sanoski, 2023, p. 594).	"Binds to an enzyme in the presence of acidic gastric pH, preventing the final transport of hydrogen ions into the gastric lumen" (Vallerand & Sanoski, 2023, p. 1009).	In the CNS, the medication binds to calcium receptors, but not opioid receptors, providing for decreased painful stimuli (Vallerand & Sanoski, 2023).	Medication lowers blood glucose levels by stimulating glucose uptake in skeletal muscle and fat and by inhibiting glucose production in the liver (Vallerand & Sanoski, 2023).
Reason Client Taking	Pain management	Addison's disease management	Gastric reflux treatment	Pain management	Blood glucose management
Contraindications (2)	1. Bronchial asthma	1. Heart failure	1. Increased risk for	1. Renal impairment	1. Hypoglycemi

	2. Products containing alcohol (Vallerand & Sanoski, 2023).	2. Addison's disease – exaggerated response (Vallerand & Sanoski, 2023).	fractures 2. Increased risk for vitamin B12 deficiency (Vallerand & Sanoski, 2023).	2. Myopathy (Vallerand & Sanoski, 2023).	a 2. Renal impairment (Vallerand & Sanoski, 2023).
Side Effects/ Adverse Reactions (2)	1. Constipation 2. Respiratory depression (Vallerand & Sanoski, 2023).	1. Muscular weakness 2. Dizziness (Vallerand & Sanoski, 2023).	1. Hyperglycemia 2. Diarrhea (Vallerand & Sanoski, 2023).	1. Peripheral edema 2. Dizziness (Vallerand & Sanoski, 2023).	1. Hypokalemia 2. Pruritis (Vallerand & Sanoski, 2023).

Medications Reference (1) (APA):

Vallerand, A. H., & Sanoski, C. A. (2023). *Davis's Drug Guide for Nurses* (18th ed.). F.A. Davis Company.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A and O x4. Patient was alert, well-groomed, calm, and open to assessment. Patient was in visible discomfort while sitting, to which he attributed to the chronic pain in his back. Patient displayed discomfort by continuously moving positions in his chair, and showing restlessness throughout the assessment.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 21** **Drains present: Y☐ N ☒** **Type:**	Patient's skin color was white and appropriate for ethnicity. Skin on upper extremities was warm and dry upon palpation. Patient displayed burns on three middle fingers of the hands bilaterally, and associated the burns with a cooking accident. Patient stated his peripheral neuropathy caused him to, "not realize the baking sheet was hot." Patient complained of continuous xerosis on lower extremities, and the skin on the bilateral lower extremities was very dry and flakey upon inspection and palpation. The patient stated he uses diabetic skin lotion for the xerosis, but it, "doesn't seem to help much." Skin turgor displayed normal mobility. Capillary refill was < 3 seconds in fingers bilaterally. Finger nails without clubbing or cyanosis. Expected quantity, distribution, and texture of hair. No rashes, drains, or lesions noted. Patient's Braden score was 21 which indicates very low risk for pressure ulcers.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head and neck are symmetrical with trachea midline without deviation. Auricles symmetrical bilaterally with no visible or palpable lumps, lesions, deformities, or drainage bilaterally. Patient's sclera white bilaterally and conjunctiva pink and moist bilaterally. No noted drainage from eyes. Bilateral eye lids pink and moist with no noted lesions. PERRLA bilaterally. EOMs intact bilaterally. Nose symmetrical with septum midline. No noted drainage or bleeding from nose. Posterior pharynx pink and moist and tonsils 1+ with no noted exudate or lesions. Uvula midline, soft palate rises and falls symmetrically, and hard palate intact. Overall oral mucosa pink and moist with no noted drainage or lesions. Overall dentition is good, with yellow discoloration which the patient attributed to years of chewing tobacco use.

