

N431 CARE PLAN

N431 Care Plan #2

Lakeview College of Nursing

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N431 CARE PLAN

Demographics (3 points)

Date of Admission 10/18/2022	Client Initials K.H.	Age 68 years old	Gender Female
Race/Ethnicity White	Occupation Retired	Marital Status Divorced	Allergies Bee pollen, erythromycin, naproxen, dicloxacillin
Code Status Full code	Height 5'5"	Weight 164 pounds	

Medical History (5 Points)

Past Medical History: Atrial fibrillation, diabetes, restless leg syndrome, sick sinus syndrome, thyroid disease, herpes virus

Past Surgical History: Gallbladder surgery, tonsillectomy, appendectomy, pacemaker placement, catheter, ablation.

Family History: Mother had cardiovascular disease and diabetes. Father had emphysema.

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

Patient reports she has quit smoking. She was a half pack a day. She has never used smokeless tobacco. She doesn't report current alcohol or drug use.

Assistive Devices: Patient uses a walker to ambulate.

Living Situation: Lives with her boyfriend.

Education Level: Patient's education level is unknown.

Admission Assessment

Chief Complaint (2 points): Boyfriend found her unresponsive

History of Present Illness – OLD CARTS (10 points): Boyfriend found her unresponsive at home. Patient reported a poor appetite with no nausea or vomiting for a few days. She reported

N431 CARE PLAN

sciatic pain and dysuria and diarrhea. Patient was taking Gabapentin for pain. Patient had not sought care for this complaint.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Sepsis

Secondary Diagnosis (if applicable): NA

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

Sepsis occurs when the body's response to an infection damages its tissue (Mayo Clinic, 2021). This infection is already present in the body, triggering a chain reaction. When the infection-fighting processes turn on the body, it can cause the organs to function poorly (Mayo Clinic, 2021). Infections that lead to sepsis often start in the lungs, skin, urinary or gastrointestinal tract (CDC, 2022). Other causes involve wounds or burns. This client had a stage three wound on her coccyx, which was one of the causes of her diagnosis of sepsis.

Patients may have an altered mental status, low blood pressure, and tachypnea (Mayo Clinic, 2021). This patient reported fever, discomfort, and an altered level of consciousness. Patients with sepsis will have elevated white blood cells and lactate, and their arterial blood gas will be abnormal. In this patient scenario, her creatinine, INR, and BNP were abnormal, along with white blood cells, lactate, and blood gas.

Multiple diagnostic tools locate the origin of infection within the body. X-rays, MRI, ultrasound, and CT are some common examples. Blood cultures, urine analysis, sputum, or stool cultures may be ordered depending on the patient's presentation and symptoms. In this patient's case, an ultrasound and CT were performed of the pelvis and abdomen. Blood cultures and

N431 CARE PLAN

urinalysis were ordered because of the suspected kidney infection. The patient's blood culture was positive for E. coli, and her urinalysis indicated an infection.

The treatment plan for sepsis includes antibiotics and intravenous fluids (Mayo Clinic, 2021). This patient was receiving Cefepime and sodium chloride. While hospitalized, continuous vital signs, lab draws, and antibiotics are the primary treatment sources. They were monitoring her lactic acid levels during this admission, as well.

Pathophysiology References (2) (APA):

Centers for Disease Control and Prevention (CDC). (2022). *What is sepsis?* CDC.

