N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 10/14/2022	**Client Initials** A.E.S	**Age** 52	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Stocker at Walmart	**Marital Status** Married	**Allergies** NKA
Code Status Full	**Height** 170cm	**Weight** 58kg	

Medical History (5 Points)

Past Medical History: Pancytopenia, hypertension, hepatitis C with cirrhosis, anemia, depression, fainting episodes, chronic hypokalemia, chronic alcohol dependence, tobacco abuse, hyperlipidemia, sinusitis, thrombocytopenia, esophageal varices

Past Surgical History: colonoscopy with biopsy (2017), esophagogastroduodenoscopy (2017), cholecystectomy (2016), tubal ligation (1991)

Family History:

Father: musculoskeletal disorder

Grandfather (Paternal): heart attack

Grandmother (Maternal): breast cancer

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

Tobacco: cigarettes, daily, a pack per day, about 40 years

Alcohol: Liquor, daily, amount varies, about 40 years

Drugs: Marijuana, daily, doesn’t know exact amount, about 10 years

Assistive Devices: N/A

Living Situation: At home with husband

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): Weakness, lightheadedness, increased confusion

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

The patient, a 52-year-old female present the emergency department with generalized weakness, and family reporting increased confusion and overall altered mental status. Patient has a history of chronic hypokalemia, hepatitis C with cirrhosis, hypertension, pancytopenia, chronic alcohol dependence, hyperlipidemia, and esophageal varices. Patient stated she began drinking alcohol again over the past two days and tripped over a rug at home the night prior. Patient's family reported an increase in jaundice. Patient states symptoms started approximately two days ago, when she began drinking again. She states she did not take any of her medication this morning. Patient states she is having difficulty walking and feeling lightheadedness. Patient denies any pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Hepatic encephalopathy

Secondary Diagnosis (if applicable): Hypokalemia

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

Hepatic encephalopathy is a life-threatening complication of liver disease and occurs with liver failure (Hinkle & Cheever, 2018). It is a neuropsychiatric manifestation of liver failure associated with portal hypertension and shunting blood from the portal venous system to systemic circulation (Hinkle & Cheever, 2018). Hepatic insufficiency may be caused by the inability of the liver to detoxify the metabolized toxic products, like ammonia or the development of collateral vessels because of portal hypertension, which allows toxic substances to enter systemic circulation (Hinkle & Cheever, 2018). The major etiological factor in the

development of encephalopathy is ammonia. When ammonia enters the brain, it excites peripheral benzodiazepine type receptors, increases neurtosteriod synthesis and stimulates gamma aminobutyric acid (GABA) neurotransmission (Hinkle & Cheever, 2018). The neurotransmission of GABA causes central nervous system depression and inhibits neurotransmission as well as synaptic regulation (Hinkle & Cheever, 2018).

Early symptoms of hepatic encephalopathy include mental status changes, motor disturbances, periods of lethargy or euphoria and the reversal of day-night sleep patterns (Hinkle & Cheever, 2018). As hepatic encephalopathy progresses, disorientation, mood swings, increased drowsiness, agitation, incoherent speech, inability to respond to painful stimuli and a comatose state may occur (Sorenson, 2018). Expected findings of hepatic encephalopathy related to the symptoms include impaired writing, asterixis, change in mood, change in mental status, fetor hepaticus, increased deep tendon reflexes, rigidity of extremities, and eventually flaccidity of extremities and absence of deep tendon reflexes (Hinkle & Cheever, 2018). The patient presented to the emergency department with generalized weakness and family reporting increased confusion.

Diagnostics tests are used to determine the presence and severity of hepatic encephalopathy. An electroencephalogram can be used and shows generalized slowing, increased amplitude of brain waves and characteristic triphasic waves (Hinkle & Cheever, 2018). Serum ammonia levels are closely monitored as well as electrolytes (Hinkle & Cheever, 2018). The patient’s ammonia levels were elevated upon admission, indicating liver dysfunction or disease. Patient also has a history of cirrhosis related to hepatitis C, which would affect ammonia levels.