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:**	S1 and S2 heart sounds auscultated with no S3, S4, murmurs, gallops, or rubs noted. Cardiac rate as expected and rhythm normal. Carotid and radial pulses palpable bilaterally and 2+. Posterior tibial pulse palpable and 1+ bilaterally. Capillary refill < 3 second in fingers bilaterally. No neck vein distention noted. No inspected or palpated edema in patient.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Normal rate and pattern of respirations. Respirations symmetrical and non-labored. Lung sounds clear anteriorly and posteriorly with no adventitious lung sounds noted. No accessory muscle use noted. No chest deformities noted. No cough or other respiratory symptoms noted.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Patient did not state diet at home. Patient's diet at facility is non-restricted and regular. Patient's height is 71 in. and weight is 90.9 Kgs. Bowel sounds were auscultated in all 4 quadrants and active with expected rate. Patient reported last BM at 0800 on day of assessment. Patient stated he uses stool softeners due to side effects from oxycodone use, and did not report any current constipation or diarrhea. Patient also reported bouts of continuous vomiting and diarrhea related to his gastroparesis, but stated that today was, "a good gut day." Abdomen nontender to palpation with no distention, incisions, masses, scars, drains, or wounds in all 4 quadrants. Patient does not have an ostomy, NG tube, or PEG tube.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	*Genitourinary was not assessed

MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 80 (high risk) **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk ☐**	*Musculoskeletal was not assessed
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	*Neurological was not assessed
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):**	***Psychosocial/cultural was not assessed

Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	100	128/84	14	36.2 C (97.1 F)	99%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions

0835	0-10	Lower back/ Kidney area	8	Dull today with sharp increase when gastroparesis issues occur	Lidocaine patch Oxycodone

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
75% of breakfast 240 ml apple juice 240 ml water	1 BM at 0800 Patient voided 1x

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

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 falls related to	This nursing diagnosis was	1. Enhance patient and	1. Patient and family are able to	Patient responded well and openly to

impaired mobility as evidenced by orthostatic hypotension, peripheral neuropathy, fall history, and Addison's disease diagnosis.	given due to the patient's recent history of falls with related injuries, and patient's own reported "scared" feeling of future falls.	family awareness of risk factors that may contribute to a fall and/or injury from a fall. 2. Promote exercise therapy to improve patient's balance and lower limb strength and mobility.	identify and make necessary changes that promote fall prevention. Example for patient: patient and family identify importance of sitting up and standing gradually to decrease risk of orthostatic hypotension episode.	nursing action. Patient was understanding that proper interventions were needed to prevent future falls, and was happy that the nursing goals were addressing his stated fears.
2. Fatigue related to depression and physical deconditioning as evidenced by drowsiness, lethargy, inability to maintain usual physical activity, and patient stating, "even sitting here talking to you I am so tired."	This nursing diagnosis was given due to the patient's stated feelings of fatigue and the effects the fatigue has on the patient's rehabilitation and quality of life.	1. Encourage patient to discuss feelings and emotions with counselor or other professional to help patient accept and cope with illness. 2. Structure patient's daily schedule based on patient's needs and desires, and encourage compliance with treatment plan.	1. Patient is able to describe improved coping mechanisms and plan to resolve fatigue issues, in both a physical and emotional sense.	Patient was generally accepting and open to discussing his stated feelings of depression and hopelessness with a mental health professional. Patient understands that he does not want to experience these feelings any longer and needs a solution to his problem.

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

Numbness in upper and lower extremities
Fatigue
Hopelessness
Fear
Difficulties with ADLs
Pain 8/10

Nursing Diagnosis/Outcomes

Risk for falls related to impaired mobility as evidenced by orthostatic hypotension, peripheral neuropathy, fall history, and Addison's disease diagnosis.
Patient and family are able to identify and make necessary changes that promote fall prevention.

Fatigue related to depression and physical deconditioning as evidenced by drowsiness, lethargy, inability to maintain usual physical activity, and patient stating, "even sitting here talking to you I am so tired."
Patient is able to describe improved coping mechanisms and plan to resolve fatigue issues, in both a physical and emotional sense.

Objective Data

Low RBC (3.84 x106/ mcL)
Low hgb (10.9 g/dL)
Low hct (31.3%)
High blood glucose (268 mg/dL)
Low calcium (8.2 mg/dL)
Low potassium (3.4 mmol/L)
MRI suggesting vertebral osteomyelitis
VS: P: 100 B/P: 128/84 R: 14 O2: 99% T: 36.2 C

Client Information

46 year old male recently diagnosed with Addison's disease.
Admitted to hospital due to leg dysfunction and orthostatic hypotension causing loss of consciousness.

Nursing Interventions

Enhance patient and family awareness of risk factors that may contribute to a fall and/or injury from a fall.
Promote exercise therapy to improve patient's balance and lower limb strength and mobility.

Encourage patient to discuss feelings and emotions with counselor or other professional to help patient accept and cope with illness.
Structure patient's daily schedule based on patient's needs and desires, and encourage compliance with treatment plan.