<https://www.cdc.gov/sepsis/what-is-sepsis.html>

Mayo Clinic Staff. (2021). *Sepsis*. Mayo Clinic. [clinic.https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214](https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214)

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	3.8-5.3	4.5	3.7	
Hgb	12-15.8	12.8	10.6	
Hct	36-47	39.3	31.7	
Platelets	140-440	196	137	
WBC	4-12	30.7	21.2	WBC count is elevated because of sepsis (Schnur, 2017).
Neutrophils	47-73	89.7	88.2	Neutrophils were elevated because of infection.
Lymphocytes	18-42	3.5	5.4	Lymphocytes could be low due to infection.
Monocytes	4-12	6.5	6.1	

N431 CARE PLAN

Eosinophils	0-5	0	0.2	
Bands	0	NA	NA	

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	NA	135	
K+	3.5-5.1	NA	3.9	
Cl-	98-107	NA	104	
CO2	22-30	NA	23	
Glucose	70-99	NA	106	The glucose was elevated because of sepsis (Schnur, 2017). This patient is also a diabetic.
BUN	10-20	NA	39	BUN was elevated because of dehydration.
Creatinine	0.6-1	NA	1.69	Creatinine is elevated because of diagnosis of sepsis (Schnur, 2017).
Albumin	3.5-5	NA	3.5	
Calcium	8.7-10.5	NA	8.1	This patient's calcium level could be low because of problems with their thyroid (Lewis, 2021).
Mag	1.6-2.6	NA	NA	
Phosphate	34-104	NA	NA	
Bilirubin	0-0.2	NA	NA	
Alk Phos	34-104	NA	NA	
AST	5-34	NA	24	
ALT	0-55	NA	15	

N431 CARE PLAN

Amylase	NA	NA	NA	
Lipase	8-78	8	NA	
Lactic Acid	0.7-2	8.1	4.3	This patient's lactic acid is elevated because they are in lactic acidosis secondary to infection (Schnur, 2017).
Troponin	0-0.04	0.037	NA	
CK-MB	NA	NA	NA	
Total CK	NA	NA	NA	

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	2.4	NA	This patient's INR is elevated because of diagnosis of sepsis (Schnur, 2017).
PT	NA	NA	NA	
PTT	NA	NA	NA	
D-Dimer	NA	NA	NA	
BNP	0-100	1528	NA	Patients with severe sepsis often have an elevated BNP because of association with organ and myocardial dysfunction (Fish-Trotter et al., 2020).
HDL	>40	NA	NA	
LDL	<130	NA	NA	
Cholesterol	<200	NA	NA	
Triglycerides	<150	NA	NA	
Hgb A1c	4-6%	NA	NA	
TSH	0.27-4.2	NA	NA	

N431 CARE PLAN

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	yellow	dark yellow	NA	Dark urine may indicate dehydration.
pH	5-9	5.0	NA	
Specific Gravity	1.003-1.03	1.015	NA	
Glucose	negative	negative	NA	
Protein	negative	negative	NA	
Ketones	negative	trace	NA	
WBC	negative	3+	NA	Elevated WBC in urine are found in pyelonephritis (Belyayeva & Jeong, 2022).
RBC	0-2	6-10	NA	Hematuria may be present because of pyelonephritis (Belyayeva & Jeong, 2022).
Leukoesterase	negative	NA	NA	

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	7.31	NA	This patient's arterial blood gas was abnormal because they have too much lactate in their bloodstream. (Mayo Clinic, 2021). This will result in abnormal ABGs.
PaO2	80-100	56	NA	This patient's arterial blood gas was abnormal because they have too

N431 CARE PLAN

				much lactate in their bloodstream, which indicates their body isn't using oxygen properly (Mayo Clinic, 2021).
PaCO₂	35-45	30	NA	This patient's arterial blood gas was abnormal because they have too much lactate in their bloodstream, which indicates their body isn't using oxygen properly (Mayo Clinic, 2021).
HCO₃	22-26	15.1	NA	This patient's arterial blood gas was abnormal because they have too much lactate in their bloodstream. (Mayo Clinic, 2021). This will result in abnormal ABGs.
SaO₂	95-100	84	NA	This patient's arterial blood gas was abnormal because they have too much lactate in their bloodstream, which indicates their body isn't using oxygen properly (Mayo Clinic, 2021).