Treatment of hepatic encephalopathy depends on the stage and includes ammonia lowering therapy, managing complications of cirrhosis and depressed consciousness (Hinkle &

Cheever, 2018). Treatments include glucose administered via IV can be given to minimize protein break down, vitamins to correct deficiencies and correcting electrolyte imbalances, especially potassium. To reduce levels of ammonia forming bacteria in the colon, antibiotics like neomycin, metronidazole and rifaximin can be administered (Hinkle & Cheever, 2018). This patient's treatment included Lactulose, an ammonia lowering therapy, while admitted to the hospital and as well as adding it to her at home medication regimen. This patient's treatment also included correcting her hypokalemia with supplemental potassium.

Pathophysiology References (2) (APA):

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

Sorenson, M., Quinn, L., & Klein, D. (2018). *Pathophysiology: Concepts of human disease* (1st ed.). Pearson.

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	F: 4.5-5 M: 4.5-6	3.47	2.76	Patient has a history of pancytopenia, indicates a decrease in red blood cells, white blood cells, and platelets (Chiravuri & De Jesus, 2022).
Hgb	F: 12-15 M: 14-16	11.5	9.6	Patient history includes hepatitis C with cirrhosis. Decreased hemoglobin related to chronic anemia associated with cirrhosis (Hinkle & Cheever, 2018).
Hct	F: 42-52 M: 35-47	34.3	28.2	Patient history includes hepatitis C with cirrhosis. Decreased hematocrit related to chronic anemia associated

				with cirrhosis (Hinkle & Cheever, 2018).
Platelets	150,000-400,00	70	67	Patient has a history of pancytopenia, indicates a decrease in red blood cells, white blood cells, and platelets (Chiravuri & De Jesus, 2022).
WBC	4,500-11,000	2.7	3.3	Patient has a history of pancytopenia, indicates a decrease in red blood cells, white blood cells, and platelets (Chiravuri & De Jesus, 2022).
Neutrophils	45-75%	56.5%	N/A	N/A
Lymphocytes	20-40%	24.9%	N/A	N/A
Monocytes	1-10%	12.1%	N/A	Increased monocytes indicate infection or stress in the body (Hinkle & Cheever, 2018).
Eosinophils	<7%	5.9%	N/A	N/A
Bands	<1%	N/A	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	140	140	N/A
K+	3.5-5.0	2.1	3.7	Decreased potassium related to history of hypokalemia and improper electrolyte absorption related to hepatic encephalopathy (Hinkle & Cheever, 2018).
Cl-	97-107	112	118	Increased chloride related to spironolactone use; side effect includes hyperchloremia (Jones & Bartlett, 2018).
CO2	20-30	21	20	N/A
Glucose	70-110	107	105	N/A

BUN	10-20	13	6	Decreased BUN due to reduced urea synthesis related to advanced liver disease or cirrhosis or related to patient's use of antibiotics while admitted to the hospital (Hinkle & Cheever, 2018).
Creatinine	0.7-1.4	0.63	0.45	Decreased creatinine due to reduced creatine production related to advanced liver disease or cirrhosis (Hinkle & Cheever, 2018).
Albumin	3.5-5	3.3	N/A	Decreased albumin related to liver disease (Hinkle & Cheever, 2018).
Calcium	8.6-10.2	9	7	Decreased calcium related to antibiotic use during hospital admission (Jones & Bartlett 2018).
Mag	1.3-2.1	2.1	1.7	N/A
Phosphate	2.5-4.5	N/A	N/A	N/A
Bilirubin	0.3-1	6.3	N/A	Increased bilirubin indication of liver and bile duct obstruction (Hinkle & Cheever, 2018).
Alk Phos	30-120	133	N/A	Increased alkaline phosphatase indication of liver damage (Hinkle & Cheever, 2018).
AST	0-35	97	N/A	Increased AST indication of liver damage (Hinkle & Cheever, 2018).
ALT	4-36	53	N/A	Increased ALT indication of liver damage (Hinkle & Cheever, 2018).
Amylase	30-220	N/A	N/A	N/A
Lipase	0-160	N/A	N/A	N/A
Lactic Acid	0.5-1	N/A	N/A	N/A
Troponin	0-0.04	0.02	N/A	N/A
CK-MB	5-25	N/A	N/A	N/A
Total CK	22-198	N/A	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	N/A	N/A	N/A
PT	11-12.5	N/A	N/A	N/A
PTT	30-40	N/A	N/A	N/A
D-Dimer	<0.4	N/A	N/A	N/A
BNP	<100	N/A	N/A	N/A
HDL	>60	N/A	N/A	N/A
LDL	<130	N/A	N/A	N/A
Cholesterol	<200	N/A	N/A	N/A
Triglycerides	<150	N/A	N/A	N/A
Hgb A1c	4-5.9%	N/A	N/A	N/A
TSH	0.4-4.0	N/A	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	Yellow and Clear	Yellow and cloudy	N/A	Cloudy urine due to patient's diagnoses of urinary tract infection (Hinkle & Cheever, 2018).
pH	5.0-8.0	7.0	N/A	N/A
Specific Gravity	1.005-1.025	1.011	N/A	N/A
Glucose	Negative	Normal	N/A	N/A
Protein	Negative	Negative	N/A	N/A
Ketones	Negative	Negative	N/A	N/A
WBC	<5	8	N/A	Increased white blood cells indication of infection, related to

				patient's diagnosed urinary tract infection (Hinkle & Cheever, 2018).
RBC	0-3	15	N/A	Increased red blood cells related to patient's diagnosis of urinary tract infection (Hinkle & Cheever, 2018).
Leukoesterase	Negative	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	7.45	N/A	N/A
PaO2	>80	153	N/A	N/A
PaCO2	35-45	40.7	N/A	N/A
HCO3	22-26	28.2	N/A	N/A
SaO2	93%-100%	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	E.coli	N/A	Bacteria related to urinary tract infection (Hinkle & Cheever, 2018).
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Chiravuri S. & De Jesus O. Pancytopenia. (2022). StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK563146/

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

Jones & Bartlett Learning. (2018). *2018 Nurse's drug handbook* (17th ed.). Jones & Bartlett Learning.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X-ray

CT without contrast of brain/head

Diagnostic Test Correlation (5 points):

Patient underwent a chest x-ray due to altered mental status. Chest radiography, commonly called chest x-ray, is one of the most frequently performed diagnostic imaging studies. This study yields information about the pulmonary, cardiac, and skeletal systems. The lungs are easily penetrated by x-rays and appear black on chest images. A routine chest x-ray includes a posteroanterior projection, in which x-rays pass from the posterior to the anterior, and a left lateral projection. (Van & Bladh, 2017). Results indicated a normal heart size, clear lungs, no visualized pneumothorax or pleural effusion and osseus structures intact.

Patient underwent a CT without contrast of brain/head due to altered mental status. Non-contrast CT is used to evaluate neurosurgical emergencies with high sensitivity, including intracranial hemorrhage, territorial infarct, brain herniation and evaluating osseous structures (Murphy, 2022). Results indicated no intracranial hemorrhage, mild parenchymal volume loss but no acute intracranial abnormality. CT indicated stable appearance when compared to prior scans.

Diagnostic Test Reference (1) (APA):

Murphy, A. (2022). *CT head (protocol): Radiology reference article*. Radiopaedia Blog. https://radiopaedia.org/articles/ct-head-protocol

Van, A. M., & Bladh, M. L. (2017). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implications.* F.A. Davis Company.