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	NA	In process	
Blood Culture	Negative	NA	Positive for E. coli	E. coli is the causative agent in pyelonephritis (Belyayeva & Jeong, 2022).
Sputum Culture	Negative	NA	NA	
Stool Culture	Negative	NA	NA	

Lab Correlations Reference (1) (APA):

Belyayeva, M., Jeong, J. (2022). *Acute pyelonephritis*. National Library of medicine.

<https://www.ncbi.nlm.nih.gov/books/NBK519537/#:~:text=On%20urinalysis%2C%20one%20should%20look,present%20as%20well%20on%20urinalysis.>

N431 CARE PLAN

Fish-Trotter, H., Ferguson, J., Patel, N., Arora, P., Allen, N., Bachmann, K., Daniels, L., Reilly, M., Lima, J., Wang, T., & Gupta, D. (2020). Inflammation and circulating natriuretic peptide levels. *Circulation: Heart Failure*, 13(7),

13:e006570.<https://doi.org/10.1161/CIRCHEARTFAILURE.119.006570>

Lewis, J. (2021). *Hypocalcemia*. Merck manual.

<https://www.merckmanuals.com/home/hormonal-and-metabolic-disorders/electrolyte-balance/hypocalcemia-low-level-of-calcium-in-the-blood#:~:text=In%20hypocalcemia%2C%20the%20calcium%20level%20in%20blood%20is,as%20from%20diet%2C%20kidney%20disorders%2C%20or%20certain%20drugs.>

Mayo Clinic Staff. (2021). *Sepsis*. Mayo clinic. <https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214>

Schnur, M. (2017). *Laboratory signs of sepsis*. Nursing center blog.

<https://www.nursingcenter.com/ncblog/march-2017/laboratory-signs-of-sepsis>

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Ultrasound of the bladder and CT of the abdomen/pelvis

Diagnostic Test Correlation (5 points): An ultrasound uses high frequency sound waves to help visualize a part of the body. Gel is applied to the skin over the area that is being examined (Mayo Clinic, 2021). A transducer is held against the skin to capture images of the organ. It can be done for many different purposes (Mayo Clinic, 2021). Some of which include, evaluate blood flow, assess joint inflammation, evaluate metabolic bone disease, and diagnose gallbladder disease (Mayo Clinic, 2021). In this client's scenario it was done to evaluate the bladder. It can detect abnormalities such as bladder diverticular, stone, or tumors (Stoppler et al., 2022). The

N431 CARE PLAN

ultrasound helped to diagnose pyelonephritis in this particular patient, which is one of the leading causes of her sepsis.

Computed tomography (CT) scans use various x-ray images taken at different angles of the body to create cross-sectional images (Radiologyinfo.org, 2022). It is a very noninvasive, painless, and fast tool used to reveal internal injuries quickly. It can be done for many different reasons. Examples include diagnosing muscle and bone disorders, detect diseases like cancer and heart disease, and detect diseases of the internal organs (Radiologyinfo.org, 2022). In this patient's scenario, it was done to help diagnose pyelonephritis.

Diagnostic Test Reference (1) (APA):

Mayo Clinic Staff. (2022). *Ultrasound*. Mayo clinic. <https://www.mayoclinic.org/tests-procedures/ultrasound/about/pac-20395177>

Radiologyinfo.com (2022). *Abdominal and pelvic CT*. Radiologyinfo. <https://www.radiologyinfo.org/en/info/abdominct>

Stoppler, M., Nabili, S., & Shiel W. (2022). *Kidney infection (pyelonephritis)*. Medicinenet. https://www.medicinenet.com/kidney_infection/article.htm

N431 CARE PLAN

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

Home Medications (5 required)