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

Home Medications (5 required)

Brand/Generic	Furosemide (Lasix)	Propranolol hydrochloride (Propranolol)	Spironolactone (Aldactone)	Gemfibrozil (Lopid)	Magnesium Oxide (Mag-200)
Dose	20mg	10mg	50mg	600mg	400mg
Frequency	Daily	BID	Daily	BID	Daily
Route	PO	PO	PO	PO	PO
Classification	Therapeutic: Antihypertensive Pharm: Loop diuretic	Therapeutic: antihypertensive, antiarrhythmic Pharm: Beta-adrenergic blocker	Therapeutic: Antihypertensive Pharm: Aldosterone antagonist	Therapeutic: Antihyperlipidemic Pharm: Fibric acid derivative	Therapeutic: Antiacid, electrolyte replacement, laxative Pharm: Antiarrhythmic, anticonvulsant
Mechanism of Action	Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation	Prevents arterial dilation and inhibits renin secretion, resulting in decreased blood pressure	Competes with aldosterone for receptors, thereby preventing sodium and water reabsorption and causing excretion	May decrease hepatic triglyceride production by decreasing hepatic extraction of free fatty acids, inhibiting peripheral	Assists all enzymes involved in phosphate transfer reactions that use adenosine triphosphate.

			through the distal convoluted tubules, therefore reducing blood volume and blood pressure	lipolysis and reducing VLDL synthesis	
Reason Client Taking	To manage mild to moderate hypertension	To manage hypertension	To treat hypertension or edema caused by hepatic cirrhosis	To treat hyperlipidemia	To prevent magnesium deficiency caused by alcoholism
Contraindications (2)	-anuria unresponsive to furosemide - hypersensitivity	-sinus bradycardia -asthma	-acute renal insufficiency - hyperkalemia	-Gallbladder disease -Hepatic or severe renal dysfunction	-renal impairment -heart disease
Side Effects/Adverse Reactions (2)	-dizziness - hyperglycemia	-Muscle weakness -Fatigue	- thrombocytopenia - fatigue	-Pruritus - Thrombocytopenia	-hypotension -respiratory depression
Nursing Considerations (2)	- use cautiously in patients with advanced hepatic cirrhosis -Obtain patient's weight before and during therapy	-use cautiously in patients with bronchospastic lung disease, may induce asthmatic attack -Administer IV no more than 1mg/ min	-Pharmacist may crush spironolactone, mix with flavored syrup or dispense as a suspension -Stop drug several days before adrenal vein catheterization	-Expect to switch to a different medication if serum cholesterol and triglycerides do not improve within 3 months -Warfarin dosages may need to be decreased to prevent adverse bleeding	-avoid giving other oral drugs within 2 hours of magnesium containing antacid -monitor for signs of hypermagnesemia

				effects in patient's taking both medications	
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	-Monitor electrolyte (especially potassium) -Monitor hepatic and renal function (BUN and creatinine)	-Monitor blood pressure, apical and radial pulses -monitor daily weight and intake and output	-assess blood pressure -assess serum potassium level after each dose adjustment, then monthly, quarterly then every six months	-monitor serum triglyceride and cholesterol levels -monitor CBC and liver enzymes periodically	-Monitor electrolyte levels -assess cardiac status
Client Teaching Needs (2)	-Take at the same time daily -Change position slowly to minimize effects of orthostatic hypotension	-take at the same time daily -notify provider immediately if shortness of breath occurs	-Take with meals or milk -May experience dizziness if fluid balance is altered	-Take 30 minutes before meals -Important to avoid alcohol	-Chew chewable tablets thoroughly before swallowing and drink with full glass of water -Do not take other drugs within 2 hours of consumption

Hospital Medications (5 required)

Brand/Generic	**Ceftriaxone sodium (Rocephin)**	**Lactulose (Cholac)**	**Pantoprazole (Protonix)**	**Lorazepam (Ativan)**	**Nicotine transdermal system (Habitrol)**
Dose	2g	20mg	40mg	1mg	21 mg
Frequency	Daily	QID	BID	PRN	Daily
Route	IV Piggyback	PO	PO	PO	Transderma l

Classification	Therapeutic: 3rd generation cephalosporin Pharm: Antibiotic	Therapeutic: Laxative, Osmotic Pharm: Ammonia Detoxicant	Therapeutic: substituted benzimidazole Pharm: antiulcer, gastric acid proton pump inhibitor	Therapeutic: Antianxiety, anticonvulsant, sedative Pharm: Benzodiazepine	Therapeutic: Smoking cessation adjunct Pharm: Pyridine alkaloid
Mechanism of Action	Interferes with bacterial cell wall synthesis by inhibiting cross linking of peptidoglycan strands. Without peptidoglycan, bacterial cells rupture and die	Breaks down in the colon into lactic acid and small amounts of acetic and formic acids, acidifying fecal contents. Prevents ammonia diffusion from intestine into blood. The trapped ammonia is expelled in feces with other nitrogenous wastes	Interferes with gastric acid secretion by inhibiting the final step in gastric acid production	May potentiate the effects of GABA and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in areas of CNS. Inhibits excitatory stimulation, which helps control emotional behavior	Binds selectively to nicotinic cholinergic receptors at autonomic ganglia in the adrenal medulla at neuromuscular junctions in the brain
Reason Client Taking	To treat infection of the urinary tract	To prevent and treat hepatic encephalopathy	To treat heartburn or GERD symptoms	To treat symptoms related to alcohol withdrawal	To relieve nicotine withdrawal symptoms
Contraindications (2)	-Calcium containing IV solution -hypersensitivity to ceftriaxone	-hypersensitivity -low galactose diet	-hypersensitivity -H. pylori infection	-acute angle closure glaucoma -psychosis	-skin disorders -nonsmokers

Side Effects/Adverse Reactions (2)	-Edema -Elevated BUN	- hyperglycemia - hypokalemia	-chest pain - hyperglycemia	-Diaphoresis -Dizziness	-pruritus -dizziness
Nursing Considerations (2)	-Use cautiously in patients who have a hypersensitivity to penicillin - Monitor for gallbladder disease, drug may cause calcium salt to deposit in gallbladder	-Plan to replace fluids lost to bowel movements -When administering via retention enema repeat dose if not retained for at least 30 minutes	-administer 30 minutes before a meal -monitor PT/ INR during therapy	-increased risk of physical and psychological dependence in patients with history of alcohol abuse -Administer no more than 2mg/min	-should not be used in patients with history of diabetes, peptic ulcer or seizures -remove patch before MRI
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Obtain culture and sensitivity -Monitor BUN and serum creatinine	-monitor serum electrolyte levels -monitor blood ammonia level	-PT/ INR -intake and output	-monitor respiratory status (may cause respiratory depression) - make sure patient with history fo depression already takes an antidepression (increased risk of suicide in patients with untreated depression)	-Assess for asthma or COPD -Assess for rash or irregular heartbeat, or indications of nicotine overdose
Client Teaching Needs (2)	-Report watery, bloody stools to provider immediately	-Take with food or dilute with juice -Do not take other	- do not crush or chew -expect relief within 2 weeks	-Avoid alcohol while taking -take exactly as prescribed and do not	-prolonged use can cause dependence -follow package

	-Report hypersensitivity reactions	laxatives while taking lactulose		stop without consulting primary care provider	instructions for best results

Medications Reference (1) (APA):

Davis's Drug Guide Online + App | DrugGuide.com. (2022). Davis Drug Guide. https://www.drugguide.com/ddo/view/Davis-Drug-Guide

Jones & Bartlett Learning. (2018). *2018 Nurse's drug handbook* (17th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A&O x 4 No signs of acute distress No impaired cognition noted Overall appearance appropriate
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin color is yellow tinged d/t jaundice Skin is warm Skin is dry and intact Elastic skin turgor No rashes Some small cuts/ scratches noted on arm, patient notes prior to admission No drains present Skin turgor is elastic Bruising noted by both ankles, patient notes prior to admission Braden score: 20
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Trach midline Nose is midline, shows no signs of polyps. Oral mucosa is pink and moist. Dentures x2 Patient states using reading glasses Eyes are equal, round, reactive and accommodate to light.