Brand/Generic	Duloxetine Cymbalta	Acyclovir Zovirax	Apixaban Eliquis	Flecainide Tambocor	Pioglitazone Actos
Dose	30 mg	200 mg	5 mg	100 mg	45 mg
Frequency	2 times a day	2 time a day	2 times a day	2 times a day	daily
Route	oral	oral	oral	oral	oral
Classification	Pharm: selective serotonin Therapeutic : antidepressant	Pharm: nucleoside analogous Therapeutic: antiretroviral	Pharm: factor Xa inhibitor Therapeutic: c: anticoagulant	Pharm: benzamide derivative Therapeutic: class IC antiarrhythmic	Pharm: thiazolidinedione Therapeutic; antidiabetic
Mechanism of Action	Inhibits dopamine, neuronal serotonin, and norepinephrine reuptake to potentiate activity in the CNS.	Several actions combine to inhibit herpes virus replication.	Inhibits free and clot-bound factor Xa and prothrombinase activity.	Inhibiting fast sodium channels of myocardial cell membranes, which increase myocardial recovery after repolarization.	Decrease insulin resistance by enhancing the sensitivity of insulin-dependent tissues.
Reason Client Taking	Depression	Herpes	To prevent stroke secondary to atrial fibrillation	To prevent ventricular tachycardia because of atrial fibrillation	Diabetes
Contraindications (2)	Chronic liver disease or severe renal impairment	Hypersensitivity to acyclovir or valacyclovir or any of their	Pathological bleeding and severe hypersensi	cardiogenic shock and recent MI	Hypersensitivity to pioglitazone or its components or

N431 CARE PLAN

		components.	tivity to apixaban		heart failure
Side Effects/Adverse Reactions (2)	palpitations orthostatic hypotension	dyspnea, visual abnormalities, elevated BUN and creatinine	hemoptysis and GI bleeding or hemorrhage	arrhythmias and hypotension	decreased hemoglobin level and hematocrit and upper respiratory infection
Nursing Considerations (2)	Obtain patient's baseline blood pressure before therapy and monitor hepatic therapy during.	Use cautiously in patients with underlying neurologic disorders and acyclovir therapy should be initiated as soon as symptoms appear.	Monitor closely for bleeding and the drug is able to be crushed and mixed with applesauce for patients unable to swallow whole tablets.	Check blood pressure, fluid intake and output, and weight regularly during therapy. Potassium levels should be monitored before and during therapy to ensure hypokalemia is not present.	Monitor for signs and symptoms of congestive heart failure, assess for signs and symptoms of hypoglycemia.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Vital signs and hepatic panel	CBC and baseline renal function	INR and PT	Urine pH and blood pressure, serum potassium	Liver panel and glucose levels
Client Teaching Needs (2)	Tell patient to take capsule whole and not to chew or crush it. Advise to not abruptly stop therapy.	Does not cure herpes infection instead helps to manage it and ensure accurate dosing before taking	Advise to report any abnormal bleeding and not to abruptly stop taking without consultation	Take regular intervals to keep a constant blood level. Advise patient to take a missed dose as soon as she remembers.	Emphasize the need for patient to continue diet control, exercise programs, and weight management. Instruct patient to keep laboratory appointments for liver enzymes.

N431 CARE PLAN

Hospital Medications (5 required)

Brand/Generic	Cefepime Maxipime	Insulin (regular) in NaCl solution	Acetaminophen Tylenol	Tizanidine Zanaflex	Digoxin Lanoxin
Dose	1 g	1-20 units/hour	650 mg	2 mg	125 mcg
Frequency	once a day	continuous drip	Q4 hours PRN	4 times a day	once
Route	IV	IV drip	oral	oral	IV
Classification	Pharm: fourth- generation cephalospor in Therapeutic : antibiotic	Pharm: human insulin Therapeutic: antidiabetic	Pharm: non salicylate Therapeutic: antipyretic	Pharm: alpha2 adrenergic agonist Therapeutic: antispasmodi c	Pharm: cardiac glycoside Therapeutic: antiarrhythm ic
Mechanism of Action	Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross- linking of peptide strands (Jones & Bartlett Learning, 2021).	Lowers blood glucose levels by stimulating peripheral glucose uptake by fat and skeletal muscle (Jones & Bartlett Learning, 2021).	Inhibits the enzyme cyclooxygenase , blocking prostaglandin production and interfering with pain impulse (Jones & Bartlett Learning, 2021).	Reduces spasticity by decreasing the release of excitatory amino acids (Jones & Bartlett Learning, 2021).	Increases the force and velocity of myocardial contraction, resulting in positive inotropic effects (Jones & Bartlett Learning, 2021).
Reason Client Taking	UTI caused by E. coli	Uncontrolled diabetes	Mild pain and fever	Muscle spasms and pain	Tachycardia, atrial fibrillation

N431 CARE PLAN

Contraindications (2)	Hypersensitivity to cefepime or other beta-lactam antibiotics (Jones & Bartlett Learning, 2021).	Chronic lung disease or hypersensitivity to regular insulin (Jones & Bartlett Learning, 2021).	Severe hepatic impairment and acute liver disease (Jones & Bartlett Learning, 2021).	Use with ciprofloxacin and hypersensitivity to tizanidine or its components (Jones & Bartlett Learning, 2021).	Hypersensitivity to digoxin or its components and digitalis toxicity (Jones & Bartlett Learning, 2021).
Side Effects/Adverse Reactions (2)	Hepatic failure, dyspnea, fever	hypoglycemia, UTI	hypotension, hypoglycemia	orthostatic hypotension and UTI	arrhythmias and diarrhea
Nursing Considerations (2)	Use cautiously in patients with impaired renal function and obtain culture and sensitivity test results (Jones & Bartlett Learning, 2021).	Monitor for signs and symptoms of hypoglycemia, which could cause seizures. Monitor for any sensitivity reactions (Jones & Bartlett Learning, 2021).	Use cautiously in patients with hepatic impairment and take appropriate dosing based on weight (Jones & Bartlett Learning, 2021).	Monitor hepatic and renal function for the first 6 months and periodically thereafter. Should be stopped slowly to prevent rebound hypertension (Jones & Bartlett Learning, 2021).	Obtain frequent EKG tracings as ordered and monitor potassium levels (Jones & Bartlett Learning, 2021).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	review culture and sensitivity results and baseline renal	Blood glucose and vitals	Assess pain level prior to administration and temperature	Assess pain level and vital signs, specifically blood pressure	Assess apical pulse prior to administration and vital signs
Client Teaching Needs (2)	report severe diarrhea and seek immediate care for mental	review signs and symptoms of hypoglycemia and avoid alcohol consumption	Tablets may be crushed or swallowed whole and follow dosage guidelines precisely (Jones	Change positions slowly to minimize effects of orthostatic hypotension	Take exactly as prescribed and warn about possible toxicity from taking too

N431 CARE PLAN

	status changes (Jones & Bartlett Learning, 2021).	(Jones & Bartlett Learning, 2021).	& Bartlett Learning, 2021).	and avoid alcohol use (Jones & Bartlett Learning, 2021).	much and decreased effectiveness of taking too little. Teach patient how to take their pulse and educate to do so before each dose (Jones & Bartlett Learning, 2021).
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Medications Reference (1) (APA):

Jones & Bartlett Learning (2021). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