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, S2 noted Normal sinus rhythm Capillary refill < 3 seconds noted in both upper and lower extremities 3+ normal radial pulses bilaterally No JVD noted No edema noted
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breath sounds clear and equal anterior and posterior in RUL, LUL, LLL, RLL and RML Regular rate and pattern noted No wheezing or crackles noted No use of accessory muscles 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:**	General diet at home, PCP prescribed heart healthy diet moving forward Heart healthy diet currently Active bowel sounds in all quadrants Last bowel movement 10/17 (today) Abdomen soft and non-tender No distention noted No incisions noted No scars noted No drains noted No wounds noted
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient's urine is clear and yellow with no odor Patient has voided 450mL No pain upon urination The patient is not on dialysis Patient's genitals show no signs of irritation No catheter in place
MUSCULOSKELETAL:	No indication of pain or numbness

Neurovascular status: **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	No decrease in sensation Active ROM No ADL assistance No supportive devices used prior to admission No assistance with toileting, walking, dressing and transferring from bed to chair Fall score: 70 High fall risk due to generalized weakness and fall prior to admission Independent mobility upon discharge noted
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Moves all extremities Pupils equal, round, react and accommodate light Equal strength in all limbs A&O x 4 Speech is clear No sensory impairment No cognitive impairment
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 coping methods include family support, mostly from her husband Developmental level is appropriate for age Patient denies religious beliefs Patient living at home with husband

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1100	80	107/62	18	37.0 C	95%
1400	78	131/76	18	36.5 C	99%

Vital Sign Trends: Vital signs appear stable. Decreased blood pressure noted at 1100, increase blood pressure noted at 1400. Increase in blood pressure could be related to history of hypertension as well as patient movement throughout the room prior to vitals.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1100	Numeric (0-10)	No pain noted	0/10	No pain noted	No interventions needed
1500	Numeric (0-10)	No pain noted	0/10	No pain noted	No interventions needed

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:**	20g Right peripheral 10/14/22 IV patent, able to flush and aspirate No phlebitis or infiltration noted Dressing dry and intact Saline lock IV discontinued 10/17

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600 mL	450 mL

Nursing Care

Summary of Care (2 points)

Overview of care: Patient admitted 10/14/22 for increased confusion, weakness and lightheadedness. Diagnosed with hepatic encephalopathy and hypokalemia

Procedures/testing done: Patient had labs drawn, Chest X-ray, CT without contrast of brain/head

Complaints/Issues: Patient had no complaints upon admission, increased confusion noted by family

Vital signs (stable/unstable): Stable, except for decreased blood pressure in the first reading and increased blood pressure in the second reading. Patient's blood pressure indicating hypertension.

Tolerating diet, activity, etc.: Tolerating diet and activities well

Physician notifications: Contact provider if confusion reoccurs. Contact if 2-3 formed stools do not occur while taking lactulose

Future plans for client: Follow up with primary care provider one week following discharge

Discharge Planning (2 points)

Discharge location: At home with husband

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Meet with primary care provider one week following discharge

Education needs: Importance of medication compliance and following a heart healthy diet at home

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	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