N431 CARE PLAN

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

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Patient is oriented times person, place, and time. She awakens upon arousal, otherwise she continues to sleep. She doesn't appear to be in any acute distress.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: 12 Drains present: Y ☐ N ☒ Type:	Skin color is pink, dry, and cool to touch. There are no lesions or rashes present. There is a stage 3 wound present on her coccyx. Skin turgor is normal, less than 3 seconds. Patient's Braden score is 12.
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	Head and neck are symmetrical upon inspection and the trachea is midline. There are no noted nodules and the thyroid is nonpalpable. Bilateral carotid pulses 2+ upon palpation. Bilateral auricles have no visible deformities or drainage. Both eyes appear to have no lesions upon inspection. PERRLA. EOMs are intact on both eyes. Septum is midline with no notable drainage. Oral mucosa is pink and moist with no noted lesions. Patient has clean, intact teeth.
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:	Normal heart sounds with no murmurs or gallops present. Rhythm is normal, rate is bradycardic. Presents with a 2+ pulse upon palpation of all pulse sites. Capillary refill is less than 3 seconds bilaterally. No edema or neck vein distension is present.
RESPIRATORY: Accessory muscle use: Y ☐ N ☒ Breath Sounds: Location, character	Normal breath sounds noted in all lung fields. Respirations and patterns are non-labored with a normal respiratory rate. Patient is not using accessory muscles when breathing.
GASTROINTESTINAL: Diet at home: Current Diet Height:	Patient was on a regular diet while at home and during hospitalization. Patient's height is 5'5" and weighs 164 pounds. Normoactive bowel sounds are present in all 4 quadrants among

N431 CARE PLAN

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:	auscultation. Last bowel movement was 10/19/2022. Upon inspection there were no distension, incisions, scars, drains, or wounds present. No ostomys, nasogastric tubes, or feeding tubes present.
GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y ☐ N ☒ Dialysis: Y ☐ N ☒ Inspection of genitals: Catheter: Y ☒ N ☐ Type: 16 Fr Size:	Patient's urine was yellow with no odor. Patient voided 600 mL during this shift. There was no pain during urination and she is not on dialysis. Unable to examine genitals. Patient had a 16 Fr catheter inserted.
MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y ☒ N ☐ Fall Risk: Y ☒ N ☐ Fall Score: 75 Activity/Mobility Status: Independent (up ad lib) ☐ Needs assistance with equipment X Needs support to stand and walk ☐	There was no noted weakness on any extremity. Muscle strength is even in all limbs. Patient needs assistance with activities of daily living. Patient uses a walker, gait belt, and 1-2 people to help ambulate. She is able to turn independently in bed. Patient's fall score is 75, according to the Morse fall score.
NEUROLOGICAL: MAEW: Y ☒ N ☐ PERLA: Y ☒ N ☐ Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐ Orientation: Mental Status:	Patient moves all extremities well. No noted weakness throughout limbs and strength is equal. Patient is alert and oriented times person, place, and time. She answers questions appropriately. Patient at times is not easy to arouse, sleeping throughout care.

N431 CARE PLAN

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 resides in home with her boyfriend. Patient appears to have good support, as evidenced by her boyfriend being at the bedside. Patient's developmental level is appropriate for her age and she has appropriate coping methods. Religious practices are unknown.

Vital Signs, 2 sets (5 points) – **HIGHLIGHT ALL ABNORMAL V**

Time	Scale	Location	Severity	Characteristics	Interventions
1320	0-10	Patient reported no pain	0	Patient reported no pain	Patient reported no pain
1615	0-10	Patient reported no pain	0	Patient reported no pain	Patient reported no pain

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:	Patient has 2 IVs in the left arm. One is a 20 gauge in the left hand and the other is a 20 gauge in the antecubital. The dressing is dry, clean, and intact. No signs of drainage or erythema present.

VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1320	76 beats per minute	86/49	16 breaths per minute	98.2 degrees temporal	100% 1.5 liters on nasal cannula
1615	117 beats per	99/46	20 breaths	97.9 degrees	99% 1.5 liters

N431 CARE PLAN

	minute		per minute	temporal	on nasal cannula
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Vital Sign Trends: Heart rate and blood pressure were inconsistent throughout this shift. Heart rate became tachycardia and blood pressure remained low. Respiratory rate, temperature, and oxygen were stable.

Pain Assessment, 2 sets (2 points)**Intake and Output (2 points)**

Intake (in mL)	Output (in mL)
75% of lunch tray	600 mL of urine
240 mL of water	unmeasured amount of stool times 1 occurrence

Nursing Care**Summary of Care (2 points)**

Overview of care: Patient was resting comfortably throughout the shift. Continuous vital signs were monitored. Dressing change on coccyx was performed.

Procedures/testing done: No procedures or tests were performed.

Complaints/Issues: Patient was resting comfortably; no complaints were presented.

Vital signs (stable/unstable): Vital signs were unstable. Blood pressures were low and heart rate was fluctuating in the 120's. Physician was notified, and new orders were placed.

Tolerating diet, activity, etc.: Patient was tolerating diet well. Activity is poor, remaining on bedrest.

N431 CARE PLAN

Physician notifications: Physician ordered a dose of Digoxin to help with heart rate.

Patient was also having loose stools; a clostridium difficile sample was ordered and the patient was put on contact precautions.

Future plans for client: Continuing to monitor lactic acid levels.

Discharge Planning (2 points)

Discharge location: Discharge to home.

Home health needs (if applicable): Does not pertain to this patient.

Equipment needs (if applicable): Does not pertain to this patient.

Follow up plan: Patient's follow up plan is to meet with the primary physician 1 week following hospital admission.

Education needs: Patient will need education on medication compliance.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
● 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	● Explain why the nursing diagnosis was chosen			● How did the client/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Impaired gas	Patient's ABGs were abnormal.	1. Monitor ABGs and pulse oximetry while	1. Client will display ABGs within normal	The client and family responded well to these

N431 CARE PLAN

exchange related to diagnosis of sepsis as evidenced by abnormal ABG readings.		providing supplemental oxygen therapy as needed. 2. Monitor vital signs every hour and note any adventitious lung sounds.	limits. Patient will not report any dyspnea and no abnormal lung sounds will be noted.	interventions. Client remained on 1.5 liters of oxygen via nasal cannula. No reports of dyspnea and vital signs were continuously monitored.
2. Decreased cardiac output related to abnormal rate and rhythm of heart.	Patient's heart rate was 117 and had a history of atrial fibrillation.	1. Monitor vital signs every hour and report any abnormalities to the provider. 2. Administer any medications ordered by the provider- Digoxin 125 mcg one time through IV.	Client's heart rate and rhythm will improve into normal limits.	The client's heart rate improved after administration of Digoxin. Will continue to monitor vital signs every hour.
3. Impaired skin integrity related to poor circulation as evidenced by stage 3 wound on her coccyx.	Patient had a stage 3 ulcer on her coccyx.	1. Ensure appropriate dressing changes are done to maximize healing of the skin. 2. Assess for fecal matter and the patient's ability to move around in bed. Repositioning client every 2 hours if needed.	1. Client will experience healing of pressure ulcers and reduction of pressure from coccyx.	The client responded well to these interventions. Patient was able to relieve pressure off her coccyx independently. Ensured appropriate shift changes every 2 hours and incontinence care was done promptly.
4. Risk for	Patient had	1. Ensure there	1. Client will	The client

N431 CARE PLAN

falls related to Morse fall score of 75.	multiple falls at home prior to admission.	are 1-2 people with the patient when ambulating. Use a gait belt and walker. 2. Ensure the bed is in low position and call light is within reach of the patient.	not experience any falls during this hospital shift.	responded well to these interventions. Patient was able to voice the importance of ambulating with staff present and to use the call light when wanting to get up.
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Other References (APA):**Concept Map (20 Points):**

Subjective Data

- Does not report any pain throughout shift. She rates it a 0 on a 0-10 scale.
- Patient reports she wants to go home.
- Expresses how her boyfriend will help with her daily care and medications.