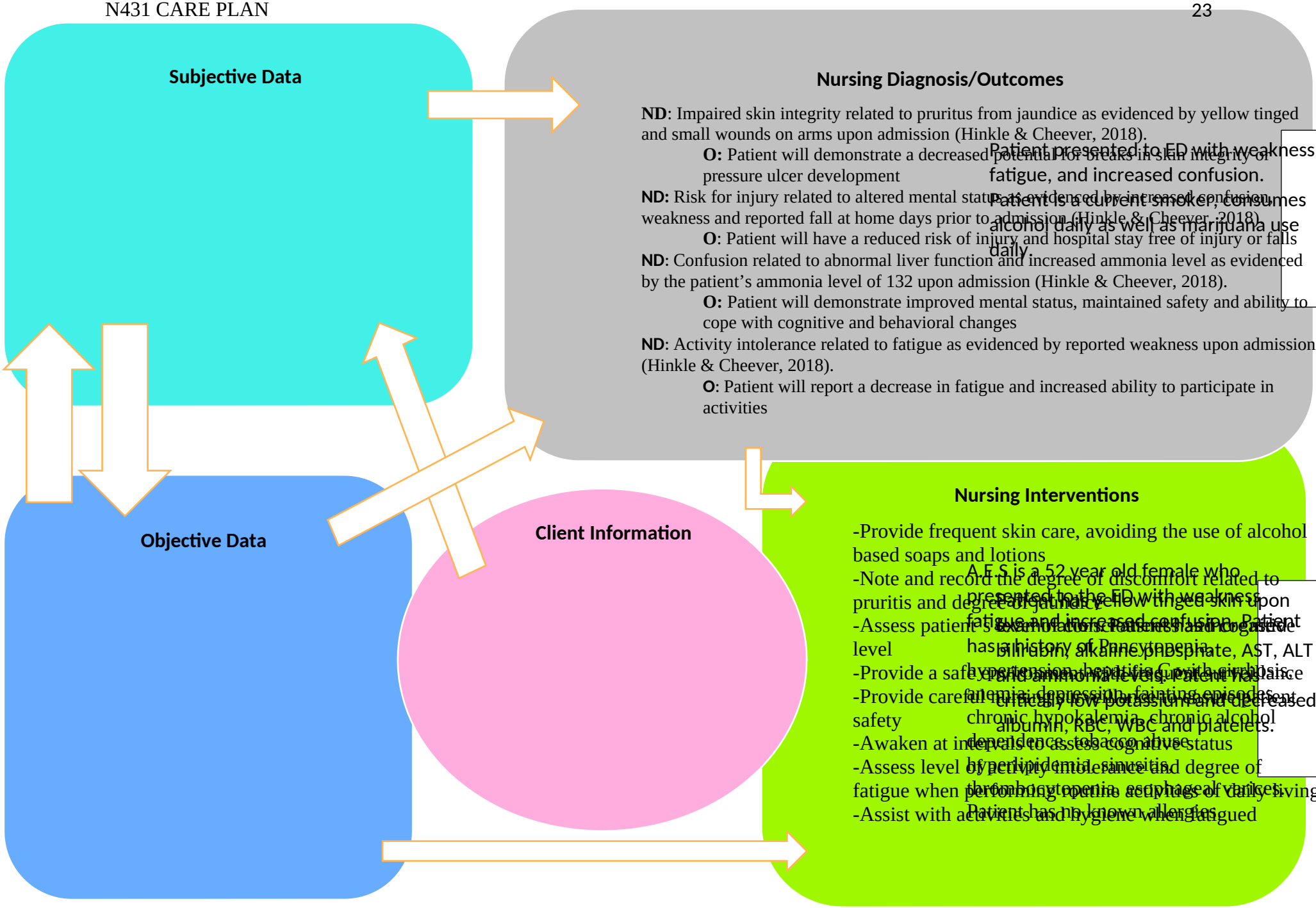
evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client				and outcomes, modifications to plan.
1. Impaired skin integrity related to pruritus from jaundice as evidenced by yellow tinged and small wounds on arms upon admission (Hinkle & Cheever, 2018).	This nursing diagnoses was chosen as the patient presented with yellow tinged skin related to jaundice and small wounds/ scratches noted on her arms during assessment	1.Provide frequent skin care, avoiding the use of alcohol-based soaps and lotions 2. Note and record the degree of discomfort related to pruritis and degree of jaundice	1. Patient will demonstrate a decreased potential for breaks in skin integrity or pressure ulcer development	Patient responded well to these nursing interventions. Patient demonstrated improvement in jaundice during hospital stay and decreased irritation surrounding scratches on her arms
2. Risk for injury related to altered mental status as evidenced by increased confusion, weakness and reported fall at home days prior to admission (Hinkle & Cheever,	This nursing diagnosis was chosen because the patient reported falling at home days prior to the increased confusion and generalized weakness that resulted in her admission	1. Assess patient's level of consciousness and cognitive level 2.Provide a safe environment with frequent surveillance	1. Patient will have a reduced risk of injury and hospital stay free of injury or falls	Patient responded well to the nursing interventions. Patient was free of falls ad injuries during admission