Nursing Diagnosis/Outcomes

- Impaired gas exchange related to diagnosis of sepsis as evidenced by abnormal ABG readings.
- Decreased cardiac output related to abnormal rate and rhythm of heart.
- Impaired skin integrity related to poor circulation as evidenced by stage 3 wound on her coccyx.
- Risk for falls related to Morse fall score of 75.
- Client will display ABGs within normal limits. Patient will not report any dyspnea and no abnormal lung sounds will be noted.
- Client's heart rate and rhythm will improve into normal limits.
- Client will experience healing of pressure ulcers and reduction of pressure from coccyx.
- Client will not experience any falls during this hospital shift.

Objective Data

- Abnormal vital signs noted, hypotension and tachycardia.
- Blood culture was positive for E. coli.
- Abnormal UA suggests kidney infection.
- Stage 3 wound on her coccyx.
- Has a 16 Fr foley catheter inserted with normal output.
- Patient is incontinent of stool.
- On antibiotics to treat UTI.
- Remains on high fall-risk precautions.
- Activity is poor, did not ambulate during this shift.
- She is 1.5 liters via nasal cannula.

Client Information

- 68 year old female was found unresponsive by boyfriend.
- Reported pain and discomfort upon admission.
- Symptoms had been persistent for a few days.
- States she has been taking Gabapentin for sciatic pain.
- Notes dysuria.

Nursing Interventions

- Monitor ABGs and pulse oximetry while providing supplemental oxygen therapy as needed.
- Monitor vital signs every hour and note any adventitious lung sounds.
- Monitor vital signs every hour and report any abnormalities to the provider.
- Administer any medications ordered by the provider- Digoxin 125 mcg one time through IV.
- Ensure appropriate dressing changes are done to maximize healing of the skin.
- Assess for fecal matter and the patient's ability to move around in bed. Repositioning client every 2 hours if needed.
- Ensure there are 1-2 people with the patient when ambulating. Use a gait belt and walker.
- Ensure the bed is in low position and call light is within reach of the patient.
-

N431 CARE PLAN

N431 CARE PLAN

Ill-defined fatty stranding involving the kidneys bilaterally with loss of corticomedullary differentiation in the upper pole and lower pole of the right kidney, suspicious for possible pyelonephritis, as well as along the upper pole of the left kidney. Correlate with clinical exam. No hydronephrosis.

Sepsis occurs when an already-present infection spirals out of control and begins to cause organ damage, and even death

She reports that she has quit smoking. Her smoking use included cigarettes. She has never used smokeless tobacco. She reports current alcohol use. She reports that she does not use drugs.

Orders to be Acknowledged

Comment | Expand | Hide

(From admission, onward)

New Orders Placed on 10/19/22 at 1511

Ordered Ordering Provider

N431 CARE PLAN

10/19/22 1511

digoxin (LANOXIN) injection 125 mcg Start: 10/19/22 2200, End: 10/20/22 0959, 125

mcg, Intravenous, ONCE, Routine

Abdelghani, Loui, MD

New Orders Placed on 10/19/22 at 1511

Ordered	Ordering Provider
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10/19/22 1511

digoxin (LANOXIN) injection 125 mcg Start: 10/19/22 1530, End: 10/20/22 0329, 125

mcg, Intravenous, ONCE, STAT

Abdelghani, Loui, MD

New Orders Placed on 10/19/22 at 1510

Ordered	Ordering Provider
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10/19/22 1510

N431 CARE PLAN

US ABDOMEN COMPLETE Start: 10/19/22 1515, End: 10/19/22 1515, 1 TIME

IMAGING, Routine

Abdelghani, Loui, MD

10/19/22 1510

C. DIFFICILE BY PCR Start: 10/19/22 1515, End: 10/19/22 1515, ONE TIME,

Routine

Abdelghani, Loui, MD

10/19/22 1510

Contact Isolation Start: 10/19/22 1515, CONTINUOUS, Today

Abnormal UA noted. Patient also noted renal failure. Patient also was AFib with RVR with tachycardic 1 dose of Cardizem was given. Unsure patient compliance with Eliquis. Patient admitted to ICU with severe sepsis and Cardiology and Pulmonary consulted.