2018).				
3. Confusion related to abnormal liver function and increased ammonia level as evidenced by the patient's ammonia level of 132 upon admission (Hinkle & Cheever, 2018).	This nursing diagnoses was chosen because the patient was admitted due to weakness and confusion reported by her family	1. Provide careful nursing surveillance to ensure patient safety 2 Awaken at intervals to assess cognitive status	1. Patient will demonstrate improved mental status, maintained safety and ability to cope with cognitive and behavioral changes	Patient responded well to these nursing interventions. Patient demonstrated improved mental status
4. Activity intolerance related to fatigue as evidenced by reported weakness upon admission (Hinkle & Cheever, 2018).	This nursing diagnosis was chosen because the patient stated she was experiencing weakness and had a fall at home a few days prior to admission	1. Assess level of activity intolerance and degree of fatigue when performing routine activities of daily living 2. Assist with activities and hygiene when fatigued	1. Patient will report a decrease in fatigue and increased ability to participate in activities	Patient responded well to these nursing interventions. Patient calls appropriately when she needs to use the bathroom or would like to walk around

Other References (APA):

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

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
ND: Impaired skin integrity related to pruritus from jaundice as evidenced by yellow tinged and small wounds on arms upon admission (Hinkle & Cheever, 2018).
O: Patient will demonstrate a decreased potential for breaks in skin integrity or pressure ulcer development
ND: Risk for injury related to altered mental status as evidenced by increased confusion, weakness and reported fall at home days prior to admission (Hinkle & Cheever, 2018).
O: Patient will have a reduced risk of injury and hospital stay free of injury or falls
ND: Confusion related to abnormal liver function and increased ammonia level as evidenced by the patient's ammonia level of 132 upon admission (Hinkle & Cheever, 2018).
O: Patient will demonstrate improved mental status, maintained safety and ability to cope with cognitive and behavioral changes
ND: Activity intolerance related to fatigue as evidenced by reported weakness upon admission (Hinkle & Cheever, 2018).
O: Patient will report a decrease in fatigue and increased ability to participate in activities
Patient presented to ED with weakness, fatigue, and increased confusion.
Patient is a current smoker, consumes alcohol daily as well as marijuana use daily.
Objective Data
Client Information
Nursing Interventions
-Provide frequent skin care, avoiding the use of alcohol based soaps and lotions
-Note and record the degree of discomfort related to pruritis and degree of jaundice
-Assess patient's orientation status and cognitive level
-Provide a safe environment to maintain safety
-Provide careful monitoring of activities to maintain safety
-Awaken at intervals to assess cognitive status
-Assess level of activity intolerance and degree of fatigue when performing routine activities of daily living
-Assist with activities and hygiene when fatigued
A.F.S is a 52 year old female who presented to the ED with weakness, fatigue and increased confusion. Patient has a history of Pancytopenia, hypertension, hepatitis C with cirrhosis, anemia, depression, fainting episodes, chronic hypokalemia, chronic alcohol dependence, tobacco abuse, hyperlipidemia, sinusitis, thrombocytopenia, esophageal varices. Patient has no known allergies.
Patient's examination findings and cognitive status
Bilirubin, alkaline phosphate, AST, ALT and ammonia levels. Patient has critically low potassium and decreased albumin, RBC, WBC and platelets.